Performance Evaluation Report

Care1st Partner Plan

July 1, 2010–June 30, 2011

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

June 2012

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1. INTRODUCTION

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, Care1st Partner Plan ("Care1st" 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

Care1st Partner Plan is a full-scope Medi-Cal managed care plan in San Diego County. Care1st serves its MCMC members under a Geographic Managed Care (GMC) model. The GMC model allows enrollees to choose from several commercial plans within a specified geographic area. Care1st became operational with the MCMC Program in San Diego County in February 2006. As of June 30, 2011, Care1st had 19,439 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 Care1st'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. The most recent medical performance review was completed in November 2007. HSAG reported findings from this audit in the 2008–2009 plan evaluation report.[3]

The review showed that Care1st showed no deficiencies; however, DMHC did recommend that the plan revise its appeal resolution letters to include the criteria used to make the determination. According to the plan's self-reported response to the EQRO's follow-up grid attached as Appendix A, Care1st has taken steps to address the DMHC recommendation. Care1st has established an audit process to ensure denials include understandable explanations of the reason and criteria used in making the decision. The plan conducts quarterly audits of independent physician associations (IPAs) until they fully meet criteria, at which point they are audited annually.

DMHC conducted an additional audit of Care1st in May 2011; however, results from this audit were not available for review at the time this report was produced. HSAG will include these audit results in the plan's next evaluation report.

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 notifications, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These member rights reviews are conducted before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

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

MRPIU conducted an on-site review of Care1st in June 2009, covering the review period of July 1, 2008, through May 2009. The scope of the review included grievances, prior authorization notifications, cultural and linguistic services, and the False Claims Act. Details from this MRPIU were included in the plan's previous plan-specific evaluation report.[4]

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[3] California Department of Health Care Services. *Performance Evaluation Report, Care1st Partner Plan—July 1, 2008 through June 30, 2009*. October 2009. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

[4] California Department of Health Care Services. *Performance Evaluation Report, Care1st Partner Plan—July 1, 2009 through June 30, 2010*. October 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

MRPIU noted findings in the areas of prior authorization notifications and cultural and linguistic services.

- The plan did not implement an effective quality improvement program in accordance with the standards in Title 10, Section 1300.70. The plan was also cited because it lacked ongoing objective and systematic monitoring and evaluation of the quality and appropriateness of care and services rendered, including conducting quality of care studies that address the quality of clinical care as well as the quality of health services delivery. Finally, pursuant to California Health and Safety Code, Section 1363.5, the plan needed a utilization management program for monitoring under- and overutilization of services; procedures to evaluate medical necessity; prior authorization policies and procedures; and criteria used for approval, referral, and denial of services.
- In the category of cultural and linguistic services, MRPIU noted two findings. First, staff members in three of the eight offices visited were not aware of the member interpreter services/access requirement. Second, in two of eight offices visited, staff did not discourage the use of family, friends, or minors as interpreters. Also, it was noted that one of eight provider offices was not aware of procedures for referring Medi-Cal members to culturally and linguistically appropriate community services programs.

Strengths

Care1st demonstrated strong performance with full compliance in its most recent medical performance review which was conducted in November 2007.

Opportunities for Improvement

Care1st has the opportunity to improve based on its 2009 MRPIU review. First, the plan should modify its policies and procedures to include the quality of care requirements; once these are modified, the plan will need to ensure that the new policies and procedures are effectively applied. Care1st should also ensure that all contracted providers are trained regarding interpreter services. In the DHCS's September 2009 final report to the plan, the State also recommended that the plan take the necessary steps to ensure that plan providers are consistently receiving and providing their staff with effective and consistent training on policies and procedures for referring Medi-Cal members to culturally and linguistically appropriate community service programs.

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 Care1st'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®)[5] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of Care1st in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates.

The audit showed that the plan could benefit from greater oversight of its encounter data submissions. The auditor recommended that the claims or analytics department run monthly monitoring reports for vendor encounter data to track monthly volumes so that the plan is aware of potentially missing data before it presents a problem.

