Performance Evaluation Report

Community Health Group Partnership Plan

July 1, 2009–June 30, 2010

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

March 2012

HSAG HEALTH SERVICES ADVISORY GROUP

DHCS California Department of HealthCareServices

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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] 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 the 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. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Community Health Group Partnership Plan ("Community Health Group," "CHG," or "the plan"), which delivers care in San Diego County, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

CHG is a full-scope managed care plan in San Diego County, serving members as a Geographic Managed Care (GMC) model type. CHG has been Knox-Keene licensed since 1985. Knox-Keene licensure is granted by the Department of Managed Health Care (DMHC) to plans that meet minimum required standards according to the Knox-Keene Health Care Service Plan Act of 1975. The act includes a set of laws that regulate managed care organizations (MCOs).

The GMC model allows enrollees to choose from several commercial plans within a specified geographic area. CHG became operational with the MCMC Program in August 1998, and as of June 30, 2010, CHG had 96,609 MCMC members.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2010*. 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 that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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 fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division often work in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits are conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

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. HSAG reported the review findings in the 2008–2009 plan evaluation report for CHG.

The 2007 audit showed that CHG was fully compliant with the requirements reviewed under the administrative and organizational capacity area. However, the plan was deficient with some requirements in these remaining areas reviewed under the scope of the audit:

- Utilization Management
- Continuity of Care
- Availability and Accessibility
- Members' Rights
- Quality Management

CHG submitted corrective action plans for all areas with findings. By the close of the audit, CHG corrected all deficiencies in the members' rights and quality management areas. The DHCS *Medical Audit Close-Out Report* letter dated May 19, 2008, noted that, at the time of the audit close-out, the plan had not fully corrected the three remaining deficient areas: utilization management, continuity of care, and availability and accessibility.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's 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 member rights reviews are conducted 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 member rights 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, 2010.

MRPIU conducted a routine monitoring review of CHG in April 2008, covering the review period of January 1, 2006, through December 31, 2007. HSAG reported the findings from the review in the 2008–2009 plan evaluation report for CHG.

Audit findings were related to member grievances and cultural and linguistic services requirements.

Strengths

By the conclusion of the 2007 medical performance audit, the DHCS found the plan fully compliant in the area of administrative and organizational capacity, quality management, and membership rights.

Opportunities for Improvement

While the *Medical Audit Close-Out Report* noted that the plan had not sufficiently addressed all areas of the deficiency, CHG included actions taken by the plan as outlined in Appendix A of this report. HSAG will re-evaluate CHG's progress once the DHCS conducts and releases more current audit results that will better demonstrate if the plan fully resolved outstanding deficient areas.

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 provide 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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed a HEDIS Compliance Audit™ of CHG in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[3] Based on the results of the compliance audit, HSAG found all measures to be reportable; however, subsequent to the final data submission, CHG notified HSAG and NCQA that a data error had been identified—the plan's software vendor had not included six months worth of pharmacy claims when calculating the final rates. While the revised rates were ultimately approved, the audit team recommended that, for future HEDIS reporting, the plan conduct a more formal review of preliminary rates and a formal reconciliation of the final data used for HEDIS production to ensure that all data are present prior to measure calculations.

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

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. Table 3.1 displays a HEDIS performance measure name key.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
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*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of CHG's HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan's HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national Medicaid 25th percentile and 90th percentile, respectively. For the CDC–H9 (>9.0 percent) measure, a low rate indicates better performance and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the national Medicaid 10th percentile.

