Performance Evaluation Report

Care 1st Partner Plan

July 1, 2009–June 30, 2010

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

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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, Care 1st Partner Plan ("Care 1st" 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

Care 1st Partner Plan is a full-scope Medi-Cal managed care plan in San Diego County. Care 1st has been Knox-Keene licensed since 1995. 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).

Care 1st serves its MCMC members under a Geographic Managed Care (GMC) model. The GMC model allows enrollees to choose from several commercial plans within a specified geographic area. Care 1st became operational with the MCMC Program in San Diego County in February 2006. As of June 30, 2010, Care 1st had 11,826 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 Care 1st'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 medical performance review reports available as of June 30, 2010, to assess the plan's compliance with State-specified standards. The most recent medical performance review was completed in November 2007. HSAG reported findings from this audit in the 2008-2009 plan evaluation report.[3]

The audit covered the areas of quality management, grievances and appeals, access and availability of services, and utilization management.[4] The survey showed no deficiencies; however, the Department of Managed Health Care did recommend that the plan revise its appeal resolution letters to include the criteria used to make the determination. The plan states it is addressing this area of concern as outlined in Appendix A.

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, 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.

The most current MRPIU review for Care 1st was conducted in June 2009, covering the review period of July 1, 2008, through May 31, 2009. The results from this audit were reported in detail in the 2008-2009 plan evaluation report. The review focused on the areas of member grievances, prior-authorization notification, cultural and linguistic services, and technical assistance. In addition, the review evaluated processes for prevention, detection, and reporting of suspected fraud/abuse.

MRPIU's file reviews found Care 1st to be fully compliant with member grievances, prior-authorization notification, and program integrity. MRPIU noted findings related to the plan's

[3] *Performance Evaluation Report – Care 1st Partner Plan, July 1, 2008–June 30, 2009*. California Department of Health Care Services. October 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

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

policies and procedures for quality of care and cultural and linguistic services. The plan outlined the actions taken to address these deficiencies in Appendix A.

Strengths

The most current review findings available showed that, overall, Care 1st showed strong performance as demonstrated by full compliance with most contract requirements including member grievances, prior-authorization notifications, and program integrity.

Opportunities for Improvement

Care 1st has an opportunity to continue to monitor the actions implemented to address the areas of deficiency to ensure that the issues have been fully resolved.

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 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.

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 Care 1st in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[5] Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

[5] 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 Care 1st'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 Care 1st–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	NA	23.3%	★★	Not Comparable	20.2%	33.4%
AWC	Q,A,T	40.9%	42.6%	★★	↔	37.9%	59.4%
BCS	Q,A	34.4%	48.7%	★★	↔	45.0%	63.0%
CCS	Q,A	60.6%	68.4%	★★	↑	60.9%	79.5%
CDC–BP	Q	‡	69.9%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	48.4%	51.3%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	46.9%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	38.7%	39.8%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	85.5%	81.4%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	40.3%	47.8%	★★★	↔	27.2%	44.7%
CDC–LS	Q,A	72.6%	77.9%	★★	↔	71.5%	82.5%
CDC–N	Q,A	87.1%	82.3%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	76.4%	79.8%	★★	↔	62.4%	80.6%
LBP	Q	‡	75.4%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	81.7%	86.5%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	62.7%	60.0%	★★	↔	57.9%	72.7%
URI	Q	91.3%	91.6%	★★	↔	81.1%	94.5%
W34	Q,A,T	68.4%	75.9%	★★	↑	64.0%	80.3%
WCC–BMI	Q	‡	50.4%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	49.6%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	29.2%	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, Care 1st demonstrated average performance with little deviation between 2009 and 2010. The plan did not have any measures with statistically significant declines in 2010, and two measures had statistically significant increases in 2010. One measure, *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*, scored above the HPL in 2010.

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 steps 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.

Breast Cancer Screening

Care 1st implemented an improvement plan targeting breast cancer screening that was successful in achieving significant improvement in 2010. Care 1st increased its score to 48.7 percent, a fourteen percentage point increase over its 2009 rate.

