



*Medi-Cal Managed Care Division*

# *state of california*



## Medi-Cal Managed Care External Quality Review Organization

### 2007-2008 Annual Report of Performance for Community Health Group

*Submitted by*  
Delmarva Foundation  
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## 2007 - 2008 Annual Report: Community Health Group

### Introduction

The Medi-Cal Managed Care Division (MMCD) of the California Department of Health Care Services (DHCS) contracts with managed care plans to provide care to 3.4 million Medi-Cal beneficiaries enrolled in managed care plans in 23 counties throughout California. Healthcare providers within each plan's contracted network provide comprehensive healthcare services—primary and preventive care, as well as the full range of specialty care mandated by federal and state law.

Federal law pertaining to Medicaid managed care programs (42 CFR § 438.240) requires the DHCS to contract with an External Quality Review Organization (EQRO) to independently evaluate the quality of care provided to Medi-Cal beneficiaries enrolled in any of California's managed care plans. The DHCS retained the services of the Delmarva Foundation for Medical Care, Inc. (Delmarva) as its EQRO during the period covered by this report to provide this independent evaluation as to whether the care and service delivered meets the federal standards for quality, access, and timeliness. Among the services provided by the EQRO is an annual assessment of each contracted plan's "... quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract..." as stated in Title 42 of the U.S. Codes.

This annual review is for the reporting years 2007 and 2008, covering performance results and quality improvement activities during 2006 and 2007.

### Definitions

The terms quality, access, and timeliness provide the framework for this plan-specific review of Community Health Group ("CHG" or "the plan"). Consistency in meaning and use of these key terms are important for a thorough understanding of this report, so definitions are provided below:

- **Quality**, as it pertains to external quality review, is defined by the Centers for Medicare & Medicaid Service (CMS) as "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) 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." (CMS, 2008)

- **Access** (or accessibility) to health care, according to the Agency for Healthcare Research and Quality (AHRQ), means having "the timely use of personal health services to achieve the best health outcomes. Attaining good access to care requires three discrete steps: gaining entry into the health care system; getting access to sites of care where patients can receive needed services; and, finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust." (AHRQ, 2007)
- **Timeliness**, according to AHRQ, is defined as "...the health care system's capacity to provide health care quickly after a need is recognized....Measures of timeliness include waiting time spent in doctors' offices and emergency departments (EDs) and the interval between identifying a need for specific tests and treatments and actually receiving those services." (AHRQ, 2007)

It is important to note that some interdependence exists among the categories (also referred to as "domains") of quality, access, and timeliness. A measure or attribute identified in one of the categories of quality, access, or timeliness may also be noted under one or both of the other two categories throughout this review.

## Data Sources

Delmarva used five sets of standards or information sources for the evaluation of performance. Each of the sources listed were used to assess the contracted health plan's ability to provide its members with care that meets the requirements for quality, access, and timeliness:

- The Healthcare Effectiveness Data and Information Set (HEDIS®)<sup>1</sup> is a nationally recognized set of performance measures developed by the National Committee for Quality Assurance (NCQA). These measures are used by health care purchasers to assess the quality, access, and timeliness of care and service provided to members of managed care plans.
- In June 2007, each DHCS health plan submitted its results to Delmarva for the 12 required HEDIS measures, which reflect 16 measurement indicators, since several measures have multiple indicators.<sup>2</sup> The 2007 HEDIS results reflect data collected for the period January 1, 2006, through December 31, 2006.

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<sup>1</sup> HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA, 2008).

<sup>2</sup> In 2007 and 2008, the DHCS required plans to report on 12 HEDIS measures. Some of these measures have multiple indicators (such as the *Comprehensive Diabetes Care* measure), so results are presented for the total number of indicators – 16 in 2007 and 23 in 2008. This report refers to the total number of indicators reported as "measures" since a result is reported for each indicator.

- In June 2008, each DHCS health plan submitted its results for the 12 required HEDIS measures, which reflect a total of 23 indicators. The 2008 HEDIS results reflect data collected for the period January 1, 2007, through December 31, 2007.<sup>3</sup> For a more detailed explanation of HEDIS, see the “Quality Assessment” discussion later under “HEDIS Performance Measures” and Appendix A: HEDIS.
- AHRQ developed the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)<sup>4</sup> surveys to support the assessment of consumers’ experiences with health care. This report utilizes results from the 2007 4.0H Adult Medicaid and the 3.0H Child Medicaid surveys. Delmarva conducted these surveys between February and May 2007. For a more detailed explanation of CAHPS, see Appendix B: CAHPS.
- Summaries of plan-conducted Quality Improvement Projects conducted during the period January 1, 2006, and December 31, 2007.
- The DHCS’s Audits and Investigations Division and the California Department of Managed Health Care conduct routine medical surveys (audits) to assess compliance with contract requirements and state regulations. Findings from any audits conducted during the period January 1, 2006, and December 31, 2007, will be discussed in this report.
- Grievance and appeal data by contracted plans submitted to the DHCS and reports prepared by MMCD’s Office of the Ombudsman during 2006 and 2007.

## Report Organization

This report provides the plan’s background and discusses each data source within the framework of quality, access, and timeliness. Due to some variations between the measures reported in the 2007 and 2008 HEDIS reports, the results and analysis of this source are presented separately by year. Where appropriate, sustainability of the plan’s performance is discussed. The plan’s performance is compared to other plan models of similar type and other state and national benchmarks. The document concludes with the plan’s overall strengths and recommendations for improving the plan’s quality of care, access to care, and timeliness of care for its members.

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<sup>3</sup> The annual *Report of the Performance Measures for Medi-Cal Managed Care Plans* is produced for the DHCS by the EQRO and includes the measurement results and comparisons of all contracted plans.

<sup>4</sup> CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ, 2008).

## Background

Medi-Cal beneficiaries receive their health care through three models of health care delivery: County Organized Health Systems (COHS), Two-Plan, and Geographic Managed Care (GMC):

- COHS plans are county-operated managed care organizations. Enrollment is mandatory for almost all Medi-Cal beneficiaries within a county operating a COHS.
- The Two-Plan model consists of (1) Commercial Plans (CPs), which are commercially-operated managed care plans, and (2) Local Initiatives (LIs), which are community-developed managed care plans that operate as quasi-governmental agencies. In a Two-Plan model, members choose between an LI and a CP. Enrollment is mandatory for specified beneficiaries.
- In the GMC model, enrollees choose from several commercially-operated plans within a certain geographic area. Enrollment is mandatory for specified Medi-Cal beneficiaries.

Community Health Group is a full-service, not-for-profit health plan, contracted in San Diego County as a GMC plan (GMC-South). CHG has been licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act since August 1, 1985. As of December 2007, CHG's total Medi-Cal enrollment was 70,991 members.

## Quality of Care Assessment

According to the CMS (2008), “[q]uality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results.” The section that follows describes the measures used to assess CHG's healthcare delivery with regard to quality.

### HEDIS Performance Measures

Delmarva categorized the HEDIS performance measures used in this report into quality, access, and timeliness areas for assessment. For a more detailed explanation of HEDIS and the specific HEDIS measures used in this report, see Appendix A: HEDIS.

### Changes in HEDIS Performance Measures from 2007 to 2008

Health plans reported on 12 measures for the HEDIS 2007 reporting year, which included multiple indicators for *Comprehensive Diabetes Care* and *Prenatal and Postpartum Care*. The 2007 reporting year represents the data collection period January through December 2006. MMCD made some performance measure changes between 2007 and 2008 reporting years as explained below.

MMCD retired the *Chlamydia Screening in Women* performance measure from the required measurement set. The required HEDIS measures included several other measures focused on women's health screening (*Breast Cancer Screening* and *Cervical Cancer Screening*), and overall plan results for *Chlamydia Screening* had trended upward for a number of years. As a result, MMCD decided to eliminate the *Chlamydia Screening* measure and, instead, require the *Ambulatory Care* measure in order to focus more on the entire Medi-Cal managed care population, including seniors and persons with disabilities.

The *Ambulatory Care* measure provides utilization information across the whole spectrum of the population – from birth to 85+ years of age. Plus, this measure provides insight regarding emergency room (ER) use, which is an area of particular interest to MMCD because many members use the ER for avoidable visits and, as a result, may not be getting appropriate preventive care and follow-up care for chronic conditions. The *Ambulatory Care* measure consists of four indicators:

- *Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months)*
- *Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months)*
- *Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months)*
- *Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months)*

Additionally, in order to increase the focus on chronic diseases, MMCD added three more *Comprehensive Diabetes Care* indicators:

- *Comprehensive Diabetes Care—HbA1c Good Control (<7.0%)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- *Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)*

### **Comparisons of HEDIS Performance Measures**

This report contains several charts displaying HEDIS rates for CHG and state and national benchmarks used for assessing plan performance. The plan's multi-year performance is also evaluated.

In some years, MMCD makes changes to the required measures. Moreover, NCQA continually updates the technical specifications for HEDIS measures. Some of the specification changes or a combination of changes can cause a significant change in the results and make comparisons with previous years' rates inappropriate. MMCD does not hold the plan to the Minimum Performance Level (MPL) in the baseline year (the first year a score is reported) and does not compare results to previous years in years when a measure's specifications have changed substantively. For these reasons, rates for measures may be displayed in the charts, but not compared in the narratives.

### 2007 HEDIS Quality Performance Measures

Table 1 provides CHG’s 2007 HEDIS results for those measures specifically related to clinical quality of care along with the state’s 2007 Medi-Cal managed care weighted averages<sup>5</sup> and the 2006 national Medicaid averages for these measures.

**Table 1. 2007 HEDIS Quality Measure Results Comparing Community Health Group to State and National Programs.**

2007 Quality Measure	2007 Community Health Group Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*
Appropriate Treatment for Children With Upper Respiratory Infection	82.7%	78.9%	82.5%
Chlamydia Screening in Women	46.8%	52.8%	50.6%
Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis†‡	81.1%	71.0%	69.4%
Use of Appropriate Medications for People With Asthma	85.6%	86.8%	85.7%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	55.5%	54.1%	48.6%
Comprehensive Diabetes Care—HbA1c Testing	72.0%	79.5%	76.2%
Comprehensive Diabetes Care—LDL-C Screening‡	75.4%	75.9%	80.5%
Comprehensive Diabetes Care—Medical Attention for Nephropathy‡	76.2%	81.0%	48.8%
Cervical Cancer Screening‡	66.0%	67.9%	65.0%

\* Rates obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Plans*.  
† For this 2007 measure, a lower rate indicates better performance.  
‡ Due to significant changes in technical specifications, MPLs and HPLs had not yet been established for 2007. The rate is displayed for informational purposes only and will not be compared to benchmarks.

For the five comparable 2007 HEDIS measures categorized in the quality domain, CHG had mixed results when compared to the 2007 Medi-Cal managed care averages and the 2006 national Medicaid averages:

- CHG scored better than the 2007 Medi-Cal managed care weighted average and 2006 national Medicaid average for two HEDIS measures:
  - *Appropriate Treatment for Children With Upper Respiratory Infection*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

<sup>5</sup> For each measure, a Medi-Cal managed care weighted average has been calculated to provide a comparative statistic. A weighted average, unlike a simple average, accounts for variations in membership across plans.



➤ CHG scored lower than both benchmarks for three HEDIS measures:

- *Chlamydia Screening in Women*
- *Use of Appropriate Medications for People With Asthma*
- *Comprehensive Diabetes Care—HbA1c Testing*

### 2008 HEDIS Quality Performance Measures

Table 2 provides CHG’s 2008 HEDIS results for those measures specifically related to clinical quality of care along with the state’s 2008 Medi-Cal managed care weighted averages and the 2007 national Medicaid averages for these measures.

Table 2. 2008 HEDIS Quality Measure Results Comparing Community Health Group to State and National Programs.

2008 Quality Measure	2008 Community Health Group Rate*	2008 Medi-Cal Managed Care Weighted Average*	2007 HEDIS National Medicaid Average*
Appropriate Treatment for Children With Upper Respiratory Infection	84.0%	83.1%	83.3%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis <sup>††</sup>	24.2%	28.4%	†
Use of Appropriate Medications for People With Asthma	86.8%	88.8%	87.1%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	46.0%	58.1%	51.4%
Comprehensive Diabetes Care—HbA1c Testing	77.6%	82.1%	78.0%
Comprehensive Diabetes Care—HbA1c Good Control (<7.0%) <sup>‡</sup>	27.7%	32.6%	¶
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%) <sup>‡§</sup>	49.1%	42.6%	48.7%
Comprehensive Diabetes Care—LDL-C Screening	74.0%	77.8%	71.1%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL) <sup>‡</sup>	34.3%	34.2%	30.6%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.2%	78.3%	74.6%
Cervical Cancer Screening	66.4%	68.7%	65.7%

\* Rates obtained from the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Plans*.  
 † The 2007 measure was called *Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis*, and a lower score was better. The 2008 measure is called *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*, and a higher score is better.  
 ‡ 2008 is the first year MMCD required reporting of this measure. Because MPLs and HPLs had not yet been established, the rate is displayed for informational purposes only and will not be compared to benchmarks.  
 § A lower rate for this measure is better as it represents better diabetes control.  
 ¶ NCQA first-year measure in 2008; national benchmark not available in 2007.