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

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. 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 Care1st'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 Care1st—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	23.3%	28.0%	★★	↔	19.7%	35.9%
AWC	Q,A,T	42.6%	45.0%	★★	↔	38.8%	63.2%
BCS	Q,A	48.7%	45.9%	★	↔	46.2%	63.8%
CCS	Q,A	68.4%	64.5%	★★	↔	61.0%	78.9%
CDC–BP	Q	69.9%	66.1%	★★	↔	53.5%	73.4%
CDC–E	Q,A	51.3%	41.8%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	46.9%	52.7%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	39.8%	30.9%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	81.4%	83.6%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	47.8%	46.1%	★★★	↔	27.2%	45.5%
CDC–LS	Q,A	77.9%	80.6%	★★	↔	69.3%	84.0%
CDC–N	Q,A	82.3%	87.3%	★★★	↔	72.5%	86.2%
CIS–3	Q,A,T	79.8%	79.8%	★★	↔	63.5%	82.0%
LBP	Q	75.4%	61.0%	★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	86.5%	80.0%	★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	60.0%	60.5%	★★	↔	58.7%	74.4%
URI	Q	91.6%	91.8%	★★	↔	82.1%	94.9%
W34	Q,A,T	75.9%	76.8%	★★	↔	65.9%	82.5%
WCC–BMI	Q	50.4%	57.2%	★★	↔	13.0%	63.0%
WCC–N	Q	49.6%	63.3%	★★	↑	34.3%	67.9%
WCC–PA	Q	29.2%	36.3%	★★	↑	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, Care1st demonstrated average performance. Two comprehensive diabetes care measures (*LDL-C Control (<100 mg/dL and Medical Attention for Nephropathy*) performed better than the national Medicaid 90th percentile. Three measures (*Breast Cancer Screening, Use of Imaging Studies for Low Back Pain, and Prenatal and Postpartum Care—Timeliness of Prenatal Care*) fell below the MPLs. Two measures (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total* and *Physical Activity Counseling: Total*), had statistically significant increases between 2010 and 2011; and there were no measures that had a statistically significant decrease in performance.

HEDIS Improvement Plans

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

For plan measure rates that required a 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with the plan's 2011 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

The plan did not have any measures fall below the MPLs in 2010; therefore, no improvement plans were required in 2011. However, Care1st will need to implement improvement plans for the *Breast Cancer Screening, Use of Imaging Studies for Low Back Pain,* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measures, all of which fell below the MPLs in 2011.

Strengths

Care1st's most notable strength was demonstrated in the *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL) and Comprehensive Diabetes Care—Medical Attention for Nephropathy* measures, as the plan scored above the HPLs. The plan also had statistically significant improvement in two measures: *Weight Assessment and Counseling for Nutrition* and *Physical Activity for Children/ Adolescents—Nutrition Counseling: Total* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total.*

Opportunities for Improvement

In 2011, the plan had three measures (*Breast Cancer Screening*, *Use of Imaging Studies for Low Back Pain,* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care)* fall below the MPLs, as opposed to not having any measures perform below the MPLs in 2010. The plan will need to address these measures with detailed improvement plans in order to recapture 2010's performance level.

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 Care1st's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Projects Conducted

Care1st had two clinical QIPs in progress during the review period of July 1, 2010–June 30, 2011. The plan's first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS's statewide collaborative QIP project. Care1st's second project aimed to reduce inappropriate antibiotics in children with upper respiratory infections (URIs) as part of a small-group collaborative.

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

Quality Improvement Project Validation Findings

The table below summarizes the validation results for Care1st's two QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Care1st—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	69%	80%	*Partially Met*
	Resubmission	89%	100%	*Met*
Small-Group Collaborative QIP				
Appropriate Treatment for Children With Upper Respiratory Infection	Annual Submission	97%	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 the plan's annual QIP submissions received an overall validation status of *Partially Met* for the *Reducing Avoidable Emergency Room Visits* QIP and a *Met* status for the *Appropriate Treatment for Children With Upper Respiratory Infection* QIP. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Upon resubmission of the *Reducing Avoidable Emergency Room Visits* QIP, Care1st achieved an overall *Met* validation status.

Table 4.2 summarizes and aggregates the validation results for Care1st's two QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Care1st—San Diego County (Number = 2 QIPs, 2 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)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	81%	6%	13%
	IX: Real Improvement Achieved†	88%	13%	0%
	X: Sustained Improvement Achieved	50%	0%	50%
Outcomes Total†		**81%**	**8%**	**12%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.
†The sum of an activity or stage may not equal 100 percent due to rounding.

Care1st successfully applied the QIP process for the design and implementation stages, scoring 100 percent *Met* on all applicable evaluation elements for six of the six applicable activities.

For the outcomes stage, Care1st was scored lower in Activity VIII for the *Reducing Avoidable Emergency Room Visits* QIP due to an incomplete interpretation of the results; not identifying whether there were factors that affected the internal and external validity of the findings; and not specifying whether there were factors that affected the ability to compare measurement periods.