Table 3.2—2009–2010 Performance Measure Results for Community Health Group Partnership Plan —San Diego County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	20.5%	23.2%	★★	↔	20.2%	33.4%
AWC	Q,A,T	39.9%	37.0%	★	↔	37.9%	59.4%
BCS	Q,A	52.1%	55.9%	★★	↑	45.0%	63.0%
CCS	Q,A	65.9%	63.0%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	59.0%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	46.6%	41.6%	★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	38.2%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	48.5%	44.0%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	79.8%	81.0%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	37.4%	26.5%	★	↓	27.2%	44.7%
CDC–LS	Q,A	77.7%	73.4%	★★	↔	71.5%	82.5%
CDC–N	Q,A	73.4%	71.0%	★	↔	73.4%	85.4%
CIS–3	Q,A,T	77.4%	72.3%	★★	↔	62.4%	80.6%
LBP	Q	‡	79.1%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	76.4%	76.6%	★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	54.3%	52.1%	★	↔	57.9%	72.7%
URI	Q	84.8%	90.3%	★★	↑	81.1%	94.5%
W34	Q,A,T	75.9%	74.9%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	38.4%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	44.8%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	34.5%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[5] Performance comparisons are based on the Chi-square 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 DHCS did not require plans to report this measure in 2009.
NA = The DHCS does not establish an MPL/HPL for first year measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.
Not Comparable = Performance could not be compared due to either significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, CHG had average to below-average performance results for its HEDIS measures. One of the plan's measures demonstrated a statistically significant decline in 2010, and two measures demonstrated statistically significant increases. Six measures fell below the MPL, two of which were *Prenatal and Postpartum Care* measures. There were no measures with rates above the HPL.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline the steps it will take to improve care.

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

Based on CHG's 2009 performance measure rates, the DHCS required the plan to submit 2009 HEDIS improvement plans for three measures:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Appropriate Medication for People with Asthma*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

HSAG reviewed CHG's 2009 HEDIS improvement plans using HEDIS 2010 rates and assessed whether the plan improved its performance in 2010. HSAG provides the following analysis of the plan's 2009 HEDIS improvement plans.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

In 2009, CHG narrowly fell below the MPL by one-tenth of a percentage point. In its improvement plan, CHG cited the principal barrier as members' perception that antibiotics are needed to treat any respiratory condition.

CHG's overall plan for improvement for this measure was to monitor and control the use of antibiotics for acute bronchitis in adults and implement prior authorization for all level two and greater antibiotic use. CHG improved this measure from 2009 to 2010 by requiring prior authorization and completion of a medical exception form for all antibiotic prescriptions. The 2010 rate rose nearly three percentage points, which put CHG above the MPL for this measure.

Appropriate Medication for People with Asthma

CHG was required to develop a HEDIS improvement plan to improve the use of appropriate medication for people with asthma. CHG's improvement plan outlined the major barrier as members' non-compliance with their medication schedule.

To address CHG's low performance on this measure, the plan implemented several interventions to improve performance.

- Case management follow-up for all hospitalizations and emergency department visits for asthma.
- Health education referral for all members with hospitalizations and emergency department visits for asthma.
- Health educator evaluation of medication regime for members with hospitalizations and emergency department visits for asthma.
- Health educator follow-up with the primary physician when the asthma member is not receiving controller medications.

The DHCS eliminated the ASM measure from the 2010 HEDIS required list of measures for reporting; therefore, HSAG could not make any comparisons between 2009 and 2010 performance.

Timeliness of Prenatal Care

CHG has struggled to improve its performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* measure. CHG has not achieved the MPL for this measure since 2008. Between 2009 and 2010, CHG improved the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure by 0.2 percentage points, which was not enough improvement to achieve the MPL.

CHG implemented an incentive program for both members and providers in an attempt to improve performance for this measure. For a prenatal visit during the first trimester, members were given their choice of a fifty-dollar gift card to Bath & Body Works, Target, or ARCO; providers were awarded $100. The plan's HEDIS Improvement Plan identified the barrier for this measure: members were not receiving prenatal care or beginning prenatal care later than the first trimester. The barrier analysis identified by the plan was not sufficient in identifying actionable areas for improvement. CHG's improvement plan requires a more thoughtful approach to both barrier analysis and intervention design and implementation.

Strengths

CHG had two measures with statistically significant increases between 2009 and 2010: *Breast Cancer Screening* and *Appropriate Treatment for Children With Upper Respiratory Infection*.

Opportunities for Improvement

CHG has the opportunity to increase its performance across several of the HEDIS measures for 2011. The plan's performance remained stagnant for most measures, and no measures achieved results above their respective HPLs.

