Performance Evaluation Report

Care1st Partner Plan

July 1, 2013–June 30, 2014

Managed Care Quality and Monitoring Division
California Department of Health Care Services

April 2015

TABLE OF CONTENTS

Performance Evaluation Report – Care1st Partner Plan
July 1, 2013 – June 30, 2014

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)[1] in the State of California through a combination of contracted full-scope and specialty managed care health plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] 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 provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and state-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and

[1] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2013–June 30, 2014). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Care1st Partner Plan ("Care1st" or "the MCP"), for the review period July 1, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Health Plan Overview

Care1st is a full-scope MCP delivering services to its MCMC members under a Geographic Managed Care (GMC) model. In the GMC model, DHCS allows MCMC beneficiaries to select from several commercial MCPs within a specified geographic area. The GMC model currently operates in San Diego and Sacramento counties.

Care1st became operational in San Diego County to provide MCMC services in February 2006. As of June 30, 2014, Care1st had 49,825 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP'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. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to evaluate key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

Medical Audits and SPD Medical Surveys

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were

conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

DHCS received authorization "1115 Waiver" from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-County Organized Health System (COHS) counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

Medical and State Supported Services Audits

DHCS conducted a joint medical and State Supported Services audit with Care1st December 3, 2013, through December 13, 2013, covering the period of October 1, 2012, through September 30, 2013. Since the final audit reports were issued outside the review period for this MCP-specific evaluation report, HSAG will provide a summary of the findings from these reviews in Care1st's 2014–15 MCP-specific evaluation report.

Department of Managed Health Care Seniors and Persons with Disabilities Medical Survey

DMHC conducted an SPD medical survey with Care1st December 3, 2013, through December 6, 2013, covering the period of October 1, 2012 through September 30, 2013. The final report was issued to DHCS on June 5, 2014. The report indicated that DMHC assessed the following areas related to Care1st's delivery of care to the SPD population:

- Utilization Management
- Continuity of Care
- Availability and Accessibility of Services

- Member Rights
- Quality Management

The June 5, 2014 report indicated that DMHC identified the following potential deficiencies:

Utilization Management

- The MCP's utilization management program does not ensure that appropriate processes are consistently used to review and approve the provision of medically necessary services.

Availability and Accessibility of Services

- The MCP does not adequately ensure that physical accessibility reviews are conducted on primary care provider sites and on all provider sites that serve a high volume of SPDs. Additionally, the MCP does not adequately ensure that the review results are consistently made available to members through Care1st's Web site and provider directories.
- The MCP's policies to ensure timely access to care do not provide an updated description of the MCP's monitoring procedures or clearly define the MCP's methodology for calculating an annual rate of compliance for appointment wait-time standards.

Member Rights

- For appeals that uphold an original delay, modification, or denial of services based on a determination in whole or in part that the service is not medically necessary, Care1st does not consistently include, along with its written response, the required application for independent medical review and instructions, including an envelope addressed to DMHC.
- The MCP does not immediately inform members of the right to contact DMHC when filing grievances requiring expedited review.

Quality Management

- The MCP's governing body does not direct ongoing operational quality improvement system modifications or track findings for follow-up in response to reports reviewed.
- The MCP does not adhere to its policy and procedure for timely evaluation and resolution of potential quality issues and, as a result, does not take effective action to improve care when deficiencies are identified to ensure that a level of care which meets professionally recognized standards of practice is being delivered to all enrollees.

The deficiencies noted in the survey required a CAP. Since the CAP was issued outside the review period for this MCP-specific evaluation report, HSAG will provide a summary of the CAP from Care1st's 2014–15 MCP-specific evaluation report.

Strengths

During the SPD medical survey, DMHC identified no potential deficiencies in the area of Continuity of Care.

Opportunities for Improvement

Care1st has the opportunity to ensure that all potential deficiencies identified during the December 2013 SPD medical survey are fully resolved.

Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal Managed Care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

HSAG conducts validation of the External Accountability Set performance measures as required by DHCS to evaluate the accuracy of the MCPs' reported results. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[4] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[4] The CMS EQR Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Performance Measure Validation

DHCS's 2014 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 32. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[6] of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for Care1st Partner Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that Care1st followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the findings is included below.

- Care1st experienced no major changes to its system in 2013.
- Care1st had adequate oversight of the enrollment process, and there were no backlogs or issues during the measurement year.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of Care1st's performance measure results for 2011–14. Note that data may not be available for all four years.

