# Performance Evaluation Report

## Care1st Partner Plan

July 1, 2012–June 30, 2013

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

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# 1. INTRODUCTION

## Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and

[1] *Medi-Cal Managed Care Enrollment Report—June 2013.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Care1st Partner Plan ("Care1st" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

## Managed Care Plan Overview

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

Care1st became operational in San Diego County to provide MCMC services in February 2006. As of June 30, 2013, Care1st had 31,448 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

## Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP's compliance with standards established by the state related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers 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, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

## Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's 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.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

### *Readiness Reviews*

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

## *Medical Performance Audits and Member Rights Reviews*

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

### Member Rights/Program Integrity Unit Monitoring Review Findings

The most recent Member Rights/Program Integrity Unit (MR/PIU) monitoring review visit for Care1st was conducted February 25, 2013, through February 27, 2013, covering the review period

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP 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 the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

of June 1, 2009, through December 31, 2012. The purpose of the visit was to review Care1st's compliance with Medi-Cal contractual requirements relating to the following areas:

- Member Grievances
- Prior Authorization Notification
- Cultural and Linguistic Services
- Marketing
- Program Integrity

A key component for the monitoring visit included a review of Care1st's compliance with SPD competency and sensitivity training, as well as the Facility Site Review (FSR) physical accessibility assessment requirement. In a report dated April 29, 2013, MR/PIU identified the following findings:

- In the area of Member Grievances, MR/PIU noted that the MCP's grievance and appeals policies and procedures were missing the required 14 calendar days extended time frame.
- In the area of SPD Sensitivity Training, MR/PIU noted that Care1st did not provide SPD training to 100 percent of its provider network, as required per the MMCD All Plan Letter 11-010.
- In the area of Program Integrity, MR/PIU indicated that Care1st did not include information about the MCP's Fraud and Abuse Program in the Care1st Member Services Guide.

Care1st was not required to respond to the findings. In the April 29, 2013, report, MR/PIU indicated that DHCS may include outstanding findings as items for further review during the next scheduled A&I audit with Care1st.

## Strengths

During the most recent MR/PIU monitoring visit, no findings were identified in the areas of Prior Authorization Notification, Cultural and Linguistic Services, or Marketing.

## Opportunities for Improvement

Care1st has the opportunity to improve in the areas of Member Grievances, SPD Sensitivity Training, and Program Integrity. These areas impact the quality and timeliness domains of care.

## Conducting the EQRO Review

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

## Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

## Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

## Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for Care1st Partner Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that Care1st followed the appropriate specifications to produce valid rates and identified no issues of concern. A review of the MCP's HEDIS audit report revealed the following observations:

- Care1st actively monitored the lab submissions from its lab vendors during the measurement year and expected to continue to see enhanced data capture. As a way to improve data capture, the MCP continued to incorporate incentives as a means to improve data completeness.
- Care1st maintained one unique identification number for each member. When members left the MCP and then returned, Care1st was able to identify them and provide the same identification numbers previously in the system. This allowed Care1st to track services and history for a member going back several years.

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

## Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

**Table 3.1—Name Key for Performance Measures in External Accountability Set**

| Performance Measure Abbreviation | Full Name of 2013 Reporting Year[†] Performance Measure |
|---|---|
| AAB | *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* |
| ACR | *All-Cause Readmissions* [‡] |
| AMB–ED | *Ambulatory Care—Emergency Department (ED) Visits* |
| AMB–OP | *Ambulatory Care—Outpatient 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)* |
| CBP | *Controlling High Blood Pressure* |
| 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* |
| MMA–50 | *Medication Management for People with Asthma—Medication Compliance 50% Total* |
| MMA–75 | *Medication Management for People with Asthma—Medication Compliance 75% Total* |
| 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* |
| 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* |

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.
‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Table 3.2 below presents a summary of Care1st's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.2 shows the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

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 2012 and 2013 Performance Measure Results**
**Care1st—San Diego County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| AAB | Q | 15.38% | 20.83% | ★★ | ↔ | 18.98% | 33.33% |
| ACR | Q, A | -- | 15.64% | -- | Not Comparable | -- | -- |
| AMB–ED | ‡ | 48.06 | 50.84 | ‡ | Not Comparable | ‡ | ‡ |
| AMB–OP | ‡ | 239.46 | 291.33 | ‡ | Not Comparable | ‡ | ‡ |
| CAP–1224 | A | 90.56% | 93.54% | ★ | ↑ | 95.56% | 98.39% |
| CAP–256 | A | 78.47% | 82.76% | ★ | ↑ | 86.62% | 92.63% |
| CAP–711 | A | 81.48% | 82.67% | ★ | ↔ | 87.56% | 94.51% |
| CAP–1219 | A | 77.75% | 81.15% | ★ | ↑ | 86.04% | 93.01% |
| CBP | Q | -- | 51.71% | -- | Not Comparable | -- | -- |
| CCS | Q,A | 66.91% | 47.98% | ★ | ↓ | 61.81% | 78.51% |
| CDC–BP | Q | 73.90% | 58.39% | ★★ | ↓ | 54.48% | 75.44% |
| CDC–E | Q,A | 47.39% | 40.39% | ★ | ↔ | 45.03% | 69.72% |
| CDC–H8 (<8.0%) | Q | 49.00% | 51.82% | ★★ | ↔ | 42.09% | 59.37% |
| CDC–H9 (>9.0%) | Q | 36.95% | 42.09% | ★★ | ↔ | 50.31% | 28.95% |
| CDC–HT | Q,A | 88.76% | 84.91% | ★★ | ↔ | 78.54% | 91.13% |
| CDC–LC (<100) | Q | 38.15% | 37.23% | ★★ | ↔ | 28.47% | 46.44% |
| CDC–LS | Q,A | 81.53% | 78.59% | ★★ | ↔ | 70.34% | 83.45% |
| CDC–N | Q,A | 88.35% | 85.40% | ★★ | ↔ | 73.48% | 86.93% |
| CIS–3 | Q,A,T | 73.24% | 72.75% | ★★ | ↔ | 64.72% | 82.48% |

**Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
Care1st—San Diego County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| IMA–1 | Q,A,T | 62.13% | 70.26% | ★★ | ↑ | 50.36% | 80.91% |
| LBP | Q | 82.72% | 70.00% | ★ | ↓ | 72.04% | 82.04% |
| MMA–50 | Q | -- | 40.59% | -- | Not Comparable | -- | -- |
| MMA–75 | Q | -- | 24.75% | -- | Not Comparable | -- | -- |
| MPM–ACE | Q | 89.19% | 81.79% | ★ | ↓ | 83.72% | 91.33% |
| MPM–DIG | Q | NA | NA | NA | Not Comparable | 87.93% | 95.56% |
| MPM–DIU | Q | 86.76% | 80.19% | ★ | ↔ | 83.19% | 91.30% |
| PPC–Pre | Q,A,T | 85.00% | 81.12% | ★★ | ↔ | 80.54% | 93.33% |
| PPC–Pst | Q,A,T | 67.06% | 59.18% | ★★ | ↓ | 58.70% | 74.73% |
| W-34 | Q,A,T | 73.44% | 67.07% | ★★ | ↔ | 65.51% | 83.04% |
| WCC–BMI | Q | 65.94% | 74.45% | ★★ | ↑ | 29.20% | 77.13% |
| WCC–N | Q | 68.37% | 72.26% | ★★ | ↔ | 42.82% | 77.61% |
| WCC–PA | Q | 46.72% | 51.58% | ★★ | ↔ | 31.63% | 64.87% |

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

## Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[8] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

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

The final selected SPD measures are listed below. Following the list of measures are Tables 3.3 and 3.4, which present a summary of Care1st's 2013 SPD measure results. Table 3.3 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.4 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*

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

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.3.

- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

**Table 3.3—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**Care1st—San Diego County**

| Performance Measure | Non-SPD Rate | SPD Rate | SPD Compared to Non-SPD* | Total Rate (Non-SPD and SPD) |
|---|---|---|---|---|
| ACR | 8.65% | 17.35% | ▼ | 15.64% |
| CAP–1224 | 93.78% | NA | Not Comparable | 93.54% |
| CAP–256 | 83.10% | 70.83% | ↓ | 82.76% |
| CAP–711 | 82.68% | 82.50% | ↔ | 82.67% |
| CAP–1219 | 81.22% | 78.13% | ↔ | 81.15% |
| CDC–BP | 63.36% | 57.00% | ↔ | 58.39% |
| CDC–E | 40.46% | 38.40% | ↔ | 40.39% |
| CDC–H8 (<8.0%) | 38.17% | 45.20% | ↔ | 51.82% |
| CDC–H9 (>9.0%) | 52.67% | 48.00% | ↔ | 42.09% |
| CDC–HT | 83.21% | 82.80% | ↔ | 84.91% |
| CDC–LC (<100) | 35.11% | 38.60% | ↔ | 37.23% |
| CDC–LS | 74.81% | 79.40% | ↔ | 78.59% |
| CDC–N | 80.92% | 88.40% | ↑ | 85.40% |
| MPM–ACE | 84.85% | 81.13% | ↔ | 81.79% |
| MPM–DIG | NA | NA | Not Comparable | NA |
| MPM–DIU | 75.23% | 81.24% | ↔ | 80.19% |

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

**Table 3.4—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**Care1st—San Diego County**

| Non-SPD Visits/1,000 Member Months* | | SPD Visits/1,000 Member Months* | |
|---|---|---|---|
| Outpatient Visits | Emergency Department Visits | Outpatient Visits | Emergency Department Visits |
| 249.97 | 43.32 | 415.00 | 73.34 |

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

## Performance Measure Result Findings

Overall, Care1st performed below average on its measures in 2013. In 2012, Care1st had one measure with a rate below the MPL and two measures with rates above the HPLs. In 2013, the MCP had nine measures with rates below the MPLs and zero measures had rates above the HPLs. Five measures had rates with statistically significant improvement from 2012 to 2013; however, there were also five measures with rates that declined significantly from 2012 to 2013.

The rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was below the MPL in 2012. Although the rate's improvement from 2012 to 2013 was not statistically significant, the rate was above the MPL in 2013.

The rate for *Use of Imaging Studies for Low Back Pain* measure was below the MPL in 2011 but had a statistically significant increase from 2011 to 2012, resulting in a rate above the HPL in 2012. Because Care1st was not able to maintain the improvement on this measure's rate, the rate declined significantly in 2013, resulting in a rate below the MPL.

In addition to the *Use of Imaging Studies for Low Back Pain* measure, the following measures had rates below the MPLs in 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Year)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Screening—Eye Exam (Retinal) Performed*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

In addition to the *Use of Imaging Studies for Low Back Pain* measure, the rates for the following measures declined significantly from 2012 to 2013:

- *Cervical Cancer Screening*
- *Comprehensive Diabetes Screening—Blood Pressure Control (<140/90 mm Hg)*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Prenatal and Postpartum Care—Postpartum Care*

The rates for the following five measures had statistically significant improvement from 2012 to 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Immunizations for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*

## Seniors and Persons with Disabilities Findings

The SPD rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure was significantly higher than the non-SPD rate.

The SPD rate for the *All-Cause Readmissions* measure was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes and within 30 days of an inpatient discharge than the non-SPD population. Additionally, the SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* measure was significantly lower than the non-SPD rate for this measure, meaning significantly fewer members aged 25 months to 6 years in the SPD population were seen by their primary care practitioner when compared to members in the non-SPD population.

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

## *Improvement Plans*

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

Care1st had an IP in place for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure during the review period. Below is a summary of the IP and HSAG's assessment of the progress the MCP made toward improving the rate on the measure.

### *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

Care1st identified the following barriers and challenges that prevented the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure from being above MPL in 2012:

- The MCP had a significant growth in its Medi-Cal population in late 2010 and all of 2011 that included a large influx of the SPD population, which the MCP indicated had a much higher incidence of bronchitis.
- The MCP identified that when submitting encounters and claims, some Medi-Cal providers did not include a competing diagnosis that may have required use of an antibiotic.
- The MCP found that many members in the SPD population remained with their providers under a letter of agreement (LOA). This resulted in the providers and the MCP's Medi-Cal members under the LOAs not receiving the education and outreach information about prescribing antibiotics that was provided to contracted primary care providers.

To address the identified barriers and improve the rate on this measure, Care1st implemented several interventions, including:

- Providing educational outreach information to providers who continued to see the MCP's Medi-Cal members under an LOA.

- Providing information to members on appropriate use of antibiotics.
- Adding the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure to the MCPs' provider profile reports, which are report cards sent to providers comparing their rates with those of their peers and Care1st overall.

Care1st's efforts resulted in the rate for this measure having statistically significant improvement from 2012 to 2013, which led to the rate being above the MPL. Care1st will not be required to submit an IP for this measure in 2013.

### 2013 Improvement Plans

The MCP will be required to submit IPs for the following measures that had rates below the MPLs in 2013:

- *Comprehensive Diabetes Screening—Eye Exam (Retinal) Performed*
- *Use of Imaging Studies for Low Back Pain*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

Although Care1st's rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures were below the MPLs in 2013, the MCP will not be required to submit IPs for these measures. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts in other areas of poor performance that have clear improvement paths and a direct population health impact.

Although Care1s's rate for the *Cervical Cancer Screening* measure was below the MPL in 2013, the MCP will not be required to submit an IP for this measure. In August 2013, it was learned that significant changes were made to the specifications for the *Cervical Cancer Screening* measure. NCQA will therefore not publically report this measure for HEDIS 2014, and DHCS made a decision that the MCPs with *Cervical Cancer Screening* rates below the MPLs in 2013 would not be required to submit an IP for the measure. Although this decision was made after the review period for this report, since the decision was made prior to the report being finalized, the information is included.

## Strengths

HSAG auditors determined that Care1st followed the appropriate specifications to produce valid performance measure rates and identified no issues of concern. As a way to improve data capture, the MCP continued to incorporate incentives as a means to improve data completeness. Additionally, since Care1st maintains one unique identification number for each member, when a

member leaves the MCP and returns, Care1st can track services and history for that member going back several years.

Care1st had five measures with statistically significant improvement from 2012 to 2013. The MCP's IP for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was successful in bringing the rate for this measure above the MPL in 2013.

## Opportunities for Improvement

Care1st has an opportunity to improve its rates by focusing on the measures with rates below the MPLs in 2013 and measures with rates that declined significantly from 2012 to 2013. By identifying the factors that have caused the MCP to perform poorly on these measures, Care1st can improve these measures' rates. Additionally, since readmissions have been associated with lack of proper discharge planning and poor care transition, Care1st has an opportunity to improve the provision of these services to the SPD population to ensure fewer readmissions.

## Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[10] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

## Validating Quality Improvement Projects and Assessing Results

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

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

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

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

## Quality Improvement Project Objectives

Care1st participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2012–June 30, 2013.

