Performance Evaluation Report

Community Health Group Partnership Plan

July 1, 2008–June 30, 2009

Medi-Cal Managed Care Division
California Department of
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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.4 million beneficiaries in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Plan-specific reports are issued in tandem with the technical report. This report is unique to the MCMC Program's contracted plan, Community Health Group Partnership Plan ("Community Health Group," "CHG," or "the plan"), for the review period July 1, 2008, to June 30, 2009. Plan-specific reports include findings for each plan regarding its organizational assessment and structure, performance measures, and QIPs as they relate to the quality, access, and timeliness domains of care. Actions taken by the plan subsequent to June 30, 2009, regarding findings identified within this report will be included in the next annual plan-specific evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

Based on the plan's 2009 performance measure rates (which reflect 2008 measurement data), QIP outcomes, and compliance review standards related to measurement and improvement, HSAG found that CHG demonstrated average performance for the quality domain of care.

To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPL indicate low performance, rates at or above the HPL indicate high performance, and rates at the MPL or between the MPL and HPL demonstrate average performance.

Most of CHG's performance measure rates fell between the established MPLs and HPLs. The plan fell below the MPLs for three of its performance measures and did not exceed the HPLs for any measures. Overall, CHG's rates demonstrated stable performance from the prior measurement period with no statistically significant change, with the exception of *Childhood Immunization Status—Combination 3 (CIS–3)*, which had a statistically significant increase.

During the review period, both of CHG's QIPs were in the baseline phase; therefore, HSAG could not assess for improvement of those health outcomes. HSAG noted that the plan has an opportunity to improve its documentation of both QIPs to comply with federal requirements for conducting a QIP. Following the Centers for Medicare & Medicaid Services (CMS) protocol for conducting a QIP increases the likelihood that the plan will achieve real and sustained improvement of health outcomes. Additionally, the plan will need to evaluate the efficacy of its intervention strategies annually and modify or replace interventions that did not result in improvement.

CHG's strength in delivering quality care to members included its rate for childhood immunizations, which had a statistically significant increase and was close to exceeding the HPL. Additionally, CHG was fully compliant with administrative and organizational capacity requirements, including a quality improvement program that supported the delivery of quality, accessible, and timely care.

CHG has opportunities to improve the quality of care for its Medi-Cal managed care members by increasing performance measure rates that fell below the established MPLs. These measures were related to prescribing practices for adults with acute bronchitis, members with asthma, and timeliness of prenatal care.

Audit findings showed that CHG's quality improvement program and work plan did not sufficiently address repeat findings from the previous audit in order to demonstrate compliance.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members.

The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess plans' compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Many performance measures fall under more than one domain. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

CHG demonstrated average performance for the access domain of care based on its 2009 performance measure rates that related to access, QIP outcomes that addressed access, and compliance review standards related to the availability of and access to care.

CHG's 2009 performance measures related to access all fell primarily between the MPLs and HPLs, with the exception of *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre),* which remained below the MPL in 2009.

Based on audit findings, the plan demonstrated processes to monitor access and availability of services to members through analysis of its provider network, member complaints, member satisfaction survey results, group needs assessment, and utilization management staff feedback.

CHG also had standards to monitor access to care for routine, preventive, prenatal care, well-baby visits, urgent care, and in-office wait times.

CHG has opportunities to improve access to care for members by extending its monitoring of specialty care to ensure compliance with the plan's access standard of two weeks. Additionally, CHG was unable to ensure case coordination for all members receiving early intervention services and developmental disabilities services at the San Diego Regional Center. The plan also lacked a mechanism to monitor and intervene with providers who were not documenting initial health assessments.

Timeliness

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

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

Based on 2009 performance measure rates for providing timely care and for compliance review standards related to timeliness, CHG demonstrated average to below-average performance in the timeliness domain of care.

For performance measures, the plan performed within the MCMC-established thresholds for well-child visits, postpartum visits, and childhood immunizations in the timeliness domain of care. The plan did not meet the MPL for timeliness of prenatal care.

