Performance Evaluation Report

Care1st Partner Plan

July 1, 2011–June 30, 2012

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

June 2013

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Performance Evaluation Report – Care1st Partner Plan

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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 members 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, Care1st Partner Plan ("Care1st" 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

Care1st is a full-scope managed care plan operating in San Diego County. Care1st 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.

Care1st became operational in San Diego County to provide MCMC services in February 2006. As of June 30, 2012, Care1st had 28,421 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 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. 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 for Care1st was conducted December 2010 as a solo A&I audit review pursuant to the Knox-Keene Health Care Services Act of 1975, specifically looking at State requirements. While not a comprehensive review of federal CFRs, the review did cover some overlapping areas and included aspects of Quality Management, Grievances and Appeals, Utilization Management, Continuity of Care, and Language Assistance Compliance Programs. The final report was issued to the plan on May 2, 2011.

Three deficiencies were identified during the December 2010 review. DMHC sent a preliminary report to Care1st outlining the deficiencies; and prior to the final report being produced, the plan had corrected two of the three deficiencies. The two deficiencies that were resolved were:

- The plan's grievance resolution letters for medically necessary delays, modifications, or denials of services did not include an envelope addressed to DMHC, allowing the member to submit an independent medical review application.
- The plan did not include notification of the availability of free language assistance services in grievance acknowledgement and resolution letters and in utilization management denial letters.

One deficiency was not fully resolved at the time of the final report: Care1st did not demonstrate effective action to address patterns of quality of care concerns with individual providers. A follow-up letter from DMHC dated April 27, 2012, indicates that subsequent to the final report, Care1st provided evidence of efforts to ensure quality of care problems are identified and corrected for all provider entities.

In addition to the deficiencies identified during the December 2010 review, DMHC identified the following recommendations for Care1st:

- Implement a mechanism to complete investigations involving quality of care issues within reasonable time frames.
- Establish a mechanism to ensure that the written record for each grievance is maintained and available as needed.
- Establish a mechanism to monitor continuity and coordination of care for patients with mental health parity conditions such as pervasive developmental disorders.

DMHC's final report stated that Care1st responded to DMHC's recommendations on April 4, 2011; however, HSAG did not receive documentation of the plan's responses.

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.

An MR/PIU review for Care1st was conducted in June 2009, covering the review period of July 1, 2008, through May 31, 2009. Details from this review were initially included in the plan's 2009–2010 evaluation report.[4] HSAG also included a summary of the findings in the plan's 2010–11 evaluation report, along with recommendations for resolving the findings.

MR/PIU noted findings in the areas of Prior Authorization Notification and Cultural and Linguistic Services. Care1st 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:

Prior Authorization Notification

Findings

- Care1st's policies and procedures did not include that the plan will implement an effective quality improvement program in accordance with State requirements.
- Care1st's policies and procedures did not include that the plan will maintain objective and systematic monitoring and evaluation of the quality and appropriateness of care and services rendered on an ongoing basis, including conducting quality of care studies that address the quality of clinical care and the quality of health services delivery.

[4] California Department of Health Care Services. *Performance Evaluation Report, Care1st Partner Plan – July 1, 2009 through June 30, 2010*. February 2012. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

- Care1st's policies and procedures did not include that the plan will maintain 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, pursuant to the California Health and Safety Code.

Cultural and Linguistic Services

Findings

- Staff members in three of the eight provider offices visited were not aware of the member interpreter services/access requirement.
- Staff members in two of the eight provider offices visited indicated that they do not discourage the use of family, friends, or minors as interpreters.

HSAG found the following information regarding actions the plan has taken that appear to address the findings:

- Care1st's self-report indicates that the plan modified its policies and procedures to address the findings in the area of prior authorization notification. The plan also stated that it ensured the policies and procedures were implemented and staff members were educated about the changes.
- Care1st's self-report indicates that the plan conducted provider training on interpreter services and how to access the services for members. The plan reports that questions related to the availability of interpreter services have been added to Care1st's provider satisfaction survey and that the results of the survey indicate that providers showed significant improvement in their understanding of the available interpreter services.

