Performance Evaluation Report

Care 1st Partner Plan

July 1, 2008–June 30, 2009

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

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1. Executive Summary

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.

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. This report is unique to the MCMC Program's contracted plan, Care 1st Partner Plan ("Care 1st" or "the plan"), for the review period of July 1, 2008, to June 30, 2009. 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.

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.

Based on the plan's 2009 performance measure rates (which reflect 2008 data), QIP outcomes, and compliance review standards related to measurement and improvement, HSAG found that Care 1st demonstrated average performance for the quality domain of care.

Most of Care 1st's performance measures fell between the MPLs and HPLs. Overall, Care 1st's performance measure rates demonstrated stable performance from the prior measurement period, with all comparable rates showing no statistically significant change.

Care 1st's strengths in delivering quality care to members included its rate for *Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N),* which exceeded the HPL. The plan improved its *Cervical Cancer Screening (CCS)* rate, which was below the MPL in 2008, to above the MPL in 2009.

Care 1st can improve the quality of care for its Medi-Cal managed care members by increasing its performance measure rate for *Breast Cancer Screening (BCS)*, which fell below the MPL.

During the review period, all three of Care 1st's QIPs were in the baseline phase; therefore, HSAG could not assess for improvement of health outcomes. HSAG noted that the plan has an opportunity to improve its documentation of all three QIPs to meet compliance with federal requirements for conducting a QIP. Following the Centers for Medicare & Medicaid Services

(CMS) protocol for conducting a QIP increases the likelihood of a plan achieving real and sustained improvement of health outcomes. Additionally, Care 1st has an opportunity to evaluate whether its interventions align with the study indicators and address identified barriers. HSAG noted that these did not always align to improve health outcomes.

Based on audit findings during the review period, the DHCS's Member Rights/Program Integrity Unit (MRPIU) noted that Care 1st did not include program requirements related to the quality program in its policy and procedures. The plan needs to update its policies and procedures to include the required elements. Despite the deficiencies noted within the policies, the plan's internal annual quality evaluation demonstrated that the plan has a quality improvement program that monitors and analyzes data related to areas of clinical care such as practice guidelines, disease management, performance measures, and quality-of-care issues.

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.

Care 1st demonstrated average performance for the access domain of care based on its 2009 performance measure rates that relate to access, QIP outcomes that address access, and compliance review standards related to the availability of and access to care.

Care 1st's 2009 performance measures related to access fell primarily between the MPLs and HPLs. The plan performed below the MPL for breast cancer screening, which could indicate an issue with access and availability of mammography services.

During the review period, audit findings showed that the plan has an opportunity to improve member access to oral translation services at its contracted provider offices and increase access to specialists. MRPIU's review found that not all of the plan's providers offered language translation services to their MCMC members. Some offices did not discourage the use of family and friends

from acting as interpreters, which may compromise medical information. The plan noted several pediatric specialty areas that were below the plan-established goal of 95 percent for having at least one specialist within 15 miles of a member's home.

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 compliance review standards related to timeliness, Care 1st demonstrated average performance in the timeliness domain of care.

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 breast cancer screening.

The MRPIU review findings showed that Care 1st was in full compliance for member grievances and prior-authorization notification files. The California Department of Managed Health Care's (DMHC's) independent, routine medical survey showed full compliance by the plan related to grievances and appeals; however, the survey recommended that the plan revise its appeal resolution letters to include the criteria used to make the determination. The plan had no audit findings related to marketing and enrollment programs and program integrity.

Care 1st noted its highest area of member concern was related to a delay in authorizations from its delegated independent physician associations (IPAs). Although the plan reviewed and found that the authorizations were made within appropriate time frames, the plan has an opportunity to reduce and address this perception of its members.

Conclusions and Recommendations

Overall, Care 1st demonstrated average performance in providing quality, accessible, and timely health care services to its Medi-Cal managed care members. Care 1st's performance measure rates were primarily between the MPLs and HPLs. Care 1st exceeded the HPL for its *Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N)* measure. The plan fell below the MPL for its *Breast Cancer Screening (BCS)* measure.

Care 1st demonstrated compliance with most MRPIU standards for member grievances, prior-authorization notification, and program integrity. Opportunities for improvement related to policy and procedures for quality of care, and cultural and linguistic services requirements.