[5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[6] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 shows the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

DHCS based the MPLs and HPLs on the NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *CDC–H9 (>9.0 percent)* measure. 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.

The reader should note the following regarding Table 3.1:

- The *All-Cause Readmissions* measure is a non-HEDIS measure used for the ACR collaborative QIP; therefore, no MPL or HPL is established for this measure.
- For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- The *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures. No MPL or HPL is established for a utilization measure. Additionally, HSAG did not compare performance for these measures.
- Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for 2014:
  - All four *Children and Adolescents' Access to Primary Care* measures.
  - *Cervical Cancer Screening*. Note: MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008; however, due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014. Consequently, HSAG did not include or make comparisons to previous years' rates in this report.
  - *Comprehensive Diabetes Care—LDL-C Control.* (This measure is being eliminated for HEDIS 2015.)
  - *Comprehensive Diabetes Care—LDL-C Screening.* (This measure is being eliminated for HEDIS 2015.)

Table 3.1—Performance Measure Results
Care1st—San Diego County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	15.64%	15.57%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	48.06	50.84	51.00	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	239.46	291.33	279.31	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	89.19%	**81.79%**	**83.72%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	86.76%	**80.19%**	83.96%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	28.00%	**15.38%**	20.83%	27.41%	↔
Cervical Cancer Screening	Q,A	—	—	—	**43.31%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	79.81%	73.24%	72.75%	**65.45%**	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**90.56%**	**93.54%**	**89.27%**	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**78.47%**	**82.76%**	**80.91%**	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**81.48%**	**82.67%**	**80.88%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**77.75%**	**81.15%**	**78.71%**	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	66.06%	73.90%	58.39%	**46.72%**	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	41.82%	47.39%	**40.39%**	**37.71%**	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	83.64%	88.76%	84.91%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	52.73%	49.00%	51.82%	42.58%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	46.06%	38.15%	37.23%	32.36%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	80.61%	81.53%	78.59%	72.99%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	87.27%	88.35%	85.40%	82.24%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	30.91%	36.95%	42.09%	51.82%	▼
Controlling High Blood Pressure	Q	—	—	51.71%	**42.82%**	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	62.13%	70.26%	67.88%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**40.59%**	54.55%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	24.75%	37.01%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	60.45%	67.06%	59.18%	60.58%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**80.00%**	85.00%	81.12%	81.02%	↔
Use of Imaging Studies for Low Back Pain	Q	**61.02%**	82.72%	**70.00%**	72.11%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	57.18%	65.94%	74.45%	54.99%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	63.26%	68.37%	72.26%	62.29%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	36.25%	46.72%	51.58%	37.96%	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	76.79%	73.44%	67.07%	**67.34%**	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[7] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

[7] Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. Managed care health plan performance measures may include measures from HEDIS; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Table 3.2 and Table 3.3, which present a summary of Care1st's 2014 SPD measure results. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[8] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[8] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.2.

Table 3.2—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Care1st—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.64%	16.90%	▼	15.57%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	76.14%	85.13%	↑	83.72%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	72.65%	85.98%	↑	83.96%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	89.78%	NA	Not Comparable	89.27%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	81.31%	69.03%	↓	80.91%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	81.93%	62.64%	↓	80.88%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	79.34%	70.67%	↓	78.71%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	51.18%	41.61%	↓	46.72%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.34%	36.98%	↔	37.71%
Comprehensive Diabetes Care—HbA1c Testing	82.28%	81.02%	↔	81.27%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	35.04%	44.04%	↑	42.58%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	26.77%	35.04%	↑	32.36%
Comprehensive Diabetes Care—LDL-C Screening	70.47%	72.51%	↔	72.99%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.62%	81.27%	↑	82.24%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	71.65%	64.72%	↔	51.82%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

▲▼ are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
Care1st—San Diego County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
237.00	44.72	399.63	68.85

*Member months are a member's "contribution" to the total yearly membership.

Performance Measure Result Findings

Care1st had no measures with rates above the HPLs, and the rates for 11 measures were below the MPLs. The rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures were below the MPLs for the third consecutive year.