For Activity IX, the plan was scored down for the lack of real improvement since one of the study indicators did not demonstrate statistically significant improvement between the most recent measurement period and the prior measurement period. All study indicators were assessed for sustained improvement in Activity X; however, only the study indicators for the *Appropriate Treatment for Children With Upper Respiratory Infection* QIP achieved sustained improvement. For the *Reducing Avoidable Emergency Room Visits* QIP, sustained improvement was not achieved since the Remeasurement 2 result was the first remeasurement period that demonstrated improvement. Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most

current measurement period's results must reflect improvement when compared to the baseline results.

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 Care1st—San Diego County (N = 2 QIPs, 2 QIP Topics) 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	13.8%	17.7%*	12.2%*	No

QIP #2—Appropriate Treatment for Children With Upper Respiratory Infection					
QIP Study Indicator 1	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Remeasurement 3 1/1/10–12/31/10**	**Sustained Improvement¥**
Percentage of high-volume PCPs serving children not prescribing an antibiotic for a URI for a member who is under 19 years of age	42.9%	66.7%*	100%*	‡	Yes
QIP Study Indicator 2	**Baseline Period 1/1/06–12/31/06**	**Remeasurement 1 1/1/07–12/31/07**	**Remeasurement 2 1/1/08–12/31/08**	**Remeasurement 3 1/1/09–12/31/09**	**Sustained Improvement¥**
Percentage of children between 3 months and 18 years who received appropriate treatment for children with URI	71.7%	86.8%*	91.3%	91.6%	Yes

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

*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05)

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

From the last submission to the current submission, Care1st corrected its baseline and Remeasurement 1 rates to reflect San Diego County only rates. The plan reported an increase in performance for the *Reducing Avoidable Emergency Room Visits* QIP study indicator; the decrease in the rate was statistically significant. Collaborative interventions were initiated in early 2009 and potentially correspond to the improvement in performance. The plan will have to maintain the improvement in a subsequent measurement period in order to achieve sustained improvement.

For the *Appropriate Treatment for Children With URI* QIP, both study indicators improved. The increase in high-volume providers not prescribing an antibiotic and the increase in children receiving the appropriate treatment were both statistically significant and demonstrated real improvement. Additionally, both study indicators achieved sustained improvement from baseline to the most recent measurement period.

Strengths

Care1st demonstrated a good understanding of documenting support for its QIP study design. The plan implemented accurate data collection methods and appropriate improvement strategies. With appropriate improvement strategies, Care1st was able to achieve a statistically significant decline in the percentage of avoidable ER visits.

The plan noted sustained statistically significant improvement for the *Appropriate Treatment for Children With URI* QIP's study indicators, which suggest that the plan benefited from the small-group collaborative efforts.

Opportunities for Improvement

Care1st has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs with its initial submission. HSAG recommends that the plan use feedback from prior QIPs as well as the QIP Completion Instructions to help achieve compliance without having to resubmit projects.

The plan implemented the collaborative interventions in 2009 for the *Reducing Avoidable ER Visits* QIP; however, when the plan implements multiple interventions, it should incorporate a method to evaluate the effectiveness of each intervention. The plan should also conduct another barrier analysis and identify new or revised plan-specific interventions to sustain the reduction of avoidable ER visits.

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 Care1st's 2011 performance measure rates, QIP outcomes, and the results of the medical performance reviews.

The plan was able to report valid rates for all 2011 performance measures; and while most of the rates were similar to the 2010 rates, the plan did have some decreases in performance that resulted in three measures falling below the MPLs. The plan did not have any measures with statistically significant declines in 2011, and two measures had statistically significant increases in 2011.

Overall, the plan was compliant with the medical performance audit standards related to the structure and operations of the quality program. In the MRPIU review, however, the plan was cited for not fully implementing a quality improvement program that met State requirements. Additionally, the plan lacked a process to evaluate the appropriateness of care and services delivered to members. It was noted that the plan's appeal resolution letters did not contain the rational for the decision; however, the plan reports that it has revised its appeal letter and implemented a process to internally audit compliance in this area.

Care1st demonstrated a good understanding of documenting support for its QIP study design. The plan implemented accurate data collection methods and appropriate improvement strategies. With appropriate improvement strategies, Care1st was able to achieve a statistically significant decline in avoidable ER visits. The plan noted sustained statistically significant improvement for the *Appropriate Treatment for Children With URI* QIP's study indicators, which suggest that the plan benefited from the small-group collaborative efforts.

