Performance Evaluation Report

Community Health Group Partnership Plan

July 1, 2011–June 30, 2012

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

June 2013

TABLE OF CONTENTS

Performance Evaluation Report – Community Health Group Partnership Plan

July 1, 2011 – June 30, 2012

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services 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 designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more 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.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, 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.

This report is specific to DHCS's contracted plan, Community Health Group Partnership Plan ("CHG" or "the plan"), which delivers care in San Diego County, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, 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 operating in San Diego County. CHG serves MCMC beneficiaries under a Geographic Managed Care (GMC) model. In the GMC model, DHCS contracts with several commercial health plans within a specified geographic area. This provides MCMC enrollees with more choices.

CHG became operational in San Diego County to provide MCMC services in August 1998. As of June 30, 2012, CHG had 121,786 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period 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.

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 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from 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. DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of DHCS's Medi-Cal Managed Care Division (MMCD) have historically worked in conjunction with the Department of Managed Health Care to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or the Department of Managed Health Care. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

The most recent medical performance review was completed in June 2007, covering the review period of June 1, 2006, through May 31, 2007. HSAG initially reported the findings from this audit in CHG's 2008–2009 plan-specific evaluation report.[4] Findings were in the areas of Utilization Management, Continuity of Care, and Availability and Accessibility. The Medical Audit Close-Out Report, dated May 19, 2008, stated that none of the items included in CHG's corrective action plan (CAP) were fully corrected. Following are the specific unresolved deficiencies and actions the plan has taken to resolve them since the 2010–2011 plan-specific report.

Since the medical performance audit was conducted more than three years prior to the review period for this report, HSAG has included a summary of the most recent audit findings in this report for historical purposes; however, HSAG has not included these outdated results when assessing overall plan performance during the review period. As part of the development of this report, HSAG reviewed documentation from the plan to determine what actions it has taken to resolve the outdated deficiencies and has included a description of those actions, when applicable.

Utilization Management

Deficiencies

- CHG did not provide evidence that requesting providers are notified of a decision to deny, defer, or modify a request for service within 24 hours of the decision or that members are notified within 28 days.
- In the plan's policies, CHG did not describe the mechanism for monitoring and ensuring that deferral letters for any required services are sent and in compliance with the contract and Health and Safety Code requirements.
- CHG did not show documented evidence of quarterly reviews of denied, modified, or deferred pharmacy and medical files.
- CHG did not provide documentation of a utilization management tool which clearly states that only a qualified physician may make decisions to deny requested authorizations for services.

Plan Response:

- CHG did not provide any documentation regarding actions the plan has taken to resolve the deficiencies in the area of Utilization Management.

[4] *Performance Evaluation Report—Community Health Group Partnership Plan July 1, 2008–June 30, 2009*. California Department of Health Care Services. December 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

Continuity of Care

Deficiencies

- CHG did not provide documented evidence that once the data are released by DHCS to the plan, that CHG had implemented procedures for identifying plan members who are also receiving services through the Regional Center program.
- CHG did not provide documented evidence that the plan coordinates all medical services with Regional Center staff members to ensure that members who are identified as also receiving Regional Center services are provided necessary medical care, preventive care, and treatment through their primary care provider (PCP).
- CHG did not submit evidence of the use of encounter data to monitor and/or intervene when providers are not documenting Initial Health Assessment/Individual Health Education Behavioral Assessment (IHA/IHEBA) attempts and/or not completing the IHEBAs within the designated time frame. Additionally, the plan did not provide documented evidence that as a result of the CAP, significant improvement had been made in the rate of completed adult and pediatric members' IHAs and IHEBAs, including completion of the IHEBA within the designated time frame.

Plan Response:

- In the Grid of CHG's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report (See Appendix B), CHG indicated that the plan is working with the primary care sites to schedule members for their IHAs within 120 days of enrollment. The plan also indicated that members are informed of the benefit of the IHA as part of the member welcome letter and during the member welcome call.
- CHG did not provide any documentation regarding actions the plan has taken to resolve any of the other deficiencies in the area of Continuity of Care.

Availability and Accessibility

Deficiencies

- CHG did not submit evidence that the plan had implemented a process to monitor specialty access, which would show whether the plan was being compliant with its two-week standard.
- CHG did not submit documentation regarding the development and implementation of a notice of action (NOA) letter that is compliant with State regulations to be sent to providers and patients to accompany denied, modified, or deferred claims.
- CHG did not submit evidence that it had amended the plan's emergency room (ER) policy to state that 99 percent of all clean ER claims shall be paid within 90 working days of submission.

