Performance Evaluation Report

Community Health Group Partnership Plan

July 1, 2010–June 30, 2011

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

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HSAG HEALTH SERVICES ADVISORY GROUP

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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 million beneficiaries (as of June 2011)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Community Health Group Partnership Plan ("Community Health Group," "CHG," or "the plan"), which delivers care in San Diego County, for the review period July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

CHG is a full-scope managed care plan in San Diego County, serving members as a Geographic Managed Care (GMC) model type. The GMC model allows enrollees to choose from several commercial plans within a specified geographic area. During the review period July 1, 2010, through June 30, 2011, CHG was one of five commercial plans contracting with the MCMC Program in San Diego County. CHG became operational with the MCMC Program in August 1998. As of June 30, 2011, CHG had 110,064 MCMC members.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

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

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about CHG's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

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

HSAG reviewed the most current medical performance audit reports available as of June 30, 2011, to assess plans' compliance with State-specified standards.

The most recent medical performance review was completed in June 2007, covering the review period of June 1, 2006, through May 31, 2007. HSAG reported findings from this audit in the 2008-2009 plan evaluation report.[3]

The review showed that CHG had audit findings in the areas of utilization management, continuity of care, availability and accessibility, members' rights, and quality management. The DHCS *Medical Audit Close-Out Report* letter dated May 19, 2008, noted that the plan had not fully corrected the audit deficiencies. CHG is due for its next three year review; however, A&I has not yet scheduled an audit date.

Medi-Cal Managed Care Member Rights and Program Integrity Review

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

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2011.

MRPIU conducted a routine monitoring review of CHG in April 2008, covering the review period of January 1, 2006, through December 31, 2007. HSAG reported the review findings in the 2008–2009 plan evaluation report for CHG. The scope of the review included grievances, prior authorization notifications, cultural and linguistic services, and marketing. MRPIU noted findings in the each of the areas reviewed.

In the category of grievances, it was noted that two of the 67 grievance files reviewed did not contain State Fair Hearing information on the resolution letters. However, after discussing the

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

matter with the plan, MRPIU determined this was an isolated incident that did not require corrective action.

In the category of prior authorization, MRPIU noted three findings. First, certain Notice of Action (NOA) letters did not meet the required time frame after authorization had been extended. Second, one file indicated the plan did not use the approved template for a denial. Finally, none of the NOA letters contained signage by a chief medical director and/or officer.

In the area of cultural and linguistic series, three findings were noted. First, office staff at one provider office did not discourage the use of family, friends, or minors as translators. Next, staff at one provider office indicated that they had not received cultural competency training. Finally, MRPIU noted that a provider office had an answering machine message in English only and the message stated that the office would respond the next business day.

In the marketing category, MRPIU noted that marketing materials were only available in English and Spanish, but the threshold languages also include Arabic and Vietnamese.

Strengths

The most recent medical performance audit found the plan fully compliant in the area of administrative and organizational capacity, and the MRPIU review showed CHG compliant in the areas of enrollment and program integrity. Additionally, MRPIU's finding in grievances was considered only an isolated incident that did not require corrective action

Opportunities for Improvement

Because the *Medical Audit Close-Out Report* noted that the plan had not sufficiently addressed all areas of the deficiency, CHG has an opportunity to develop and implement quality control mechanisms to ensure that all areas of deficiency are corrected.

Based on unresolved areas of deficiency, the plan needs to address the following recommendations:

- Notify members of a decision to deny, defer, or modify a prior authorization.
- Ensure that the UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization.
- Develop and implementing systems to identify children who may be eligible to receive services from the Early Start program.
- Develop and implementing procedures for the identification of members with developmental disabilities and referring these members to a regional center.

- Cover and ensure the provision of an initial health assessment (IHA) to each new member within appropriate timelines, making reasonable attempts to contact a member and schedule an IHA, and documenting attempts that demonstrate plan's unsuccessful efforts to contact a member and schedule an IHA.
- Develop, implement, and maintain a procedure to monitor wait times in the providers' offices, for telephone calls, and for time to obtain an appointment.
- Pay timely and appropriately for emergency services received by a member from non-contractor providers.
- Ensure members have the right to access family planning services through any family planning provider without prior authorization, and informing its members in writing of this right in its Member Services Guide.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about CHG's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[4] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of CHG in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. The audit found CHG fully compliant with information standards to produce valid rates.