For the seven comparable 2008 HEDIS measures categorized in the quality domain, CHG had mixed results when compared to the 2008 Medi-Cal managed care averages and the 2007 national Medicaid averages:

- CHG's rates were higher than both benchmark performance rates for the HEDIS measure, *Appropriate Treatment for Children With Upper Respiratory Infection*.
- CHG scored lower than the Medi-Cal managed care weighted average, but scored higher than the national average on three HEDIS measures:
  - *Comprehensive Diabetes Care—LDL-C Screening*
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
  - *Cervical Cancer Screening*
- CHG scored lower than both benchmarks on three HEDIS measures:
  - *Use of Appropriate Medications for People With Asthma*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  - *Comprehensive Diabetes Care—HbA1c Testing*
- MMCD retired the *Chlamydia Screening in Women* performance measure from the required measurement set for 2008.

### CAHPS Survey Results Pertaining to Quality

During this reporting period, the 2007 CAHPS 4.0H Adult Medicaid and 3.0H Child Medicaid surveys were conducted among members of Medi-Cal managed care's contracted health plans. The table reflects survey results for three populations: Adult, Child, and Children with Special Health Care Needs (CSHCN). (See Appendix B: CAHPS for further detail.)

Delmarva chose two CAHPS composite areas to most appropriately represent the quality domain in this report: *Getting Needed Care* and *How Well Doctors Communicate*. Table 3 shows the plan's CAHPS scores for these composite categories.<sup>6</sup>

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<sup>6</sup> See Appendix B: CAHPS for further detail about categories and DHCS's *Results of the 2007 CAHPS for Medi-Cal Managed Care Health Plans* for more detail about calculation methods.

Table 3. 2007 CAHPS Quality Survey Results Comparing Community Health Group and the Medi-Cal Managed Care Program.

2007 CAHPS Composite	Population	2007 Community Health Group Result	2007 Medi-Cal Managed Care Weighted Average*
Getting Needed Care	Adult	37%	40%
	Child	81%	80%
	CSHCN†	74%	‡
How Well Doctors Communicate	Adult	57%	59%
	Child	58%	52%
	CSHCN†	61%	‡
* Medi-Cal average was calculated from scores of all contracted health plans and weighted to be proportionate to plan enrollment. † CSHCN - Child with Special Health Care Needs. ‡ MCMC overall averages were not calculated for CSHCN members because they are subsets of the same sampling and data cannot be used due to possibility of double counting. Refer to Appendix B: CAHPS for further detail.			

CHG’s composite score for *Getting Needed Care* indicates a possible area for improvement with just 37 percent of adult members responding that they always got the care they needed. It should be noted, however, that CHG’s score was only three percentage points lower than the 2007 Medi-Cal managed care weighted average in this category. In the composite *How Well Doctors Communicate*, 57 percent of CHG’s adult members indicated their doctor always communicated well—two percentage points lower than the Medi-Cal managed care weighted average in that composite.

CHG’s parents/guardians of child members appeared more pleased in these two areas than the plan’s adult members. For the composite *Getting Needed Care*, 81 percent of responding parents/guardians indicated their children always received the care they needed—one percentage point higher than the Medi-Cal managed care weighted average. For the composite *How Well Doctors Communicate*, 58 percent of parents/guardians indicated their doctor or health care provider always communicated well—6 percentage points higher than the state average.

### Quality Improvement Projects

One of CHG’s Quality Improvement Projects (QIPs)—*Decreasing Hospitalizations and Emergency Department Visits Among Medi-Cal Asthmatics*—is categorized in the quality domain for assessment purposes. The QIP and its results are discussed below:

## Decreasing Hospitalizations and Emergency Department Visits Among Medi-Cal Asthmatics

### ➤ **Relevance:**

CHG reported asthma and related respiratory diseases were consistently among the top five inpatient conditions identified in its Medi-Cal managed care membership. Five percent of the total members were identified as asthmatic. Asthma was also noted to be among the top five diagnoses for emergency department visits.

### ➤ **Goals:**

- Achieve a ten percent reduction in the number of asthmatics who have an admission due to asthma by 2006.
- Achieve a ten percent reduction in the number of asthmatics who have an emergency department visit by 2006.

### ➤ **Best Interventions:**

- Amended prior authorization criteria, so controller medications can be ordered without authorization.
- Referral of high-risk asthmatics to the Preventive Services Department for health education.
- Implemented case management outreach calls to follow-up on high-risk members.

### ➤ **Outcomes:**

- The rate of hospitalizations (asthma related) per 1,000 asthmatic members:
  - ◊ 4/1999-3/2000 (Baseline): 52.30
  - ◊ 4/2000-3/2001 (Remeasurement 1): 44.67
  - ◊ 4/2001-3/2002 (Remeasurement 2): 40.78
  - ◊ 1/2002-12/2002 (Remeasurement 3): 44.32
  - ◊ 1/2003-12/2003 (Remeasurement 4): 45.13
  - ◊ 1/2004-12/2004 (Remeasurement 5): 45.08
  - ◊ 1/2005-12/2005 (Remeasurement 6): 49.27
  - ◊ 1/2006-12/2006 (Remeasurement 7): 40.61
- The rate of emergency department visits (asthma related) per 1,000 asthmatic members:
  - ◊ 4/1999-3/2000 (Baseline): 233.7
  - ◊ 4/2000-3/2001 (Remeasurement 1): 201.2
  - ◊ 4/2001-3/2002 (Remeasurement 2): 181.2
  - ◊ 1/2002-12/2002 (Remeasurement 3): 160.0
  - ◊ 1/2003-12/2003 (Remeasurement 4): 156.1
  - ◊ 1/2004-12/2004 (Remeasurement 5): 212.2
  - ◊ 1/2005-12/2005 (Remeasurement 6): 227.9
  - ◊ 1/2006-12/2006 (Remeasurement 7): 270.5

➤ ***Attributes/Barriers to Outcomes:***

- Barrier: Members lacked the ability to access needed supplies.
- Barrier: Patient non-compliance with prescribed medication regimens.
- Barrier: Lack of practitioner follow-up on hospitalized members.

The *Decreasing Hospitalizations and Emergency Department Visits Among Medi-Cal Asthmatics* QIP results were mixed. The rate of hospitalizations (asthma related) per 1,000 asthmatic members decreased while the emergency department visits showed an increase. While improvement is still needed for the second indicator, the plan was asked to close out the project since the plan began participating in the statewide collaborative *Avoidable Emergency Room Visits*. Asthma is one of the diagnoses included in the collaborative.

### **Medi-Cal Audit Findings**

Plans are required to submit to the medical performance audits every three years. Usually within 60 days of the audit, an Exit Conference Report is issued by the auditors and presented to the plan. The Exit Conference Report lists deficiencies that require corrective action and provide recommendations to the plan for correcting the deficiencies. The plan then has 45 days to submit a Corrective Action Plan (CAP) to the Auditors, which provides proof of correction of the deficiencies, challenges the deficiencies, or provides the Auditors with a plan to correct the deficiencies. Within 60 days of receipt of the CAP, auditors and the DHCS nurse evaluators review the CAP and issue a public report assessing the plan's compliance with the original findings. The plan is given an additional 120 days to address uncorrected deficiencies. Within 180 days from the date of issuance of the public report, the DHCS issues a final closeout letter to the plan that assesses compliance with the original findings.

In June 2007, the Department of Health Care Services (DHCS) conducted a medical performance audit of CHG jointly with the Department of Managed Health Care (DMHC) that covered the audit period of June 1, 2006, through May 31, 2007. The DHCS and the DMHC auditors assessed CHG specifically in the areas of Utilization Management, Continuity of Care, Availability and Accessibility, Member's Rights, Quality Management, and Administrative and Organizational Capacity. The audit consisted of document review, verification studies, and interviews conducted at plan headquarters.

Auditors provided the plan with a copy of the draft report of preliminary findings prior to the Exit Conference held with CHG administrators in August 2007. Auditors found CHG to have deficiencies in several categories.

- In the *Continuity of Care* category, auditors identified deficiencies in the following components:
  - *Coordination of Care: Outside the Network/Special Arrangements.* CHG had no way to track members referred to the San Diego Regional Center prior to membership in CHG, but was working on a collaborative effort with the center to acquire a reporting system. The auditors recommended that the plan continue to work with San Diego Regional Center to obtain identity of members in the center's program to ensure they are provided necessary medical and preventive care and treatments through their primary care provider.
  - *Initial Health Assessment.* Auditors found that improvements were needed—specifically regarding Initial Health Assessment (IHA) and Initial Health Education Behavioral Assessment (IHEBA) completion rates. Auditors recommended that CHG conduct periodic facility site reviews. Additionally, through quality improvement activities, CHG should intervene when appropriate to ensure providers are documenting IHA/IHEBA attempts and completing IHEBAs within the designated timeframe. This is a repeat finding from the 2001 audit.
  
- In the *Member's Rights* category, auditors identified deficiencies in the *Grievance System* component. Auditors recommended that every issue involved in a grievance must be addressed by the grievance evaluation and resolution process.
  
- In the *Quality Management* category, auditors identified deficiencies in the following components:
  - *Qualified Providers.* Auditors made three recommendations to CHG:
    - ◊ Address repeat noncompliance (from previous audits) by re-evaluating problem-solving activities and developing additional corrective actions in the quality improvement work plan.
    - ◊ Develop a process for monitoring and improving provider access to assure members have timely access to both specialty and primary care.
    - ◊ Decrease potential risk to members by following written policy to document follow-up with involved providers when potential quality issues are identified.
  - *Credentialing.* For consistency with CHG's process and to ensure all providers are appropriately qualified, auditors recommended that the plan submit a modified policy to state that all providers are monitored continuously for quality activities—not just the primary care physician/practitioner and high volume behavioral healthcare providers.

CHG was allowed 45 calendar days from the date of the Exit Conference to submit additional information and a CAP. The plan submitted a CAP in September 2007. Although some portions of the problems were corrected within the 45-day corrective period (after the CAP was submitted), an additional 120 days was allotted to correct the remaining deficiencies. The expiration of the additional corrective period extended into the next reporting period (CY 2008); therefore, Delmarva was unable to include in this report the findings in the auditors' closeout report.

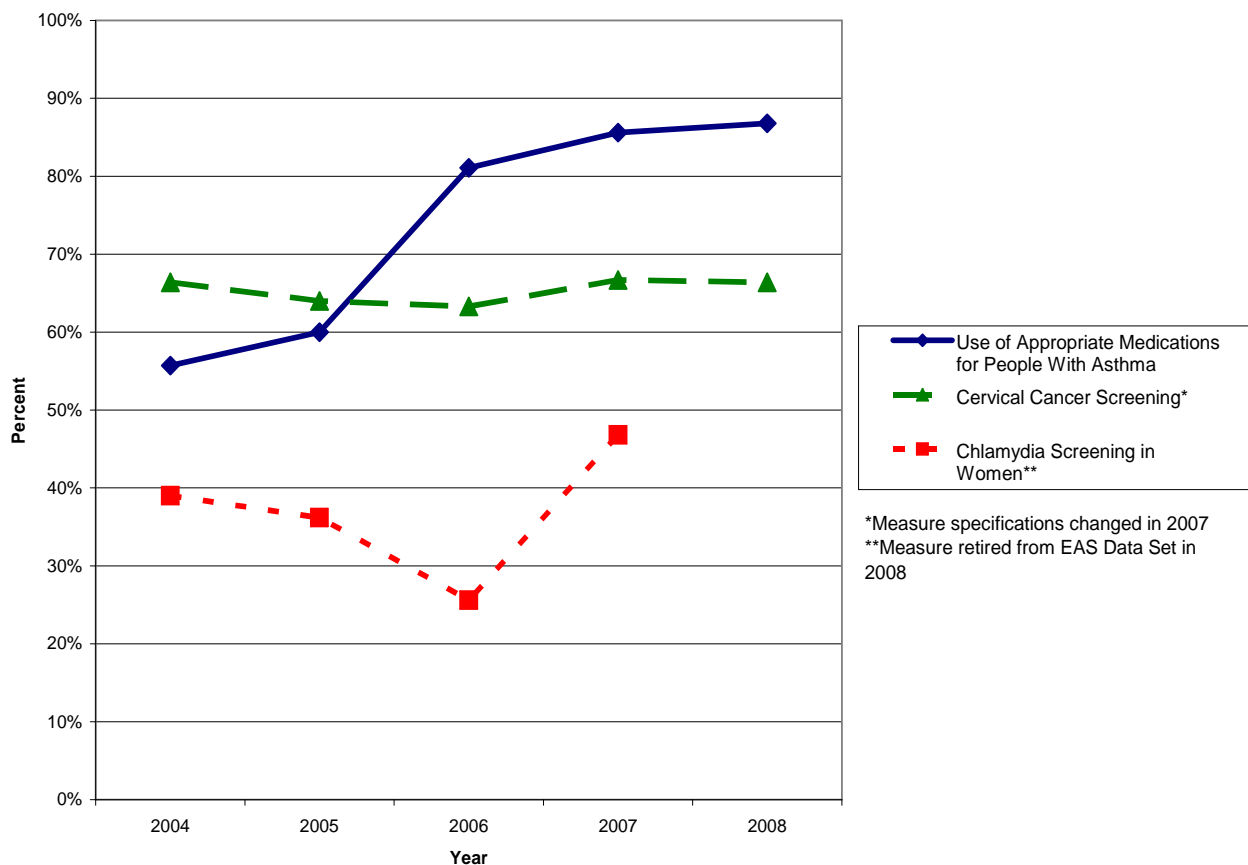
### Sustainability of Quality Indicators

Sustainability of quality improvement correlates with a health plan’s ability to bring about positive change in health care processes. Performance measurement results can be trended when three or more years of data are available. The trend graph in Figure 1 (below) charts sustainability of improved performance of quality measures.