- CHG did not submit documentation to show that the plan was monitoring and analyzing the prescription activity of members with an ER encounter by hospital and addressing identified issues with hospitals, as appropriate.

Plan Response:

- CHG did not provide any documentation regarding actions the plan has taken to resolve the deficiencies in the area of Availability and Accessibility.

DHCS A&I conducted an audit in December 2012 for the audit period May 1, 2011, through April 30, 2012. The plan exit conference was conducted on March 6, 2013. Since the audit took place after the reporting period covered by this evaluation report, the findings from the December 2012 audit will be reported in CHG's 2012–2013 plan-specific evaluation report.

Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity.

The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current medical performance reviews and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

The most recent MR/PIU review was conducted with CHG in January 2011. The period of review was January 1, 2008, through April 30, 2010.

No findings were identified in the areas of Member Grievances, Marketing, Cultural and Linguistic Services, and Program Integrity. Two findings were identified in the area of Prior Authorization Notification. CHG was not required to respond to the findings. MR/PIU will follow up with the plan on the findings during its next review. Listed below are the findings.

MR/PIU reviewed 50 prior authorization notification case files that included non-delegated and delegated cases. Two findings were identified related to the NOA letter:

- One of three files reviewed for one of the medical groups contained an NOA letter that was missing the required reason or citation supporting the action taken.
- One of three files reviewed for one of the medical groups was missing the required "Your Rights" attachment, which was referenced in the NOA letter.

In addition to the findings summarized, MR/PIU noted the presence of two technical assistance issues:

- Seven of the 50 prior authorization files reviewed had NOA letters that were missing the medical director's name. Since MR/PIU's review of additional documentation revealed evidence demonstrating medical director review, MR/PIU did not deem this as a finding and recommended that CHG take the necessary steps to ensure that the medical director's name and signature appear on all NOA letters.
- Nine of 15 prior authorization files reviewed from one delegated medical group were missing the received and decision made dates. The files were from 2008, and MR/PIU noted that CHG had addressed the issue with the medical group. All files from 2009 and 2010 were fully compliant. This issue was therefore not deemed a finding by MR/PIU.

Strengths

The most recent MR/PIU review conducted in January 2011 identified no findings in the areas of Member Grievances, Marketing, Cultural and Linguistic Services, and Program Integrity. MR/PIU commended CHG for excellent performance in its Member Grievances, Marketing, and Cultural and Linguistic Services areas. Based on CHG's self-report, the plan indicated that it is working with its providers to address the timely completion of IHAs.

Opportunities for Improvement

CHG's greatest opportunities for improvement are related to resolution of the unresolved deficiencies from the plan's June 2007 medical performance review. Additionally, the plan has two findings to address from the January 2011 MR/PIU review. HSAG provides the following opportunities for improvement:

- CHG should provide evidence that requesting providers are notified of a decision to deny, defer, or modify a request for service within 24 hours of the decision and that members are notified within 28 days.
- CHG should ensure that the plan's policies describe the mechanism for monitoring and ensuring that deferral letters for any required services are sent and in compliance with the contract and Health and Safety Code requirements.
- CHG should provide documented evidence of quarterly reviews of denied, modified, or deferred pharmacy and medical files.
- CHG should provide a utilization management tool which clearly states that only a qualified physician may make decisions to deny requested authorizations for services.
- CHG should provide documented evidence of the implemented procedures for identifying plan members who are also receiving services through the Regional Center program.
- CHG should provide documented evidence that the plan coordinates all medical services with the Regional Center staff members to ensure that members who are identified as also receiving Regional Center services are provided necessary medical care, preventive care, and treatment through their PCP.
- CHG should provide evidence that the plan has implemented a process to monitor specialty access.
- CHG should submit documentation regarding the development and implementation of an NOA letter that is compliant with State regulations to be sent to providers and patients to accompany denied, modified, or deferred claims.
- CHG should provide evidence that it has amended the plan's ER policy to state that 99 percent of all clean ER claims shall be paid within 90 working days of submission.
- CHG should provide documentation to show that the plan is monitoring and analyzing the prescription activity of members with an ER encounter by hospital and addressing identified issues with hospitals, as appropriate.
- CHG should ensure that all NOA letters sent by delegated medical groups contain the reason or citation supporting the action taken.
- CHG should ensure that all delegated medical groups include the "Your Rights" attachment when sending NOA letters to members.

Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). 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 DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by DHCS for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the plan's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of CHG in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

Performance Measure Validation Findings

No concerns were identified by the HSAG audit team during CHG's HEDIS Compliance Audit, and all rates were valid. The auditors noted that CHG worked to obtain electronic medical record (EMR) data for a large pediatric provider group to conduct reviews and address any gaps in coding and claims/encounter data receipt that might exist. This and other similar activities were identified as CHG best practices and helped to improve data completeness for HEDIS reporting.

Performance Measure Results

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

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions (internally developed measure)*
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
AWC	*Adolescent Well-Care Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
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*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*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*

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
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 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

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

Table 3.2—Comparison of 2011 and 2012 Performance Measure Results for Community Health Group Partnership Plan—San Diego County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	17.3%	14.1%	★	↔	18.8%	31.6%
AMB–ED	‡	--	32.7	--	Not Comparable	--	--
AMB–OP	‡	--	329.0	--	Not Comparable	--	--
AWC	Q,A,T	42.9%	51.8%	★★	↑	39.6%	64.1%
CAP–1224	A	--	96.2%	--	Not Comparable	--	--
CAP–256	A	--	90.3%	--	Not Comparable	--	--
CAP–711	A	--	89.6%	--	Not Comparable	--	--
CAP–1219	A	--	88.5%	--	Not Comparable	--	--
CCS	Q,A	65.2%	69.1%	★★	↔	64.0%	78.7%
CDC–BP	Q	65.7%	57.2%	★★	↓	54.3%	76.0%
CDC–E	Q,A	61.1%	53.3%	★★	↓	43.8%	70.6%
CDC–H8 (<8.0%)	Q	52.3%	47.7%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	37.7%	43.8%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	88.3%	87.3%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	40.6%	35.0%	★★	↔	27.3%	45.9%
CDC–LS	Q,A	84.7%	82.2%	★★	↔	70.4%	84.2%
CDC–N	Q,A	77.2%	79.1%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	78.1%	74.0%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	73.5%	--	Not Comparable	--	--
LBP	Q	77.7%	75.0%	★★	↔	72.3%	82.3%
MPM–ACE	Q	--	87.1%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	85.0%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	79.1%	77.9%	★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	57.2%	60.1%	★★	↔	59.6%	75.2%
W-34	Q,A,T	75.0%	77.1%	★★	↔	66.1%	82.9%
WCC–BMI	Q	63.3%	73.5%	★★★	↑	19.7%	69.8%
WCC–N	Q	69.8%	71.5%	★★	↔	39.0%	72.0%
WCC–PA	Q	40.4%	56.0%	★★	↑	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS'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] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, CHG had average performance on the measures. One measure (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*) had statistically significant improvement and performed above the HPL for the second year in a row. Two other measures (*Adolescent Well-Care Visits* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*) also had statistically significant improvement from 2011.

Two measures performed below the MPLs in 2012 (*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*). CHG's performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure also was below the MPL in 2009 and 2011. Performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure was below the MPL in 2009, 2010, and 2011. Improvement plans were implemented for these measures during the review period, and details regarding the improvement plans are below in the *HEDIS Improvement Plans* section.

Two measures, *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, had statistically significant decline in performance from 2011 to 2012.

HEDIS Improvement Plans

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

HSAG compared the plan's 2011 IP (if one was required) with the plan's 2012 HEDIS rate for that measure 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.

CHG implemented IPs for each of the three measures with rates that fell below the established 2011 MPLs. Following is a summary of each IP and HSAG's assessment of the effectiveness of each IP.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

CHG indicated that the greatest barrier to the plan performing above the MPL on this measure was the member's perception that antibiotics are needed for any respiratory condition.

CHG listed several interventions the plan implemented to reduce the rate of antibiotic treatment in adults with bronchitis, including:

- Implementing a process that requires prior authorization and completion of a medical exception form for any prescriptions for level two antibiotics.
- Updating and distributing to each primary care site a HEDIS requirement and documentation guide.
- Including an article on avoidance of antibiotics for adults with acute bronchitis in the plan's provider newsletter.
- Distributing a provider alert during the peak of the cold season reminding providers of the importance of avoiding antibiotic use for adults with acute bronchitis.
- Developing educational materials for distribution at physicians' offices.

CHG's interventions continue to be ineffective in improving the plan's performance on this measure. Although not statistically significant, performance on this measure declined from 2011 to 2012. The plan will need to continue its IP for this measure in 2013.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

CHG identified several challenges and barriers to the plan not reaching the MPL on this measure, including:

- Identifying pregnant members early enough in their pregnancy to assist them in obtaining care within the first trimester.
- Members not understanding the importance of obtaining care within the first trimester of pregnancy.
- Members not having transportation to their physician's office.
- Providers scheduling or performing the required prenatal exam outside of the HEDIS-specified time frame.