The rates for both *Medication Management for People with Asthma* measures improved significantly from 2013 to 2014, and the improvement for the *Medication Compliance 50% Total* indicator resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014. Note that the MCP was not held accountable to meet the MPL for this indicator in 2013 since 2013 was the first year the measure was reported.

The rates for the following measures improved from 2013 to 2014; and although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in 2013 to above the MPLs in 2014:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Use of Imaging Studies for Low Back Pain*

The rates for 10 measures were significantly worse in 2014 when compared to 2013, and the significant change led to the rates for the following measures moving from above the MPLs in 2013 to below the MPLs in 2014:

- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Controlling High Blood Pressure*

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure declined from 2013 to 2014; and although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in 2013 to below the MPL in 2014.

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for the following measures:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

The SPD rates were significantly worse than the non-SPD rates for the following measures:

- *All-Cause Readmissions*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however, rates should be interpreted with caution as high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures, and HSAG does not provide comparative analysis.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act cycle. DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates

(measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid cycle approach (including the Plan-Do-Study-Act cycle) to strengthen these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

Assessment of MCP's Improvement Plans

Care1st had nine measures with rates below the MPLs in 2013. The MCP was not required to submit IPs for five of the measures (all four *Children and Adolescents' Access to Primary Care* measures and the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure). DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years to prioritize DHCS and MCP efforts in other areas of poor performance that have clear improvement paths and direct population health impact. DHCS did not hold the MCPs accountable to meet the MPLs for the *Medication Management for People with Asthma* measures in 2013 since 2013 was the first year the measures were reported. Following is a summary of Care1st's improvement efforts related to the four remaining measures.

Annual Monitoring for Patients on Persistent Medications—Ace Inhibitors or ARBs and Diuretics

Care1st identified the following barriers to the rates for these measures being above the MPLs:

- Lack of direct data submissions from lab providers
- Lack of gap reports to providers
- Member noncompliance with lab tests

To address the barriers, the MCP implemented the following interventions:

- Added the annual monitoring for patients on persistent medications services to provider profiles
- Added the annual monitoring for patients on persistent medications services to gap reports, which are printed with the eligibility check at the provider office
- Linked annual monitoring for patients on persistent medications services with provider incentives
- Included information about disease self-management in member educational mailings
- Reminded members, by U.S. mail and telephone, of the need for testing

Care 1st's efforts resulted in the rates for both indicators improving. Although the improvement was not statistically significant, the improvement for the *Diuretics* indicator resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014. The MCP will not be required to continue the IP for the *Diuretics* indicator; however, since the rate for the *ACE and ARBs* indicator remained below the MPL in 2014, the MCP will be required to continue the IP for this measure.

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

Since Care1st has a *Comprehensive Diabetic Care* QIP in place, the MCP is addressing improvement for this measure through the QIP and was therefore not required to submit an IP. Information regarding the QIP is included in Section 4 of this report. Since the rate for this measure continued to be below the MPL in 2014, Care1st will be required to continue its improvement efforts in 2014 to address the MCP's poor performance on the measure.

Use of Imaging Studies for Low Back Pain

Care1st identified the following barriers to the rates for these measures being above the MPLs:

- Members' lack of ability to self-manage their diseases
- Members requesting imaging diagnostics
- Provider lack of treatment knowledge
- Provider improper coding
- MCP utilization management team lacking knowledge regarding authorization criteria
- Diagnosis codes not being captured appropriately

The MCP implemented the following interventions to address the barriers:

- Provided education to high-priority providers
- Conducted educational outreach to providers regarding proper coding and disease management
- Conducted educational outreach to members regarding disease self-management
- Provided training for MCP utilization management staff regarding the criteria for imaging studies

Care1st's efforts resulted in the rate for this measure moving from below the MPL in 2013 to above the MPL in 2014. The MCP will not be required to continue this IP in 2014.

Other Measures Requiring an Improvement Plan in 2014

In addition to continuing the IP for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure and continuing to address the poor performance on the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure through the *Comprehensive Diabetic Care* QIP, the MCP will be required to submit IPs for the following measures that had rates below the MPLs in 2014:

- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Controlling High Blood Pressure*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Strengths

The rates for two measures improved significantly from 2013 to 2014, and the rates for three measures moved from below the MPLs in 2013 to above the MPLs in 2014.