CHG needs to evaluate its internal process for documenting a HEDIS Improvement Plan and move from documentation compliance to improvement in health outcomes. Based on the 2010 HEDIS results, the plan continued to demonstrate poor performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure, and the plan has not taken the appropriate steps documented in its HEDIS Improvement Plan to support the likelihood of success.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Quality Improvement Projects Conducted

CHG had three clinical QIPs in progress during the review period of July 1, 2009, through June 30, 2010. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. CHG's second project was 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.

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. The postpartum screening QIP's purpose was to increase screening for postpartum depression and the percentage of members with positive depression screens that received follow-up care. Providing the necessary follow-up care is essential to ensure

the mental health of the member. All three QIPs fell under the quality domain of care, and the statewide collaborative QIP also fell under the access domain of care.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for both of CHG's QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Community Health Group Partnership Plan—San Diego County July 1, 2009, through June 30, 2010

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	65%	90%	*Partially Met*
	Resubmission	97%	100%	*Met*
Internal QIPs				
Improving Treatment of COPD	Annual Submission	84%	100%	*Met*
Increasing Screens for Postpartum Depression	Annual Submission	44%	54%	*Not Met*
	Resubmission	88%	100%	*Met*

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

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

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

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

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met, Partially Met,* or *Not Met*. In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that CHG's annual submission of its *Improving Treatment of COPD* QIP received an overall validation status of *Met.* Additionally, for its annual submissions, CHG received a *Partially Met* validation status for its *Reducing Avoidable Emergency Room Visits* QIP and a *Not Met* validation status for its *Increasing Screens for Postpartum Depression* QIP. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation

feedback, the plan resubmitted the two QIPs that did not initially receive a *Met* validation status. After subsequent validation, CHG achieved an overall *Met* validation status for the *Reducing Avoidable Emergency Room Visits* QIP and the *Increasing Screens for Postpartum Depression* QIP.

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

Table 4.2—Quality Improvement Project Average Rates*
for Community Health Group Partnership Plan—San Diego County
(Number = 3 QIP Submissions 3 QIP Topics)
July 1, 2009, through June 30, 2010

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	94%	6%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**98%**	**2%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	95%	5%	0%
	VII: Appropriate Improvement Strategies	89%	11%	0%
Implementation Total		**94%**	**6%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	76%	24%	0%
	IX: Real Improvement Achieved	67%	25%	8%
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		**73%**	**24%**	**3%**

* The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity. See Table B.1 in Appendix B for the number and description of evaluation elements.

‡ No QIPs were assessed for this activity/evaluation element.

For all three QIPS, the plan submitted Remeasurement 1 data; therefore, HSAG validated Activity I through Activity IX. Ninety-eight percent of the applicable elements within the Design stage were scored *Met* and 94 percent of the applicable elements within the Implementation stage were scored *Met*. The plan was scored down in Activity I for not discussing the eligible population in its *Increasing Screens for Postpartum Depression* QIP. In Activity VI, CHG did not include Remeasurement 2 in its timeline for its *Improving Treatment of COPD* QIP. For Activity VII, the plan did not discuss how it would standardize and monitor the interventions in the *Reducing Avoidable Emergency Room Visits* QIP. For the Outcomes stage, CHG did not include an interpretation of the baseline results in Activity VIII for its *Increasing Screens for Postpartum Depression* QIP. Additionally, for the same activity for the same QIP, the plan did not provide accurate *p* values or correct interpretations of both the *p* values and the study results. Activity VIII was also scored down for the *Improving*

Treatment of COPD QIP. The plan's documentation demonstrated some inconsistencies and the *p* values could not be replicated. For Activity IX, the plan was scored lower because only two of the three study indicators demonstrated improvement for the *Increasing Screens for Postpartum Depression* QIP; and only one study indicator in the *Treatment of COPD* QIP demonstrated improvement.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods. Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Table 4.3—Quality Improvement Project Outcomes for Community Health Group Partnership Plan—San Diego County July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement**
Percentage of avoidable ER visits	17.9%	16.5%*	‡	‡
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**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement**
1) Percentage of members 40 years of age or older with a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis	11.4%	19.5%	‡	‡
2) Percentage of acute inpatient hospitalization discharges of members with COPD	54.9%	68.8%*	‡	‡
3) Percentage of emergency department (ED) visits for members with COPD	69.0%	70.5%	‡	‡
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%	41.1%	‡	‡
b) Bronchodilator within 30 days of the event	75.0%	68.9%	‡	‡