For the purpose of this report, a plan’s ability to achieve sustainability is generally categorized as follows:

- Sustained improvement – performance level improves at some point and then levels off or continues to improve.
- Maintaining performance level – rates over multiple years reflect no meaningful change (generally a flat line).
- Declining – performance goes down.

**Figure 1. Community Health Group’s Sustainability of Quality of Care Indicators.**



HEDIS technical specification changes in 2006 for the *Use of Appropriate Medications for People With Asthma* measure resulted in more accurate identification of true asthmatics in the denominator. Likewise, in 2007, the *Cervical Cancer Screening* measure had specification changes; however, both measures remained trendable over the four-year measurement period.

CHG demonstrated sustained improvement for *Use of Appropriate Medications for People With Asthma*. Over the four-year measurement period, the plan's rates increased over 30 percentage points. Over the same measurement period, CHG's rates for the *Cervical Cancer Screening* measure fluctuated within four percentage points. Since the 2004 and 2008 rates were the same, the plan was unable to demonstrate improvement for the *Cervical Cancer Screening* measure. The plan's rates for the *Chlamydia Screening in Women* measure had a sharp decline in 2006 and then showed significant improvement in 2007. MMCD retired the *Chlamydia Screening in Women* measure in 2008.

### **Grievance and Ombudsman Reports**

The Medi-Cal Managed Care Division (MMCD) currently requires contracted health plans to maintain grievance systems in accordance with the California Code of Regulations, Title 28, Section 1300.68. All grievances received by a plan—in writing or verbally—must be tracked in a grievance log. Plans submit quarterly reports to MMCD, as well as to the Department of Managed Health Care (DMHC), with detailed information about pending grievances and those that were not resolved within 30 days (MMCD All Plan Letter No. 03-008).

MMCD's Office of the Ombudsman also provides assistance to members who have questions or problems related to provider and plan services, as well as other areas, such as Medi-Cal eligibility. The Office of the Ombudsman functions, in part, to help solve problems from a neutral standpoint to ensure that members receive all medically necessary covered services for which plans are contractually responsible. Complaints or issues that are not resolved immediately by the Office of the Ombudsman are entered into the Ombudsman Case Management System (OCMS) for tracking and follow-up. The Office of the Ombudsman also assists members who wish to request a formal hearing with the State Fair Hearings Board.

It should be noted that the DHCS monitors plans' quarterly grievance reports and MMCD Office of the Ombudsman monthly statistics in order to understand what aspects of provider and plan performance generate many or few grievances, calls, or requests for State Fair Hearings over time. Unusual patterns in grievances, calls, or hearing requests are discussed with plans when appropriate. The DHCS does not generally perceive any particular number of grievances, calls, or hearing requests as indicators of poor plan performance. Rather, these statistics are an ongoing indication of the degree to which plan members are using the various avenues available to them to ask questions or raise concerns about healthcare quality and plan service.



### ***Community Health Group's Grievance Reports***

CHG reported 72 grievances in quarterly reports during 2006 and 2007. The grievances were not categorized.

### ***Office of the Ombudsman's Reports<sup>7</sup>***

- 2006: 65 OCMS cases (2.1 percent of all cases; 0.948 cases per 1,000 members)
- 2006: 21 State Fair Hearings (2.2 percent of all cases; 0.306 cases per 1,000 members)
- 2007: 106 OCMS cases (2.3 percent of all cases; 1.368 cases per 1,000 members)
- 2007: 4 State Fair Hearings (0.8 percent of all cases; 0.052 cases per 1,000 members)

### **Summary of Quality**

Delmarva assessed CHG's quality of care in six ways: HEDIS performance measure rates, CAHPS survey results, QIPs, grievance and Ombudsman reports, audit findings and sustainability of improvement of quality indicators.

For 2007 HEDIS reporting year, CHG scored better than the 2007 Medi-Cal managed care weighted average and 2006 national Medicaid average in two of five comparable HEDIS measures in the quality domain:

*Appropriate Treatment for Children With Upper Respiratory Infection* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*. The plan scored lower than both benchmarks in the *Chlamydia Screening in Women*, *Use of Appropriate Medications for People With Asthma*, and *Comprehensive Diabetes Care—HbA1c Testing* measures.

For the 2008 HEDIS reporting year, CHG's rates were higher than both benchmark performance rates for one of seven measures: *Appropriate Treatment for Children With Upper Respiratory Infection*. CHG scored lower than both benchmarks on three measures: *Use of Appropriate Medications for People With Asthma*, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, and *Comprehensive Diabetes Care—HbA1c Testing*.

CHG's CAHPS scores for the composites *Getting Needed Care* and *How Well Doctors Communicate* exceeded the Medi-Cal managed care averages in the Child categories; however, the plan fell below the benchmark in the Adult categories.

CHG completed one QIP categorized in the quality area: *Decreasing Hospitalizations and Emergency Department Visits Among Medi-Cal Asthmatics*. Results were mixed, as the rate of asthma-related hospitalizations decreased while the emergency department visits increased. While improvement is still needed for the second indicator, the plan was asked to close out the project since the plan began participating in the statewide collaborative on *Avoidable Emergency Room Visits*.

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<sup>7</sup> OCMS cases and State Fair Hearings are presented as a percentage of all managed care plan cases and rates per 1,000 members.

The DHCS and the DMHC conducted a joint medical performance audit of CHG in June 2007. Auditors identified several quality of care-related deficiencies in the course of the audit. Under the category of *Continuity of Care*, deficiencies were found in the components *Coordination of Care: Outside the Network/Special Arrangements* and *Initial Health Assessment*. Deficiencies were also found under the categories of *Members' Rights* and *Quality Management: Qualified Providers*. The DHCS and the DMHC provided oversight for CHG's corrective action process; however, some deficiencies were not corrected within the initial 45-day corrective timeframe, and the final closeout report was not issued in time to include results in this report.

Finally, in the sustainability area, CHG demonstrated sustained improvement for *Use of Appropriate Medications for People With Asthma*. The plan's rates increased over 30 percentage points over the four-year measurement period. The plan did not demonstrate sustained improvement for the *Cervical Cancer Screening* and *Chlamydia Screening in Women* measures.

### Access to Care Assessment

One of MMCD's goals is to protect enrollee access to care. Access is an essential component of a quality-driven system of care. The findings with regard to the access domain for CHG are presented below.

#### 2007 HEDIS Performance Measures Pertaining to Access

Delmarva used two HEDIS measures *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Postpartum Care* as indicators for access to care in this report. Table 4 shows CHG's 2007 results for these access-related HEDIS measures.

Table 4. 2007 HEDIS Access Measure Results Comparing Community Health Group to State and National Averages.

2007 Access Measure	2007 Community Health Group Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*
Adolescent Well-Care Visits	36.5%	36.9%	40.6%
Prenatal and Postpartum Care—Postpartum Care	49.6%	58.7%	57.0%

\* Rates obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Plans*.

CHG reported a 2007 HEDIS score equal to the Medi-Cal managed care weighted average and lower than 2006 national Medicaid average for the *Adolescent Well-Care Visits* measure. CHG reported a score lower (by more than seven percentage points) than both benchmarks for the *Prenatal and Postpartum Care—Postpartum Care* measure.

## 2008 HEDIS Performance Measures Pertaining to Access

Table 5 shows CHG’s 2008 results for access-related HEDIS measures.

Table 5. 2008 HEDIS Access Measure Results Comparing Community Health Group to State and National Averages.

2008 Access Measure	2008 Community Health Group Rate*	2008 Medi-Cal Managed Care Weighted Average*	2007 HEDIS National Medicaid Average*
Adolescent Well-Care Visits	36.0%	39.6%	43.7%
Prenatal and Postpartum Care—Postpartum Care	51.3%	59.1%	59.1%

\* Rates obtained from the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Plans*.

CHG reported 2008 HEDIS scores lower than both the Medi-Cal managed care weighted average and the 2007 national Medicaid average for the *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Postpartum Care* measures.

## CAHPS Survey Results Pertaining to Access

Delmarva chose the CAHPS composite, *Getting Care Quickly*, to represent the access domain of this report. The results of this composite are presented in Table 6 and discussed below.

Table 6. 2007 CAHPS Access Survey Results Comparing Community Health Group and the Medi-Cal Managed Care Average.

2007 CAHPS Composite	Population	2007 Community Health Group Result	2007 Medi-Cal Managed Care Weighted Average*
Getting Care Quickly	Adult	34%	45%
	Child	42%	37%
	CSHCN†	38%	‡

\* Medi-Cal average was calculated from scores of all contracted health plans and weighted to be proportionate to plan enrollment.  
 † CSHCN - Child with Special Health Care Needs.  
 ‡ MCMC overall averages were not calculated for CSHCN members because they are subsets of the same sampling and data cannot be used due to possibility of double counting. Refer to Appendix B: CAHPS for further detail.

CHG’s composite score for *Getting Care Quickly* showed 34 percent of responding adult members indicated they always received care quickly—11 percentage points lower than the Medi-Cal managed care weighted average. In the Child category, 42 percent of parents/guardians of CHG’s child members indicated their children always received care quickly—5 percentage points higher than the state benchmark.

## Quality Improvement Projects

CHG engaged in three Quality Improvement Projects (QIPs) categorized in the access domain:

- *Increasing Follow-up for a Positive Postpartum Depression Screen*
- *Improving the Rate and Quality of Adolescent Health Well Visits*
- *Avoidable Emergency Room Visits*

The *Improving the Rate and Quality of Adolescent Health Well Visits* and *Avoidable Emergency Room Visits* QIPs are statewide collaborative projects. The QIPs and associated outcomes are discussed below.

### Increasing Follow-up for a Positive Postpartum Depression Screen

#### ➤ **Relevance:**

CHG reviewed its 2002 obstetrical medical records and found that only 35 percent of the records had any documentation of postpartum depression screening and there were no records documenting follow-up treatment. There was no documented use of the postpartum depression screening tool.

#### ➤ **Goals:**

- Achieve a rate of 45.89 percent for documenting of postpartum depression screening of members by Remeasurement 3.
- Achieve a rate of 47.51 percent for postpartum depression screening of members via use of the screening tool by Remeasurement 3.
- Achieve a rate of 94.28 percent of postpartum depression screening and documented follow-up care of members by Remeasurement 3.

#### ➤ **Best Interventions:**

- Presented postpartum depression guidelines to practitioners.
- Placed calls to mothers after delivery reminding them of the importance of postpartum visits.
- Offered postpartum appointment scheduling and transportation assistance to members.

#### ➤ **Outcomes:**

- Documentation of postpartum depression screening:
  - ◊ 2002 (Baseline): 23.16%
  - ◊ 2004 (Remeasurement 1): 34.39%
  - ◊ 2005 (Remeasurement 2): 41.72%
  - ◊ 2006 (Remeasurement 3): 54.54%
- Postpartum depression screening via use of screening tool:
  - ◊ 2002 (Baseline): 8.51%
  - ◊ 2004 (Remeasurement 1): 19.74%
  - ◊ 2005 (Remeasurement 2): 43.19%
  - ◊ 2006 (Remeasurement 3): 48.45%

- Documentation of follow-up for depression:
  - ◊ 2002 (Baseline): 63.63%
  - ◊ 2004 (Remeasurement 1): 85.72%
  - ◊ 2005 (Remeasurement 2): 88.57%
  - ◊ 2006 (Remeasurement 3): 100%

➤ ***Attributes/Barriers to Outcomes:***

- Barrier: Mothers take babies to well-child visits, but do not take the time to go to their own postpartum visits.
- Attribute: System-level interventions led to improved outcomes.

### Improving the Rate and Quality of Adolescent Health Well Visits

➤ ***Relevance:***

CHG recognized that adolescent well-care visits were under-utilized by their Medi-Cal managed care members. CHG reported having over 20,000 members 12 to 17 years of age.