Opportunities for Improvement

Care1st has the opportunity to assess the factors leading to poor performance on several measures and identify improvement strategies that have the potential to result in positive outcomes. Additionally, to ensure Care1st is meeting the needs of the SPD population, the MCP has the opportunity to assess the factors leading to the SPD rates for five measures being significantly worse than the non-SPD rates. While Care1st documented actions the MCP has taken to address the significantly worse SPD rates for the *All-Cause Readmissions* and *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measures (see Appendix D), the efforts did not result in fewer readmissions or improvement in the SPD population aged 25 months to 6 years being seen by their primary care practitioners.

Conducting the EQRO 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 CMS validation protocol[9] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

HSAG organized, aggregated, and analyzed Care1st's validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[9] The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Quality Improvement Project Objectives

Care1st participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2013–June 30, 2014.

Table 4.1 below lists Care1st's QIPs and indicates whether the QIP is clinical or nonclinical and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

Table 4.1—Quality Improvement Projects for Care1st
July 1, 2013, through June 30, 2014

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Comprehensive Diabetic Care	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management, leading to improved health outcomes.

The *Comprehensive Diabetic Care* QIP targeted members with diabetes and focused on increasing LDL screening, nephropathy monitoring, retinal eye exams, and HbA1c screening, and on decreasing the percentage of members with an HbA1c test result greater than 9 percent (indicating poor control). Ongoing management of members with diabetes is critical to preventing complications and ensuring optimal health.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Validation Activity
Care1st—San Diego County
July 1, 2013, through June 30, 2014

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				
All-Cause Readmissions	Annual Submission	56%	57%	*Not Met*
	Annual Resubmission 1	63%	57%	*Partially Met*
	Annual Resubmission 2	94%	100%	*Met*
Internal QIPs				
Comprehensive Diabetic Care	Annual Submission	74%	90%	*Partially Met*
	Annual Resubmission 1	85%	90%	*Partially Met*
	Annual Resubmission 2	85%	90%	*Partially Met*
	Annual Resubmission 3	91%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP 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 noncritical) 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*.

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that Care1st's annual submission of its *All-Cause Readmissions* QIP received an overall validation status of *Not Met*. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, Care1st resubmitted the QIP and, after two resubmissions, achieved an overall *Met* validation status, with 94 percent of the evaluation elements and 100 percent of the critical elements receiving a met score. The *Comprehensive Diabetic Care* QIP annual submission received an overall *Partially Met* validation status. Care1st resubmitted the QIP and, upon the third resubmission, achieved an overall *Met* validation status, with 91 percent of the evaluation elements and 100 percent of the critical elements receiving a met score.

Table 4.3 summarizes the aggregated validation results for Care1st's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
Care1st—San Diego County
(Number = 7 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	86%	7%	7%
	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%
	V: Valid Sampling Techniques (if sampling is used)**	88%	13%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		**95%**	**4%**	**1%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	73%	13%	15%
	VIII: Appropriate Improvement Strategies	67%	33%	0%
Implementation Total		**71%**	**18%**	**11%**
Outcomes	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**25%**	**0%**	**75%**

*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 stage and/or activity totals may not equal 100 percent due to rounding.

HSAG validated Activities I through VIII for Care1st's *All-Cause Readmissions* QIP annual submission and Activities I through IX for the MCP's *Comprehensive Diabetic Care* QIP annual submission.

Care1st demonstrated a strong application of the Design stage across all QIPs, meeting 95 percent of the requirements for all applicable elements within the study stage. The MCP did not document MCP-specific data to support the selection of the *All-Cause Readmissions* topic, resulting in a lower score for Activity I for this QIP. For the *Comprehensive Diabetic Care* QIP, the MCP did not include the margin of error associated with its sampling techniques, resulting in a lower score for Activity V.

Both QIPs progressed to the Implementation stage during the reporting period. The MCP demonstrated an adequate application of the Implementation stage, meeting 71 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The

All-Cause Readmissions and *Comprehensive Diabetic Care* QIPs had multiple implementation issues, resulting in lower scores for Activities VII and VIII. HSAG held a technical assistance call with Care1st to discuss ways the MCP could improve implementation of the QIPs and to address the deficiencies. Care1st corrected the deficiencies in the resubmissions, resulting in both QIPs achieving an overall *Met* validation status.

Only the *Comprehensive Diabetic Care* QIP progressed to the Outcomes stage during the reporting period. The QIP did not achieve statistically significant improvement over baseline for any of the five study indicators, resulting in only 25 percent of the requirements for all applicable elements being met for Activity IX. Activity X was not assessed since sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved.