The plan implemented two new interventions in 2012:

- Offering an incentive to members who provided timely notification of their pregnancy. The incentive was described in the new member packet, yearly member mailing, and member newsletter.
- Conducting follow-up calls with members who provided timely notification of their pregnancy to assist them with scheduling the prenatal visit within the first trimester and providing taxi transportation to and from the appointment.

One intervention from the plan's original IP was abandoned because it did not prove to be effective (development of an educational brochure for physicians' offices).

CHG's interventions continue to be ineffective in improving the plan's performance on this measure. Although not statistically significant, performance on this measure declined from 2011 to 2012. The plan will need to continue its IP for this measure in 2013.

Prenatal and Postpartum Care—Postpartum Care

CHG identified several challenges and barriers to the plan not reaching the MPL on this measure, including:

- Members not understanding the importance of obtaining care within 21–56 days after delivery.
- Members not having transportation to their physician's office.
- Providers scheduling or performing the required prenatal exam outside of the HEDIS-specified time frame.

CHG described several interventions, including:

- Hiring a HEDIS manager and created a HEDIS department to ensure full-time resources were allocated to improving processes related to care impacting performance on HEDIS measures and data capture.
- Training billers at provider sites on coding requirements and distributing the quick reference guides to each site.
- Calling members following delivery to assist them with scheduling the postpartum visit and arranging transportation, if needed.
- Offering an incentive to members who attend their postpartum appointment within 21–56 days after delivery. The incentive was described in the new member packet, yearly member mailing, and member newsletter.

CHGs efforts resulted in improvement on the measure that resulted in performance above the MPL in 2012. The plan will not be required to continue the IP for this measure in 2013.

Strengths

HSAG's auditors determined that CHG produced valid performance measure rates and noted that CHG worked to obtain electronic medical record (EMR) data for a large pediatric provider group to conduct reviews and address any gaps in coding and claims/encounter data receipt that might exist. This and other similar activities were identified as CHG best practices and helped to improve data completeness for HEDIS reporting.

Three measures had statistically significant improvement from 2011 to 2012:

- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*

The *BMI Assessment: Total* measure performed above the HPL for the second year in a row. The Plan's IP for the *Prenatal and Postpartum Care—Postpartum Care* measure was successful in bringing the measure's performance above the MPL in 2012.

Opportunities for Improvement

CHG has the following opportunities for improvement:

- The plan should assess the factors that are leading to a continued decline in performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure and identify interventions to be implemented that will result in an improvement in performance. The plan needs to consider implementing new interventions since the existing efforts have been ineffective.
- The plan should assess the factors that are leading to a continued decline in performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and identify interventions to be implemented that will result in an improvement on performance. The plan needs to consider implementing new interventions since the existing efforts have been ineffective.
- The plan should assess the factors that led to a statistically significant decline in performance on the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measures to prevent further decline in performance.

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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

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

CHG had four clinically-focused QIPs in progress during the review period of July 1, 2011, through June 30, 2012. Two of the four QIPs were statewide collaborative QIPs. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of DHCS's current statewide collaborative. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative QIP, which focused on reducing readmissions for members aged 21 years and older. CHG also participated in a small-group collaborative aimed at increasing the assessment, diagnosis, and appropriate treatment of chronic obstructive pulmonary disease (COPD). Finally, CHG's internal QIP targeted increasing postpartum depression screening and follow-up care for positive screens. All four QIPs fell under the quality domain of care, and the two statewide collaborative QIPs also fell under the access domain of care.

The current 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. At the initiation of the QIP, CHG had identified 3,612 ER room visits that were avoidable, which was 17.9 percent of the plan's ER visits. CHG's objective was to reduce this rate by using member, provider, and system improvement strategies. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

The new statewide collaborative QIP proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members leading to improved health outcomes.

The plan's small-group COPD collaborative QIP 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. At the initiation of the QIP, CHG identified that only 11.4 percent of eligible members had received the appropriate spirometry testing. Sixty-nine percent of members with COPD had an ER visit and 54.9 percent had an inpatient hospitalization. Of the members who had been to the ER or were hospitalized, 52.5 to 75.0 percent had been dispensed timely and appropriate medication.