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

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Table 3.2.

Table 3.1—HEDIS® 2011 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2011 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of CHG's HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. The table shows the plan's HEDIS 2011 performance compared to the MCMC-established MPLs and HPLs.

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

Table 3.2—2010–2011 Performance Measure Results for Community Health Group—San Diego County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	23.2%	17.3%	★	↔	19.7%	35.9%
AWC	Q,A,T	37.0%	42.9%	★★	↑	38.8%	63.2%
BCS	Q,A	55.9%	54.5%	★★	↔	46.2%	63.8%
CCS	Q,A	63.0%	65.2%	★★	↔	61.0%	78.9%
CDC–BP	Q	59.0%	65.7%	★★	↑	53.5%	73.4%
CDC–E	Q,A	41.6%	61.1%	★★	↑	41.4%	70.1%
CDC–H8 (<8.0%)	Q	38.2%	52.3%	★★	↑	38.7%	58.8%
CDC–H9 (>9.0%)	Q	44.0%	37.7%	★★	↑	53.4%	27.7%
CDC–HT	Q,A	81.0%	88.3%	★★	↑	76.0%	90.2%
CDC–LC (<100)	Q	26.5%	40.6%	★★	↑	27.2%	45.5%
CDC–LS	Q,A	73.4%	84.7%	★★★	↑	69.3%	84.0%
CDC–N	Q,A	71.0%	77.2%	★★	↑	72.5%	86.2%
CIS–3	Q,A,T	72.3%	78.1%	★★	↔	63.5%	82.0%
LBP	Q	79.1%	77.7%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	76.6%	79.1%	★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	52.1%	57.2%	★	↔	58.7%	74.4%
URI	Q	90.3%	92.7%	★★	↑	82.1%	94.9%
W34	Q,A,T	74.9%	75.0%	★★	↔	65.9%	82.5%
WCC–BMI	Q	38.4%	63.3%	★★★	↑	13.0%	63.0%
WCC–N	Q	44.8%	69.8%	★★★	↑	34.3%	67.9%
WCC–PA	Q	34.5%	40.4%	★★	↔	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, CHG had average performance results for its HEDIS measures. The plan did not have any measures with statistically significant declines in 2011 and had an impressive twelve measures with statistically significant increases. Three measures fell below the national Medicaid standard of the 25th percentile (*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and the two *Prenatal Care* and *Postpartum Care*measures). Three measures landed above the national Medicaid 90th percentile (*LDL-C Screening, BMI Assessment: Total,* and *Nutrition Counseling: Total).*

HEDIS Improvement Plans

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

For measures requiring a 2010 improvement plan, HSAG used 2011 HEDIS scores to evaluate progress during the year. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or develop new improvement plans.

CHG was not required to conduct any HEDIS improvement plans in 2011 based on 2010 rates; however, the plan will need to conduct three improvement plans in 2012.

Strengths

CHG had three measures(*LDL-C Screening, BMI Assessment: Total,* and *Nutrition Counseling: Total)* perform above HPLs in 2011. The plan also had 12 out of 21 (57%) measures perform with a statistically significant increase over 2010 results, which shows that CHG has increased the focus on HEDIS performance.

Opportunities for Improvement

CHG has the opportunity to increase three measures(*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis, Timeliness of Prenatal Care,* and *Postpartum Care*) that fell below MPLs in 2011.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Quality Improvement Projects Conducted

CHG had three clinical QIPs in progress during the review period of July 1, 2010, through June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. CHG's second project was part of a small-group collaborative aimed at increasing the assessment, diagnosis, and appropriate treatment of chronic obstructive pulmonary disease (COPD). CHG's third QIP targeted increasing postpartum depression screening and follow-up care for positive screens. All three QIPs fell under the quality domain of care, and the statewide collaborative QIP also fell under the access domain of care.