➤ ***Goal:***

Achieve a rate of 54.3 percent for the HEDIS *Adolescent Well-Care Visits* measure by Remeasurement 2.

➤ ***Best Interventions:***

- Mailed incentive letter mailed to members promoting wellness exams.
- Initiated outreach to practitioners, offering incentive for completion and proper billing of adolescent well-care visits.

➤ ***Outcomes:***

- HEDIS *Adolescent Well-Care Visits*:
  - ◊ 2004 (Baseline): 29.68%
  - ◊ 2005 (Remeasurement 1): 24.57%
  - ◊ 2006 (Remeasurement 2): 36.50%

➤ ***Attributes/Barriers to Outcomes:***

- Barrier: Lack of member knowledge regarding well-care exams.
- Barrier: Members unaware of clinics providing well-care exam services.

### Avoidable Emergency Room Visits

➤ ***Relevance:***

In 2006, CHG had 28.7 emergency room (ER) visits per 1,000 member months. The plan's top three diagnoses for emergency room care which did not result in a hospitalization included: vomiting, fever, and earache; all three diagnoses are related to avoidable ER visits.

➤ ***Goals:***

- Decrease the rate of members seen in the ER to 25 visits per 1,000 member months by Remeasurement 1.
- Decrease avoidable ER visits to five percent by Remeasurement 1.

➤ **Best Interventions:**

Collaborative interventions were being developed during this reporting period.

➤ **Outcomes:**

- HEDIS rate of members seen in the ER:
  - ◊ 2006 (Baseline): 28.7 visits per 1,000 member months
- Rate of members seen in the ER with designated avoidable visits:
  - ◊ 2006 (Baseline): 6.87%

➤ **Attributes/Barriers to Outcomes:**

Attributes and barriers to outcomes were not available to Delmarva in time to be included in this report.

The *Increasing Follow-up for a Positive Postpartum Depression Screen* QIP showed significant improvement in all three postpartum indicators since baseline measurement. This project was closed out after Remeasurement 3 in 2006.

While results of the *Improving and Increasing Adolescent Well-Care Visits* QIP did not meet the project goal, they were promising as CHG saw a seven percentage point increase in the *Adolescent Well-Care Visit* measure from the baseline measurement. This project was closed during the third quarter of 2007.

CHG initiated work on the new *Avoidable Emergency Room Visits* statewide collaborative QIP, but no remeasurement information was available at the time this report was prepared.

### Medi-Cal Audit Findings

Delmarva reviewed the access of care aspects of the combined findings from the DHCS medical performance audit and the DMHC routine medical survey of CHG conducted in June 2007. Auditors found deficiencies in several categories:

- In the *Availability and Accessibility* category, auditors identified deficiencies in the following components:
  - *Access to Medical Care.*
    - ◊ CHG did not have a documented system to monitor waiting time for specialty care to ensure appointments are made within the plan's access standard of two weeks. The plan's modified *Office Management Survey* tool, which is used to measure member access at the time of the facility site review, does not include a process for monitoring access to specialist appointments. Auditors recommended CHG develop and implement a process for monitoring provider offices' compliance with the plan's access standard of scheduling appointments for specialty care within two weeks.
    - ◊ CHG needed to submit a documented process for monitoring member telephone calls to ensure Member Service Representatives were not providing incorrect referral or medical advice.
    - ◊ Auditors recommended that a policy change be made to the provider manual by adding minor consent services for drug or alcohol abuse by children 12 years of age or older.

- *Access to Emergency Services.* Auditors provided the following recommendations:
    - ◊ Amend the ER policy to include the payment of a minimal fee for screening services.
    - ◊ Develop and implement the use of an action letter to be sent to providers and patients, to accompany denied, modified, or deferred claims in compliance with State regulations.
    - ◊ Amend the ER policy to require that 99 percent of all clean ER claims shall be paid within 90 working days of submission.
    - ◊ Institute a procedure to ensure that “misdirected” claims are paid within required timeframes and describe that procedure in plan policies.
    - ◊ Redirect claims to the entity responsible for payment within the 10-day timeframe stipulated in the plan’s ER policy.
  - *Access to Pharmaceutical Services.* Auditors recommended that policies and procedures be changed to ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the member can reasonably be expected to have a prescription filled.
  - *Access to Specific Services.* In relation to family planning, auditors recommended that CHG:
    - ◊ Develop and implement the use of an action letter to be sent to providers and patients to accompany denied, modified, or deferred claims.
    - ◊ Amend *Policy 7811: Reimbursement for Freedom of Choice/Family Planning Services* to state that all family planning claims will be paid within 45 working days of receipt of clean claims in compliance with state regulations.
    - ◊ Develop a mechanism to ensure payment of misdirected family planning claims within contractual timeframes; describe the mechanism in Plan policies.
    - ◊ Amend plan policies to specify that providers have up to one year to submit claims for out-of-plan services.
- In the *Member Rights* category, auditors’ made recommendations in one area:
- *Confidentiality Rights.* Auditors recommended that the Breach of Security policy required the CHG:
    - ◊ Report the discovery that protected health information has been improperly used or disclosed to the DHCS Contract Manager within 24 hours during a workweek.
    - ◊ Notify DHCS within 24 hours during a workweek of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of protected health information and/or any actual or suspected use or disclosure of data.
    - ◊ Provide a written report of the investigation of the breach or unauthorized use or disclosure of protected health information to the DHCS Privacy Officer within 15 working days of the discovery of the breach or unauthorized use.

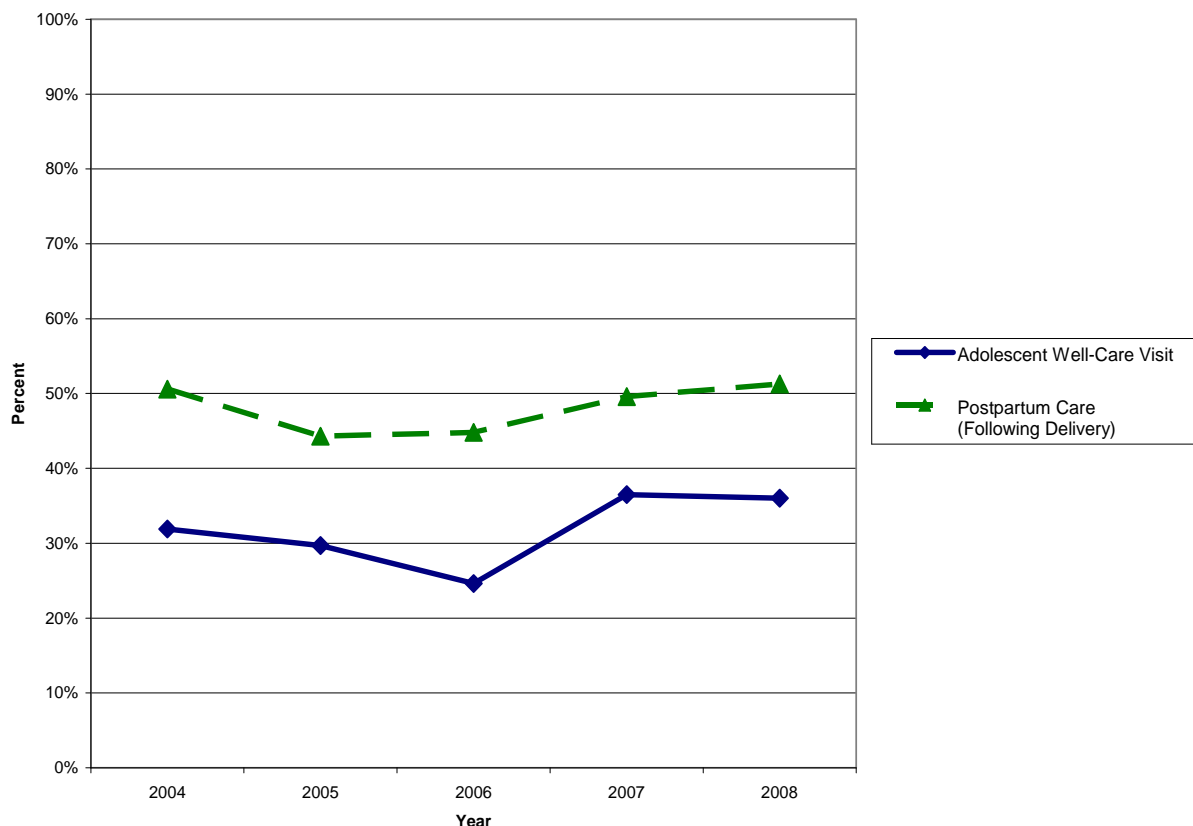
As with the quality of care deficiencies discussed earlier in this report, CHG participated in a corrective action process addressing some of the access to care deficiencies during the CAP period. The plan was given

additional time to correct the remaining deficiencies, and the additional corrective period extended into the next reporting period. As a result, Delmarva was unable to include the findings in the auditors' closeout report in this report.

### Sustainability of Access Measures

Sustainability of access measures indicates a plan's ability to improve and maintain improvement of enrollee access to healthcare services. Delmarva chose two measures to represent the access domain: *Prenatal and Postpartum Care—Postpartum Care* and *Adolescent Well-Care Visits*. Figure 2 charts the rates for those measures over a four-year period.

Figure 2. Community Health Group's Sustainability of Access to Care Indicators.



Despite a dip in the 2005 and 2006 rates, CHG showed overall improvement in its *Adolescent Well-Care Visits* performance over a four-year period with 2007 and 2008 rates higher than the 2004 rate. The plan's performance on the *Prenatal and Postpartum Care—Postpartum Care* measure was weaker as it was unable to demonstrate sustained improvement over the four-year measurement period.



## Summary of Access

Delmarva assessed CHG in five areas of the access domain: HEDIS performance measure rates, CAHPS survey results, QIPs, audit findings, and sustainability of improvement of access to care indicators.

CHG reported a 2007 HEDIS score equal to the Medi-Cal managed care weighted average and lower than 2006 national Medicaid average for the *Adolescent Well-Care Visits* measure. CHG reported scores lower (by more than seven percentage points) than both benchmarks for the *Prenatal and Postpartum Care—Postpartum Care* measure. CHG reported 2008 HEDIS scores lower than both the Medi-Cal managed care weighted average and the 2007 national Medicaid average for the *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Postpartum Care* measures.

CAHPS survey results showed that for the composite *Getting Care Quickly*, CHG enrollees rated the plan eleven percentage points lower than the state benchmark in the Adult category and rated the plan five percentage points higher in the Child category.

In the QIP area, CHG's *Increasing Follow-up for a Positive Postpartum Depression Screen* QIP showed significant improvement in all three postpartum indicators over baseline measurement. While the results of the *Improving and Increasing Adolescent Well-Care Visits* QIP did not meet the project goal, results were promising as CHG saw an increase of seven percentage points from the baseline measurement in *Adolescent Well-Care Visits* indicator. In 2007, the plan initiated work on the new *Avoidable Emergency Room Visits* statewide collaborative QIP, but no remeasurement information was available at the time this report was prepared.

The DHCS and the DMHC conducted a joint medical performance audit of CHG in June of 2007. Auditors identified several deficiencies related to quality of care. Under the category of *Availability and Accessibility*, deficiencies were found in the components *Access to Medical Care*, *Access to Emergency Services*, *Access to Pharmaceutical Services*, and *Access to Specialty Services*. Deficiencies were also found under the *Confidentiality Rights* component of the *Member Rights* category. The DHCS and the DMHC provided oversight for CHG's corrective action process; however, some deficiencies were not corrected within the initial 45-day corrective timeframe and the final closeout report was not issued in time for Delmarva to include results in this report.

In the sustainability area, CHG showed an overall improvement in its *Adolescent Well-Care Visits* performance, but was unable to demonstrate sustained improvement for the *Prenatal and Postpartum Care—Postpartum Care* measure.

## Timeliness of Care Assessment

Access to necessary health care and related services alone is insufficient to advance the health status of Medi-Cal managed care enrollees. Timely delivery of those services is equally important. The findings related to timeliness are described below.

### 2007 HEDIS Performance Measures Pertaining to Timeliness of Care

Delmarva included the five measures shown in Table 7 in the timeliness domain because each measure is associated with the receipt of services within a certain timeframe.

Table 7. 2007 HEDIS Timeliness Measure Results Comparing Community Health Group to State and National Averages.

2007 Timeliness Measure	2007 Community Health Group Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*
Breast Cancer Screening†	48.8%†	48.6%	53.9%
Childhood Immunization Status—Combination 2	79.8%	77.9%	70.4%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	75.9%	79.4%	79.1%
Well-Child Visits in the First 15 Months of Life	44.5%	57.7%	48.6%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	72.7%	74.3%	63.3%

\* Rates obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Plans*.  
 † Due to significant changes in technical specifications, this measure is treated as a first-year measure in 2007. Because new MPLs and HPLs had not yet been established, the rate is displayed for informational purposes only and will not be compared to benchmarks.