Quality Improvement Project Outcomes and Interventions

The *All-Cause Readmissions* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP's interventions for the *All-Cause Readmissions* QIP:

- Discharge Planning:
  - Select hospitals have on-site hospitalist and in-house case management.
  - Case management and discharge planning begins when the member is admitted to any of the select hospitals.
  - Case manager is assigned, social services goals are set, and a plan is developed to assess triggers for readmission.
  - Ensure that all members being discharged have a follow-up appointment with their PCP or specialist scheduled within seven days of discharge.
  - Ensure that full medication reconciliation is completed with the PCP within seven days of discharge.
- Assuring Members Follow up with PCP:
  - Case manager or coordinator places a reminder call to the member the day prior to the scheduled PCP or specialist follow-up appointment.
  - Follow-up call is made to member after the PCP or specialist visit to confirm the member was seen and, if not, the appointment is rescheduled.
  - Free transportation is arranged for members as needed.

Outcome information for the *All-Cause Readmissions* QIP will be included in Care1st's 2014–15 MCP-specific evaluation report.

Table 4.4 summarizes the *Comprehensive Diabetic Care* QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained

improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

Table 4.4—Quality Improvement Project Outcomes for Care1st—San Diego County July 1, 2013, through June 30, 2014

QIP #1—Comprehensive Diabetic Care			
Study Indicator 1: The percentage of diabetic members 18–75 years of age who received at least one HbA1c screening test			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
83.6%	88.8%	84.9%	‡
Study Indicator 2: The percentage of diabetic members 18–75 years of age with an HgbA1c result of >9 (poor control) or no HbA1c screening test^			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
30.9%	37.0%	42.1%	‡
Study Indicator 3: The percentage of diabetic members 18–75 years of age who received an LDL screening test			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
80.6%	81.5%	78.6%	‡
Study Indicator 4: The percentage of diabetic members 18–75 years of age who received a retinal eye exam			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
41.8%	47.4%	40.4%	‡
Study Indicator 5: The percentage of diabetic members 18–75 years of age who received a nephropathy screening test			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
87.3%	88.4%	85.4%	‡

^A lower percentage indicates better performance.

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

Comprehensive Diabetic Care QIP

For the *Comprehensive Diabetic Care* QIP, Care1st set the project objective to the NCQA Medicaid percentile that was the next percentile category higher than the reported rate for each measure. For example, if the measure was currently at the NCQA Medicaid 50th percentile, the goal would be the 75th percentile. At Remeasurement 2, the QIP still had not achieved statistically significant improvement over baseline for any of the five study indicators. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- As in previous years, Care1st did not provide complete and/or accurate information throughout the QIP Summary Form, resulting in the MCP having to resubmit the QIP three times.
- Initially, Care1st did not document the process used to identify the barriers or provide an evaluation plan for each of the implemented interventions. The MCP provided this documentation in its resubmissions.
- Due to the decline in rates for all five study indicators, Care1st performed a new causal/barrier analysis for the *Comprehensive Diabetic Care* QIP. Although multiple issues were identified, the MCP indicated that the main factor for the decline in rates was due to a large influx of SPD members with diabetes.
- Although the interventions were not successful at improving the QIP outcomes, following is a brief description of the interventions implemented by Care1st:
  - Identified members who were not controlled or who were still in need of diabetes preventive services by using the following interventions:
    - Mailed educational materials semiannually to the members.
    - Developed a proactive outreach program that focused on placing follow-up calls; sending medication adherence postcards; using case managers, pharmacists, or clinical educators to remind members of the importance of taking insulin and educating them on medication adherence; and identifying members in need of transportation services.
  - Assigned a dedicated project manager to focus on quality improvement projects.
  - Developed a methodology to identify the top 10 high-volume, low-performing providers. Once these providers were identified, implemented high-touch interventions including the following:
    - Conducted face-to-face visits.
    - Provided educational materials and seminars on-site at provider offices or via webinar that focused on treatment protocols, management of short- and long-term complications, ways to develop the care plan, and efficient use of clinic staff.
    - Reviewed medical records for accuracy.
    - Expedited specialty care referrals for endocrinology, ophthalmology, podiatry, nephrology, and neurology.
    - Made direct member referrals to an endocrinologist.
    - Provided templates of care plans to the providers.
  - Worked with labs and vision service providers to get more real-time data.
  - Relaunched the MCP's provider incentive program.