The plan identified several barriers and implemented interventions that targeted these barriers. Types of interventions included direct member mailings, implementing a Women's Health phone line service, and provider training.

Strengths

Care 1st's most notable strength came in the *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure, as it ranked above the HPL. The plan also demonstrated the ability to focus on a measure that fell below the MPL in 2009 and to improve its rate considerably in 2010 to above the MPL. No performance measure rates fell below the MPLs in 2010.

Opportunities for Improvement

There are no glaring areas for immediate improvement based on the plan's 2010 results; however, rates remain fairly unchanged from 2009. Care 1st has the opportunity to expand the number of metrics that finish above the HPL in 2011 and to show statistically significant increases.

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 Care 1st's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Projects Conducted

Care 1st had three clinical QIPs in progress during the review period of July 1, 2009, through June 30, 2010. 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 table below summarizes the validation results for Care 1st's three QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Care 1st—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	57%	30%	*Not Met*
	Resubmission	89%	100%	*Met*
Small-Group Collaborative QIP				
Appropriate Treatment for Children With Upper Respiratory Infection	Annual Submission	84%	90%	*Not Met*
	Resubmission	97%	100%	*Met*
Internal QIP				
Improving Treatment of Chronic Obstructive Pulmonary Disease (COPD)	Annual Submission	51%	27%	*Not Met*
	Resubmission	93%	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 the annual submissions by Care 1st for each of its QIPs did not meet the validation requirements; however, upon resubmission, all three projects achieved an overall *Met* validation status.

Table 4.2 summarizes and aggregates the validation results for Care 1st's three QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Care 1st—San Diego County (Number = 3 QIPs, 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)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	95%	0%	5%
	VII: Appropriate Improvement Strategies	89%	11%	0%
Implementation Total†		**93%**	**3%**	**3%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved	58%	17%	25%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total†		**86%**	**5%**	**8%**

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

†The sum of an activity or stage may not equal 100 percent due to rounding.

Care 1st successfully applied the QIP process for the Design and Implementation stages, scoring 94 percent *Met* or better on all evaluation elements for five of the six applicable activities. Scores were lower for Activity VII in the *COPD* QIP since the plan did not include a discussion of how successful interventions would be standardized or monitored.

For the Outcomes stage, Care 1st was scored lower in Activity IX, due to the lack of real improvement since not all of the study indicators demonstrated statistically significant improvement between the most recent measurement period and the prior measurement period. All study indicators that were assessed for sustained improvement achieved sustained improvement. Sustained improvement is defined as improvement in performance over baseline, that 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.

Quality Improvement Project Outcomes

Table 4.3 summarizes 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.

Table 4.3––Quality Improvement Project Outcomes for Care 1st—San Diego County
(N = 3 QIPs, 3 QIP Topics)
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	13.8%	17.7%*	‡	‡
QIP #2—Appropriate Treatment for 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¥**
Percentage of members with COPD that received spirometry testing	15.4%	27.7%	32.5%	Yes
Percentage of members with COPD that received a pneumococcal vaccination	54.3%	66.0%	70.6%	Yes
Percentage of members COPD that were counseled on smoking cessation	36.2%	61.5%*	75.8%*	Yes
QIP #3—Appropriate Treatment for Children with an Upper Respiratory Infection				
QIP Study Indicator 1	**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 high-volume PCPs serving children not prescribing an antibiotic for a URI for a member who is under 19 years of age	51.6%	82.9%*	‡	‡
QIP Study Indicator 2	**Baseline Period 1/1/06–12/31/06**	**Remeasurement 1 1/1/07–12/31/07**	**Remeasurement 2 1/1/08–12/31/08**	**Sustained Improvement¥**
Percentage of children between 3 months and 18 years who received appropriate treatment for children with URI	71.7%	86.8%*	91.3%	Yes

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

Care 1st reported a decline in performance for the *Reducing Avoidable Emergency Room Visits* QIP study indicator; the increase in the rate was statistically significant.