The plan had several audit findings that noted areas for improvement related to timeliness of prior authorization requests, noncompliance with required language within the notice of action letters, and denial decisions made by non-physicians. These were repeat areas of noncompliance.

A review of emergency room claims found that CHG's procedures for processing out-of-network claims were inadequate to ensure appropriate and timely payment. Additionally, the plan lacked a process to monitor payment timeliness for claims that the plan had redirected to a delegated entity. CHG's notification of providers regarding denied claims did not include information about the provider dispute resolution process and only minimal information regarding the reason for denial. Also, regarding member grievances, the plan failed to provide State fair hearing information to members for all files reviewed.

Conclusions and Recommendations

Overall, CHG demonstrated average performance in providing quality and accessible health care services and average to below-average performance in providing timely services to its MCMC members. CHG's performance measure rates were primarily between the established MPLs and HPLs. CHG was below the MPLs for three performance measures related to appropriate treatment for acute bronchitis in adults and for members with asthma, as well as for prenatal care.

CHG demonstrated compliance with all of the DHCS standards for structure and operations. Opportunities for improvement exist for member rights, continuity and coordination of care, and the grievance system.

Based on the overall assessment of CHG in the areas of quality and timeliness of and access to care, HSAG recommends the following:

- Focus targeted efforts to improve areas of performance below the MPL for appropriate treatment for adults with acute bronchitis, appropriate treatment for members with asthma, and for timeliness of prenatal care.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.
- Evaluate the efficacy of QIP intervention strategies annually and modify or replace interventions that have not resulted in improvement.
- Incorporate deficient audit areas within the work plan to ensure action, monitoring, and ongoing improvement.
- Extend the current process for monitoring access to specialty care for compliance with the plan's established standard of two weeks.
- Establish a process to ensure case coordination for all members receiving early intervention services and members with developmental disabilities.
- Develop a mechanism to monitor and intervene with providers who are not documenting initial health assessments.
- Implement a review of the prior authorization process to ensure that notice of action letters include all required language and that the notifications are sent in a timely manner.
- Modify the process for payment of out-of-network claims to address timely and appropriate payment deficiencies.

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

Plan Overview

Community Health Group Partnership Plan (CHG) is a full-scope Medi-Cal managed care plan in San Diego County. CHG became operational with the MCMC Program in August 1998, and as of June 30, 2009, CHG had 84,377 MCMC members. [1]

CHG delivers care to its members as a Geographic Managed Care (GMC) model. In the GMC model, Medi-Cal beneficiaries in both mandatory and voluntary aid codes choose between several commercial plans within a specified county.

[1] *Medi-Cal Managed Care Enrollment Report, June 2009*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about CHG's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards primarily fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Joint Audit Review

The DHCS's Audits and Investigations (A&I) Division works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A joint audit is conducted for each MCMC plan approximately once every three years. In addition, A&I periodically conducts non-joint medical audits of five MCMC plans; however, CHG is not among those plans designated for a non-joint medical audit.

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. The most recent joint audit for CHG was conducted in June 2007, covering the review period of June 1, 2006, through May 31, 2007. The audit showed that CHG was fully compliant with the requirements reviewed under the administrative and organizational capacity area. The plan was deficient with some requirements in the remaining areas

reviewed under the scope of the audit for utilization management, continuity of care, availability and accessibility, members' rights, and quality management.

CHG demonstrated a utilization management program that it continually updates. Utilization management decisions are made based on established medical guidelines. The plan's chief medical officer is responsible for overseeing the quality and effectiveness of patient care. The plan has an operational structure that supports ongoing reporting, monitoring, and analysis of under- and over-utilization, including drug utilization, as part of its committee reporting.

For prior authorizations, CHG's policy and procedure allowed review of denials by other health professionals when the contract required that a physician review all treatment request denials. The plan updated its policy to be compliant with this contract requirement. The audit revealed omission of required language within prior authorization notification letters and late or no issuance of the letters, a repeat finding from the last review. While CHG tracked referrals from prior authorizations, this process lacked monitoring for timeliness and continuity of care.