Additional Observations

Although not categorized as a finding, MR/PIU noted that staff members in one of the eight provider offices visited were not aware of procedures for referring MCMC members to culturally and linguistically appropriate community services programs. HSAG noted the following information regarding actions the plan has taken to address the observation:

- Care1st reported that the plan conducts routine facility site review audits and ensures staff members at the facilities are aware of the policies and procedures for culturally and linguistically appropriate services and programs. Care1st also reported that the plan tracks member complaints regarding cultural and linguistic issues and re-educates providers when necessary. Finally, Care1st reported that the plan surveys providers annually to ensure they understand the requirements and how to access culturally and linguistically appropriate community services programs.

Strengths

Care1st fully resolved all deficiencies from the most recent medical performance review, and the plan appears to have taken the necessary action to modify its policies and procedures based on the MR/PIU findings.

Opportunities for Improvement

Despite actions taken by the plan to correct its compliance documentation, HSAG could not find demonstrated evidence within the plan's internal 2011 annual evaluation that the plan implemented its outlined actions. HSAG found that the quality improvement evaluation lacked an analysis of under- and overutilization. In addition, while Care1st included information related to facility site reviews in its annual evaluation, there was no mention of goals related to cultural and linguistic services requirements. The plan has opportunities to ensure that the identified findings are fully addressed and operationalized within its quality improvement process.

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 Care1st 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

In Care1st's 2011–12 plan-specific evaluation report, HSAG recommended that the plan run monthly monitoring reports for vendor encounter data to track monthly volumes to ensure complete encounter data submissions. Care1st's self-report indicates that the plan's Encounter Department obtains monthly files from all contracted independent practice associations/medical groups, and error reports are generated back to each group. Care1st reports that the plan is actively working with the medical groups to evaluate the errors to prevent future inaccuracies. The 2012 HEDIS Compliance Audit did not identify any issues; however, the auditor recommended that the plan continue to monitor laboratory encounter data to track monthly volumes so the plan is aware of potentially missing data before they become a problem.

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*

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
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*
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 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 Care1st Partner 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	28.0%	15.4%	★	↔	18.8%	31.6%
AMB–ED	‡	--	48.1	--	Not Comparable	--	--
AMB–OP	‡	--	239.5	--	Not Comparable	--	--
AWC	Q,A,T	45.0%	52.6%	★★	↑	39.6%	64.1%
CAP–1224	A	--	90.6%	--	Not Comparable	--	--
CAP–256	A	--	78.5%	--	Not Comparable	--	--
CAP–711	A	--	81.5%	--	Not Comparable	--	--
CAP–1219	A	--	77.8%	--	Not Comparable	--	--
CCS	Q,A	64.5%	66.9%	★★	↔	64.0%	78.7%
CDC–BP	Q	66.1%	73.9%	★★	↔	54.3%	76.0%
CDC–E	Q,A	41.8%	47.4%	★★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	52.7%	49.0%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	30.9%	36.9%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	83.6%	88.8%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	46.1%	38.2%	★★	↔	27.3%	45.9%
CDC–LS	Q,A	80.6%	81.5%	★★	↔	70.4%	84.2%
CDC–N	Q,A	87.3%	88.4%	★★★	↔	73.9%	86.9%
CIS–3	Q,A,T	79.8%	73.2%	★★	↓	64.4%	82.6%
IMA–1	Q,A,T	--	62.1%	--	Not Comparable	--	--
LBP	Q	61.0%	82.7%	★★★	↑	72.3%	82.3%
MPM–ACE	Q	--	89.2%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	86.8%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	80.0%	85.0%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	60.5%	67.1%	★★	↔	59.6%	75.2%
W-34	Q,A,T	76.8%	73.4%	★★	↔	66.1%	82.9%
WCC–BMI	Q	57.2%	65.9%	★★	↑	19.7%	69.8%
WCC–N	Q	63.3%	68.4%	★★	↔	39.0%	72.0%
WCC–PA	Q	36.3%	46.7%	★★	↑	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, Care1st demonstrated average performance. One measure, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis,* fell below the MPL in 2012. Another measure, *Childhood Immunization Status—Combination 3*, had a statistically significant decrease in performance between 2011 and 2012. In 2011, Care1st performed below the MPL on the *Use of Imaging Studies for Low Back Pain* measure and in 2012 had statistically significant improvement on the measure, which resulted in performance above the HPL. The plan also performed above the HPL on the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure.