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 and QIP outcomes 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 2011 performance measure rates that related to access, QIP outcomes related to access, and results of the medical performance related to the availability and accessibility of care.

In the access domain, the plan attained the HPL for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure. In the medical record review, the plan had no deficiencies related to access. In the MRPIU review, the audit found contract provider staff in certain offices that did not follow cultural and linguistic service requirements.

With appropriate improvement strategies, Care1st was able to achieve a statistically significant decline in the *Reducing Avoidable Emergency Room Visits* QIP.

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.

Care1st demonstrated below average performance in the timeliness domain of care. This assessment was based on 2011 performance measure rates for providing timely care, QIP outcomes related to access, and medical performance. Results from the MRPIU review showed that Care1st lacked critical elements within its utilization management program including monitoring of under- and overutilization of services; procedures to evaluate medical necessity; prior authorization policies and procedures; and criteria for determining approval, referral, or denial of services. All of these elements can impact the plan's ability to make timely decisions for members in need of care. Performance measure rates related to timeliness showed that the plan performed below the MPL for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure.

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. Care1st's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, Care1st had average performance in providing quality, accessible, and timely health care services to its MCMC members. The plan was generally compliant with documentation requirements across performance measures, QIPs, and State and federal requirements; however, the plan experienced challenges with three measures(*Breast Cancer Screening* , *Use of Imaging Studies for Low Back Pain*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*) falling below the MPLs, as opposed to not having any measures perform below the MPLs in 2010.

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

- Modify policies and procedures to include the quality of care requirements. Once these are modified, the plan will need to ensure that the new policies and procedures are effectively applied.
- Ensure that all contracted providers are trained regarding interpreter services.

- Ensure that plan providers are consistently receiving and providing their staff with effective and consistent training on policies and procedures for referring Medi-Cal members to culturally and linguistically appropriate community service programs.
- Run monthly monitoring reports for vendor encounter data to track monthly volumes to ensure complete encounter data submissions.
- Formally document the internal audit of appeal resolution letters conducted on a quarterly basis to ensure the revised letters include understandable explanations of the reason and criteria used in making the decision.
- Address the three measures falling below the MPLs with detailed improvements plans in order to recapture 2010's performance level.
- Use feedback from prior QIPs as well as the QIP Completion Instructions to help achieve compliance without having to resubmit projects.
- Incorporate a method to evaluate the effectiveness of each intervention when multiple interventions are implemented and conduct another barrier analysis to identify new or revised plan-specific interventions to sustain the reduction of avoidable ER visits.

In the next annual review, HSAG will evaluate Care1st'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 Care1st Partner Plan

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report specific to Care1st, along with the plan'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 Care1st's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	Care1st's Self-Reported Actions That Address the EQR Recommendation
Expand the number of metrics that finish above the HPL in 2011.	Care1st Health Plan developed and expanded our Quality Outreach Program to include the following enhancements: ◆ Proactive outreach visits to PCP offices, addressing HEDIS service gaps, tools for tracking members, medical record reminders, providing incentives for completing services. ◆ Mailing required service reminders to members. ◆ Initiated the Woman's Health Program, fast tracking authorizations for mammograms, providing toll-free direct support line to help arrange services. ◆ New Web portal technology planned at that time and is now implemented.
Improve QIP documentation to increase compliance with the CMS protocol for conducting QIPs with the initial QIP submission.	Care1st Health Plan is utilizing the QIP tool designed by Health Services Advisory Group (HSAG), which meets all components required by both the State and CMS. Care1st also has hired additional full-time employees with primary responsibility to track, monitor, and complete QIPs and submissions to assure compliance.
Reduce the number of barriers that can be addressed in a single measurement period and/or implement targeted interventions to address barriers.	Care1st has made revisions to our process to align interventions directly to barriers identified. In the past we would identify all possible barriers to a specific improvement need and evaluate the barriers to identify the barriers that would be most appropriate to address. Care1st will document this process better and align the intervention to the barrier being addressed.
Review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program–2010 Care1st CAHPS Plan-Specific Report.*	Care1st Health Plan has initiated a pilot project called Proactive CAHPS, where we survey members proactively to identify issues we can resolve. We have reviewed the recommendations outlined in the Medi-Cal Managed Care Program and are working to implement these recommendations. We are providing education to physicians and their office staff through outreach visits. Although the DHCS has not conducted CAHPS surveys in the past couple of years, Care1st has contracted a vendor to continue to have an annual CAHPS study completed.