The plan demonstrated procedures for providing case management to members through their primary care physicians, a case manager at the primary site, and the plan's case management team. CHG had evidence that it ensured communication between specialty and primary care providers and coordinated care for those members transitioning from the inpatient to outpatient setting. The plan demonstrated processes to monitor coordination of care through facility site reviews, member service referrals, online referral tracking for physicians, and denial rates.

The audit revealed two areas of deficiency for continuity and coordination of care. CHG was unable to ensure case coordination for all members receiving early intervention services and members with developmental disabilities. However, the plan has taken action to collaborate with the regional center to obtain access to a monthly data file and identify members receiving services. The plan also lacked a mechanism to monitor and intervene with providers who were not documenting initial health assessments.

CHG monitors access and availability of services to members through analysis of its provider network, member complaints, member satisfaction survey results, group needs assessment, and utilization management staff feedback. The plan has policies that include standards for access to care for routine, preventive, and prenatal care; well-baby visits; urgent care; and in-office wait times. The audit showed that the plan lacked a mechanism to monitor access to specialty care with the plan's access standard of two weeks. The audit found that member services representatives gave incorrect information or medical advice.

Auditors reviewed a sample of emergency room claims. The audit found that CHG's procedures for processing out-of-network claims were inadequate to insure appropriate and timely payment. Additionally, the plan lacked a process to monitor timely claims payment after a claim was

redirected by the plan to a delegated entity. CHG did not send written notification to members for claims denials. CHG's provider notification of a denied claim did not include information about the provider dispute resolution and provided minimal information regarding the reason for the action.

Under members' rights, the plan's policy and procedure related to protected health information lacked reporting requirements to notify the DHCS regarding a suspected or actual breach of security.

Finally, CHG's quality improvement program and work plan did not sufficiently address repeat findings from the previous audit in order to demonstrate compliance.

Member Rights and Program Integrity Monitoring Review

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

As part of the monitoring process, the MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance.

For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2009. MRPIU conducted a routine monitoring review of CHG in April 2008, covering the review period of January 1, 2006, through December 31, 2007. MRPIU noted nine review findings.

Under member grievances, two files did not contain State fair hearing information. For prior authorizations, the audit found two case files in which the notice of action (NOA) letters did not meet the required time frame after the authorization had been extended. One file lacked the approved NOA letter. All NOAs lacked a signature by a chief medical director or officer and only included the delegated entity name.

One provider office reviewed did not discourage the use of family, friends, or minors as interpreters, which can compromise the reliability of medical information. Additionally, one provider office indicated that it had not received cultural competency training. The DHCS

requires that members have access to 24-hour oral interpretation services. One provider office indicated that its answering machine provided information in English only. The DHCS requires that plans provide marketing materials in all languages where the plan meets an established threshold. The review found that CHG lacked marketing materials in Vietnamese and Arabic languages.

Strengths

CHG was fully compliant with administrative and organizational capacity requirements, including a quality improvement program that supports the delivery of quality, accessible, and timely care.

The plan's internal 2008 quality improvement program evaluation showed that CHG monitored many key indicators such as performance measures results, access and availability of services, member demographics, continuity and coordination of care, disease management, quality improvement projects, health education and assessments, quality of care complaints, member and provider satisfaction, provider site visits compliance, credentialing, claims, cultural and linguistic activities, utilization management, case management, technology assessment, safety, and fraud, abuse and waste.[2]

Opportunities for Improvement

CHG has an opportunity to review its prior authorization process to ensure that notice of action letters include all required languages and that it sends timely notification. The plan should implement a process to monitor ongoing compliance in this area. Additionally, the plan needs to revise its process for payment of out-of-network claims to address all areas of noncompliance.

While the plan demonstrated monitoring of many aspects of quality within its annual internal quality improvement program evaluation, CHG should incorporate deficient audit areas within its work plan to ensure action, monitoring, and ongoing improvement.

[2] Community Health Group. *2008 Quality Improvement Program Quality Evaluation*.