For 2007 HEDIS measures designated in the timeliness domain, CHG had mixed results when compared to the 2007 Medi-Cal managed care averages and the 2006 national Medicaid averages:

- CHG’s rates were higher than both the 2007 Medi-Cal managed care average and the 2006 national Medicaid average in the timeliness domain for one of four comparable HEDIS measures: *Childhood Immunization Status—Combination 2*.
- CHG scored lower than the state average and higher than the national average for the *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* measure, but scored higher than the 2006 national Medicaid average.
- CHG’s performance was lower than both benchmarks for two HEDIS measures:
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Well-Child Visits in the First 15 Months of Life*

## 2008 HEDIS Performance Measures Pertaining to Timeliness of Care

For the 2008 reporting year, Delmarva used the same measures used for the 2007 reporting year to represent the timeliness domain and added a newly required measure, *Childhood Immunization Status—Combination 3*. Table 8 shows the results of the 2008 HEDIS timeliness measures.

**Table 8. 2008 HEDIS Timeliness Measure Results Comparing Community Health Group to State and National Averages.**

2008 Timeliness Measure	2008 Community Health Group Rate*	2008 Medi-Cal Managed Care Weighted Average*	2007 HEDIS National Medicaid Average*
Breast Cancer Screening	49.9%	50.4%	49.1%
Childhood Immunization Status—Combination 2	69.1%	80.1%	73.3%
Childhood Immunization Status—Combination 3 <sup>†</sup>	64.2%	72.0%	60.6%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	73.0%	82.6%	81.2%
Well-Child Visits in the First 15 Months of Life	46.5%	60.2%	55.6%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	74.7%	75.8%	66.8%
<p>* Rates obtained from the <i>Report of the 2008 Performance Measures for Medi-Cal Managed Care Plans</i>.  <sup>†</sup> 2008 is the first year MMCD required reporting of this measure. Because MPLs and HPLs had not yet been established, the rate is displayed for informational purposes only and will not be compared to benchmarks.</p>			

For 2008 HEDIS measures designated in the timeliness domain, CHG had mixed results when compared to the 2008 Medi-Cal managed care averages and the 2007 national Medicaid averages:

- CHG’s rates were lower than the 2008 Medi-Cal managed care average and higher than the 2007 national Medicaid average in the timeliness domain for one of five comparable HEDIS measures: *Breast Cancer Screening*.
- CHG scored lower than both the state and national benchmarks on the remaining comparable HEDIS measures:
  - *Childhood Immunization Status—Combination 2*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Well-Child Visits in the First 15 Months of Life*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*

### CAHPS Survey Results Pertaining to Timeliness

Delmarva chose two CAHPS composites, *Courteous and Helpful Office Staff* and *Health Plan's Customer Service*, to represent the timeliness of care domain. The results of the composite scores are presented in Table 9, which is followed by a discussion of the results.

**Table 9. 2007 CAHPS Timeliness Survey Results Comparing Community Health Group to the Medi-Cal Managed Care Program.**

2007 CAHPS Composite	Population	2007 Community Health Group Result	2007 Medi-Cal Managed Care Weighted Average*
Courteous and Helpful Office Staff	Adult	†	†
	Child	56%	52%
	CSHCN‡	58%	§
Health Plan's Customer Service	Adult	36%¶	45%
	Child	79%¶	79%
	CSHCN‡	80%¶	§
* Medi-Cal average was calculated from scores of all contracted health plans and weighted to be proportionate to plan enrollment. † The composite <i>Courteous and Helpful Office Staff</i> was eliminated from the 2007 CAHPS Adult survey. ‡ CSHCN - Child with Special Health Care Needs. § MCMC overall averages were not calculated for CSHCN members because they are subsets of the same sampling and data cannot be used due to the possibility of double counting. Refer to Appendix B: CAHPS for further detail. ¶ The plan received <100 responses to some of the questions in this area, so this result is not statistically valid.			

In the CAHPS composite *Courteous and Helpful Office Staff*, 56 percent of CHG's parents/guardians of child members indicated that the office staff was always courteous and helpful, compared to the Medi-Cal managed care weighted average for this composite of 52 percent.

In the CAHPS composite, *Health Plan's Customer Service*, the plan received less than 100 responses to some of the questions. Rates in the above table that are noted as not statistically valid are not discussed here.

### Quality Improvement Projects

CHG did not engage in any QIPs categorized in the timeliness domain during this reporting period.

### Medi-Cal Audit Findings

Delmarva reviewed the timeliness of care aspects of the combined findings of the DHCS medical performance audit and the DMHC routine medical survey of CHG conducted in June 2007. Auditors assessed several components in the *Utilization Management* category and found opportunities for improvement in all but one component of that category:

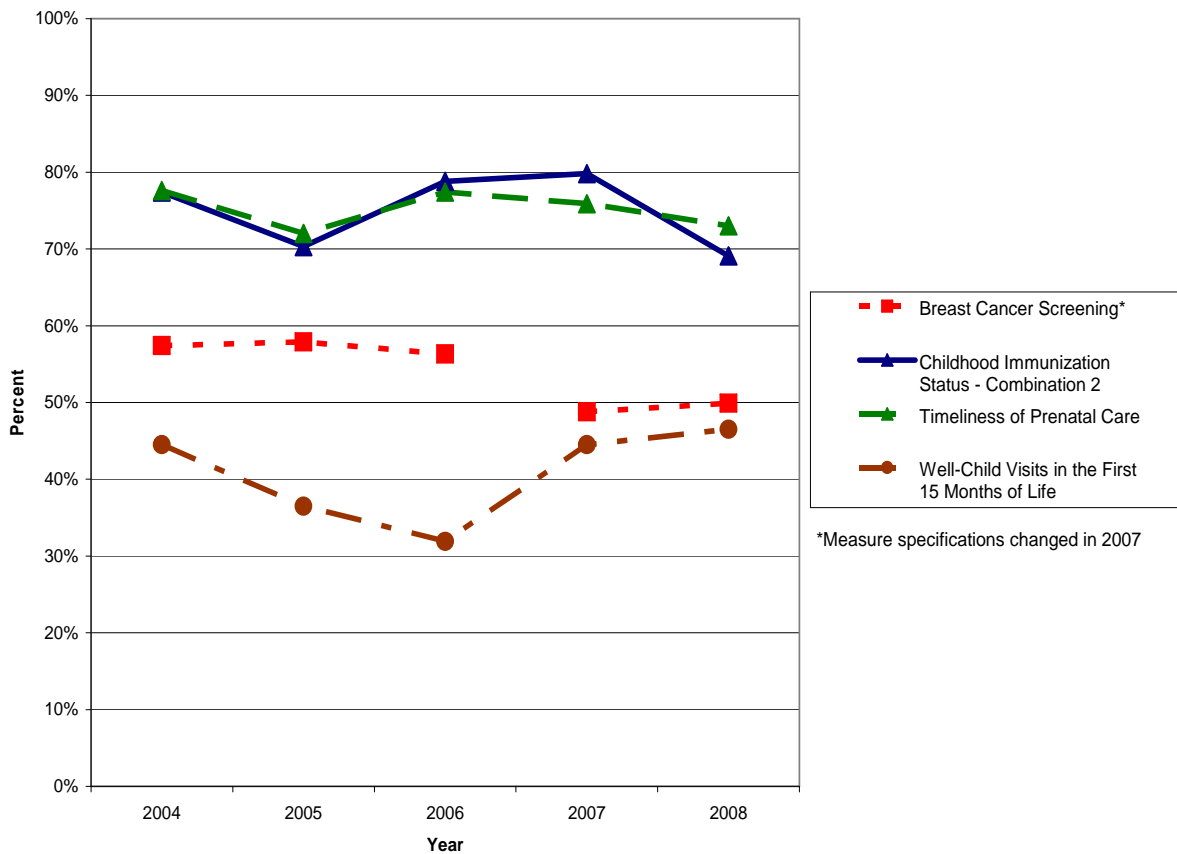
- *Prior Authorization Review Requirements.* Auditors recommended that CHG revise its policies in this area as follows:
- Amend policies to include the statement that a qualified physician shall review all denials.
  - Specifically mention minor consent services and preventive services among the items not requiring prior authorization in the *Services Not Requiring Prior Authorization* document in the Provider Manual.
  - Update the list of *Services Not Requiring Prior Authorization* on the plan's website.
- *Notification of Prior Authorization Denial, Deferral, or Modification.* Auditors recommended that the plan:
- Amend Policy 7251.7 to acknowledge that the limit for deciding prior authorization requests is 28 calendar days from the time of receipt of the original request for service.
  - Notify plan members within 28 days of decisions to deny, modify, or defer a prior authorization.
  - Notify requesting providers within 24 hours of a decision to deny, defer, or modify a request for service.
  - Ensure that deferral letters for any service requested contain language and content in compliance with its DHCS contract and State regulations.
  - When services are deferred, send members written notices containing the contractually required language and content.
- For this component, the plan's failure to meet required notification timeframes and not sending deferral letters to beneficiaries were repeat findings.
- *Referral Tracking.* Auditors recommended that CHG develop a system-wide centralized plan for tracking and following-up referrals requiring prior authorization.
- *Delegation of Utilization Management.* Auditors identified a repeat finding. Auditors recommended that CHG ensure that delegated entities' utilization management programs require that a qualified physician shall review all denials.

As with audit-identified deficiencies discussed earlier in this report, CHG participated in a corrective action process addressing some of the timeliness of care deficiencies. The plan was given additional time to correct the remaining deficiencies. That additional corrective period extended into the next reporting period, so Delmarva was unable to include the findings in the auditors' closeout report in this report.

### Sustainability of Timeliness of Care Measures

Sustainability of timeliness relates to the plan’s delivery of screening tests, preventive health visits, and/or preventive health procedures early enough to prevent the consequences of delayed care. Delmarva chose four measures to represent timeliness for this assessment as charted in Figure 3.

Figure 3. Community Health Group’s Sustainability of Timeliness of Care Indicators.



The trend line for the *Breast Cancer Screening* measure is broken between 2006 and 2007 to reflect the substantive changes in the measure’s 2007 technical specifications; therefore, Delmarva cannot determine sustainability of the *Breast Cancer Screening* rates over the measurement period.

CHG rates fluctuated over the four-year measurement period for the measures *Well-Child Visits in the First 15 Months of Life*, *Childhood Immunization Status—Combination 2*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*. By 2008, CHG’s score for the *Well-Child Visits in the First 15 Months of Life* measure reached a level above the trend start point in 2004. The 2008 rates for *Childhood Immunization Status—Combination 2* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* are lower than the trend start point of 2004, translating to an overall decline in performance for those two measures.

## Summary of Timeliness of Care

Delmarva assessed CHG in four areas of the timeliness domain: HEDIS performance measure rates, CAHPS survey results, audit findings, and sustainability of improvement of timeliness of care indicators. CHG had no QIP related to timeliness during this reporting period.

For the 2007 HEDIS reporting year, CHG scored higher than both the 2007 Medi-Cal managed care average and the 2006 national Medicaid average in the timeliness domain for one measure, *Childhood Immunization Status—Combination 2*. The plan scored lower than the state benchmark and higher than the national benchmark for the *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* measure. CHG scored lower than both benchmarks for the measures *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Well-Child Visits in the First 15 Months of Life*.

For the 2008 HEDIS reporting year, CHG had mixed results for the *Breast Cancer Screening* measure in the timeliness domain—the plan's rates were higher than the 2006 national Medicaid average but lower than the 2007 Medi-Cal managed care average—*Breast Cancer Screening*. The plan scored lower than both state and national benchmarks on the remaining comparable measures: *Childhood Immunization Status—Combination 2*; *Prenatal and Postpartum Care—Timeliness of Prenatal Care*; *Well-Child Visits in the First 15 Months of Life*; and *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*.

In the CAHPS composite *Courteous and Helpful Office Staff*, a higher percentage of CHG parents/guardians of child members indicated that the office staff was always courteous and helpful compared to the Medi-Cal managed care weighted average. In the composite area, *Health Plan's Customer Service*, the plan received less than 100 responses to some of the questions, meaning the results are not statistically valid for evaluation.

The DHCS and the DMHC conducted a joint medical performance audit of CHG in June 2007. Auditors found opportunities for improvement in several components of the *Utilization Management* category: *Prior Authorization Review Requirements*; *Notification of Prior Authorization Denial, Deferral, or Modification*, *Referral Tracking*, and *Delegation of Utilization Management*. The DHCS and the DMHC provided oversight for CHG's corrective action process, but some deficiencies were not corrected within the initial 45-day corrective timeframe.

In the sustainability area, the CHG was unable to demonstrate sustained improvement for the three trendable access domain measures. The plan's performance decline for the two measures *Childhood Immunization Status—Combination 2* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

## Comparison of Community Health Group's 2007 and 2008 HEDIS Scores

Delmarva presents CHG's 2007 and 2008 HEDIS rates in Table 10 and a brief discussion of the rate comparisons following the table.