In addition to the statistically significant increase in performance on the *Use of Imaging Studies for Low Back Pain* measure, the following measures had statistically significant increases between 2011 and 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*

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.

Care1st had three measures fall below the MPLs in 2011:

- *Breast Cancer Screening*
- *Use of Imaging Studies for Low Back Pain*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

The plan was required to conduct improvement plans for each of these measures and the details for each are below.

Breast Cancer Screening

Care1st's improvement plan summarized the interventions the plan implemented to improve breast cancer screening rates. The interventions were designed to address some of the identified barriers, including challenges with the authorization process, member non-compliance, and the lack of proactive outreach to members. Care1st implemented various interventions including proactive pre-authorizations, member direct reminder mailings, and proactive calls to members to remind them to schedule their breast cancer screening. Since DHCS did not require plans to report on this measure for 2012, the effectiveness of the plan's interventions cannot be determined.

Use of Imaging Studies for Low Back Pain

Care1st reported that it did not have any specific interventions in place for this measure prior to the implementation of the 2012 improvement plan. Lack of provider knowledge about this measure was identified as the main barrier, and Care1st provided physician education on this measure through direct mailings, the plan's Web portal, and the provider newsletter. The interventions appear to have been extremely effective, with the performance on this measure improving by more than 20 percentage points and the measure performing above the HPL.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

Care1st identified several barriers and challenges to providing timely prenatal care to members, including:

- Member noncompliance, with younger members having the greater probability of being noncompliant.
- Early identification of newly pregnant members.
- Limited internal resources to complete investigation of prenatal vitamin listings to identify pregnant members.

The plan also indicated that the sample size in San Diego County for this measure is very small, which means that rate changes are more dramatic than with full-sample sizes.

Care1st reported that in 2011, the plan revamped its Healthy Start Prenatal and Postpartum Program, which had been suspended in 2010, and hired two new employees to manage daily program processes. The plan built a new database that enables staff members to proactively track members and established new processes for making proactive calls to assure members are

receiving early prenatal care and identifying members through prenatal vitamin reviews and aid code reports.

Care1st's efforts resulted in improvement on this measure by 5 percentage points and performance above the MPL in 2012.

Care1st will be required to conduct one improvement plan during the next measurement period for *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, since performance on this measure was below the MPL in 2012.

Strengths

Care1st's 2012 improvement plan for the *Use of Imaging Studies for Low Back Pain* resulted in performance above the HPL, and the improvement plan for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure resulted in performance above the MPL. Care1st also performed above the HPL on the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure, and four measures had statistically significant improvement.

Opportunities for Improvement

Care1st has an opportunity for improvement on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, since this measure performed below the MPL in 2012. The plan will need to develop a detailed improvement plan that documents the barriers and challenges to performing above the MPL on this measure and interventions the plan will implement to improve performance.

Care1st should consider assessing the factors that led to a statistically significant decrease in performance on the *Childhood Immunization Status—Combination 3* measure. Although performance remained above the MPL on this measure in 2012, the plan would benefit from identifying and implementing strategies to improve performance on this measure so performance does not continue to decline.