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about CHG's performance in providing quality, accessible and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Performance Measure Validation

HSAG performed a HEDIS® Compliance Audit™[3] of CHG in 2009. HSAG found all measures to be reportable and that CHG's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

Audit recommendations involved pursuing methods to gather data for outside services provided to members. The plan should also consider additional steps to capture more completed encounter data. CHG could improve encounter timeliness by examining the plan's existing approach and implementing appropriate changes.

[3] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS Compliance Audit™ is a trademark of the NCQA.

Performance Measure Results

The table below presents a summary of CHG's county-level HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measures results (based on calendar year 2007 data). In addition, the table shows the plan's HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the National Committee for Quality Assurance (NCQA) national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—a low rate indicates better performance and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the Medicaid 10th percentile.

Due to significant methodology changes for the *Comprehensive Diabetes Care—HbA1c Control (< 7.0 Percent)* measure in 2009, the MCMC Program was unable to compare 2008 and 2009 performance results for this measure.

Appendix A includes a performance measure name key with abbreviations contained in the following table.

Table 4.1 2008–2009 Performance Measure Results for Community Health Group—San Diego County

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	24.2%	20.5%	★	↔	20.6%	35.4%
ASM	Q	86.8%	84.7%	★	↔	86.1%	91.9%
AWC	Q,A,T	36.0%	39.9%	★★	↔	35.9%	56.7%
BCS	Q,A	49.9%	52.1%	★★	↔	44.4%	61.2%
CCS	Q,A	66.4%	65.9%	★★	↔	56.5%	77.5%
CDC–E	Q,A	46.0%	46.6%	★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	27.7%	29.5%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	49.1%	48.5%	★★	↔	52.5%	32.4%
CDC–HT	Q,A	77.6%	79.8%	★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	34.3%	37.4%	★★	↔	25.1%	42.6%
CDC–LS	Q,A	74.0%	77.7%	★★	↔	66.7%	81.8%
CDC–N	Q,A	76.2%	73.4%	★★	↔	67.9%	85.4%
CIS–3	Q,A,T	64.2%	77.4%	★★	↑	59.9%	78.2%
PPC–Pre	Q,A,T	73.0%	76.4%	★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	51.3%	54.3%	★★	↔	54.0%	70.6%
URI	Q	84.0%	84.8%	★★	↔	79.6%	94.1%
W15	Q,A,T	46.5%	51.0%	★★	↔	44.5%	73.7%
W34	Q,A,T	74.7%	75.9%	★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for full name of each HEDIS measure.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.
[4] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[5] Performance comparisons are based on the *z* test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
† The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.
Not Comparable = Performance could not be compared due either to significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, CHG demonstrated average performance, falling between the MPLs and HPLs for most of its reported performance measures in 2009. The plan did not exceed the HPLs for any measure. The plan had below-average performance in three areas: *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB), Use of Appropriate Medications for People With Asthma (ASM),* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre*). Between 2008 and 2009, CHG had stable performance for comparable rates with only one measure, *Childhood Immunization Status—Combination 3 (CIS–3),* demonstrating a statistically significant change.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. Plans that have rates below these minimum levels must submit an improvement plan to the DHCS for each area of deficiency, outlining the steps they will take to improve care.

Based on the plan's 2008 performance, the DHCS required CHG to submit improvement plans for each of the three HEDIS measures that fell below the MPL. Improvement plans required were for both the prenatal and the postpartum care measures and another was required for the *Well-Child Visits in the First 15 Months of Life (W15)* measure.

CHG continued its existing efforts—put into place in 2006—as a strategy for increasing well-child visits and postpartum care since these interventions demonstrated year-over-year improvement. For well-child visits, these interventions included provider education and incentives, patient reminders, implementation of an internal task force, and provider reminders. For postpartum care, these interventions included member and provider education, member and provider incentives, implementation of an internal task force, high-volume provider data initiatives, data tracking, and provider profiling. Although CHG did not have statistically significant improvement for these three rates in 2009, the plan's *Prenatal and Postpartum Care—Postpartum Care* (*PPC–Pst*) and *Well-Child Visits in the First 15 Months of Life (W15)* rates increased above the MPLs, and improvement plans were not required for these measures for the plan's HEDIS 2009 performance.