The purpose of CHG's internal QIP was to increase the screening for postpartum depression, as well as the percentage of members with positive depression screens who received follow-up care. Initially, CHG identified that only 23.1 percent of the eligible members had been screened for depression. Of those, only 9.5 percent of the screenings had been done with a screening tool. Of the members who were positive for postpartum depression, only 63.6 percent had documented 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 QIP validation results and status across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Community Health Group Partnership Plan—San Diego County July 1, 2011, through June 30, 2012

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	97%	100%	*Met*
*All-Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Pass*
Small-Group Collaborative				
Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD	Annual Submission	92%	100%	*Met*
Internal QIPs				
Increasing Screens for Postpartum Depression	Annual Submission	92%	92%	*Partially Met*
	Resubmission	98%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a 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 noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

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

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

*During the review period, the *All-Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that CHG's annual submission of its *Reducing Avoidable Emergency Room Visits* and *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* QIPs received an overall validation status of *Met*. CHG received a *Partially Met* validation status for its *Increasing Screens for Postpartum Depression* QIP. As of July 1, 2009, 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. For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

Due to unique, one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

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

Table 4.2—Quality Improvement Project Average Rates* for Community Health Group Partnership Plan—San Diego County (Number = 4 QIP Submissions, 3 QIP Topics) July 1, 2011, through June 30, 2012

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	100%	0%	0%
	VII: Appropriate Improvement Strategies	80%	20%	0%
Implementation Total		**95%**	**5%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	91%	9%	0%
	IX: Real Improvement Achieved	81%	19%	0%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**89%**	**11%**	**0%**

*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.

For all three QIPS, the plan submitted Remeasurement 3 data; therefore, HSAG validated Activities I through X. One hundred percent of the applicable elements within the design stage were scored *Met*, and 95 percent of the applicable elements within the implementation stage were scored *Met*. For Activity VII of the implementation stage, the plan was scored down in all three QIPs for continuing interventions without discussing how the interventions were monitored and evaluated.

For the outcomes stage, CHG initially was scored down in Activity VIII for incorrectly reporting one of the outcomes and for several rounding errors associated with its interpretation in its *Increasing Screens for Postpartum Depression* QIP. For Activity IX, the plan was scored lower because two of three study indicators in the *Increasing Screens for Postpartum Depression* QIP and two of four study indicators in the *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* QIP did not demonstrate statistically significant improvement. For all three QIPs, Activity X was scored *Met* since all study indicators that had documented statistically significant improvement during the project and were evaluated for sustained improvement achieved sustained improvement. Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes and Interventions

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 Partnership Plan—San Diego County July 1, 2011, through June 30, 2012

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**	**Remeasurement 3 1/1/10–12/31/10**	**Sustained Improvement¥**
Percentage of avoidable ER visits^	17.9%	16.5%*	21.6%*	15.2%*	Yes
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**	**Remeasurement 3 1/1/10–12/31/10**	**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%	19.1%	Yes
2) Percentage of acute inpatient hospitalization discharges of members with COPD^	54.9%	68.8%*	23.5%*	8.3%*	Yes
3) Percentage of emergency department (ED) visits for members with COPD^	69.0%	70.5%	30.3%*	20.0%*	Yes

QIP #2—Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD (cont.)						
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**	**Remeasurement 3 1/1/10–12/31/10**	**Sustained Improvement¥**
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 cortico-steroid within 14 days of the event	52.5%	41.1%	45.3%	55.6%	‡
	b) Broncho-dilator within 30 days of the event	75.0%	68.9%	60.0%	69.4%	‡

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**	**Remeasurement 3 11/6/09–11/5/10**	**Sustained Improvement¥**
Percentage of members who had a live birth	1) and were screened for depression at their postpartum visit	23.1%	34.3%*	32.4%	43.3%*	Yes
	2) and were screened for depression using a screening tool at their postpartum visit	9.5%	19.2%*	17.3%	21.9%	Yes
	3) and screened positive for depression with documentation of follow-up care	63.6%	85.7%	81.3%	88.5%	Yes

^A lower percentage indicates better performance.

¥ 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 the measurement period and prior measurement period (p value < 0.05).

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

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, CHG set a goal to reduce the avoidable ER visits to 5 percent. For this project outcome, a lower rate demonstrates improved performance. While the plan did not meet its overall objective, it was able to reduce the percentage of avoidable ER visits. The plan reported two separate statistically significant increases in performance (1) from baseline to the first remeasurement period (1.4 percentage points) and (2) from the second to the third remeasurement period (6.4 percentage points). The plan reduced the percentage of avoidable ER visits from baseline to Remeasurement 3, demonstrating sustained improvement for the project.