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

Quality Improvement Project Objectives

Care1st had one clinical QIP and two clinical QIP proposals in progress during the review period of July 1, 2011–June 30, 2012. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the current DHCS statewide collaborative QIP. Care1st's second project, an internal QIP, aimed to improve the management of diabetes in members 18 to 75 years of age. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative, which focused on reducing readmissions for members aged 21 years and older. All three QIPs fell under the quality and access domains 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, Care1st had identified 156 ER room visits that were avoidable, which

was 13.8 percent of its ER visits. The plan's objective was to reduce this rate by 10 percent with the use of 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 diabetes management QIP proposal targeted diabetic members and focused on increasing LDL screening, nephropathy monitoring, retinal eye exams, and HbA1c screening, and decreasing the percentage of members with an HbA1c test result greater than nine percent (indicating poor control). Ongoing management of diabetic members is critical to preventing complications and ensuring optimal health for these members.

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 Care1st Partner 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	76%	100%	*Partially Met*
	Resubmission	84%	100%	*Met*
*All-Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Fail*
	Proposal Resubmission	Not Applicable	Not Applicable	*Pass*
Internal QIP				
Comprehensive Diabetic Care	Proposal	28%	18%	*Not Met*
	Proposal Resubmission 1	68%	77%	*Not Met*
	Proposal Resubmission 2	85%	91%	*Partially Met*
	Proposal Resubmission 3	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*.

* During the review period, the *All-Cause Readmissions* QIP proposal was reviewed and scored as *Pass/Fail* only, since the project had developed common language which was used in the study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that Care1st's annual submission of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Partially Met*. 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 QIP and upon subsequent validation, achieved an overall *Met* validation status. During the review period, the plan resubmitted its *Comprehensive Diabetic Care* QIP proposal three times before receiving a *Met* validation status. During this time period, a change in Care1st staff

responsible for QIP submissions may have contributed to the need for multiple resubmissions. HSAG provided technical assistance to the plan after its second resubmission. For the *All-Cause Readmissions* QIP proposal, Care1st initially did not include the collaborative-approved study indicators and received a *Fail* score. In its resubmission, Care1st 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 Care1st's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Care1st Partner Plan—San Diego County (Number = 6 QIP Submissions, 2 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	97%	3%	0%
	II: Clearly Defined, Answerable Study Question(s)	83%	17%	0%
	III: Clearly Defined Study Indicator(s)	92%	8%	0%
	IV: Correctly Identified Study Population	81%	13%	6%
Design Total		**91%**	**8%**	**1%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	0%	0%	100%
	VI: Accurate/Complete Data Collection	74%	11%	15%
	VII: Appropriate Improvement Strategies	93%	7%	0%
Implementation Total		**66%**	**9%**	**25%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	45%	17%	38%
	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**38%**	**13%**	**49%**

*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.

HSAG validated Activities I through VIII for the *Comprehensive Diabetic Care* QIP and Activities I through X for the *Reducing Avoidable Emergency Room Visits* QIP.

Care1st demonstrated an appropriate application of the design stage overall, receiving a *Met* score of 91 percent of the applicable elements scored for this stage. In Activities II through IV of the

Comprehensive Diabetic Care QIP, Care1st had incorrectly defined the study questions, the study indicators, and the study population in its first resubmission; however, the plan corrected these deficiencies in the second resubmission.

The plan also struggled with providing adequate documentation of the implementation stage (Activities V through VII) for the *Comprehensive Diabetic Care* QIP. The plan did not clearly indicate whether sampling was used in Activity V. This deficiency was not addressed until the third resubmission, at which time the plan documented that sampling would not be used and Activity V was subsequently scored *Not Applicable*. In Activity VI, the plan did not completely identify the data collected or the administrative and manual data collection elements required when using the hybrid method for data collection. Care1st addressed these deficiencies in its third resubmission. In Activity VII, the plan did not provide the barrier analysis process until its third resubmission.