Table 10. Comparison of Community Health Group's 2007 and 2008 HEDIS Performance Rates.

2008 Performance Measure	2007 Community Health Group Rate*	2008 Community Health Group Rate*
Childhood Immunization Status—Combination 2	79.8%	69.1%
Childhood Immunization Status—Combination 3 <sup>†</sup>	†	64.2%
Well-Child Visits in the First 15 Months of Life	44.5%	46.5%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	72.7%	74.7%
Adolescent Well-Care Visits	36.5%	36.0%
Prenatal and Postpartum Care— Timeliness of Prenatal Care	75.9%	73.0%
Prenatal and Postpartum Care— Postpartum Care	49.6%	51.3%
Breast Cancer Screening	48.8%	49.9%
Cervical Cancer Screening	66.7%	66.4%
Use of Appropriate Medications for People With Asthma	85.6%	86.8%
Appropriate Treatment for Children With Upper Respiratory Infection	82.7%	84.0%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis <sup>††</sup>	†	24.2%
Comprehensive Diabetes Care— Eye Exam (Retinal) Performed	55.5%	46.0%
Comprehensive Diabetes Care— HbA1c Testing	72.0%	77.6%
Comprehensive Diabetes Care— HbA1c Good Control (<7.0%) <sup>†</sup>	†	27.7%
Comprehensive Diabetes Care— HbA1c Poor Control (>9.0%) <sup>†§</sup>	†	49.1% <sup>§</sup>
Comprehensive Diabetes Care— LDL-C Screening	75.4%	74.0%
Comprehensive Diabetes Care— LDL-C Control (<100mg/dL) <sup>†</sup>	†	34.3%
Comprehensive Diabetes Care— Medical Attention for Nephropathy	76.2%	76.2%



2008 Performance Measure	2007 Community Health Group Rate*	2008 Community Health Group Rate*
Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months) †	†	222.51
Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months) †	†	23.35
Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months) †	†	2.94
Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months) †	†	0.10
<p>* Rates obtained from the <i>Report of the 2008 Performance Measures for Medi-Cal Managed Care Plans</i>.            † Since 2008 is the first year MMCD required reporting of this measure, no rates were reported for 2007. Because MPLs and HPLs had not yet been established, the 2008 rate is displayed for informational purposes only and will not be compared to benchmarks.            ‡ 2007 and 2008 rates cannot be compared. The 2007 measure was called <i>Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis</i>, and a lower score was better. The 2008 measure is called <i>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</i>, and a higher score is better.            § This measure represents poor diabetes control as measured by HbA1c levels. A lower number represents better diabetes control.</p>		

Due to 2007 HEDIS specification changes, the plan’s rates of *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* measure cannot be compared between reporting years 2007 and 2008. MMCD eliminated the *Chlamydia Screening* measure and instead required the *Ambulatory Care* measure in order to focus more on the entire Medi-Cal managed care population, including seniors and persons with disabilities. The *Ambulatory Care* measure provides utilization information across the whole spectrum of the population – from birth to 85+ years of age. Plus, this measure provides insight regarding emergency room (ER) use, which is an area of particular interest to MMCD because many members use the ER for avoidable visits and, as a result, may not be getting appropriate preventive care and follow-up care for chronic conditions. Although rates for the four *Ambulatory Care* indicators are included, conclusions should not be drawn regarding plan performance for these indicators as noted in the Table 10 footnotes.

A comparison of CHG’s 2007 and 2008 HEDIS scores provided Delmarva with some insight as to plan performance:

- CHG improved on 7 of the 15 comparable HEDIS scores:
  - *Well-Child Visits in the First 15 Months of Life*
  - *Well-Child visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Breast Cancer Screening*
  - *Use of Appropriate Medications for People with Asthma*
  - *Appropriate Treatment for Children With Upper Respiratory Infection*
  - *Comprehensive Diabetes Care—HbA1c Testing*

- CHG's performance in three HEDIS measures remained relatively unchanged:
  - *Adolescent Well-Care Visits*
  - *Cervical Cancer Screening*
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
  
- CHG's performance in four HEDIS measures decreased:
  - *Childhood Immunization Status—Combination 2*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  - *Comprehensive Diabetes Care—LDL-C Screening*

### Comparison of 2007 and 2008 HEDIS Measures by Model Type

Medi-Cal beneficiaries receive their health care through three models of health care delivery—County Organized Health Systems (COHS), Two-Plan, and Geographic Managed Care (GMC).

- COHS plans are county-operated managed care organizations. Enrollment is mandatory for almost all Medi-Cal beneficiaries within a county operating a COHS.
  
- The Two-Plan model consists of two plan types: Commercial Plans (CPs), which are commercially-operated managed care plans; and Local Initiatives (LIs), which are community-developed managed care plans operated as quasi-governmental agencies. In a Two-Plan model, members choose between an LI and a CP. Enrollment is mandatory for specified beneficiaries.
  
- In the GMC model, enrollees choose from several commercially operated plans within a certain geographic area. Enrollment is mandatory for specified Medi-Cal beneficiaries.

CHG is contracted in San Diego County as a GMC-South (GMC-S) plan. Tables 11 (2007) and 12 (2008) show the ranking (1 through 5) of the five different plan models when HEDIS results were compared across plan types. Note that averages are not ranked (1 through 5) for measures where MPLs and HPLs were not applied in the reporting year.

Table 11. Comparison of 2007 Medi-Cal Managed Care Weighted Averages by Plan Type.

2007 Performance Measure	Plan Type % (ranking among plan types)				
	COHS*	CP†	LI†	GMC-N‡	GMC- S‡
Childhood Immunization Status—Combination 2	82.9% (1)	79.5% (3)	75.6% (4)	73.6% (5)	80.2% (2)
Well-Child Visits in the First 15 Months of Life	68.0% (1)	44.8% (5)	53.0% (3)	57.2% (2)	51.4% (4)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	76.3% (1)	73.6% (3)	74.6% (2)	70.3% (5)	72.5% (4)
Adolescent Well-Care Visits	47.8% (1)	36.8% (3)	34.0% (5)	36.7% (4)	37.8% (2)
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.0% (2)	81.4% (3)	77.5% (5)	77.9% (4)	82.6% (1)
Prenatal and Postpartum Care—Postpartum Care	64.3% (1)	56.6% (4)	58.7% (2)	58.5% (3)	53.8% (5)
Chlamydia Screening in Women	54.4% (3)	52.8% (4)	50.5% (5)	58.1% (2)	59.8% (1)
Breast Cancer Screening ¶	55.6%	42.8%	48.4%	47.8%	50.6%
Cervical Cancer Screening ¶	70.1%	65.7%	69.3%	62.9%	66.5%
Use of Appropriate Medications for People With Asthma	88.7% (1)	85.8% (4)	86.9% (2)	86.4% (3)	84.9% (5)
Appropriate Treatment for Children With Upper Respiratory Infection	81.3% (3)	74.5% (5)	79.3% (4)	84.8% (2)	85.1% (1)
Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis §¶	71.0%	73.7%	70.2%	71.8%	64.6%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	68.7% (1)	54.6% (3)	45.5% (5)	54.2% (4)	56.9% (2)
Comprehensive Diabetes Care—HbA1c Testing	85.4% (1)	79.5% (2)	76.7% (4)	76.1% (5)	78.0% (3)
Comprehensive Diabetes Care—LDL-C Screening ¶	80.7%	74.5%	74.2%	71.4%	77.5%
Comprehensive Diabetes Care—Medical Attention for Nephropathy¶	81.2%	75.4%	83.8%	77.7%	78.3%

Plan Model Definitions:

\* County Organized Health System (COHS) – County-operated and managed care organizations. Enrollment is mandatory for almost all Medi-Cal beneficiaries within a county operating a COHS.

† Two-Plan consists of two plan types:

Commercial Plans (CPs) are commercially-operated managed care plans.

Local Initiatives (LIs) are community-developed managed care plans operated as quasi-governmental agencies.

Members choose between an LI and a CP. Enrollment is mandatory for some beneficiaries.

‡ Geographic Managed Care (GMC) - Enrollees choose from several commercially-operated plans within a certain geographic area. Enrollment is mandatory for specified Medi-Cal beneficiaries.

§ For this measure, a lower score indicates better performance.

¶ Averages not ranked for measures where MPLs and HPLs are not applied in the reporting year.

For reporting year 2007, GMC-S plans ranked as follows:

- GMC-S plans ranked first of the five plan types in the following HEDIS measures:
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Chlamydia Screening in Women*
  - *Appropriate Treatment for Children With Upper Respiratory Infection*
- GMC-S plans ranked second of the five plan types in the following HEDIS measures:
  - *Childhood Immunization Status—Combination 2*
  - *Adolescent Well-Care Visits*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- GMC-S plans ranked third of the five plan types in the following HEDIS measure:
  - *Comprehensive Diabetes Care—HbA1c Testing*
- GMC-S plans ranked fourth of the five plan types in the following HEDIS measures:
  - *Well-Child Visits in the First 15 Months of Life*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
- GMC-S plans ranked fifth of the five plan types in the following HEDIS measures:
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Use of Appropriate Medications for People With Asthma*

Table 12. Comparison of 2008 Medi-Cal Managed Care Weighted Averages by Plan Type.

2008 Performance Measure	Plan Type % (ranking among plan types)				
	COHS*	CP†	LI†	GMC – N‡	GMC – S‡
Childhood Immunization Status— Combination 2	83.3% (1)	77.4% (3)	82.3% (2)	70.8% (5)	71.4% (4)
Childhood Immunization Status— Combination 3†	77.4%	68.8%	73.6%	65.8%	62.8%
Well-Child Visits in the First 15 Months of Life	72.3% (1)	46.6% (5)	56.7% (2)	55.9% (3)	49.5% (4)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	78.9% (1)	75.1% (3)	76.1% (2)	69.1% (5)	73.1% (4)
Adolescent Well-Care Visits	48.4% (1)	38.8% (2)	38.4% (4)	38.7% (3)	37.1% (5)
Prenatal and Postpartum Care— Timeliness of Prenatal Care	85.2% (1)	83.1% (2)	81.9% (3)	81.7% (4)	80.8% (5)
Prenatal and Postpartum Care— Postpartum Care	66.9% (1)	57.4% (3)	59.1% (2)	54.8% (4)	52.0% (5)
Breast Cancer Screening	56.4% (1)	45.3% (5)	50.5% (3)	47.4% (4)	51.3% (2)
Cervical Cancer Screening	69.1% (2)	69.9% (1)	68.2% (3)	68.2% (3)	67.0% (4)
Use of Appropriate Medications for People with Asthma	90.1% (1)	88.8% (3)	89.0% (2)	86.6% (4)	85.1% (5)
Appropriate Treatment for Children with Upper Respiratory Infection	85.2% (3)	81.3% (5)	82.5% (4)	89.5% (1)	88.4% (2)
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis†	26.1%	30.3%	28.4%	28.7%	26.5%
Comprehensive Diabetes Care— Eye Exam (Retinal) Performed	69.6% (1)	58.2% (2)	52.0% (5)	56.2% (3)	52.4% (4)
Comprehensive Diabetes Care— HbA1c Testing	85.3% (1)	81.0% (4)	81.4% (2)	78.1% (5)	81.1% (3)
Comprehensive Diabetes Care— HbA1c Good Control (<7.0%)†	39.7%	27.4%	31.0%	32.8%	32.1%
Comprehensive Diabetes Care— HbA1c Poor Control (>9.0%)§†	35.5%	49.4%	43.1%	42.9%	45.5%
Comprehensive Diabetes Care— LDL-C Screening	81.3% (1)	76.4% (4)	77.4% (2)	72.0% (5)	77.0% (3)
Comprehensive Diabetes Care— LDL-C Control(<100mg/dL) †	40.0%	28.9%	32.9%	32.3%	40.6%
Comprehensive Diabetes Care— Medical Attention for Nephropathy	82.0% (1)	77.7% (3)	76.9% (4)	75.1% (5)	78.8% (2)

2008 Performance Measure	Plan Type % (ranking among plan types)				
	COHS*	CP†	LI†	GMC-N‡	GMC-S‡
Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months)¶	322.4	254.8	268.1	263.2	250.0
Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months)¶	43.5	33.4	38.2	34.0	33.8
Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months)¶	5.0	2.0	2.1	2.5	2.9
Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months)¶	2.9	0.3	0.5	0.3	0.4
<b>Plan Model Definitions:</b> * County Organized Health System (COHS) – County-operated and managed care organizations. Enrollment is mandatory for almost all Medi-Cal beneficiaries within a county operating a COHS. † Two-Plan consists of two plan types: Commercial Plans (CPs) are commercially-operated managed care plans. Local Initiatives (LIs) are community-developed managed care plans operated as quasi-governmental agencies. Members choose between an LI and a CP. Enrollment is mandatory for some beneficiaries. ‡ Geographic Managed Care (GMC) - Enrollees choose from several commercially-operated plans within a certain geographic area. Enrollment is mandatory for specified Medi-Cal beneficiaries. § This measure represents poor diabetes control as measured by HbA1c levels. A lower number represents better diabetes control. ¶ Averages not ranked for measures where MPLs and HPLs are not applied in the reporting year.					