While the plan did achieve overall improvement, there was a decline in performance from the first to the second remeasurement period; the rate of avoidable ER visits increased by a statistically significant amount. A critical analysis of the plan's improvement strategy resulted in the following observations:

- The plan initially used member and provider survey data to identify barriers and develop interventions; however, the plan did not document any other barrier analysis as the project progressed.
- Collaborative interventions were initiated in early 2009; however, they did not correspond to any improvement in performance. Specifically, the plan did not report success with the plan-hospital data collection collaboration. CHG reported that the participating hospital reported 100 percent of the data to the plan within 15 days; however, none of the data were received any earlier. Similarly, CHG reported that it only contacted 50 percent of the members within 14 days of receiving notice of their first ER visit. Evaluation of this intervention showed that the avoidable ER visit rates were approximately three times higher at the participating hospital compared to the non-participating hospitals (36.1 percent versus 13.2 percent).
- The plan implemented several plan-specific interventions including contracts with retail clinics, Minute Clinic (November 2008) and Palomar Express (October 2009), to provide an alternative setting for urgent care visits. Additionally, the plan initiated a pilot program in November 2009, the Multiple Admitter's Program (MAP). This program was a focused case management project to provide intensive follow-up for members with multiple hospital inpatient and/or emergency department admissions. The plan made the program permanent in December 2010. The plan did not report any evaluation plan for the interventions, and it did not provide any specific data to support the interventions' effectiveness.
- CHG also had numerous member interventions that were implemented prior to the project and continued throughout the project. The plan was not able to address why the decline occurred from the first to the second remeasurement period since there was no evaluation of the interventions and these same interventions were in place for all measurement periods.

The plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine whether to modify or discontinue existing interventions, or implement new ones, thereby reducing the likelihood of achieving project objectives and improving performance.

Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD QIP

For the *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* QIP, the plan reported varied performance across outcomes and measurement periods. Ultimately, the plan demonstrated sustained improvement with Remeasurement 3 rates improved over baseline rates for increased spirometry testing, decreased ER visits, and decreased inpatient discharges. For timely dispensing of medications after inpatient discharge or ER visit, the third remeasurement period was the first time that the rate for corticosteroids within 14 days was improved over baseline, while the rate for bronchodilators within 30 days never improved over baseline. A critical analysis of the plan's improvement strategy resulted in the following observations:

- The plan's barrier analysis was conducted by a clinical quality improvement committee. The plan reported that the committee identified barriers, although the barriers were not prioritized. Additionally, the plan did not provide any specific results of the barrier analyses or any data-driven rationale for the selection of the interventions. Additionally, the plan identified barriers through literature reviews; however, the plan did not then use plan data to identify which, if any, of these barriers were applicable to its population.
- CHG did not identify measure-specific interventions. Instead, the plan implemented more global interventions targeting COPD members. Interventions to increase spirometry testing may be different than interventions to improve timely dispensing of corticosteroids after an ER visit or inpatient hospitalization.
- The plan reported implementing approximately 20 interventions from 2008 to 2010; however, the plan did not include an evaluation plan for any of the interventions.

Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

Increasing Screening for Postpartum Depression QIP

For the *Increasing Screens for Postpartum Depression* QIP, the plan improved performance for all study outcomes from baseline to the first remeasurement period and from the second to the third remeasurement period. From the first to the second remeasurement period, the plan reported a decline in performance for all three outcomes; however, the decreases were not statistically significant. The rates at Remeasurement 3 were still improved over the baseline rates; therefore, the plan was able to demonstrate sustained improvement for all three outcomes: increased

depression screenings, increased depressions screenings using a screening tool, and increased follow-up care for members with a positive screen result.

- The plan's barrier analysis was conducted by a clinical quality improvement committee. The plan reported that the committee identified barriers, although the barriers were not prioritized. Additionally, the plan did not provide any specific results of the barrier analyses or any data-driven rationale for the selection of the interventions. Additionally, the plan identified barriers through literature reviews; however, the plan did not then use plan data to identify which, if any, of these barriers were applicable to its population.
- CHG implemented three interventions in the second half of 2008, which may have not allowed enough time for the interventions to affect the outcomes.
- Many interventions were continued throughout the project; however, the plan did not report any evaluation plan for the interventions, and it did not provide any specific data to support the interventions' effectiveness.

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 only one resubmission for the QIP, which indicated a proficiency with the QIP validation process.

The plan was able to reduce the percentage of avoidable ER visits and sustain that improvement through the final remeasurement period.

For its members with COPD, CHG was able to significantly improve care by increasing spirometry testing, decreasing ER visits, and decreasing inpatient discharges over the course of the COPD project.

CHG was able to increase depression screening and the use of a depression screening tool at the time of a member's postpartum visit. Additionally, the plan increased the percentage that received follow-up care after a positive depression screen.