Strengths

Care1st demonstrated an excellent application of the QIP Design stage for both the *All-Cause Readmissions* and *Comprehensive Diabetic Care* QIPs.

Opportunities for Improvement

As discussed in previous years, Care1st required multiple QIP resubmissions before achieving a *Met* validation status for both the *All-Cause Readmissions* and the *Comprehensive Diabetic Care* QIPs. Care1st has the opportunity to make improvements in its documentation on the QIP Summary Form. The MCP should refer to the QIP Completion Instructions and previous QIP Validation Tools prior to submitting the QIPs to ensure completeness of the data.

For the *Comprehensive Diabetic Care* QIP, Care1st has the opportunity to discontinue or modify existing interventions or to identify new interventions to better address the priority barriers, including the large influx of SPD members with diabetes.

Conducting the EQRO Review

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each MCP in the three domains of care—quality, access, and timeliness. A numerical score is calculated for each domain of care for performance measure rates, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care and converted to a rating of above average, average, or below average. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the MCPs' medical audit/SPD medical survey reviews and assessment of the accuracy and completeness of encounter data to determine overall performance within each domain of care, as applicable. A more detailed description of HSAG's scoring process is included in Appendix C.

Please note that when a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[10]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP 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, DHCS monitors aspects of an MCP'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. DHCS also uses the results

[10] This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

HSAG reviewed Care1st's quality improvement program description and work plan and found documentation of processes the MCP implements to ensure that quality care is provided to its MCMC members.

During the December 2013 SPD medical survey, DMHC identified two potential deficiencies in the area of Quality Management, which could affect the quality of care being delivered to MCMC members.

No quality performance measures had rates above the HPLs, and the following quality measures had rates below the MPLs:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates for both *Medication Management for People with Asthma* measures, which fall into the quality domain of care, improved significantly from 2013 to 2014; and the improvement for the *Medication Compliance 50% Total* indicator resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014. The rates for the following quality measures improved from 2013 to 2014; and although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in 2013 to above the MPLs in 2014:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Use of Imaging Studies for Low Back Pain*

The rates for the following quality measures were significantly worse in 2014 when compared to 2013:

- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

- *Controlling High Blood Pressure*
- All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

Twelve of the measures stratified for the SPD population fall into the quality domain of care, and the SPD rates for five of these measures were significantly better than the non-SPD rates. The SPD rates for two measures were significantly worse than the non-SPD rates:

- *All-Cause Readmissions*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

Both of Care1st's QIPs fell into the quality domain of care. Only the *Comprehensive Diabetic Care* QIP progressed to the Outcomes stage during the reporting period. At Remeasurement 2, the QIP still had not achieved statistically significant improvement over baseline for any of the five study indicators, suggesting that the MCP has opportunities for improving the quality of care being provided to members with diabetes.

Overall, Care1st showed below-average performance related to the quality domain of care.

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP'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. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

During the December 2013 SPD medical survey, DMHC identified two potential deficiencies in the area of Availability and Accessibility of Services, which could affect MCMC members' access to needed health care services.

HSAG reviewed Care1st's available quality improvement information and found that the MCP included goals and objectives in its quality improvement program description designed to ensure members' access to needed health care services. The MCP's quality improvement evaluation

document provides descriptions of Care1st's assessment of its performance related to access to care and identifies opportunities for improvement and areas in which the MCP needs to focus to ensure access to care for its members.

No access performance measures had rates above the HPLs, and the following access measures had rates below the MPLs:

- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

No access measures had rates that improved significantly from 2013 to 2014, and the rates for the following access measures declined significantly from 2013 to 2014:

- *Childhood Immunization Status—Combination 3*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*

Nine of the performance measures stratified for the SPD population fall into the access domain of care. The SPD rate for one of these measures, *Comprehensive Diabetes Care—Medical Attention for Nephropathy,* was significantly better than the non-SPD rate. The SPD rates were significantly worse than the non-SPD rates for the following access measures:

- *All-Cause Readmissions*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Both of Care1st's QIPs fell into the access domain of care. Only the *Comprehensive Diabetic Care* QIP progressed to the Outcomes stage during the reporting period. At Remeasurement 2, the QIP still had not achieved statistically significant improvement over baseline for any of the five study indicators, suggesting that the MCP has opportunities for improving access to care for members with diabetes.