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

screens that received follow-up care. Providing the necessary follow-up care is essential to ensure the mental health of the member.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for the three CHG QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Community Health Group—San Diego County July 1, 2010, through June 30, 2011

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	87%	100%	*Met*
Small-Group Collaborative				
Improving Treatment of COPD	Annual Submission	89%	100%	*Met*
Internal QIPs				
Increasing Screens for Postpartum Depression	Annual Submission	69%	69%	*Not Met*
	Resubmission	90%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that CHG's annual submission of its *Improving Treatment of COPD* QIP received an overall validation status of *Met*. Additionally, for its annual submissions, CHG received a *Met* validation status for its *Reducing Avoidable Emergency Room Visits* QIP and a *Not Met* validation status for its *Increasing Screens for Postpartum Depression* QIP. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted the *Increasing Screens for Postpartum Depression* QIP and upon subsequent validation, CHG achieved an overall *Met* validation status.

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

Table 4.2—Quality Improvement Project Average Rates* for Community Health Group—San Diego County (Number = 3 QIP Submissions, 3 QIP Topics) July 1, 2010, through June 30, 2011

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	95%	5%	0%
	VII: Appropriate Improvement Strategies	89%	11%	0%
Implementation Total		**94%**	**6%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	96%	0%	4%
	IX: Real Improvement Achieved	25%	25%	50%
	X: Sustained Improvement Achieved	33%	0%	67%
Outcomes Total†		**70%**	**8%**	**23%**

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

† The sum may not equal 100 percent due to rounding.

For all three QIPS, the plan submitted Remeasurement 2 data; therefore, HSAG validated Activity I through Activity X. One hundred percent of the applicable elements within the design stage were scored *Met* and 94 percent of the applicable elements within the implementation stage were scored *Met*. For Activity VII of the implementation stage, the plan was scored down for implementing new interventions late in the measurement year, which affected the efficacy of the interventions. For the outcomes stage, Activity IX was scored lower because none of the study indicators demonstrated improvement for the *Increasing Screens for Postpartum Depression* QIP or the *Reducing Avoidable Emergency Room Visits* QIP; and only two study indicator and one subindicator in the *Treatment of COPD* QIP demonstrated improvement. Additionally Activity X was scored down since only the *Increasing Screens for Postpartum Depression* QIP demonstrated sustained improvement for its study indicator outcomes. Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

Table 4.3 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3—Quality Improvement Project Outcomes for Community Health Group—San Diego County July 1, 2010, through June 30, 2011

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement¥**
Percentage of avoidable ER visits	17.9%	16.5%*	21.6%*	No
QIP #2—Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement¥**
1) Percentage of eligible members with at least one Spirometry test in the two years before or six months after the Index Episode Start Date	11.4%	19.5%	11.1%	No
2) Percentage of acute inpatient hospitalization discharges of members with COPD	54.9%	68.8%*	23.5%*	‡
3) Percentage of emergency department (ED) visits for members with COPD	69.0%	70.5%	30.3%*	‡
4) Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter who were dispensed:				
a) Systemic corticosteroid within 14 days of the event	52.5%	41.1%	45.3%	‡
b) Bronchodilator within 30 days of the event	75.0%	68.9%	60.0%	‡

Table 4.3—Quality Improvement Project Outcomes for Community Health Group—San Diego County July 1, 2010, through June 30, 2011

QIP #3—Increasing Screening for Postpartum Depression				
QIP Study Indicator	**Baseline Period 11/6/06–11/5/07**	**Remeasurement 1 11/6/07–11/5/08**	**Remeasurement 2 11/6/08–11/5/09**	**Sustained Improvement¥**
1) Percentage of members who had a live birth and were screened for depression at their postpartum visit	23.1%	34.3%*	32.4%	Yes
2) Percentage of members who had a live birth and were screened for depression using a screening tool at their postpartum visit	9.5%	19.2%*	17.3%	Yes
3) Percentage of members who had a live birth and screened positive for depression with documentation of follow-up care	63.6%	85.7%	81.3%	Yes

¥ Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

*A statistically significant difference between baseline and Remeasurement 1 (p value < 0.05).

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

CHG reported a decline in performance for the *Reducing Avoidable Emergency Room Visits* QIP study indicator from Remeasurement 1 to Remeasurement 2. The increase in the avoidable ER visits indicator outcome was statistically significant and reflected a decline in performance. Collaborative interventions were initiated in early 2009; however, they did not correspond to any improvement in performance. The plan did not demonstrate overall improvement from baseline to Remeasurement 2, and therefore, it did not achieve sustained improvement.