Based on the overall assessment of Care 1st in the areas of quality and timeliness of and access to care, HSAG recommends the following:

- Explore factors contributing to the low rate for *Breast Cancer Screening (BCS)* and implement interventions to improve performance.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance toward increasing compliance with the CMS protocol for conducting QIPs.
- Evaluate and revise QIP interventions that align with the QIP's study indicators and identified barriers to increase the likelihood of achieving success.
- Revise policies and procedures related to the quality program to include all required elements.
- Educate providers on language translation requirements to improve access to oral translation services.
- Continue efforts to expand the provider network to achieve thresholds for all high-volume specialists.
- Revise appeal resolution letters to include the criteria used to make the determination.
- Implement strategies to decrease member concerns related to a delay in authorization from delegated IPAs.

During the review process for this report, Care 1st noted that it had already initiated improvement activities related to many of the above opportunities for improvement recommended by HSAG. Although documenting those activities is outside the scope of the time period covered by this report. In the next annual review, HSAG will evaluate Care 1st's progress with these recommendations along with its continued successes.

Plan Overview

Care 1st Partner Plan is a full-scope Medi-Cal managed care plan in San Diego County. Care 1st serves its MCMC members under a Geographic Managed Care (GMC) model. Care 1st became operational with the MCMC Program in San Diego County in February 2006. As of June 30, 2009, Care 1st had 9,199 MCMC members.[1]

In the GMC model, enrollees choose from three or more commercial plans offered in a county. Beneficiaries with designated, mandatory aid codes must enroll in a managed care plan. Seniors and individuals with disabilities who are eligible for Medi-Cal benefits under the Supplemental Security Income (SSI) program and a small number of beneficiaries in several other aid codes are not required to enroll in a plan but may choose to do so. These "voluntary" beneficiaries may either enroll in a managed care plan or receive services through the Medi-Cal fee-for-service program.

[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 Care 1st's performance in providing quality, accessible, and timely health care 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

For the purposes of this report, HSAG reviews the most current medical survey/medical audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards.

The DHCS's Audits and Investigations (A&I) Division works in conjunction with DMHC to conduct routine, joint medical surveys/medical audits (joint audits) of MCMC plans. These joint audits assess plans' compliance with contract requirements and State and federal regulations. Generally, a joint audit is conducted for each MCMC plan approximately once every three years. Although the A&I Division periodically conducts non-joint medical audits of five Medi-Cal managed care plans, Care 1st is not among those plans designated for a non-joint medical audit.

While neither a joint medical survey/medical audit nor a non-joint medical audit by the A&I Division were conducted since the plan became operational in 2006, DMHC conducted a medical

survey independent of a joint audit of Care 1st in November 2007. The scope of the independent, routine medical survey covered the areas of quality management, grievances and appeals, access and availability of services, and utilization management.[2]

The survey results showed no deficiencies as the plan was compliant with the requirements in all areas covered under the review. DMHC did recommend that the plan revise its appeal resolution letters to include the criteria used to make the determination. Although the plan indicated that the member could request a copy of the criteria used, DMHC found that this practice did not meet the requirement.

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, 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, 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 Care 1st in June 2009, covering the review period of July 1, 2008, through May 31, 2009. The review found Care 1st to be fully compliant with member grievances, prior-authorization notification, marketing and enrollment programs, and program integrity. MRPIU noted findings related to the plan's policies and procedures for quality of care and cultural and linguistic services.

Care 1st's policies and procedures lacked documentation of three required elements related to quality of care for:

- Implementing an effective quality improvement program.
- Maintaining objective and systematic monitoring and evaluation of the quality and appropriateness of care and services delivered on an ongoing basis.
- Maintaining a utilization management program.

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[2] Department of Managed Health Care, Division of Plan Surveys. *Final Report – Routine Medical Survey Care 1st Health Plan.* April 24, 2008.

Under cultural and linguistic services, three of eight provider offices were not aware of the member interpreter services/access requirements. Additionally, two of these offices indicated that they do not discourage the use of family, friends, or minors as interpreters. Using these individuals as interpreters can compromise the reliability of medical information.

Strengths

The plan complied with State and federal requirements to become fully operational under the MCMC Program in 2006.

The MRPIU review findings showed that Care 1st was in full compliance with requirements for member grievances and prior-authorization notification files. The plan also had no audit findings related to marketing and enrollment programs and program integrity. Care 1st was fully compliant with requirements in the areas of quality management, grievances and appeals, access and availability of services, and utilization management as reported in the DMHC routine medical survey.