Overall, Care1st showed below-average performance related to the access domain of care.

Timeliness

The timeliness domain of care relates to an MCP'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.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' 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. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

HSAG reviewed Care1st's available quality improvement information and found that the MCP included some information related to processes designed to assess and ensure timely access to services for MCMC members.

During the December 2013 SPD medical survey, DMHC identified one potential deficiency in the area of Utilization Management and two potential deficiencies in the area of Member Rights, all of which could affect the timeliness of care delivered to MCMC members.

The rate for the *Childhood Immunization Status—Combination 3* measure, which falls into the timeliness domain of care, declined significantly from 2013 to 2014, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014. The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, which is a timeliness measure, was below the MPL in 2014.

Overall, Care1st showed average performance in the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2012–13 MCP-specific evaluation report. Care1st's self-reported responses are included in Appendix D.

Recommendations

Based on the overall assessment of Care1st in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following to the MCP:

- Ensure that all potential deficiencies identified during the December 2013 SPD medical survey in the areas of Utilization Management and Member Rights are fully resolved.
- Since the MCP had 11 measures with rates below the MPLs and 10 measures with rates that were significantly worse in 2014 when compared to 2013, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once. Care1st may want to focus efforts on the following measures first:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
  - *Childhood Immunization Status—Combination 3*
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  - *Controlling High Blood Pressure*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Assess the factors leading to the SPD rates for five measures being significantly worse than the non-SPD rates to ensure that the MCP is meeting the needs of the SPD population.
- Refer to the QIP Completion Instructions and previous QIP Validation Tools prior to submitting QIPs to ensure completeness of the data.
- For the *Comprehensive Diabetic Care* QIP, discontinue or modify existing interventions or identify new interventions to better address the recently identified priority barriers, including the large influx of SPD members with diabetes.

In the next annual review, HSAG will evaluate Care1st's progress with these recommendations along with its continued successes.

Table A.1 provides two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table A.1—HEDIS 2014 SPD Trend Table
Care1st—San Diego County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	17.35%	16.90%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	73.34	68.85	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	415.00	399.63	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.13%	85.13%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.24%	85.98%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	70.83%	69.03%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	82.50%	62.64%	↓
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	78.13%	70.67%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	57.00%	41.61%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	38.40%	36.98%	↔
Comprehensive Diabetes Care—HbA1c Testing	82.80%	81.02%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.20%	44.04%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.60%	35.04%	↔
Comprehensive Diabetes Care—LDL-C Screening	79.40%	72.51%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	88.40%	81.27%	↓
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	48.00%	64.72%	▼

*Member months are a member's "contribution" to the total yearly membership.

Table B.1 provides two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table B.1—HEDIS 2014 Non-SPD Trend Table
Care1st—San Diego County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.65%	8.64%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	43.32	44.72	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	249.97	237.00	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.85%	76.14%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	75.23%	72.65%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	93.78%	89.78%	↓
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.10%	81.31%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	82.68%	81.93%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	81.22%	79.34%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.36%	51.18%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	40.46%	41.34%	↔
Comprehensive Diabetes Care—HbA1c Testing	83.21%	82.28%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	38.17%	35.04%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	35.11%	26.77%	↔
Comprehensive Diabetes Care—LDL-C Screening	74.81%	70.47%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.92%	73.62%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	52.67%	71.65%	▼

*Member months are a member's "contribution" to the total yearly membership.

Quality, Access, and Timeliness Scoring Process

Scale
2.5–3.0 = Above Average
1.5–2.4 = Average
1.0–1.4 = Below Average

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[11] This process allows HSAG to evaluate each MCP's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.1)

Quality Domain

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.
   - If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.
3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

[11] The CMS protocols specify that the EQRO must include an assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Access and Timeliness Domains

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.
   - If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

Validation *(Table 4.2)*: For each QIP submission and subsequent resubmission(s), if applicable.

1. **Above Average** is not applicable.
2. **Average** = *Met* validation status.
3. **Below Average** = *Partially Met* or *Not Met* validation status.