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

**Table 4.1—Quality Improvement Projects for Care1st—San Diego County July 1, 2012, through June 30, 2013**

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

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

Before initiating the statewide collaborative QIP, Care1st had a 30-day readmission rate of 29.0 percent among Medi-Cal beneficiaries. Care1st did not specify the readmission rates for the SPD and non–SPD populations.

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

## Quality Improvement Project Validation Findings

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

**Table 4.2—Quality Improvement Project Validation Activity**
**Care1st—San Diego County**
**July 1, 2012, through June 30, 2013**

| Name of Project/Study | Type of Review[1] | Percentage Score of Evaluation Elements *Met*[2] | Percentage Score of Critical Elements *Met*[3] | Overall Validation Status[4] |
|---|---|---|---|---|
| **Statewide Collaborative QIP** | | | | |
| *All-Cause Readmissions* | Study Design Submission | 60% | 60% | *Partially Met* |
| | Study Design Resubmission 1 | 100% | 100% | *Met* |
| **Internal QIPs** | | | | |
| *Comprehensive Diabetic Care* | Annual Submission | 26% | 10% | *Not Met* |
| | Annual Resubmission 1 | 64% | 88% | *Not Met* |
| | Annual Resubmission 2 | 89% | 100% | *Met* |

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

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

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

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

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that Care1st's study design submission of its *All-Cause Readmissions* QIP received an overall validation status of *Partially Met.* As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on the validation feedback, Care1st resubmitted the study design submission and upon subsequent validation, achieved an overall *Met* validation status with 100 percent of both the critical and evaluation elements receiving a *Met* status. Care1st received a *Not Met* validation status for its *Comprehensive Diabetic Care* QIP annual submission and first resubmission. For the second resubmission, Care1st achieved an overall *Met* validation status with 100 percent of critical elements and 89 percent of evaluation elements being met. Table 4.3 summarizes the aggregated validation results for Care1st's QIPs across CMS protocol activities during the review period.

**Table 4.3—Quality Improvement Project Average Rates***
**Care1st—San Diego County**
**(Number = 5 QIP Submissions, 2 QIP Topics)**
**July 1, 2012, through June 30, 2013**

| QIP Study Stages | Activity | *Met* Elements | *Partially Met* Elements | *Not Met* Elements |
|---|---|---|---|---|
| Design | I: Appropriate Study Topic | 90% | 10% | 0% |
| | II: Clearly Defined, Answerable Study Question(s) | 80% | 20% | 0% |
| | III: Clearly Defined Study Indicator(s) | 60% | 40% | 0% |
| | IV: Correctly Identified Study Population | 80% | 20% | 0% |
| | V: Valid Sampling Techniques (if sampling is used) | 0% | 0% | 100% |
| | VI: Accurate/Complete Data Collection | 62% | 15% | 23% |
| **Design Total** | | **63%** | **18%** | **19%** |
| Implementation | VII: Sufficient Data Analysis and Interpretation | 68% | 16% | 16% |
| | VIII: Appropriate Improvement Strategies | 75% | 25% | 0% |
| **Implementation Total** | | **70%** | **19%** | **11%** |
| Outcomes | IX: Real Improvement Achieved | 25% | 25% | 50% |
| | X: Sustained Improvement Achieved | Not Assessed | Not Assessed | Not Assessed |
| **Outcomes Total** | | **25%** | **25%** | **50%** |

*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 VI for Care1st's *All-Cause Readmission* study design submission and Activities I through IX for the MCP's *Comprehensive Diabetes Care* QIP annual submission.

Care1st demonstrated an adequate application of the Design stage (Activities I through VI) for the *All-Cause Readmission* study design submission. In Activity III, Care1st included a second study indicator; however, the indicator was not part of the collaborative QIP, resulting in Care1st receiving a lower score on this activity. In the QIP resubmission, Care1st removed the second study indicator and added it to Activity VII as an additional outcome being measured by the MCP. In Activity VI for the *All-Cause Readmission* QIP, Care1st's score was lowered because the MCP did not specify the data source for the administrative data or describe its data analysis plan. Care1st corrected these deficiencies in the resubmission and achieved an overall *Met* validation status.

Care1st struggled with providing adequate documentation for both the Design and Implementation stages (Activities I through VIII) for the *Comprehensive Diabetic Care* QIP. Initially, the QIP Summary Form submitted by Care1st did not include previously submitted information. Excluding the updated information continued to affect Care1st's validation score throughout the

QIP submission process. In Activity III, the study indicators and measurement periods were not well-defined, which resulted in a lower score. The QIP also received a lower score in Activity V because the MCP did not provide the sampling specifications. Finally, Activity VI for the *Comprehensive Diabetic Care* QIP received a lower score because Care1st did not identify all of the data elements collected; did not define the systematic process for collecting data; did not describe the training, qualifications, and experience of the collection staff; did not supply the collection tool; did not clarify the hybrid data collection process; and did not discuss the data analysis plan.