Although MRPIU's findings revealed the lack of required elements within the plan's policies and procedures, HSAG's review of Care 1st's 2008 Fourth Quarter Report/Annual Evaluation[3] found evidence that the plan has implemented both a quality improvement program and a utilization management program and monitors and evaluates quality of care on an ongoing basis. Care 1st demonstrated monitoring and analyzing data related to areas of clinical care such as practice guidelines, disease management, performance measures, and quality of care issues during the review period. Additionally, the evaluation included analysis of access and availability, continuity and coordination of care, member and provider satisfaction, facility site review and patient safety, and credentialing.

Opportunities for Improvement

Care 1st has an opportunity to update its policies and procedures to include the required elements related to the quality program. Additionally, the plan needs to ensure that its providers offer language translation services to its MCMC members and discourage family and friends from acting as an interpreter, which may compromise medical information. Based on the DMHC routine medical survey, Care 1st will need to revise its appeal resolution letters to include the criteria used to make the determination.

The 2008 Fourth Quarter Report/Annual Evaluation noted several pediatric specialty areas that were under the plan's goal of 95 percent for having at least one specialist within 15 miles of a

[3] Care 1st Health Plan. *2008 4th Quarter Report/Annual Evaluation*, San Diego County Medi-Cal.

member's home. The plan has an opportunity to continue its recruitment efforts to increase coverage.

The plan noted within its annual evaluation report that its highest volume of member concerns related to a delay in authorizations from its delegated IPAs. Although the plan reviewed and found that the authorizations were made within appropriate time frames, the plan has an opportunity to reduce and address this perception of its members, which has an impact on the timeliness domain of care.

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 for objectively evaluating plans' delivery of services.

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

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about Care 1st'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™[4] of Care 1st in 2009. HSAG found all measures to be reportable and that Care 1st's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

Recommendations from the audit involved pursuing methods to gather data for outside services provided to members. The plan should also consider additional steps to capture more complete encounter data. Care 1st could improve encounter timeliness by examining the plan's existing approach.

[4] 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

Table 4.1 presents a summary of Care 1st'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)'s 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 national Medicaid 10th percentile.

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

Care 1st reported several performance measure rates for the first time in 2009 despite becoming operational in 2006. This was due to several factors, including the relatively small number of enrolled members during 2007 after the plan became operational, the continuous enrollment criteria for many of the measures' specifications, and the need for enough members within certain disease-specific measures to report a rate. Therefore, Table 4.1 displays many audit results for HEDIS 2008 as *Not Applicable (NA)*. Additionally, HSAG could not compare performance between 2008 and 2009 of measures for which the plan could not report a 2008 rate.

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

Table 4.1—2008–2009 Performance Measure Results for Care 1st—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	NA	NA	Not Comparable	Not Comparable	20.6%	35.4%
ASM	Q	NA	NA	Not Comparable	Not Comparable	86.1%	91.9%
AWC	Q,A,T	40.6%	40.9%	★★	↔	35.9%	56.7%
BCS	Q,A	NA	34.4%	★	Not Comparable	44.4%	61.2%
CCS	Q,A	58.9%	60.6%	★★	↔	56.5%	77.5%
CDC–E	Q,A	NA	48.4%	★★	Not Comparable	39.7%	67.6%
CDC–H7 (<7.0%)	Q	NA	29.0%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	NA	38.7%	★★	Not Comparable	52.5%	32.4%
CDC–HT	Q,A	NA	85.5%	★★	Not Comparable	74.2%	88.8%
CDC–LC (<100)	Q	NA	40.3%	★★	Not Comparable	25.1%	42.6%
CDC–LS	Q,A	NA	72.6%	★★	Not Comparable	66.7%	81.8%
CDC–N	Q,A	NA	87.1%	★★★	Not Comparable	67.9%	85.4%
CIS–3	Q,A,T	61.5%	76.4%	★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	88.2%	81.7%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	63.2%	62.7%	★★	↔	54.0%	70.6%
URI	Q	86.8%	91.3%	★★	↔	79.6%	94.1%
W15	Q,A,T	53.3%	73.1%	★★	↔	44.5%	73.7%
W34	Q,A,T	72.3%	68.4%	★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the 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, Care 1st demonstrated average performance, with rates falling between the MPLs and HPLs for most of its reported performance measures in 2009. The plan exceeded the MCMC goal (HPL) for *Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N)*. The plan had below-average performance for one measure: *Breast Cancer Screening (BCS)*. Care 1st had stable performance between 2008 and 2009 for comparable rates, with no statistically significant changes.