Opportunities for Improvement

CHG should conduct an annual barrier analysis, at minimum. The plan should improve the documentation of the barrier analysis, providing the data, the identified barriers, and the rationale for how the barriers are prioritized. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone.

The interventions implemented should address the high-priority barriers. A method to evaluate the effectiveness of each intervention should be documented, as well as the results of the intervention's evaluation for each measurement period.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care. A more detailed description of HSAG's scoring process is included in Appendix A.

Quality

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

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries 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, 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.

Overall, CHG had average performance in the quality domain of care. The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* measure, which falls into the quality domain of care, had statistically significant improvement from 2011 to 2012 and performed above the HPL in 2012. Additionally, two other measures falling into the quality domain of care had statistically significant improvement from 2011 to 2012—*Adolescent Well-Care Visits* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*. Two measures, *Avoidance of Antibiotic*

Treatment in Adults With Acute Bronchitis and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, performed below the MPLs in 2012.

All four of CHG's QIPs fell into the quality domain of care. Three of those QIPs had study indicators that achieved sustained improvement during the review period as follows:

- The *Reducing Avoidable Emergency Room Visits* QIP achieved sustained improvement for its study indicator.
- The *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* QIP achieved sustained improvement for three of the project's five indicators.
- The *Increasing Screening for Postpartum Depression* QIP achieved sustained improvement for all three of the project's study indicators.

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 MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and 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. Medical performance reviews, MR/PIU reviews, 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Overall, CHG performed average in the access domain of care. The plan has outstanding deficiencies from its June 2007 medical performance review in the areas of Continuity of Care and Availability and Accessibility. Additionally, findings were identified in the area of Prior Authorization Notification during the plan's January 2011 MR/PIU review. MR/PIU found the plan fully compliant in the area of Cultural and Linguistic Services, which suggests that the plan's members have access to health care services that meet their cultural and linguistic needs.

The *Adolescent Well-Care Visits* measure, which falls into the access domain of care, had statistically significant improvement in performance from 2011 to 2012. The *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure, which is also an access measure, had statistically significant decline in performance. The *Reducing Avoidable Emergency Room Visits* QIP fell into the access domain of care and, as stated above, achieved sustained improvement for the QIP's study indicator.

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.

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.

Overall, CHG had average performance in the timeliness domain of care. The plan had outstanding deficiencies from its June 2007 medical performance review in the area of Utilization Management and, as stated above, in the area of Continuity of Care. During the January 2011 MR/PIU review, the plan was found to be fully compliant in the area of Member Grievances.

The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure, which falls into the timeliness domain of care, performed below the MPL in 2012. All other timeliness measures had average performance, with one—*Adolescent Well-Care Visits*—showing statistically significant improvement from 2011 to 2012.

Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. CHG's self-reported responses are included in Appendix B.

Recommendations

Based on the overall assessment of CHG in the areas of quality, timeliness, and accessibility of care, HSAG provides the following recommendations to the plan.

CHG should resolve all deficiencies identified during the June 2007 medical performance review. Specifically, the plan should:

- Provide evidence that requesting providers are notified of a decision to deny, defer, or modify a request for service within 24 hours of the decision and that members are notified within 28 days.

- Ensure that the plan's policies describe the mechanism for monitoring and ensuring that deferral letters for any required services are sent and in compliance with the contract and Health and Safety Code requirements.
- Provide documented evidence of quarterly reviews of denied, modified, or deferred pharmacy and medical files.
- Provide a utilization management tool which clearly states that only a qualified physician may make decisions to deny requested authorizations for services.
- Provide documented evidence of the implemented procedures for identifying plan members who are also receiving services through the Regional Center program.
- Provide documented evidence that the plan coordinates all medical services with the Regional Center staff members to ensure that members who are identified as also receiving Regional Center services are provided necessary medical care, preventive care, and treatment through their PCP.
- Provide evidence that the plan has implemented a process to monitor specialty access.
- Submit documentation regarding the development and implementation of an NOA letter that is compliant with State regulations to be sent to providers and patients to accompany denied, modified, or deferred claims.
- Provide evidence that it has amended the plan's ER policy to state that 99 percent of all clean ER claims shall be paid within 90 working days of submission.
- Provide documentation to show that the plan is monitoring and analyzing the prescription activity of members with an ER encounter by hospital and addressing identified issues with hospitals, as appropriate.

CHG also should ensure the findings from the January 2011 MR/PIU review are addressed. Specifically the plan should:

- Ensure that all NOA letters sent by delegated medical groups contain the reason or citation supporting the action taken.
- Ensure that all delegated medical groups include the "Your Rights" attachment when sending NOA letters to members.