Care1st continued to struggle with the Implementation stage for the *Comprehensive Diabetic Care* QIP. In Activity VII, Care1st failed to provide sampling information or methodology, discuss factors that may have threatened the validity of the data, and include documentation regarding Remeasurement 1 and $p$ values. Additionally, Care1st did not describe the quality improvement process used to identify causes/barriers or discuss how it determined the efficacy of the interventions, resulting in a lower score in Activity VIII. Care1st corrected these deficiencies in the subsequent resubmissions and achieved an overall *Met* validation status on the QIP.

Only the *Comprehensive Diabetic Care* QIP progressed to Outcomes stage during the reporting period. Care1st demonstrated improvement for three of the four study indicators for this QIP; however, the improvements were not statistically significant improvements over baseline. Activity X was not assessed for this QIP since it had not yet progressed to that activity.

### Quality Improvement Project Outcomes and Interventions

Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

The *All-Cause Readmissions* QIP did not progress to the implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information for this QIP is included in the table.

**Table 4.4—Quality Improvement Project Outcomes for Care1st—San Diego County July 1, 2012, through June 30, 2013**

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

^A lower percentage indicates better performance.

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

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

## *Comprehensive Diabetic Care* QIP

For the *Comprehensive Diabetic Care* QIP, Care1st set the project objective to the NCQA Medicaid percentile that was the next percentile category higher than the reported rate for each measure. For example, if the measure was currently at the NCQA Medicaid 50th percentile, the goal would be the 75th percentile. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- Initially, Care1st did not include previously submitted information in the QIP Summary Form it submitted to HSAG. The MCP should reference the QIP Completion Instructions and the previous QIP submissions to ensure that all documentation requirements for each activity have been addressed and updated to avoid incomplete documentation of the various elements.
- In the second resubmission, Care1st described its process to evaluate the efficacy of the interventions and how the MCP determined which interventions would be ongoing. Additionally, the MCP described how it would address the decline for Study Indicator 2 and what strategies would be implemented.
- Care1st did not provide complete and/or accurate information throughout the QIP Summary Form and had to resubmit the QIP two times. The MCP should reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to the QIP submission.

## Strengths

Care1st demonstrated an adequate application of the QIP process. Although Care1st did not achieve statistically significant improvement on any of the *Comprehensive Diabetes Care* QIP indicators, study indicators 1, 3, 4, and 5 showed improvement over the baseline rates. Additionally, the MCP described how it would address the decline for Study Indicator 2 and what strategies would be implemented.

## Opportunities for Improvement

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

For the *Comprehensive Diabetic Care* QIP, Care1st has the opportunity to build on the successes that led to an improvement in rates for study indicators 1, 3, 4, and 5.

## Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Care1st's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

## Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about Care1st's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

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

CAHPS Global Rating Measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

CAHPS Composite Measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

**Table 5.1—CAHPS Measures Domains of Care**

| Measure | Domains of Care |
|---|---|
| *Rating of Health Plan* | Q |
| *Rating of All Health Care* | Q |
| *Rating of Personal Doctor* | Q |
| *Rating of Specialist Seen Most Often* | Q |
| *Getting Needed Care* | Q, A |
| *Getting Care Quickly* | Q, T |
| *How Well Doctors Communicate* | Q |
| *Customer Service* | Q |
| *Shared Decision Making* | Q |

## National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

**Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures**

| Star Rating | Adult and Child Percentiles |
|---|---|
| ★★★★★ Excellent | At or above the 90th percentile |
| ★★★★ Very Good | At or above the 75th and below the 90th percentiles |
| ★★★ Good | At or above the 50th and below the 75th percentiles |
| ★★ Fair | At or above the 25th and below the 50th percentiles |
| ★ Poor | Below the 25th percentile |

Table 5.3 through Table 5.4 present the star ratings for the global ratings and composite measures for Care1st's adult and child Medicaid populations.[15]

**Table 5.3—Medi-Cal Managed Care County-Level Global Ratings**
**Care1st—San Diego County**

| Population | Rating of Health Plan | Rating of All Health Care | Rating of Personal Doctor | Rating of Specialist Seen Most Often |
|---|---|---|---|---|
| **Adult** | ★ | ★ | ★ | ★ |
| **Child** | ★★ | ★ | ★★★ | ★★★★★+ |

*+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.*

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.
[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.
[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

**Table 5.4—Medi-Cal Managed Care County-Level Composite Measures**
**Care1st—San Diego County**

| Population | Getting Needed Care | Getting Care Quickly | How Well Doctors Communicate | Customer Service |
|---|---|---|---|---|
| **Adult** | ★ | ★ | ★★ | ★★★ |
| **Child** | ★ | ★ | ★ | ★★★ |

*+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.*

## Strengths

Care1st received an *Excellent* rating for the child *Rating of Specialist Seen Most Often* measure and a *Good* rating for the child *Rating of Personal Doctor* measure. The *Customer Service* measure for both the child and adult populations received a *Good* rating. Since the MCP had fewer than 100 respondents for the child *Rating of Specialist Seen Most Often* measure, caution should be exercised when evaluating these results. Care1st was able to improve upon the child *Rating of Personal Doctor* measure and the adult and child *Customer Service* measures when compared to the 2009–10 CAHPS survey results.