While CHG conducted a barrier analysis related to poor performance for timeliness of prenatal care, the plan did not implement an intervention until January 2009. Therefore, the member and practitioner incentive intervention was not in place during the 2008 measurement year. The *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre*) measure remained below the MPL in 2009. The plan will need to monitor its 2010 rate to determine if the member and provider incentive intervention was effective in improving the rate.

Based on the plan's 2009 performance, the DHCS required CHG to submit improvement plans for three HEDIS measures that fell below the MPLs: *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB), Use of Appropriate Medications for People With Asthma (ASM),* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre).*

Strengths

Although CHG did not perform above the MMCD HPLs on any measure, the plan's *Childhood Immunization Status—Combination 3 (CIS–3)* rate had a statistically significant increase over the prior year and the rate was only 0.8 of a percentage point below the HPL.

The plan showed improvement for all of its rates below the MPLs in 2008 and achieved a rate above the MPLs for two of those three measures in 2009. CHG had no statistically significant declines in performance between 2008 and 2009, which indicates stability of its rates.

Opportunities for Improvement

CHG's rate for its *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* measure remains below the MPL and therefore continues to present as an opportunity for improvement. Additionally, the rate for *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)* is only 0.3 of a percentage point above the MPL. CHG's performance in this area may point to issues with health care access, timeliness, and/or quality.

Additional areas of opportunity include *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)* and *Use of Appropriate Medications for People With Asthma (ASM),* both of which declined in performance below the MPLs in 2009 and may indicate issues with prescribing practices and the quality of care.

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about CHG's performance in providing quality, accessible, and timely care and services to its MCMC members. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Quality Improvement Projects Conducted

CHG had three clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted the reduction of avoidable ER visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. CHG's second project is part of a small-group collaborative aimed at increasing the assessment, diagnosis, and appropriate treatment of chronic obstructive pulmonary disease (COPD). CHG's third QIP targeted increasing postpartum depression screening and follow-up care for positive screens. This QIP, however, was not validated during the review period; therefore, validation results and outcome data for this project will be reported in the next annual evaluation report.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider in an office or clinic setting. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease. The plan's COPD project attempted to improve the quality of care delivered to members with a chronic disease by evaluating aspects of care such as testing,

treatment, and hospitalizations. Both QIPs fell under the quality domain of care. The statewide collaborative QIP also fell under the access domain of care.

Quality Improvement Project Validation Findings

The DHCS contracted with HSAG as its new EQRO in the second half of 2008. HSAG began validation for QIPs submitted by the plans after July 1, 2008.

Table 5.1 summarizes the validation results for both of CHG's QIPs across CMS protocol activities during the review period.

Table 5.1—QIP Validation Results for Community Health Group—San Diego County (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	100%	0%	0%
II.	Clearly Defined, Answerable Study Question(s)	50%	0%	50%
III.	Clearly Defined Study Indicator(s)	54%	38%	8%
IV.	Correctly Identified Study Population	0%	50%	50%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	25%	25%	50%
VII.	Appropriate Improvement Strategies	100%	0%	0%
VIII.	Sufficient Data Analysis and Interpretation	42%†	17%†	42%†
IX.	Real Improvement Achieved	25%	0%	75%
X.	Sustained Improvement Achieved	‡		
Percentage Score of Applicable Evaluation Elements *Met*		**50%**		
Validation Status		***Not Applicable****		

‡ The QIP did not progress to this activity during the review period and could not be assessed.
* QIPs were not given an overall validation status during the review period.
† The sum may not equal 100 percent due to rounding.

Neither of CHG's QIPs had progressed to a second remeasurement period during the review period. For that reason, HSAG could not assess for sustained improvement.

During the period covered by this report, HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the MCMC plans. As a result, many plans had difficulty complying fully with these requirements during the first cycle of QIP validations by HSAG. This was the case with CHG's two QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided CHG, as well as other plans, with an overall validation status of "Not Applicable" for both QIPs. This allowed time for plans to receive technical assistance and training with HSAG's validation requirements without holding up the ongoing progress of QIPs that were already underway.