In Activity VIII of the outcomes stage, the *Comprehensive Diabetic Care* QIP baseline data were available at the time of the plan's first submission; however, the plan did not report the baseline results and the related requirements until its third resubmission. In Activity VIII of the *Reducing Avoidable Emergency Room Visits* QIP, Care1st initially did not identify whether there were factors that threatened the validity of the results or the ability to compare measurement periods, include a complete interpretation of the results, and evaluate the success of the study. In its third resubmission, Care1st only addressed two of the four deficiencies, correctly documenting the validity factors and the interpretation of the results.

Only the *Reducing Avoidable Emergency Room Visits* QIP had two or more remeasurement periods and could be assessed for statistically significant and sustained improvement. Care1st was scored lower for not achieving statistically significant improvement of the outcome in Activity IX. The plan also was unable to achieve sustained improvement for this QIP from baseline to the third remeasurement period. 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 Care1st Partner 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 ER visits that were avoidable^	13.8%	17.7%*	12.2%*	29.0%*	No

QIP #2—Comprehensive Diabetic Care				
QIP Study Indicator	**Baseline Period 1/1/10–12/31/10**	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
The percentage of diabetic members who received at least one HbA1c screening test	83.6%	‡	‡	‡
The percentage of diabetic members with an HbA1c result of >9 (poor control) or no HbA1c screening test^	30.9%	‡	‡	‡
The percentage of diabetic members who received an LDL screening test	80.6%	‡	‡	‡
The percentage of diabetic members who received a retinal eye exam	41.8%	‡	‡	‡
The percentage of diabetic members who received a nephropathy screening test	87.3%	‡	‡	‡

^A lower percentage indicates better performance.

¥ 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.

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, Care1st set an overall objective to achieve a 10 percent reduction in ER visits designated as avoidable. 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 for one measurement period. From the first to the second remeasurement period, the plan's avoidable ER visit rate demonstrated a statistically significant decrease of 5.5 percentage points.

Conversely, the plan reported two separate statistically significant declines in performance: (1) from baseline to the first remeasurement period (3.9 percentage points) and (2) from the second to the third remeasurement period (16.8 percentage points). The plan did not achieve overall improvement; rather, it demonstrated a decline in performance over the course of the project as evidenced by the increased rate of avoidable ER visits at the final remeasurement period compared to the baseline rate. A critical analysis of the plan's improvement strategy identified some weaknesses, which may have led to the lack of improvement in outcomes:

- The plan's barrier analysis was conducted by a quality improvement subcommittee. The plan reported that the subcommittee identified the interventions; however, it did not provide a list of the identified barriers or the rationale for how they were prioritized. The plan reported that the interventions addressed all of the barriers, which was not supported by any documentation.
- The plan documented taking part in the statewide collaborative interventions; however, it only discussed provider educational mailings and it did not report results of the plan-hospital data collection collaboration.
- Four plan-specific interventions were implemented without documentation of an evaluation plan for any of the interventions. All interventions were implemented between March 2008 and December 2008 and were not modified during the remainder of the project. The plan attributed the improvement from Remeasurement 1 to Remeasurement 2 to the Nurse Advice Line; however, the plan did not provide specific data to support the intervention's effectiveness. This improvement in performance was followed by the largest decline in performance of the project, which occurred from Remeasurement 2 to Remeasurement 3. The plan was not able to address why the decline occurred since there was no evaluation of the interventions and the same interventions were in place for both measurement periods.

With the implementation of any intervention (and especially for multiple interventions), the plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of each intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

Comprehensive Diabetic Care QIP

For the *Comprehensive Diabetic Care* QIP, the plan set the project objective to the NCQA Medicaid percentile that was the next percentile category higher than the reported rate for each measure. For example, if the measure was currently at the NCQA Medicaid 50th percentile, the goal would be the 75th percentile. An analysis of the plan's improvement strategy identified some areas that may have negatively affected the plan's ability to improve outcomes:

- The plan's barrier analysis was conducted by a quality improvement subcommittee. The plan reported that the subcommittee identified barriers, although the barriers were not prioritized.