HSAG recommends the following to the plan related to performance measures:

- Assess the factors that are leading to a continued decline in performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure and identify interventions to be implemented that will result in an improvement on performance.

- Assess the factors that are leading to a continued decline in performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and identify interventions to be implemented that will result in an improvement on performance.
- Assess the factors that led to a statistically significant decline in performance on the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measures to prevent further decline in performance.

HSAG recommends the following to the plan related to QIPs:

- Conduct an annual QIP barrier analysis, at minimum. The plan should improve the documentation of the barrier analysis, providing the data, the identified barriers, and the rationale for how the barriers are prioritized. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone.
- Ensure that the QIP interventions implemented address the high-priority barriers. A method to evaluate the effectiveness of each intervention should be documented, as well as the results of the intervention's evaluation for each measurement period.

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

Quality, Access, and Timeliness

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

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) greater than negative three, if there are two or less measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than three.
3. To be considered ***Below Average***, a plan will have three or more measures below the MPLs than it has above the HPLs.

Access Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus and the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Timeliness Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

Validation *(Table 4.1)*: For each QIP submission and subsequent resubmission(s), if applicable.

- **Above Average** is not applicable.
- **Average** = *Met* validation status.
- **Below Average** = *Partially Met* or *Not Met* validation status.

Outcomes *(Table 4.3)*: Activity IX, Element 4—**Real Improvement**

- **Above Average** = All study indicators demonstrated statistically significant improvement.
- **Average** = Not all study indicators demonstrated statistically significant improvement.
- **Below Average** = No study indicators demonstrated statistically significant improvement.

Sustained Improvement *(Table 4.3)*: Activity X—**Achieved Sustained Improvement**

- **Above Average =** All study indicators achieved sustained improvement.
- **Average =** Not all study indicators achieved sustained improvement.
- **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

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

Medical performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain.

Appendix B. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

for **Community Health Group Partnership Plan**

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with CHG's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table B.1—Grid of CHG's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	CHG's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Notify members of a decision to deny, defer, or modify a prior authorization.	Community Health Group (CHG) notifies members in writing of all decisions when referrals are denied, deferred or modified as per policy #7251.0.
Ensure that the UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization.	CHG has implemented a process for specialty referral tracking and follow up of referrals requiring prior authorization. A report identifies members with open authorizations for which claims have not been received. Letters are sent to members and providers informing them of the need to follow up on outstanding referrals.
Develop and implement systems to identify children who may be eligible to receive services from the Early Start program.	CHG receives data identifying members ages 0-3, with open cases at Regional Center/Early Start. These data are entered in our system. Upon identification, cases are identified and referred based on clinical criteria.
Develop and implement procedures for the identification of members with developmental disabilities and refer these members to a regional center.	CHG receives data identifying members with open cases at Regional Center/Early Start. These data are entered in our system. Upon identification, cases are identified and referred based on clinical criteria.
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 the plan's unsuccessful efforts to contact a member and schedule an IHA.	CHG is working with the primary care sites to schedule members for the initial health assessments within 120 days of enrollment. Members are also informed of the benefit of the initial health assessment as part of the Member Welcome Letter and during the Member Welcome Call.
Develop, implement, and maintain a procedure to monitor wait times in the providers' offices, for telephone calls, and for time to obtain an appointment.	CHG has a process to monitor wait times in the provider offices per policy CQ7606.1. This policy describes a process for monitoring that regulatory standards are met to ensure members have full access to appropriate and necessary medical care.
Pay timely and appropriately for emergency services received by a member from non-contractor providers.	UM policy 7251.8 Review of Requests, describes the process to not require prior authorization for emergency services, even when received from non-contracted providers.
Ensure members have the right to access family planning services through any family planning provider without prior authorization, and inform its members in writing of this right in its Member Services Guide.	On page 9 of the plan's Member Guide, members are informed of their right to access family planning services through any family planning provider without prior authorization.
Improve three measures' performance (*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, *Prenatal and Postpartum Care—Timeliness of Prenatal Care,* and *Prenatal and Postpartum Care—Postpartum Care*) that fell below the MPL in 2011.	On March 2, 2012, DHCS approved improvement plans submitted addressing these three measures.

Table B.1—Grid of CHG's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	CHG's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Improve QIP intervention strategies 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.	Additional documentation of barrier analysis will be included with all future QIP submissions.
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.	Documentation of the evaluation of the effectiveness of each intervention will be included with all future QIP submissions.