Table 4.3—Quality Improvement Project Outcomes for Community Health Group Partnership Plan—San Diego County July 1, 2009, through June 30, 2010

QIP #3—Increasing Screening for Postpartum Depression				
QIP Study Indicator	**Baseline Period 11/6/06–11/5/07**	**Remeasurement 1 11/6/07–11/5/08**	**Remeasurement 2 11/6/08–11/5/09**	**Sustained Improvement**
1) Percentage of members who had a live birth and were screened for depression at their postpartum visit	23.1%	34.3%*	‡	‡
2) Percentage of members who had a live birth and were screened for depression using a screening tool at their postpartum visit	9.5%	19.2%*	‡	‡
3) Percentage of members who had a live birth and screened positive for depression with documentation of follow-up care	63.6%	85.7%	‡	‡

*A statistically significant difference between baseline and Remeasurement 1 (*p* value < 0.05).
‡The QIP did not progress to this phase during the review period and could not be assessed.

In the *Reducing Avoidable ER Visits* QIP, CHG reported a decrease in the percentage of avoidable ER visits; furthermore, the decrease was statistically significant and was probably not due to chance. A decrease for this measure reflects an improvement in performance. Since collaborative interventions were not initiated until early 2009, HSAG could not evaluate the effectiveness of those interventions.

In the *Improving Treatment of COPD* QIP, only the first study indicator demonstrated any improvement; however, the improvement was not statistically significant. The other study indicators for the study declined in performance, although the decline was only statistically significant for the second study indicator for which there were a higher percentage of acute inpatient hospitalization discharges for members with COPD.

All three study indicators improved for the *Increasing Screens for Postpartum Depression* QIP. The improvement was statistically significant for Study Indicator 1 and Study Indicator 2. There was an increase in the percentage of women who were screened for postpartum depression and also the percentage of women who were screened using a screening tool.

Strengths

CHG demonstrated a thorough application of the QIP process for QIP topic selection, the development of study questions, and the definition of the study population. 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, non-urgent conditions. CHG contracted with a retail clinic to provide an additional location for urgent care other than the ER.

Opportunities for Improvement

CHG has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan use HSAG's QIP Completion Instructions, which will help the plan document all required elements within the CMS protocol activities. Additionally, the plan should request technical assistance for statistical testing before next year's submission.

CHG should include methods to evaluate the efficacy of any interventions implemented, thereby using data to support decisions regarding the revision or continuation of interventions. The plan should implement interventions that will affect the study indicators by addressing specific barriers. Having identified mixed results for the four study indicators in the *Improving Treatment of COPD* QIP, the plan may need to implement multiple study indicator-specific interventions.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan surveys.[4]

The administration of the CAHPS surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS surveys be administered to both adult members and the parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

The Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about CHG's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures as follows:

CAHPS Global Rating Measures:

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

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

CAHPS Composite Measures:

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

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance (NCQA)'s HEDIS® benchmarks and thresholds or NCQA's national Medicaid data, when applicable. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 5.1.

Table 5.1—Star Ratings Crosswalk

Stars	Adult Percentiles	Child Percentiles
★★★★★	≥ 90th percentile	≥ 80th percentile
★★★★	75th percentile–89th percentile	60th percentile–79th percentile
★★★	50th percentile–74th percentile	40th percentile–59th percentile
★★	25th percentile–49th percentile	20th percentile–39th percentile
★	< 25th percentile	< 20th percentile

Table 5.2—Community Health Group Partnership Plan—San Diego County Medi-Cal Managed Care County-Level Global Ratings

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★	★★★
Child	★★	★★	★★★	★

Table 5.3—Community Health Group Partnership Plan—San Diego County
Medi-Cal Managed Care County-Level Composite Ratings

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Adult	★	★	★	★+	★★
Child	★	★	★	★★★	★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Strengths

CHG performed the highest on the adult global rating measure, *Rating of Specialist Seen Most Often* and for the child population global rating measure, *Rating of Personal Doctor*. For the composite ratings, the *Customer Service* category scored above the 40th percentile for the child population.