## Opportunities for Improvement

Care1st's CAHPS results showed below-average performance for the majority of the child and adult global ratings and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision-makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as Care1st's highest priorities: *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 Care1st CAHPS MCP-Specific Report.* Areas for improvement spanned the quality, access, and timeliness domains of care.

## Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

## Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[16] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[16] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Care1st's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

## Encounter Data Validation Findings

### Review of Encounter Systems and Processes

Overall, the information provided in Care1st's Roadmap and the supplemental questionnaire demonstrate that the MCP has well-established operational policies and practices for the creation, validation, correction, and ongoing monitoring of encounter data submissions. Approximately 85 percent of Care1st's claims and encounters are from capitated providers. The MCP requires that 70 percent of capitated provider encounters be received within 90 days of the dates of service. Key providers and medical groups are also incentivized to meet benchmarks for volume, quality, and timeliness. Care1st provides monthly performance feedback to providers regarding the benchmarks. The MCP also educates providers on reducing errors. Care1st preprocesses encounters submitted by its contracted providers to identify and return any encounters that require correction. All providers are required to resubmit corrections within 30 days. The MCP scrubs the encounters to ensure that there are no duplicates in the bimonthly data submissions. Care1st's approach for managing encounter data minimizes potential issues when reconciling the data with DHCS.

### Record Completeness

Overall, Care1st had very low record omission and record surplus rates for the Pharmacy claim type, indicating very complete data when comparing DHCS's Pharmacy data and the data extracted from Care1st's data system for this study. Care1st had record omission rates greater than 10 percent for the other three claim types. The highest record omission rate was 35.8 percent for

the long term care (LTC) records. However, this only indicated that 24 LTC records were omitted from the DHCS data warehouse. Care1st's record omission rates for the Medical/Outpatient and Hospital/Inpatient claim types were worse than the statewide rates by 16.6 and 1.8 percentage points, respectively. More than 55 percent of the Medical/Outpatient and Hospital/Inpatient records omitted from DHCS's data had beginning dates of service between March and May 2011. The record surplus rates for Care1st were better than the respective statewide results among all four claim types, with the highest record surplus rate of 6.0 percent for the Hospital/Inpatient claim type and the lowest record surplus rate of 0.0 percent for the LTC claim type.

### Data Element Completeness

Care1st had good data element completeness results, with element omission and element surplus rates of 0.0 percent for all key data elements except the *Rendering Provider Number* in the Medical/Outpatient claim type. The *Rendering Provider Number* had an element omission rate of 50.9 percent, which was worse than the statewide rate by 39.2 percentage points.

### Data Element Accuracy

Care1st had data element accuracy rates of at least 90 percent for all key data elements. The *Referring/Prescribing/Admitting Provider Number* was the only data element that did not have a 100.0 percent accuracy rate for the Hospital/Inpatient, Pharmacy, and LTC claim types. The element inaccuracy for the *Referring/Prescribing/Admitting Provider Number* was due to the different types of provider numbers populated in the two data sources. All of the element accuracy rates across the four claim types met or exceeded the respective statewide rates.

The Medical/Outpatient claim type had the lowest all-element accuracy rate (47.7 percent), which was below the statewide all-element accuracy rate of 64.0 percent. However, the Hospital/Inpatient, Pharmacy, and LTC claim types had high all-element accuracy rates (greater than 90 percent).

## Recommendations

Based on its review, HSAG recommends the following:

- One of Care1st's responses in the questionnaire stated that the error resubmissions account for approximately 10 percent of all encounter submissions. However, neither the MCP's data nor DHCS's data contained adjustment records. Care1st should explore why the data did not contain any adjustment records and explore opportunities to improve the encounter data quality.
- The Medical/Outpatient encounters in the DHCS data warehouse did not contain Outpatient records as identified by the data element *Claim Type* with a value of "1" (Outpatient). Care1st

should evaluate whether there are any Outpatient records in its data system for the data submissions to DHCS.

- Care1st should investigate the reason(s) for the high record omission rate for the Medical/Outpatient claim type and create strategies for future improvement.
- The Medical/Outpatient claim type had approximately 200,000 matched records in Care1st's data and DHCS's data. The values for the data element *Rendering Provider Number* were missing for 50.9 percent of DHCS's records. In addition, HSAG noticed that all Medical/Outpatient records in the MCP's data had the same values for the *Billing/Reporting Provider Number* and *Rendering Provider Number*. Care1st should evaluate whether it is reasonable to populate the *Rendering Provider Number* field with the values from the data element *Billing/Reporting Provider Number*. If it is reasonable, Care1st should modify its process and procedures so that it submits all values for the data element *Rendering Provider Number* to DHCS.
- All Medical/Outpatient records in both data sources were missing values for the *Referring/Prescribing/Admitting Provider Number* data element. The percentage of records without values for this data element was high compared to the other MCPs. Care1st should investigate whether more values for the data element *Referring/Prescribing/Admitting Provider Number* can be submitted to DHCS.
- All Hospital/Inpatient records in both data sources were missing values for the *Secondary Diagnosis Code, Primary Surgical Procedure Code,* and *Secondary Surgical Procedure Code* data elements. Care1st should determine whether more values for these data elements can be submitted to DHCS.
- Although there were fewer than 100 LTC records in Care1st's data and in DHCS's data, all of the records were missing values for the *Secondary Diagnosis Code* data element. Care1st should collect and submit values for the *Secondary Diagnosis Code* to DHCS, when available.

## Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

### *Quality*

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[17]

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

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

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

HSAG reviewed Care1st's 2013 quality improvement program description and 2013 work plan. The documents include descriptions of quality improvement efforts that support the delivery of quality care to the MCP's Medi-Cal members.

During the February 2013 MR/PIU monitoring review visit, MR/PIU found that Care1st was only providing SPD Sensitivity Training to 20 percent of the MCP's provider network, which fell very short of the 100 percent requirement. Neglecting to provide this training could impact the quality of care delivered to the MCP's Medi-Cal SPD population. Additionally, MR/PIU noted a finding in the area of Program Integrity, which could impact the quality of care delivered to members.

The following quality measures had rates with statistically significant improvement from 2012 to 2013:

- *Immunizations for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*

The following quality measures had rates that significantly declined from 2012 to 2013 and the rates were below the MPLs in 2013.

- *Cervical Cancer Screening*
- *Use of Imaging Studies for Low Back Pain*
- *Annual Monitoring for Patients on Persistent Medications—ACE*

Of particular note is the rate for the *Use of Imaging Studies for Low Back Pain* measure, which was above the HPL in 2012 but fell below the MPL in 2013.

In addition to the quality measures above with rates that fell below the MPLs in 2013, the following quality measures had rates below the MPLs:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care and the SPD rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure was significantly better than the non-SPD rate. The SPD rate for the *All-Cause Readmissions* measure, which is in the quality domain of care, was worse than the non-SPD rate,

showing that more of the MCP's members in the SPD population (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than members in the non-SPD population.

All CAHPS measures fall into the quality domain of care. Most of the measures for both the child and adult populations had a *Poor* rating. One measure, the child *Rating of Specialists Seen Most Often,* had an *Excellent* rating.

Both of Care1st's QIPs fall into the quality domain of care. Only the *Comprehensive Diabetic Care* QIP progressed to the Implementation and Outcomes stages. While this QIP saw improvement in four of its five study indicators at Remeasurement 1, none of the improvement was statistically significant over baseline.

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

## Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HSAG reviewed Care1st's 2013 work plan, which includes goals and activities to support members' access to needed services.

During the February 2013 MR/PIU monitoring review visit, MR/PIU did not identify any findings that would impact members' access to care.

Six measures falling into the access domain of care had rates below the MPLs. These measures were:

- All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

The rates for three of the *Children and Adolescents' Access to Primary Care Practitioners* measures (*12–21 Months*, *25 Months–6 Years*, and *12–19 Years*) had statistically significant improvement from 2012 to 2013 and the rate for the *Cervical Cancer Screening* measure declined significantly from 2012 to 2013.

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

- *All-Cause Readmissions*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*

The *Getting Needed Care* CAHPS measure falls into the access domain of care. Care1st received a *Poor* rating on this measure for both the adult and child populations.

Both of Care1st's QIPs fall into the access domain of care. As indicated above, although the MCP saw some improvement on four of the five indicators for the *Comprehensive Diabetic Care* QIP, none of the improvement was statistically significant over the baseline.

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

## Timeliness

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

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

During the February 2013 MR/PIU monitoring review visit, MR/PIU identified one finding in the area of Member Grievances, which could impact the timeliness of care delivered to members.

The rate for the *Immunizations for Adolescents—Combination 1*, which is a timeliness measure, had statistically significant improvement from 2012 to 2013.

The *Prenatal and Postpartum Care—Postpartum Care* measure also falls into the timeliness domain of care. This measure's rate declined significantly from 2012 to 2013.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. This measure received a *Poor* rating for both the adult and child populations.

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

## Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-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 the following to the MCP:

- Ensure that all findings from the February 2012 MR/PIU review are fully addressed. Specifically:
  - Revise the MCP's grievance and appeals policies and procedures to include the requirement that the time frame to resolve an appeal may be extended up to 14 calendar days if the MCP shows there is a need for additional information and how the delay is in the member's interest. Additionally, ensure that the policies and procedures are implemented.
  - Ensure that Care1st's entire provider network receives the required SPD sensitivity trainings, per MMCD All Plan Letter 11-010.
  - Include information about Care1st's Fraud and Abuse Program in the Member Services Guide.
- Since Care1st had nine measures with rates below the MPLs and five measures with rates that declined significantly from 2012 to 2013, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.
- Assess the factors leading to the SPD rate for the *All-Cause Readmissions* measure being significantly higher than non-SPD rate and the SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners (25 Months –6 Years)* measure being significantly lower than the non-SPD rate to ensure the MCP is meeting the needs of the SPD population.