HEDIS Improvement Plans

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

In 2008, the DHCS required Care 1st to submit one improvement plan to the DHCS for *Cervical Cancer Screening (CCS)*. The improvement plan was unavailable to HSAG for review; however, per Care 1st's annual evaluation, the plan identified several factors contributing to the low rate. These factors included difficulty identifying where women were receiving well-woman care, lack of documentation in the medical record of a Pap test, and lack of lab data from the plan's IPAs. To increase its rate, the plan initiated several interventions, including patient reminders, provider reminders, outreach to members to assist in scheduling appointments, and obtaining additional lab data.

Although Care 1st did not have statistically significant improvement of its *Cervical Cancer Screening (CCS)* rate, the plan's rate was above the MPL for HEDIS 2009. No improvement plan for this measure was required for its 2009 performance.

Based on its 2009 performance, the DHCS required Care 1st to submit an improvement plan for its *Breast Cancer Screening (BCS)* measure, which fell below the MPL.

Strengths

Care 1st performed above the MCMC Program goal and the HPL on the *Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N)* measure. Comprehensive diabetes care spans the domains of quality and access.

The plan was able to report rates for several additional measures in 2009 and achieved rates above the MPL for its first year of reporting for these measures.

Opportunities for Improvement

Care 1st had one of the lowest rates of all MCMC plans for its *Breast Cancer Screening (BCS)* measure, reflecting a significant opportunity for improvement. Care 1st's performance in this area may indicate issues with health care quality and/or access.

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 Care 1st'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

Care 1st had three clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The plan's first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS's statewide collaborative QIP project. Care 1st's second project aimed to reduce inappropriate antibiotics in children with upper respiratory infections (URIs) as part of a small-group collaborative. The third QIP focused on the treatment of chronic obstructive pulmonary disease (COPD) by increasing the use of spirometry testing, increasing the rate of pneumonia vaccines, and increasing counseling about smoking exposure and cessation to members with COPD.

All three QIPs fell under the quality domain of care, with the ER QIP also falling under the access domain of care. The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease. The plan's URI project attempted to improve the

quality of care delivered to children with URIs by reducing the amount of antibiotics prescribed by providers. Care 1st's COPD QIP attempted to improve the quality of care for members with a chronic disease by evaluating aspects of care such as vaccines and counseling.

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.

The table below summarizes the validation results for all three of Care 1st's QIPs across the CMS protocol activities during the review period

Table 5.1—Quality Improvement Project Validation Results for Care 1st San Diego County (N=3 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	89%	11%	0%
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	48%	33%	19%
IV.	Correctly Identified Study Population	0%	44%	56%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	19%	27%	54%
VII.	Appropriate Improvement Strategies	57%	29%	14%
VIII.	Sufficient Data Analysis and Interpretation	19%┼	19%┼	63%┼
IX.	Real Improvement Achieved	25%	0%	75%
X.	Sustained Improvement Achieved	‡		
Percentage Score of Applicable Evaluation Elements *Met*		**36%**		
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.
┼Percentage totals for an activity may exceed 100 percent due to rounding.

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 the plan's QIPs, none of which fully met the new validation criteria. As directed by the DHCS, HSAG provided Care 1st, as well as other plans, with an overall validation status of "Not Applicable" for all three 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 below displays Care 1st's data for its QIPs. For the ER collaborative QIP, Care 1st's goal was to reduce the overall rate of members who use the ER, with an annual reduction of 10 percent or a 30 percent cumulative decline by 2010.

For the URI QIP, Care 1st did not report a goal for its first indicator and reported four quarters of data that were combined into an annual rate by HSAG. For the second indicator, the plan reported 76.7 percent as the baseline goal for the percentage of children, 3 months to 18 years of age, who received a prescription for antibiotic medication on or three days after the episode date.