Opportunities for Improvement

CHG's CAHPS results showed several opportunities to improve. For the adult category global ratings, *Rating of Health Plan, Rating of All Health Care*, and *Rating of Personal Doctor* all scored less than the 25th percentile. For the composite level ratings, eight out of the ten categories across both adult and child populations scored at the lowest rating possible.

HSAG conducted a key drivers of satisfaction analysis that focused on the top three priorities based on the plan's CAHPS results. The purpose of this analysis was to help decision makers identify specific aspects of care most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as Community Health Group's highest priority: *Rating of Health Plan, Getting Care Quickly, and Getting Needed Care*. The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 Community Health Group CAHPS Plan-Specific Report*. Areas for improvement spanned the quality, access, and timeliness domains of care.

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 the results of performance measures and quality improvement projects (QIPs) 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.

The plan showed average to below-average performance in the quality domain. This assessment was based on CHG's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, CAHPS survey results, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

The plan was able to report valid rates for all 2010 performance measures. However, CHG had six measures with rates that fell below the MPL and no measures with a rate above the HPL.

The plan has complied with submitting 2009 HEDIS improvement plans for measures that fell below the minimum performance levels (MPLs); however, the plan should consider making its barrier interventions more robust. As part of the 2010 improvement plans, CHG needs to conduct barrier analysis prior to implementing interventions to help increase the likelihood of success.

QIP results showed that the plan did well with selecting the QIP topic, developing the study questions, and defining the study population. The plan has an opportunity to further develop its QIP submissions by using HSAG to provide technical assistance with statistical testing.

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 a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

The plan demonstrated average to below-average performance in the access domain. This assessment was based on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results. Performance measure rates for which HSAG identified a need for focused improvement efforts—*Adolescent Well-Care Visits, Comprehensive Diabetes Care*, *Timeliness of Prenatal Care*, and *Postpartum Care*—all fell under the access domain of care.

For access-related compliance standards, the most current audit results showed that the plan had not fully addressed all areas of deficiency.

Timeliness

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

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.

CHG demonstrated below-average to average performance in the timeliness domain of care. This assessment was based on 2010 performance measure rates for providing timely care, medical performance and member rights reviews related to timeliness, and member satisfaction results related to timeliness. CHG performed well in the area of member grievances; furthermore, CHG met all required time frames for handling member grievances.

Performance measure rates related to timeliness showed that the plan performed below the MPL for these measures: *Adolescent Well-Care Visits, Timeliness of Prenatal Care,* and *Postpartum Care.* This low performance suggests that for the most part, members are not receiving care within the appropriate time frame after a need for services is identified. CHG performed between the 25th and 90th national Medicaid percentiles for *Childhood Immunization Status—Combination 3* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.*

Member satisfaction results showed that the plan demonstrated poor performance in the *Getting Care Quickly* category for both adult and child populations. This suggests that members perceive that they do not always receive care in a timely manner.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. CHG's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, CHG had below-average to average performance in providing quality, accessible, and timely health care services to its MCMC members.

CHG showed relatively unchanged performance measures rates in 2010 compared with 2009 rates. The plan was generally compliant with documentation requirements across performance measures, QIPs, and State and federal requirements; however, the plan experienced challenges with improving actual health outcomes for members.

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

- Conduct barrier analysis to determine factors that contributed to low performance for all measures that fell below the MPL.
- Implement a more formal review of preliminary rates and a formal reconciliation of the final data used for HEDIS production to ensure that all data are present prior to measure calculations.

- Evaluate the plan's internal process for documenting a HEDIS Improvement Plan to improve analysis and documentation to increase the likelihood of improved performance.
- Request technical assistance from HSAG related to statistical testing for QIPs.
- Design and implement interventions that will affect the QIP study indicators by addressing specific barriers that were identified.
- Review the 2010 plan-specific CAHPS results report and develop strategies to address the following priority areas: *Rating of Health Plan, Getting Care Quickly, and Getting Needed Care*.