For the *Appropriate Treatment for COPD* QIP, all study indicators demonstrated improvement and the improvement in the percentage of COPD members that were provided smoking cessation counseling was statistically significant. Additionally, all three study indicators achieved sustained improvement.

For the *URI* QIP, both study indicators improved. The increase in high-volume providers not prescribing an antibiotic was statistically significant. The percentage of children who received appropriate treatment for a URI achieved sustained improvement from baseline through Remeasurement 2.

Strengths

Care 1st demonstrated a good understanding of documenting support for its QIP topic selections. For its *Appropriate Treatment for COPD* QIP, the plan was able to achieve sustained improvement for all three study indicators. 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 with its initial submission. HSAG recommends that the plan use feedback from prior QIPs as well as the QIP Completion Instructions to help achieve compliance without having to resubmit each project.

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.

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.[6]

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 Care 1st'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*

[6] 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—Care 1st—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	★★	★	★	★★★★★+

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

Table 5.3—Care 1st—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

Care 1st performed best on the *Rating of Specialist Seen Most Often* for its child population, with a rate above the national Medicaid 80th percentile.

Opportunities for Improvement

Care 1st's CAHPS results showed primarily poor performance for all adult global rating categories and all of the composite measures for adult surveys. Child survey CAHPS results showed poor performance for most of the child composite ratings. While Care 1st showed a need for improvement in all areas of member satisfaction across both adult and child populations, 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 the key-drivers-of-satisfaction analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key-driver analysis, HSAG identified the following measures as Care 1st's highest priorities: *Rating of All Health Care*, *Rating of Health Plan,* and *Rating of Personal Doctor*. 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 Care 1st 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 above-average performance in the quality domain. This assessment was based on Care 1st's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, 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, and most of the rates performed similarly to the 2009 rates. The plan did not have any measures with statistically significant declines in 2010, and two measures had statistically significant increases in 2010.

Care 1st implemented a successful improvement plan targeting its low breast cancer screening rate that was below the MPL in 2009. The plan achieved statistically significant improvement in 2010 bringing its rate above the MPL.

Care 1st demonstrated a good understanding of documenting support for its QIP topic selections. However, the plan had challenges with its initial QIP submissions, receiving *Not Met* status for all three QIPs. The plan was able to respond and receive a *Met* status for these QIPs in its subsequent resubmissions. Despite meeting validation requirements, the plan still has an opportunity to further analyze factors that may be preventing improved outcomes.

Overall, the plan was compliant with medical performance reviews. For the areas identified as deficient, the plan has documented action taken to bring the plan into compliance for the next review.

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 performance in the access domain. This assessment was based on a review of 2010 performance measure rates that related to access, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results.

Member satisfaction results for adults and children demonstrated poor performance for the *Getting Needed Care* composite. This composite assesses members' satisfaction with accessing care once a need is identified. HSAG identified this area as an important opportunity for improvement.

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.

Care 1st demonstrated 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. The plan excelled in the area of member grievances. MRPIU commended the plan for its processes to resolve member grievances. Care 1st met all required time frames for handling member grievances.

Performance measure rates related to timeliness showed that the plan performed above the MPL for well-child visits and childhood immunizations, suggesting that members are receiving care within the appropriate time frame after a need is identified for preventive services.

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. Care 1st's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, Care 1st had average performance in providing quality, accessible, and timely health care services to its MCMC members. Care 1st's performance measure rates in 2010 compared with 2009 rates with no significant improvement or decline. 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 Care 1st in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following:

- Expand the number of metrics that finish above the HPL in 2011.
- Improve QIP documentation to increase compliance with the CMS protocol for conducting QIPs with the initial QIP submission.
- Reduce the number of barriers that can be addressed in a single measurement period and/or implement targeted interventions to address barriers.