Additionally, the plan did not provide any specific results of the barrier analysis or any data-driven rationale for the selection of the interventions.

- The plan did not identify measure-specific interventions. Instead, the plan implemented more global interventions targeting diabetic members. Interventions to increase screening may be different than interventions to improve HbA1c control.
- The plan reported implementing six interventions in January 2011; however, the plan did not include an evaluation plan for each intervention.

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

Strengths

The plan adequately documented the design stage, receiving a *Met* score on 91 percent of the applicable elements scored for all submissions of the *Reducing Avoidable ER Visits* QIP and the *Comprehensive Diabetic Care* QIP.

Opportunities for Improvement

Care1st required multiple QIP resubmissions before receiving a *Met* validation status for both the *Reducing Avoidable ER Visits* QIP and the *Comprehensive Diabetic Care* QIP. The plan should address all of the deficiencies identified in the QIP Validation Tool and incorporate the recommendations before resubmitting its QIPs.

Care1st should better document the barrier analysis process and results by providing the supporting data, including the identified barriers, and providing the rationale for the prioritization of the barriers.

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.

For the *Comprehensive Diabetic Care* QIP, Care1st could potentially target interventions to high-volume providers with low performance. By targeting improvement efforts to fewer providers and providing more one-on–one education and support, the plan may increase the likelihood of success of the project.

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 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 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, 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.

Care1st showed average performance in the quality domain of care. The plan was able to report valid rates for all 2012 performance measures, and overall performance on measures in the quality domain was average. Two measures in the quality domain of care had rates above the HPLs and four measures in the quality domain had statistically significant improvement from 2011 to 2012. Improvement plans for two measures impacting quality of care resulted in improvement in performance, with one of the measures (*Use of Imaging Studies for Low Back Pain*) showing statistically significant improvement and movement from performance below the MPL to above the HPL from 2011 to 2012.

All of Care1st's QIPs fall within the quality domain of care. Although the plan struggled with providing all required documentation for its QIP proposals, which resulted in several resubmissions, the plan eventually demonstrated overall understanding of the QIP design and implementation stages.

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 members. 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 members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Care1st showed average performance in the access domain of care. Measures within the access domain of care performed average overall, with one measure performing above the HPL. One access-related measure had statistically significant improvement from 2011 to 2012, and one had statistically significant decline in performance.

During the MR/PIU review, it was noted that one of the eight provider offices visited was not aware of procedures for referring MCMC members to culturally and linguistically appropriate community services programs. In response to this observation, the plan reported engaging in activities to ensure members have access to culturally and linguistically appropriate community services programs; however, this area was not addressed by the plan within its internal 2011 annual evaluation under the facility site review.

Care1st's *Reducing Avoidable Emergency Room Visits* QIP falls within the access domain of care. Although the plan was able to reduce the percentage of avoidable ER visits for one measurement period, the plan showed a decline in performance from the baseline to Remeasurement 1 and from Remeasurement 2 to Remeasurement 3. Overall, Care1st demonstrated a decline in performance over the course of the project.

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.

Care1st showed average performance in the timeliness domain of care. The plan showed average performance on all measures falling in the timeliness domain. One measure within the timeliness domain of care showed statistically significant improvement from 2011 to 2012 (*Adolescent Well-Care Visits*), and one measure showed statistically significant decline in performance (*Childhood Immunization Status—Combination 3*).

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

Recommendations

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

- Ensure all medical performance review recommendations are fully addressed. Specifically:
  - Implement a mechanism to complete investigations involving quality of care issues within reasonable time frames.
  - Establish a mechanism to ensure that the written record for each grievance is maintained and available as needed.
  - Establish a mechanism to monitor continuity and coordination of care for patients with mental health parity conditions such as pervasive developmental disorders.
- Ensure that the plan's efforts to ensure all staff members at all provider offices are aware of the procedures for referring MCMC members to culturally and linguistically appropriate community services programs have resolved the concerns identified by MR/PIU.