Quality Improvement Project Outcomes

Table 5.2 shows CHG's data for its QIPs. For the ER collaborative QIP, CHG's goal was to reduce the overall rate of members who used the emergency room to less than 5 percent in its avoidable ER visits rate. The plan's baseline rate for this measure was 17.9 percent. The plan has submitted its data for Remeasurement 1 and, while HSAG validated the data, the results are not presented in Table 5.2 for consistency in reporting collaborative data. HSAG will present Remeasurement 1 results in the next plan-specific evaluation report for 2009–2010.

For its QIP, *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD,* CHG set the following goals:

- Increase the percentage of members (appropriate for Spirometry testing) who receive a Spirometry test to 12.5 percent (the rate reported at baseline measurement was 11.4 percent).
- Decrease the percentage of acute inpatient hospitalization discharges of members with COPD to 49.4 percent (the rate reported at baseline measurement was 54.9 percent).
- Decrease the percentage of emergency department visits for members with COPD to 61.1 percent (the rate reported at baseline measurement was 69.0 percent).
- For member 40 years of age and older who had an acute inpatient discharge or ED visit, increase the percentage of members who were dispensed a systemic corticosteroid within 14 days to 57.8 percent and increase the percentage of members who were dispensed a bronchodilator within 30 days to 82.5 percent (the rates reported at baseline measurement were 52.5 and 75.0 percent, respectively).

Table 5.2—QIP Outcomes for Community Health Group—San Diego County

QIP #1—Reducing Avoidable Emergency Room Visits				
		Remeasurement Period		
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	1 1/1/08–12/31/08	2 1/1/09–12/31/09	Sustained Improvement
Percentage of ER visits that were avoidable	17.9%	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD			
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Sustained Improvement
1) Percentage of eligible members with at least one Spirometry test in the two years before or six months after the Index Episode Start Date	11.4%	‡	‡
2) Percentage of acute inpatient hospitalization discharges of members with COPD	54.9%	‡	‡
3) Percentage of emergency department (ED) visits for members with COPD	69.0%	‡	‡
4) Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter who were dispensed :			
a) Systemic corticosteroid within 14 days of the event	52.5%	‡	‡
b) Bronchodilator within 30 days of the event	75.0%	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.			

Strengths

CHG demonstrated a good understanding of documenting support for its QIP topic selections and for providing plan-specific data. In addition, CHG's interventions to address identified causes/barriers and system interventions are likely to induce permanent change.

Opportunities for Improvement

CHG's greatest opportunity for improvement is bolstering its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with the DHCS requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

As part of CHG's group needs assessment and telephonic survey on ER use in October 2007, the plan identified that more than 90 percent of members who accessed the ER did not know how to contact the 24-hour advice line and had not tried to contact the advice line before going to an ER. The plan had several interventions that had been ongoing since 1996 to educate members regarding the advice line and use of the ER. Those interventions, however, were not effective. The plan will need to develop new interventions and then evaluate their efficacy annually.

The statewide collaborative QIP's member health education campaign attempts to educate members about contacting their providers before going to the ER for many common, nonurgent conditions. CHG will need to gain provider support and participation to meet the collaborative campaign goal of treating patients in an outpatient setting rather than referring them to the ER.

CHG had not yet identified interventions for its COPD QIP. The plan should implement interventions that will affect the study indicators by addressing specific barriers. Having identified four study indicators, the plan may need to implement multiple study indicator-specific interventions.

The table below provides abbreviations of HEDIS performance measures used throughout this report.

Table A.1—HEDIS® Performance Measures Name Key

Abbreviation	Full Name of HEDIS® Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ASM	*Use of Appropriate Medications for People With Asthma*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–E	*Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed*
CDC–H7	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)*
CDC–H9	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC	*Comprehensive Diabetes Care—LDL-C Control*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W15	*Well-Child Visits in the First 15 Months of Life (Six or More Visits)*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*