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

APPENDIX A. FOLLOW-UP ON THE PRIOR YEAR'S RECOMMENDATIONS GRID

for Community Health Group Partnership Plan

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
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.	*Adults With Acute Bronchitis* ♦ Any prescriptions for level two antibiotics require prior authorization and completion of a medical exception form. - On-going *Appropriate Treatment for Members with Asthma* ♦ Case management follow-up for all hospitalizations and emergency department visits for asthma. - On-going ♦ Health education referral for all members with hospitalizations and emergency department visits for asthma. - On-going ♦ Health educator evaluation of medication regime for members with hospitalizations and emergency department visits for asthma. - On-going ♦ Health educator follow-up with primary physician when asthma member is not receiving controller meds. - On-going *Prenatal* ♦ Executive team approved to provide a $50 incentive choice of either Bath & Body Works, Target, or Arco Gas gift card to mothers for completing a prenatal care visit during the first trimester of their pregnancy. - March 2010 ♦ Developed and distributed a flyer announcing the incentive program to women of childbearing age. - April 2010 ♦ Executive team approved to provide an incentive of $100 to practitioners for completing a prenatal care visit during the first trimester of pregnancy. - March 2010 ♦ Distributed a provider alert announcing incentive program. - March 2010 ♦ Updated and distributed to each primary care site, *"Project HEDIS—Document the Care You Give,"* a HEDIS requirement and documentation guide for practitioners. – March 2010 ♦ Developed coding quick reference guides and initiated provider site trainings - April 2010 ♦ Initiated site training for practitioners and staff regarding the incentive program. - March 2010 ♦ Added HEDIS requirements and documentation to the site case manager's luncheon agenda. - March 2010 ♦ Implemented on-going medical record review for members identified as having delivered a live birth to ensure capture of all possible prenatal care visits. - June 2010 ♦ Developed educational brochure for physicians' offices. - March 2010

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.	Implemented HSAG's QIP Summary Form as indicated: ♦ July 2009—Postpartum Depression Screening QIP ♦ September 2009—COPD QIP ♦ October 2009—ER Collaborative QID
Evaluate the efficacy of QIP intervention strategies annually and modify or replace interventions that have not resulted in improvement.	Evaluation of the efficacy of QIP interventions was implemented with the use of the HSAG QIP Summary Form.
Incorporate deficient audit areas within the work plan to ensure action, monitoring, and ongoing improvement.	Implemented individual work plans for deficient audit areas as noted above.
Extend the current process for monitoring access to specialty care for compliance with the plan's established standard of two weeks.	Effective September 2008, CHG implemented a system wide centralized plan for tracking and following up on referrals requiring prior authorization.
Establish a process to ensure case coordination for all members receiving early intervention services and members with developmental disabilities.	CHG disputed this deficiency since the San Diego Regional Center is unable to provide the plan with information on plan members. CHG will continue to work with the San Diego Regional Center to develop and implement a process to identify plan members.
Develop a mechanism to monitor and intervene with providers who are not documenting initial health assessments.	Effective July 2008, implemented the process to generate a member-specified report that shows which members still need to have the assessment completed at 90 days of enrollment. This member-specific report is sent to the providers requesting that they schedule the member for an initial or established member assessment within 30 days. This report is generated monthly for all primary care providers.
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.	Effective September 2008, CHG modified policy #7251.1 to reflect (1) that the time limit for deciding prior authorization requests is 28 days from the time of receipt of the original request for services, and (2) that requesting providers will be notified within 24 hours of a decision to deny, defer or modify a request for service. Internal monitoring and auditing processes were also modified to include quarterly file review and monitoring of complaints related to timeliness and notification standards.
Modify the process for payment of out-of-network claims to address timely and appropriate payment deficiencies.	Effective September 2008, CHG amended and renumbered the policy on Reimbursement for Freedom of Choice/Family Planning Services so that it states that all family planning claims will be paid within 45 working days of receipt of clean claims.