Rates reported by the plan should reflect the plan's MCMC targeted population; however, the plan reported a baseline rate that only included Medi-Cal results in Los Angeles County since there were no eligible members in the San Diego population at the time baseline data were collected. Conversely, the plan reported its first remeasurement data, which included only the targeted Medi-Cal managed care San Diego population. Therefore, to ensure consistent methodology, HSAG eliminated the Los Angeles baseline rate and instead recommended that the plan report the Remeasurement 1 rate as the corrected baseline rate. All future remeasurement periods will include only San Diego MCMC data.

For the COPD QIP, Care 1st did not report a goal for its first indicator related to spirometry testing. For the second indicator, the plan established a baseline goal of 85 percent for the percentage of eligible members with a new or newly active COPD diagnosis and a pneumonia vaccination within the measurement year. For the third indicator, Care 1st set a baseline goal of 80 percent for the percentage of eligible members with a new or newly active COPD diagnosis and documented counseling about tobacco exposure and resources for smoking cessation within the measurement year.

Table 5.2—Quality Improvement Project Outcomes for Care 1st—San Diego County

QIP #1—Reducing Avoidable Emergency Room Visits				
		Remeasurement Period		
QIP Study Indicator	Baseline Period 1/1/06–12/31/06	1 1/1/07–12/31/07	2 1/1/07–12/31/08	Sustained Improvement
Percentage of ER visits that were avoidable.	7.3%	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Appropriate Treatment for Children with an Upper Respiratory Infection				
		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
1) Percentage of high volume PCPs serving children prescribing an antibiotic for a URI for a member who is under 19 years of age.	51.6%^	‡	‡	‡
2) Percentage of children 3 months to 18 years, who received a prescription for antibiotic medication on or three days after the episode date.	71.7%	‡	‡	‡

^The plan reported quarterly rates; therefore, HSAG combined the corresponding four quarters of data to report an annual rate.

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

QIP #3—Improving Treatment of Chronic Obstructive Pulmonary Disease				
		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
1) Percentage of eligible members with a new or newly active COPD diagnosis and who have had the Spirometry testing completed within the measurement year.	8.7%	‡	‡	‡
2) Percentage of eligible members with a new or newly active COPD diagnosis and who have had pneumonia vaccination within the measurement year.	18.8%	‡	‡	‡
3) Percentage of eligible members with a new or newly active COPD diagnosis and who have had documented counseling about tobacco exposure and resources for smoking cessation within the measurement year.	26.1%	‡	‡	‡

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

For its ER QIP, Care 1st implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits; however, these interventions did not specifically target the top avoidable ER visit codes or the population of individuals younger than 19 years of age. The plan focused on expanding case management of chronic diseases from coronary artery disease (CAD) and COPD to congestive heart failure (CHF) and asthma. Additionally, not enough information was provided as to how interventions such as a nurse advice line correlated to improving the results for the study indicators. Similarly, the plan did not explain how this intervention would address access-related barriers identified by the plan, such as a small number of urgent care centers, long wait times, or the lack of same-day appointments. Care1st may need to develop, revise, and/or implement more targeted interventions that can affect the avoidable ER rate.

Care 1st identified several barriers related to its COPD QIP, but the study indicators, barriers, and interventions did not align to improve the outcomes of the QIP. None of the interventions identified specifically targeted improving the rate of counseling for smoking cessation or pneumonia vaccines for members with COPD. Additionally, the plan did not document how disease management or physician education addressed cultural and linguistic differences among members or how referral request delays would be eliminated.

Strengths

Care 1st demonstrated a good understanding of documenting support for its QIP topic selections. The plan is participating in a small-group collaborative for its URI QIP. Other plans that are further along in their projects have all noted significant improvement and sustained improvement for at least one of the study indicators, which suggests that the plan may also benefit from the collaborative efforts.

Opportunities for Improvement

Care 1st has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with the DHCS's requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

The plan had challenges in reporting baseline and remeasurement rates using consistent methodology for the eligible population within its URI QIP. The plan should adjust its QIP and use Remeasurement 1 data as its baseline rate to allow for valid comparisons between measurement periods for its Medi-Cal managed care population.

HSAG noted several examples showing that the QIP study indicators, identified barriers, and targeted interventions were not aligned. An opportunity exists for the plan to better align its QIP

study indicators, identified barriers, and interventions. In addition, the plan may need to reduce the number of barriers that can be addressed in a single measurement period and/or implement targeted interventions to address barriers that impact a high proportion of the population, thereby increasing the likelihood of achieving real and sustained improvement for the rates identified in the QIP.

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*