For the *Treatment of COPD* QIP, the plan reported statistically significant improvement between Remeasurement 1 and Remeasurement 2 for reducing the percentage of inpatient hospitalizations discharges of members with COPD and reducing ER visits for COPD. Additionally, the plan increased the percentage of inpatient discharged members who were dispensed a systemic corticosteroid within 14 days. Initially, from baseline to Remeasurement 1, the plan had reported a decline in the performance for all study indicators except Study Indicator 1; therefore, only Study Indicator 1 could be assessed for sustained improvement. For Study Indicator 1, the percentage of members with at least one spirometry test at Remeasurement 2 was lower than the percentage at baseline. The plan was unable to sustain the initial improvement reported from baseline to Remeasurement 1.

From Remeasurement 1 to Remeasurement 2 for the *Increasing Screens for Postpartum Depression* QIP, the plan reported a decline in performance for all three study indicators; however, the decreases were not statistically significant. The plan reported that new interventions were not implemented

until the last quarter of the most recent measurement year, which minimized the potential impact on the outcomes. Although the plan's most recent performance had declined, the outcomes at Remeasurement 2 were still improved over the baseline outcomes. Therefore, the plan was able to demonstrate sustained improvement for all three study indicators.

Strengths

CHG demonstrated a thorough application of the QIP process for the design and implementation stages. The plan achieved these scores with the benefit of a resubmission for only one of the three QIPs, which indicated a proficiency with the QIP validation process.

Additionally, for the *Treatment of COPD* QIP, CHG documented statistically significant improvement in the outcomes from the first to the second remeasurement period, which demonstrated improvement in reducing both the inpatient discharges and ER visits for COPD. CHG was also able to achieve sustained improvement for its *Increasing Screens for Postpartum Depression* QIP, demonstrating improvement from baseline to the second remeasurement period in screening postpartum members for depression, using a screening tool, and providing follow-up care to members with positive screens.

Opportunities for Improvement

CHG has an opportunity to improve its intervention strategies in order to achieve sustained improvement of its QIP outcomes. At a minimum, barrier analysis should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone. Additionally, HSAG recommends that CHG implement a method to evaluate the effectiveness of each intervention. Based on the evaluation results, the plan can make appropriate revisions or implement new interventions, if necessary. If the intervention evaluation demonstrates that an intervention is successful, the plan should clearly document the process and how it was used to monitor and standardize the intervention in the QIP. Interventions should be implemented at the beginning of a measurement period, maximizing their potential to affect the study outcomes throughout the measurement period.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

The plan showed average performance in the quality domain. This assessment was based on CHG's 2011 performance measure rates (which reflect 2010 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

The plan was able to report valid rates for all 2011 performance measures. CHG scores improved from last year, with 12 measures showing statistically significant improvement, and three measures scoring above the HPL.

All three QIPs conducted by the plan fell within the quality domain. CHG's *Reducing Avoidable Emergency Room Visits* QIP did not have the anticipated results of reducing the burden of unnecessary emergency room visits by the plan's population. The *Treatment of COPD* QIP showed statistically significant improvement in the outcomes from the first to the second remeasurement period, which demonstrated improvement in reducing both the inpatient discharges and ER visits for COPD. The plan's *Increasing Screens for Postpartum Depression* QIP, indicated improvement from baseline to the second remeasurement period in screening postpartum members for depression, and provided follow-up care to members with positive screens.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the Medi-Cal Managed Care Program.

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

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

Performance measure rates for which HSAG identified a need for focused improvement efforts (*Prenatal and Postpartum Care—Timeliness of Prenatal Care,* and *Prenatal and Postpartum Care—Postpartum Care)* both fell under the access domain of care.

In the MRPIU review, there were several findings noted in the area of cultural and linguistic services which impact quality. First, office staff at one provider office did not discourage the use of family, friends, or minors as translators. Next, staff at one provider office indicated that they had not received cultural competency training. Finally, MRPIU noted that a provider office had an answering machine message in English only and the message stated that the office would respond the next business day.

Timeliness

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

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations,

well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

CHG demonstrated average performance in the timeliness domain of care. This assessment was based on 2011 performance measure rates for providing timely care, and medical performance and member rights reviews related to timeliness.

Performance measure rates for which HSAG identified a need for focused improvement efforts (*Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care)* both fell under the access domain of timeliness.