Outcomes *(Table 4.4)*: Activity IX, Element 4—Real Improvement

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

Sustained Improvement *(Table 4.4)*: Activity X—Achieved Sustained Improvement

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Some, but not all, study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

APPENDIX D. MCP'S SELF-REPORTED FOLLOW-UP ON EXTERNAL QUALITY REVIEW RECOMMENDATIONS FROM THE JULY 1, 2012–JUNE 30, 2013 PERFORMANCE EVALUATION REPORT

for Care1st Partner Plan

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with Care1st's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table D.1—Care1st's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

2012–13 External Quality Review Recommendation Directed to Care1st	Actions Taken by Care1st During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Ensure that all findings from the February 2012 MR/PIU review are fully addressed. Specifically:	
a. Revise the MCP's grievance and appeals policies and procedures to include the requirement that the time frame to resolve an appeal may be extended up to 14 calendar days if the MCP shows there is a need for additional information and how the delay is in the member's interest. Additionally, ensure that the policies and procedures are implemented.	The policy has been updated to reflect the following: "Care1st Health Plan must extend this time frame by up to fourteen (14) calendar days if the enrollee/requestor requests an extension. The time frame may also be extended by up to fourteen (14) calendar days if Care1st Health Plan can justify the benefit of an extension to the enrollee."
b. Ensure that Care1st's entire provider network receives the required SPD sensitivity trainings, per MMCD All Plan Letter 11-010.	In addition to multiple training sessions that occurred within the community, SPD sensitivity training is included in all in-service materials for new providers, starting in November 2013. The materials will be sent out to the entire network by July 25, 2014.
c. Include information about Care1st's Fraud and Abuse Program in the Member Services Guide.	"Preventing Health Care Fraud" is included in the Care1st Evidence of Coverage, which is provided to each new member and sent out annually to existing membership.
2. Since Care1st had nine measures with rates below the MPLs and five measures with rates that declined significantly from 2012 to 2013, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.	Care1st Health Plan has developed a number of interventions to improve HEDIS rates.Care1st has selected *CDC–Eye Exam* and *Low Back Pain* as two key measures to focus on for 2014. As recommended by DHCS, Care1st is following the Plan–Do–Study–Act (PDSA) cycle approach to improving performance. The staff members at Care1st have ongoing meetings with the program manager at DHCS to discuss barriers, processes, and current performance.

2012–13 External Quality Review Recommendation Directed to Care1st	Actions Taken by Care1st During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
3. Assess the factors leading to the SPD rate for the *All-Cause Readmissions* measure being significantly higher than non-SPD rate and the SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* measure being significantly lower than the non-SPD rate to ensure the MCP is meeting the needs of the SPD population.	Care1st has a QIP that focuses on improving readmission rates for SPD patients. These factors have been assessed and described in the QIP. Care1st has achieved a "Met" status on the validation for this QIP. Care1st has identified members that have not received care or accessed their primary care provider (PCP) during 2014 and is calling members to schedule appointments. This rate will be tracked monthly to assess change in performance.
4. For the MCP's QIPs:	
a. Refer to the QIP Completion Instructions prior to submitting QIPs to ensure completeness of data and to avoid having to resubmit QIPs to achieve a *Met* validation status.	This activity is complete and Care1st has achieved a "Met" status on the validation.
b. For the *Comprehensive Diabetic Care* QIP, build on the successes that led to an improvement in rates for study indicators 1, 3, 4, and 5.	Care1st Health Plan has developed/enhanced a number of interventions to improve HEDIS rates for all the CDC indicators. These include enhancing the pay for performance program, member outreach and appointment scheduling calls, provider outreach including distribution of gaps in care reports, collection of supplemental medical records to capture additional data, etc.
5. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly* priority areas.	Care1st has worked with its CAHPS vendor to analyze data at the Independent Physician Association (IPA) and Group level. This will help Care1st identify the high and low performing groups. These results will be shared with the groups at the Joint Operations meetings. Care1st will work together with the groups to identify the best strategy on how to improve care for the members so they can get the care they need in a timely manner.
6. Review the *2012–13 MCP-Specific Encounter Data Validation Study Report* and identify strategies to address the recommendations to ensure accurate and complete encounter data.	The report has been reviewed and will be used to identify strategies to address the recommendations to ensure accurate and complete encounter data. In addition, Care1st is adopting the DHCS measures (from the recent DHCS Quality Measures for Encounter Data_v0_93) as internal measurements to assist in identifying and addressing issues.

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