- Review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program–2010 Care 1st CAHPS Plan-Specific Report.*

In the next annual review, HSAG will evaluate Care 1st's progress with these recommendations along with its continued successes.

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
Explore factors contributing to the low rate for Breast Cancer Screening (BCS) and implement interventions to improve performance.	Care 1st initiated a Woman's Health Program in late 2008 aimed at addressing authorization-related barriers to obtaining breast cancer screening. In 2009 the QI Department initiated a toll free phone line that members can call for assistance in getting this service authorized and scheduled. In 2010 the QI department worked with UM to establish preferred vendors to directly schedule members for this specific service to avoid the authorization process completely. In 2011 the QI department embedded a Quality Outreach Coordinator in the UM Department to track and proactively contact members who have not had this service and help them to schedule it directly.
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance for increasing compliance with the CMS protocol for conducting QIPs.	The Care 1st QI Department submitted QIPs in 2009 using the NCQA QIP form, and these QIPs were evaluated by HSAG. The evaluation summarized the need to use the HSAG QIP Summary Form moving forward. The Care 1st QI Department has complied and has been using and submitting QIPs on the HSAG Summary Form from that point forward.
Evaluate and revise QIP interventions that align with the QIP's study indicators and identified barriers to increase the likelihood of achieving success.	Care 1st has evaluated and made revisions to our QIP intervention to align with the QIP indicators. We document a complete barrier analysis that focuses interventions that increase the likelihood of achieving successful outcomes. Care 1st has re-submitted corrected QIP forms demonstrating these revisions.
Revise policies and procedures related to the quality program to include all required elements.	Care 1st has a process in place whereby all required elements are evaluated annually, and policies and procedures are revised to ensure our program includes these elements. When new requirements are established, our compliance department summarizes the requirements and works with the QI Department to ensure that our policies and procedures are revised to meet the new requirements. This has been an annual review process by the P&P committee, Medical Services Committee (and Credentialing as appropriate), and the Board of Directors.
Educate providers on language translation requirements to improve access to oral translation services.	Care 1st requires that all our providers have policies and procedures in place and are given all contact information to access our translation services. Our translation services include all required translation services, and we audit provider offices to ensure they understand these requirements. We conduct annual surveys of provider offices to ensure understanding and provide this information annually and continuously through our Web portal.

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

EQR Recommendation	Plan Actions That Address the Recommendation
Continue efforts to expand the provider network to achieve thresholds for all high-volume specialists.	Care 1st analyzed our network of PCPs, specialist, hospitals and ancillary providers by conducting geographical mapping studies to ensure appropriate coverage. We have met compliance with 95% or higher availability of specific specialists within five miles of a member's home for all high-volume providers and have met this requirement on lower-volume specialists also. Areas where access is limited involve rural geographical areas where specific specialists are not available. In these areas, Care 1st provides free transportation to get members to the specialist they need.
Revise appeal resolution letters to include the criteria used to make the determination.	Care 1st has a strong process in place to ensure criteria used are clear in the determination in appeal decisions. Care 1st has established a strong audit process of contracted IPAs to ensure any denial includes understandable explanation of the reason(s) and criteria used for the decision. Care 1st conducts quarterly audits of the IPAs which remain on quarterly monitoring until they fully meet criteria at which time they are placed on an annual audits process. This audit process was written up as a QIP and has resulted in an ongoing change in process.
Implement strategies to decrease member concerns related to a delay in authorization from delegated IPAs.	Care 1st has tracking and trending processes in place that track not only IPA but also individual providers for delay in authorization or care-related issues. The Care 1st QI department presents trends to the Peer Review Committee for recommendations and action. One example of this process is when the QI Department identified refraction or eye glasses referrals as being the most frequently cited reason for delay. This resulted in changing our process to use an eye care vendor thus providing direct access to eye care and limiting this as a barrier for our members. We continue to look for and support direct-access processes–including our Woman's Health Program–to limit barriers to members obtaining services and care.