In the MRPIU review, certain Notice of Action letters did not meet the required time frame after authorization had been extended, which impacted the domain of timeliness.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 plan-specific evaluation report. CHG's self-reported responses are included in Appendix A.

Conclusions and Recommendations

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

CHG showed improvement in performance measure rates in 2011 compared with 2010 rates with many rates experiencing a statistically significant increase. The plan was generally compliant with documentation requirements across performance measures and QIPs. However, the plan must show progress made toward resolving the deficiencies outlined in the Medical Performance Report and MRPIU.

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

Based on unresolved areas of deficiency, the plan needs to address the following recommendations:

- Notify members of a decision to deny, defer, or modify a prior authorization.
- Ensure that the UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization.

- Develop and implementing systems to identify children who may be eligible to receive services from the Early Start program.
- Develop and implementing procedures for the identification of members with developmental disabilities and referring these members to a regional center.
- Cover and ensure the provision of an initial health assessment (IHA) to each new member within appropriate timelines, making reasonable attempts to contact a member and schedule an IHA, and documenting attempts that demonstrate plan's unsuccessful efforts to contact a member and schedule an IHA.
- Develop, implement, and maintain a procedure to monitor wait times in the providers' offices, for telephone calls, and for time to obtain an appointment.
- Pay timely and appropriately for emergency services received by a member from non-contractor providers.
- Ensure members have the right to access family planning services through any family planning provider without prior authorization, and informing its members in writing of this right in its Member Services Guide.
- Improve three measures (*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, *Timeliness of Prenatal Care*, and *Postpartum Care*) that fell below the MPL in 2011.
- Improve QIP intervention strategies to order to achieve sustained improvement for QIP outcomes. At a minimum, barrier analysis should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone.
- Implement a method to evaluate the effectiveness of each intervention. Based on the evaluation results, the plan can make appropriate revisions or implement new interventions, if necessary. If the intervention evaluation demonstrates that an intervention is successful, the plan should clearly document the process and how it was used to monitor and standardize the intervention in the QIP. Interventions should be implemented at the beginning of a measurement period, maximizing their potential to affect the study outcomes throughout the measurement period.

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

APPENDIX A. GRID OF PLAN'S FOLLOW-UP ON EQR RECOMMENDATIONS FROM THE JULY 1, 2009–JUNE 30, 2010 PERFORMANCE EVALUATION REPORT

for Community Health Group Partnership Plan

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with CHG's self-reported actions that address the recommendations. Neither Health Services Advisory Group, Inc. (the external quality review organization for Medi-Cal Managed Care) nor any State agency has confirmed implementation of the actions that the plan self-reported in the grid.

Table A.1—Grid of CHG's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	CHG's Self-Reported Actions That Address the EQR Recommendation
Conduct barrier analysis to determine factors that contributed to low performance for all measures that fell below the MPL.	The Total Quality Integration (TQI) Team conducts barrier analysis for all HEDIS measures.
Implement a more formal review of preliminary rates and a formal reconciliation of the final data used for HEDIS production to ensure that all data are present prior to measure calculations.	HEDIS preliminary rates are reviewed by the HEDIS Manager, Informatics Manager, and the Director of Corporate Quality and reported to the Total Quality Integration Team which conducts the oversight for HEDIS.
Evaluate the plan's internal process for documenting a HEDIS Improvement Plan to improve analysis and documentation to increase the likelihood of improved performance.	The HEDIS Improvement Plans are developed by the HEDIS Manager and Director of Corporate Quality based on the barrier analysis conducted by the Total Quality Improvement Team. The final plans are presented to and approved by the TQI Team.
Request technical assistance from HSAG related to statistical testing for QIPs.	Completed in 2010 and provided with web site link for calculations.
Design and implement interventions that will affect the QIP study indicators by addressing specific barriers that were identified.	The HEDIS Improvement Plans are developed by the HEDIS Manager and Director of Corporate Quality based on the barrier analysis conducted by the Total Quality Improvement Team. The final plans are presented to and approved by the TQI Team.
Review the 2010 plan-specific CAHPS results report and develop strategies to address the following priority areas: *Rating of Health Plan, Getting Care Quickly,* and *Getting Needed Care*.	The Total Quality Improvement Team reviewed the 2010 CAHPS results, conducted barrier analysis, and developed and implemented interventions aimed at improving the rates.