- Continue to monitor laboratory encounter data to track monthly volumes to ensure encounter data completeness.
- Develop a detailed improvement plan for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure that documents the barriers and challenges to performing above the MPL on this measure and interventions the plan will implement to improve performance.
- Consider assessing the factors that led to a statistically significant decrease in performance on the *Childhood Immunization Status—Combination 3* measure. Although performance remained above the MPL on this measure in 2012, the plan would benefit from identifying and implementing strategies to improve performance on this measure so performance does not continue to decline.
- Develop and implement a process to ensure that all deficiencies identified in the QIP Validation Tool are addressed and all recommendations are incorporated before QIPs are resubmitted.
- Improve documentation of the QIP barrier analysis process and results by providing the supporting data, including the identified barriers, and providing the rationale for the prioritization of the barriers.
- 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.
- Consider targeting interventions to high-volume providers with low performance for the *Comprehensive Diabetic Care* QIP. By targeting improvement efforts to fewer providers and providing more one-on–one education and support, the plan may increase the likelihood of success of the project.
- Assess whether any of the interventions used to successfully increase the plan's *Use of Imaging Studies for Low Back Pain* score can be applied to any of the plan's lagging HEDIS measures or QIPs.

In the next annual review, HSAG will evaluate Care1st'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 Care1st Partner 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 Care1st'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 Care1st's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	Care1st's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
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.	Care1st has modified policies and procedures in accordance with EQRO recommendations and has assured the policies and procedures have been implemented and staff education of changes completed.
Ensure that all contracted providers are trained regarding interpreter services.	Care1st has demonstrated compliance in training providers and their staff about interpreter services and how to access these services for their members. We have added these questions to our provider satisfaction survey and have seen significant improvement in this understanding during audit.
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.	Care1st not only conducts routine facility site review audits, during these audits we assure providers and office staff are aware of the policies and procedures for culturally and linguistically appropriate services and programs. We track member complaints concerning these issues and re-educate when necessary. We also survey our providers annually to assure they understand these requirements and how to access.
Run monthly monitoring reports for vendor encounter data to track monthly volumes to ensure complete encounter data submissions.	The Encounter Department obtains monthly files from all contracted IPA/Medical Groups, and error reports are generated back to each group. Care1st is actively working with groups to evaluate the errors to prevent errors in the future.
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.	Care1st has a process in place to assure criteria used are clear in the determination in appeal decisions. Care1st has a process to monitor contracted IPAs to assure denial letters include an understandable explanation of the reason and criteria used for the decision. Care1st conducts quarterly audits of the IPAs and they remain on monitoring quarterly until they fully meet criteria. Then, they are placed on an annual audits process. This audit process was written up as a QIP and has resulted in an ongoing change in process.
Address the three measures falling below the MPLs with detailed improvement plans in order to recapture 2010's performance level.	Care1st Quality Improvement Department formally submitted a corrective action plan to the EQRO addressing the three measures that scored below minimum performance levels. We have initiated the corrective action plan and will re-measure these in 2013.
Use feedback from prior QIPs as well as the QIP Completion Instructions to help achieve compliance without having to resubmit projects.	Care1st has had to re-submit our QIP submissions to make requested revisions. We have worked to document common trends and have worked to limit the amount of submissions where subjects are partially or not met. We have seen some improvement in our submissions. Care1st is also looking to add a manager-level employee to track these submissions going forward to assure completeness on submission.

Table B.1—Grid of Care1st's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	Care1st's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
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.	Care1st conducts a new barrier analysis each time our QIAs are updated. Care1st also looks to develop interventions and evaluations in the QIA where we can document and measure how each individual intervention performed.