- For the MCP's QIPs:
  - Refer to the QIP Completion Instructions prior to submitting QIPs to ensure completeness of data and avoid having to resubmit QIPs to achieve a *Met* validation status.
  - For the *Comprehensive Diabetic Care* QIP, build on the successes that led to an improvement in rates for study indicators 1, 3, 4, and 5.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly* priority areas.
- Review the *2012–13 MCP-Specific Encounter Data Validation Study Report* and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

## Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

## Performance Measure Rates

*(Refer to Table 3.2)*

### Quality Domain

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

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

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

### Access and Timeliness Domains

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

## CAHPS Survey Measures

*(Refer to Tables 5.3 through 5.4)*

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

### Quality Domain

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

### *Access Domain*

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

### *Timeliness Domain*

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

## Quality Improvement Projects (QIPs)

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

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

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

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

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

## Calculating Final Quality, Access, and Timeliness Scores

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

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

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

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 and Medi-Cal Managed Care Division reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures, CAHPS measures, and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the encounter data validation (EDV) study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

# *Appendix B.* MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

*for* **Care1st Partner Plan**

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with Care1st's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

**Table B.1—Care1st's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report**

| 2011–12 External Quality Review Recommendation | Care1st's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation |
|---|---|
| **Ensure all medical performance review recommendations are fully addressed. Specifically:** | |
| 1. Implement a mechanism to complete investigations involving quality of care issues within reasonable time frames. | Care1st has implemented a new software program that automated many aspects about the quality review process. Investigations are done electronically and the medical director can review nurse abstracts through the system. We have changed our policies to set deadlines for each step of the process. |
| 2. Establish a mechanism to ensure that the written record for each grievance is maintained and available as needed. | The software program includes all specific issues about the grievance; any hard-copy written record is scanned into the system so that the entire case is in electronic format. |
| 3. Establish a mechanism to monitor continuity and coordination of care for patients with mental health parity conditions such as pervasive developmental disorders. | Care1st has a Case Management Software Program to monitor the continuity and coordination of care for patients with complex conditions, including but not limited to mental health conditions such as pervasive developmental disorders. The program allows the care management team to generate activity reports, member list, create and update care plans, reminders for follow-ups, notes, and document care coordination activities. |
| **Additional Recommendations:** | |
| 1. 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. | Care1st San Diego Health Educator visited provider offices to explain to the staff how to refer to community services. Additionally, the Health Educator distributed a San Diego Community Resource Directory to all offices. This directory outlines the community resources available in the various San Diego areas. |

| 2011–12 External Quality Review Recommendation | Care1st's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation |
|---|---|
| 2. Continue to monitor laboratory encounter data to track monthly volumes and ensure encounter data completeness. | Care1st has a lab repository where we obtain direct lab data feeds from contracted vendors through CALINX format. Monthly volumes are tracked and we also have a consultant who works to obtain additional data when an error is identified. The QI Department monitors members monthly who were due for specific labs and works to assure they obtain the testing if they have been identified as not having it during the measurement time frame. |
| 3. 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 as well as interventions the plan will implement to improve performance. | Care1st has worked with AWARE and has been collaborating to send out provider tool kits concerning antibiotic treatment. When the tool kits were sent we reinforced this with our quality outreach efforts. The most recent rate is now above the Minimum Performance Level ($25^{th}$ percentile), which is trending in the right direction. |
| 4. 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. | Care1st has identified a shortage of DtAP in the first measurement year, which caused a decline in the Combo 3 rates. This has been corrected and should not have an effect on new rates. New Combo 3 rates in 2012 involve a significantly different population than the previous year. We went from very little SPD population to greater than 35 percent in 2012. We have re-vamped our process to include proactive reminder calls to members due for specific immunizations. We are obtaining information from the immunization registry several times a year instead of at the end of the year so we can act upon gaps sooner. |
| 5. 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. | Care1st has addressed all deficiencies identified in the QIP Validation Tool and these recommendations will be incorporated before any new submissions. |
| 6. 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. | Care1st performs a significant barrier analysis that makes attempts to capture all possible barriers. We have changed based on HSAG recommendations to complete the barrier analysis to identify possible barriers, but do an additional analysis of the possible barrier to establish if there is documentation the potential barrier is an actual barrier. The actual barriers are used in the analysis and rationale is provided. |
| 7. 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. | Care1st had attended the HSAG QIP training and has implemented the new tool for all our QIPs. We will prioritize the barriers identified. |

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| 8. 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. | Care1st has implemented a very proactive process for identification monthly of all diabetic members with a gap for HgbA1c, LDL, eye exam, or nephropathy monitoring. We contact every member identified and make attempts to schedule them to complete the services. We offer the member the opportunity for a home visit to have their labs done. We started this late 2012 because of the high SPD membership we currently have. |
| 9. 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. | Interventions included provider education efforts and these efforts are used for all other measures and QIPs. We have a significant Quality Outreach Program where we schedule annual on-site meetings with the provider to go over all these measures, how to access our web portal that tracks all gap services. |