For reporting year 2008, GMC-S plans ranked as follows:

- GMC-S plans did not rank first of the five plan types in any of the HEDIS measures.
- GMC-S plans ranked second of the five plan types in the following HEDIS measures:
  - *Breast Cancer Screening*
  - *Appropriate Treatment for Children With Upper Respiratory Infection*
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- GMC-S plans ranked third of the five plan types in the following HEDIS measures:
  - *Comprehensive Diabetes Care—HbA1c Testing*
  - *Comprehensive Diabetes Care—LDL-C Screening*
- GMC-S plans ranked fourth of the five plan types in the following HEDIS measures:
  - *Childhood Immunization Status—Combination 2*
  - *Well-Child Visits in the First 15 Months of Life*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Cervical Cancer Screening*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

- GMC-S plans ranked fifth of the five plan types in the following HEDIS measures:
- *Adolescent Well-Care Visits*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Use of Appropriate Medications for People With Asthma*

### **Comparison to Other National and California State Programs**

In each of the quality, access, and timeliness assessments provided earlier in this report, CHG's performance was compared with the Medi-Cal managed care weighted average and the national Medicaid average. This section provides two comparisons that have not been made elsewhere in this report—with national commercial averages and the California Healthy Families Program averages. The Healthy Families Program, administered by the California Managed Risk Medical Insurance Board, is a low cost health, dental, and vision coverage plan for uninsured children (up to age 19) of working families. In addition to the new rate comparisons, the Medi-Cal managed care weighted averages and the national Medicaid averages are provided in Tables 13 and 14.

Table 13. 2007 Performance Measurement Rates Comparing Community Health Group to National and State Programs.

2007 Performance Measure	2007 Community Health Group Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*	2006 HEDIS National Commercial Average*	2007 California Healthy Families Average†
Childhood Immunization Status—Combination 2	79.8%	77.9%	70.4%	77.8%	79.2%
Well-Child Visits in the First 15 Months of Life	44.5%	57.7%	48.6%	71.0%	56.6%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	72.7%	74.3%	63.3%	64.4%	72.9%
Adolescent Well-Care Visits	36.5%	36.9%	40.6%	38.7%	43.5%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	75.9%	79.4%	79.1%	91.9%	‡
Prenatal and Postpartum Care—Postpartum Care	49.6%	58.7%	57.0%	81.5%	‡
Chlamydia Screening in Women	46.8%	52.8%	50.6%	34.9%	41.1%
Breast Cancer Screening§	48.8%	48.6%	53.9%	72.0%	‡
Cervical Cancer Screening§	66.7%	67.9%	65.0%	81.8%	‡
Use of Appropriate Medications for People With Asthma	85.6%	86.8%	85.7%	89.9%	94.0%
Appropriate Treatment for Children With Upper Respiratory Infection	82.7%	78.9%	82.5%	82.9%	83.1%
Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis¶	81.1%	71.0%	69.4%	66.1%	‡
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	55.5%	54.1%	48.6%	54.8%	‡
Comprehensive Diabetes Care—HbA1c Testing	72.0%	79.5%	76.2%	87.6%	‡
Comprehensive Diabetes Care—LDL-C Screening§	75.4%	75.9%	80.5%	92.3%	‡
Comprehensive Diabetes Care—Medical Attention for Nephropathy§	76.2%	81.0%	48.8%	55.1%	‡

\* Rates obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Plans*.

† 2007 rates obtained from the Healthy Families Program at [http://www.mrmib.ca.gov/MRMIB/quality\\_reports.html](http://www.mrmib.ca.gov/MRMIB/quality_reports.html).

‡ Healthy Families did not report data on these measures.

§ Due to significant changes in technical specifications, MPLs and HPLs had not yet been established for 2007.

The rate is displayed for informational purposes only and will not be compared to benchmarks.

¶ For this 2007 measure, a lower rate indicates better performance. For 2008, this measure will be called *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*, and a higher score will be better.



Delmarva focused on comparing CHG's 2007 HEDIS rates to the national and Healthy Families Program benchmarks in this section. In addition, a summary of comparisons with other benchmarks follows.

- CHG had rates equal to or higher than the national commercial average for 5 of the 11 comparable HEDIS measures:
  - *Childhood Immunization Status—Combination 2*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Chlamydia Screening in Women*
  - *Appropriate Treatment for Children With Upper Respiratory Infection*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  
- CHG had rates equal to or higher than the 2007 California Healthy Families rates on three of the seven comparable HEDIS measures:
  - *Childhood Immunization Status—Combination 2*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Appropriate Treatment for Children With Upper Respiratory Infection*
  
- CHG had rates equal to or better than all benchmarks for the following HEDIS measures:
  - *Childhood Immunization Status—Combination 2*
  - *Appropriate Treatment for Children With Upper Respiratory Infection*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  
- CHG had mixed results on the following HEDIS measures:
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* (CHG scored lower than the Medi-Cal managed care weighted average, but higher than all other benchmarks.)
  - *Chlamydia Screening in Women* (CHG scored higher than the national commercial average, but lower than all other benchmarks.)
  - *Adolescent Well-Care Visits* (CHG scored equal to the Medi-Cal managed care weighted average, but lower than all other benchmarks.)
  
- CHG performed worse than all benchmarks for the following HEDIS measures:
  - *Well-Child Visits in the First 15 Months of Life*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Use of Appropriate Medications for People With Asthma*
  - *Comprehensive Diabetes Care—HbA1c Testing*

Table 14. 2008 Performance Measurement Rates Comparing Community Health Group to National and State Programs.

2008 Performance Measure	2008 Community Health Group Rate <sup>(a)</sup>	2008 Medi-Cal Managed Care Weighted Average <sup>(a)</sup>	2007 HEDIS National Medicaid Average <sup>(a)</sup>	2007 HEDIS National Commercial Average <sup>(a)</sup>	2007 California Healthy Families Average <sup>(b)</sup>
Childhood Immunization Status—Combination 2	69.1%	80.1%	73.3%	79.8%	79.2%
Childhood Immunization Status—Combination 3 <sup>(c)</sup>	64.2%	72.0%	60.6%	65.8%	73.4%
Well-Child Visits in the First 15 Months of Life	46.5%	60.2%	55.6%	72.9%	56.6%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	74.7%	75.8%	66.8%	66.7%	72.9%
Adolescent Well-Care Visits	36.0%	39.6%	43.7%	40.3%	43.5%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	73.0%	82.6%	81.2%	90.6%	(d)
Prenatal and Postpartum Care—Postpartum Care	51.3%	59.1%	59.1%	79.9%	(d)
Breast Cancer Screening	49.9%	50.4%	49.1%	68.9%	(d)
Cervical Cancer Screening	66.4%	68.7%	65.7%	81.0%	(d)
Use of Appropriate Medications for People with Asthma	86.8%	88.8%	87.1%	91.6%	94.0%
Appropriate Treatment for Children with Upper Respiratory Infection	84.0%	83.1%	83.3%	82.8%	83.1%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis <sup>(e)</sup>	24.2%	28.4%	(e)	(e)	(d)
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	46.0%	58.1%	51.4%	54.7%	(d)
Comprehensive Diabetes Care—HbA1c Testing	77.6%	82.1%	78.0%	87.5%	(d)
Comprehensive Diabetes Care—HbA1c Good Control (<7.0%) <sup>(e)</sup>	27.7%	32.6%	N/A	41.8%	(d)
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%) <sup>(e)(f)</sup>	49.1%	42.6%	48.7%	29.6%	(d)
Comprehensive Diabetes Care—LDL-C Screening	74.0%	77.8%	71.1%	83.4%	(d)
Comprehensive Diabetes Care—LDL-C Control(<100mg/dL) <sup>(e)</sup>	34.3%	34.2%	30.6%	43.0%	(d)
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.2%	78.3%	74.6%	79.7%	(d)

2008 Performance Measure	2008 Community Health Group Rate <sup>(a)</sup>	2008 Medi-Cal Managed Care Weighted Average <sup>(a)</sup>	2007 HEDIS National Medicaid Average <sup>(a)</sup>	2007 HEDIS National Commercial Average <sup>(a)</sup>	2007 California Healthy Families Average <sup>(b)</sup>
Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months) <sup>(c) (g)</sup>	222.5	271.6	318.0	296.7	(d)
Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months) <sup>(c) (g)</sup>	23.4	37.3	57.0	16.7	(d)
Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months) <sup>(c) (g)</sup>	2.9	2.6	5.3	10.5	(d)
Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months) <sup>(c) (g)</sup>	0.1	0.8	1.8	.8	(d)
<p>(a) Rates obtained from the <i>Report of the 2008 Performance Measures for Medi-Cal Managed Care Plans</i>.                      (b) 2007 rates obtained from the Healthy Families Program at <a href="http://www.mrmib.ca.gov/MRMIB/quality_reports.html">http://www.mrmib.ca.gov/MRMIB/quality_reports.html</a>.                      (c) Due to first-year reporting requirements, MPLs and HPLs were not established for 2008. The rate is displayed for informational purposes only and will not be compared to benchmarks.                      (d) Healthy Families did not report data on these measures.                      (e) 2007 and 2008 rates cannot be compared. The 2007 measure was called <i>Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis</i>, and a lower score was better. The 2008 measure is called <i>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</i>, and a higher score is better.                      (f) This measure represents poor diabetes control as measured by HbA1c levels. A lower number represents better diabetes control.                      (g) MMCD has yet to determine whether to apply an MPL or HPL to the <i>Ambulatory Care</i> measure. Scores are reported, but no conclusions should be drawn regarding plan performance in this area.</p>					

Plan performance of newly required measures is not assessed because the first-year results are considered “baseline” results, and MMCD does not apply the MPL or HPL to these measures. In addition, the newly required *Ambulatory Care* indicators are not scored as percentages, but rather as utilization counts per 1,000 member months. MMCD has yet to determine whether to apply MPLs or HPLs to these measures.

In this section, Delmarva focused on comparing CHG’s 2008 HEDIS rates to the rates of California’s Healthy Families Program and national benchmarks. In addition, a summary of comparisons for other benchmarks follows.

- CHG reported rates higher rates for 2 of the 14 comparable HEDIS measures when compared with the national commercial average:
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Appropriate Treatment for Children With Upper Respiratory Infection*
- CHG had higher rates for two of the six comparable HEDIS measures when compared with the 2007 California Healthy Families rates:
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Appropriate Treatment for Children With Upper Respiratory Infection*

- CHG performed better than all benchmarks for the measure, *Appropriate Treatment for Children With Upper Respiratory Infection*.
  
- CHG had mixed results on the following measures:
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* (CHG scored lower than the Medi-Cal managed care weighted average, but higher than all other benchmarks.)
  - *Breast Cancer Screening* (CHG scored equal to or higher than the Medi-Cal managed care weighted average and the national Medicaid average, but lower than all other benchmarks.)
  - *Cervical Cancer Screening* (CHG scored higher than the national Medicaid average, but lower than all other benchmarks.)
  - *Use of Appropriate Medications for People With Asthma* (CHG scored equal to the national Medicaid average, but lower than all other benchmarks.)
  - *Comprehensive Diabetes Care—HbA1c Testing* (CHG scored equal to the national Medicaid average, but lower than all other benchmarks.)
  - *Comprehensive Diabetes Care—LDL-C Screening* (CHG scored higher than the national Medicaid average, but lower than all other benchmarks.)
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy* (CHG scored higher than the national Medicaid average, but lower than all other benchmarks.)
  
- CHG performed worse than all benchmarks for the following measures:
  - *Childhood Immunization Status—Combination 2*
  - *Well-Child Visits in the First 15 Months of Life*
  - *Adolescent Well-Care Visits*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

## 2007 Overall Strengths

- CHG rated better than the state and national benchmark for two HEDIS measures in the quality domain: *Appropriate Treatment for Children With Upper Respiratory Infection* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*.
- CHG rated higher than the state benchmark in the Child category for the CAHPS composite items *Getting Needed Care* and *How Well Doctors Communicate*.
- In the sustainability area, CHG successfully sustained improvement for one comparable quality HEDIS measure—*Use of Appropriate Medications for People With Asthma*.
- CHG performed better than the 2007 Medi-Cal managed care weighted average in the CAHPS Child category for the composite area *Getting Care Quickly*.
- CHG reported significant improvement in the QIP *Increasing Follow-up for a Positive Postpartum Depression Screen*.
- CHG rated better than the state and national benchmarks for a HEDIS measure in the timeliness domain, *Childhood Immunization Status—Combination 2*.
- CHG's parent/guardian respondents indicated satisfaction more often than the Medi-Cal managed care weighted average for the CAHPS timeliness composite areas *Courteous and Helpful Office Staff*.

## 2007 Recommendations

Delmarva's overall assessment of CHG in the areas of quality, access, and timeliness has identified several opportunities for improvement. Delmarva recommends that the plan focus on:

- Why its performance on the HEDIS quality measures *Use of Appropriate Medications for People With Asthma*, and *Comprehensive Diabetes Care—HbA1c Testing* was worse than all state and national benchmarks.
- Which factors may be causing CHG's adult population to respond with a lower rate for CHG in the CAHPS quality survey items *Getting Needed Care* and *How Well Doctors Communicate*.
- Why its performance on the HEDIS access measures *Adolescent Well-Care Visits* was worse than the Medi-Cal managed care weighted average and the national Medicaid average.
- Why its performance on the HEDIS access measure *Prenatal and Postpartum Care—Postpartum Care* was worse than all state and benchmarks.
- Which factors may be causing CHG's adult population to respond with a lower rate for CHG in the CAHPS access survey item *Getting Care Quickly*.
- Why its performance on the HEDIS timeliness measures *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Well-Child Visits in the First 15 Months of Life* was worse than all state and benchmarks.

## 2007 Summary

Both strengths and continued opportunities for improvement exist for CHG in the areas of quality, access, and timeliness. CHG is performing well in several areas, including the following 2007 HEDIS measures:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Childhood Immunization Status—Combination 2*

Additionally, on the 2007 CAHPS survey, CHG parent/guardian respondents scored the plan's performance higher than Medi-Cal managed care weighted averages on the following composite areas: *Getting Needed Care*, *How Well Doctors Communicate*, *Getting Care Quickly*, and *Courteous and Helpful Office Staff*.

Delmarva recommends that CHG focus on adult perceptions for all CAHPS composite items. The plan also should address its lower performance on the measures:

- *Use of Appropriate Medications for People With Asthma*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Adolescent Well-Care Visits*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Well-Child Visits in the First 15 Months of Life*

## 2008 HEDIS Measure Strengths

CHG's 2008 HEDIS rate was higher than all benchmark rates for the *Appropriate Treatment for Children With Upper Respiratory Infection* measure.

When comparing CHG's 2007 HEDIS rates to its 2008 HEDIS rates, the plan improved on 7 of the 15 comparable measures:

- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child visits in the Third, Fourth, Fifth and Sixth Years of Life*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Breast Cancer Screening*
- *Use of Appropriate Medications for People with Asthma*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Comprehensive Diabetes Care—HbA1c Testing*

## 2008 Recommendations

Delmarva's assessment of CHG's 2008 HEDIS measures in the areas of quality, access, and timeliness has identified several opportunities for improvement. Delmarva recommends that the plan focus on:

- Why its performance on the following 2008 HEDIS measures was worse than all other benchmarks:
  - *Childhood Immunization Status—Combination 2*
  - *Well-Child Visits in the First 15 Months of Life*
  - *Adolescent Well-Care Visits*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  
- Factors that led to its excellent performance on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure. Once identified, CHG should consider how it might reproduce the activities and behaviors for other similar projects.

## 2008 Summary

Delmarva concludes that both strengths and continued opportunities for improvement exist for CHG in the area of HEDIS performance measures as presented in this report. In particular, CHG is performing well on the measure *Appropriate Treatment for Children With Upper Respiratory Infection*. CHG should focus on improving its rates for all measures where its performance is worse than all other benchmarks.

## Appendix A: HEDIS®

### HEDIS Background

The Healthcare Effectiveness Data and Information Set (HEDIS®)<sup>8</sup> is a nationally recognized, standardized set of performance indicators developed by the National Committee for Quality Assurance (NCQA).

NCQA's Committee on Performance Measurement annually evaluates and makes collective decisions about the content of the measures and the entire HEDIS process. State governments, employer and business groups, payers, and consumers use the results of these measures. More than 90 percent of all national health plans use HEDIS to measure their performance on established dimensions of health care and plan services.

HEDIS data collection and validation is standardized across all plans. HEDIS methodology makes it possible to compare the performance of health plans to each other and to national benchmarks. Results are used to identify performance variances to help plans focus their quality improvement activities.

### HEDIS Domains of Care

- NCQA assigns each of the technically-defined HEDIS measures (71 measures in 2007 and 70 measures in 2008) to one of eight domains of care:
  - Effectiveness of Care
  - Access/Availability of Care
  - Satisfaction with the Experience of Care (Adult and Child CAHPS)
  - Use of Services
  - Cost of Care
  - Health Plan Descriptive Information
  - Health Plan Stability
  - Informed Health Care Choices

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<sup>8</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).



## DHCS-Required Measures

### 2007 DHCS-Required HEDIS Measures

For the 2007 Reporting Year, the DHCS required plans to report on 12 selected HEDIS measures—including multiple indicators for *Comprehensive Diabetes Care* and *Prenatal and Postpartum Care*—for a total of 16 measurement indicators.<sup>9</sup>

- *Adolescent Well-Care Visits*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Breast Cancer Screening\**
- *Cervical Cancer Screening\**
- *Childhood Immunization Status—Combination 2*
- *Chlamydia Screening in Women*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Screening\**
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy\**
- *Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis\**
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Use of Appropriate Medications for People With Asthma*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*

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<sup>9</sup>The measures are set forth annually in All Plan Letters issued by the DHCS and available on its website. See All Plan Letter No. 06-010, entitled “Quality and Performance Improvement Program Requirements for 2007.”

\* MPLs/HPLs were not applied to these measures in 2007.

## 2008 DHCS-Required HEDIS Measures

For the 2008 Reporting Year, the DHCS required plans to report on 12 selected HEDIS measures—including multiple indicators for *Ambulatory Care*, *Childhood Immunization Status*, *Comprehensive Diabetes Care*, and *Prenatal and Postpartum Care*—for a total of 23 measurement indicators.<sup>10</sup>

- *Adolescent Well-Care Visits*
- *Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months)\**
- *Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months)\**
- *Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months)\**
- *Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months)\**
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis\**
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 2*
- *Childhood Immunization Status—Combination 3\**
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Good Control (<7.0%)\**
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)\**
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)\**
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Use of Appropriate Medications for People With Asthma*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*

The DHCS strives to select measures that gauge the quality of care provided to and access to care experienced by the largest segments of the Medi-Cal managed care population. The EQRO compiles and validates the measurement results from all the plans and communicates the results to the DHCS in an annual *Performance Measures for Medi-Cal Managed Care Plans* report.

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<sup>10</sup>The measures are set forth annually in All Plan Letters issued by the DHCS and available on its website. See All Plan Letter No. 07-013, entitled “Quality and Performance Improvement Program Requirements for 2008.”

\* MPLs/HPLs were not applied to these measures in 2008.

The *Report of the 2007 Performance Measures for Medi-Cal Managed Care Plans* and the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Plans* (“*Annual Performance Measures reports*”) provide the Medi-Cal managed care weighted average for each measure. The Medi-Cal managed care weighted average accounts for variation in membership across plans. The plans’ HEDIS data processes are audited according to the protocols described in the *Annual Performance Measures reports*. CHG’s rates in this plan report were taken from the *Annual Performance Measures reports*, as were the state and national benchmark rates used for comparison.

### **Performance Level Criteria**

This report utilizes the following established benchmarks in assessing plans’ performance on measures:

- Medi-Cal Managed Care Weighted Average (Same Year)
- National Medicaid Average (Prior Year)
- National Commercial Average (Prior Year)

The DHCS compares plan rates to Minimum Performance Levels (MPLs) and High Performance Levels (HPLs) for each measure to assess further program-wide quality of care and to identify specific health plan improvement needs. MPLs and HPLs are equal to the 25<sup>th</sup> and the 90<sup>th</sup> percentiles, respectively, of the 2006 and 2007 national Medicaid results. The performance benchmarks (MPLs and HPLs) were taken from NCQA’s *Quality Compass* for the previous year.

The HPL rates help identify plans that outperform the national Medicaid 90<sup>th</sup> percentile from the previous year. The DHCS does not apply the MPL and HPL to the first-year scores reported for any measure since that rate establishes a “baseline”. Similarly, the MPL and HPL are not applied in years when there were substantive changes to a measure’s technical specifications, since making a comparison to the previous rate would be inappropriate.

## Appendix B: CAHPS®

### CAHPS Background

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)<sup>11</sup> program is funded and administered by the U.S. Agency of Healthcare Research and Quality (AHRQ). AHRQ works closely with a consortium of public and private organizations to develop and support a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their health care experiences.

The CAHPS surveys capture members' ratings of health care experiences and probe those aspects of care for which members are the best, and sometimes, the only source of information. CAHPS results allow the DHCS to determine how well health plans are meeting their members' expectations and provide individual feedback to plans. This data-driven communication encourages health plan accountability and supports health plan efforts to develop and implement action plans for improving members' satisfaction with their healthcare and plan services. CAHPS results are presented and discussed in this report in relation to quality, access, and timeliness.

The DHCS generally has CAHPS surveys administered every two years. The survey discussed in this report was administered in 2007. Across all Medi-Cal managed care plans, a total of 38,824 adult surveys and 85,028 child surveys were mailed to members. A total of 12,985 adult members and 25,224 child members responded to this survey—a 35 percent and 30 percent adjusted response rate,<sup>12</sup> respectively.

### CAHPS Measurements

During this reporting period, the 2007 CAHPS 4.0H Adult Medicaid Survey and the 3.0H Child Medicaid Survey were administered to members of the Medi-Cal managed care contracted health plans.

The 2007 Adult (4.0H CAHPS) survey consisted of 51 questions. The 51 questions were categorized into five major areas:

- Your Health Care in the Last 6 Months
- Your Personal Doctor
- Getting Health Care From Specialists
- Your Health Plan
- About You

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<sup>11</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

<sup>12</sup> The adjusted response rate for the category is calculated by dividing the total number of surveys completed by the difference between the number of surveys mailed and the number of surveys found to be ineligible.

The 2007 Child (3.0H CAHPS) survey consisted of 110 questions. The 110 questions were categorized into seven major areas:

- Your Child's Personal Doctor or Nurse
- Getting Health Care From a Specialist
- Your Child's Health Care in the Last 6 Months
- Specialized Services
- Your Child's Health Plan
- Prescription Medicines
- About Your Child and You

Survey results were divided into composite areas. The composite areas are used to report plan scores and are derived by combining similar questions. Composite areas include *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, and *Customer Service*. As with other data sources used throughout this report, Delmarva assessed CAHPS scores using the quality, access, and timeliness framework. CAHPS composite scores were divided as follows:

- Quality
  - *Getting Needed Care*
  - *How Well Doctors Communicate*
- Access
  - *Getting Care Quickly*
- Timeliness
  - *Courteous and Helpful Office Staff*
  - *Customer Service*

Adult members were classified as those 18 years or older and child members were classified as those members 17 years or younger for survey purposes.

Medi-Cal Adult and Child overall averages were calculated from the ratings of all 30 contracts within the Medi-Cal managed care plans operating in the State of California and were weighted to be proportionate to plan enrollment. Delmarva employed a calculation method whereby a plan's result is considered indicative of high performance in a CAHPS composite area when 80 percent or more of the total responses for the composite area fall within the most positive response category (*i.e.*, definitely yes, always, etc.). It should be noted that this calculation method differs from the standardized scoring method established by NCQA. For future CAHPS surveys, California is likely to adopt NCQA's calculation methods, including scoring.

## **Sample Selection and Survey Methodology**

Sample selection and survey methodology are summarized below:

### ***Sample Groups***

Surveyors pulled a random sample of eligible members from each managed care plan for participation in the survey.

### ***Adult Sample***

For each managed care plan, the CAHPS 4.0H adult survey sample was drawn first, employing the required sample size. An overall score was calculated for the adult population by collecting the results from all plans and weighting the results by each plan's population size relative to the total Medi-Cal managed care population.

### ***Child Sample***

The CAHPS 3.0H child survey sample was drawn second, employing the required sample size.

### ***Children with Chronic Conditions and CSHCN Population***

The Children with Chronic Conditions (CCC) supplemental sample is drawn from the set of prescreened members who were not already selected for the CAHPS 3.0H child survey sample. The CCC survey-based screening tool contains five questions representing five different health consequences. A child member is identified as having a chronic condition if all parts of the question for at least one of the specific health consequences are answered "Yes."

The CSHCN population consists of all child members identified as having a chronic condition, as defined by the parent/guardian's responses to the CCC survey-based screening tool. The term "CSHCN" refers to all child members surveyed who met the criteria for Children with Special Health Care Needs. After Sample A was drawn, an oversample (Sample B) was drawn as required by NCQA sampling methodology. Sample B contains the CCC Measurement Set. The prescreening process described above identified these children. Therefore, it is important to note that the CCC population data set is a subset of Sample A/General Population and the CCC population may also have been included in the results for Sample B.

Calculating an overall score by collecting the results from all plans and weighting the results by plan population size could not be accomplished for the CSHCN population due to the selection methodology and possibility of "double counting". Overall, 31 percent of child members across all plans qualified as having special health care needs based on parent's/guardian's responses to the CCC screening tool.

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