Performance Evaluation Report

Central California Alliance for Health

July 1, 2008–June 30, 2009

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

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1. Executive Summary

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.4 million beneficiaries in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Plan-specific reports are issued in tandem with the technical report. This report is unique to the MCMC Program's contracted plan, Central California Alliance for Health ("CCAH" or "the plan") for the review period of July 1, 2008, to June 30, 2009. Plan-specific reports include findings for each plan regarding its organizational assessment and structure, performance measures, and QIPs as they relate to the quality, access, and timeliness domains of care. Actions taken by the plan subsequent to June 30, 2009, regarding findings identified within this report will be included in the next annual plan-specific evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

Based on the plan's 2009 performance measure rates (which reflect 2008 data), QIP outcomes, and compliance review standards related to measurement and improvement, HSAG found that CCAH demonstrated average to above-average performance for the quality domain of care.

To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPLs indicate low performance, rates at or above the HPLs indicate high performance, and rates at the MPLs or between the MPLs and HPLs demonstrate average performance.

All of CCAH's 2009 performance measures rates were above the MPLs. This is consistent with its 2008 performance. The plan performed above the HPLs for *Breast Cancer Screening (BCS)*, *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)*, and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*. The breast cancer screening rate had a statistically significant improvement between 2008 and 2009 rates and is a strong area of performance for the plan.

CCAH's quality improvement evaluation and work plan from 2008 showed ongoing monitoring of plan performance measure rates, a complex case management program, and quality improvement projects, all of which demonstrated a structure that supports quality care.

CCAH's case management QIP has the potential to decrease hospital admissions for patients with diabetes and congestive heart failure. These interventions have the potential to improve care coordination between the case management, disease management, and utilization management areas. During the review period, both of CCAH's QIPs were in the baseline phase; therefore, HSAG could not assess for improvement of those health outcomes.

The plan can improve quality of care for its Medi-Cal managed care members by addressing the statistically significant decline for 7 out of 17 of its comparable 2009 performance measures, all of which were hybrid measures. Of these, the rates for *Adolescent Well-Care Visits (AWC)* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* are now only slightly above the MPLs. The plan noted that during the time covered by this review it had resource challenges related to medical record review that affected its ability to achieve scores above the MPLs for these hybrid measures. Results presented in the next annual plan-specific evaluation report will indicate whether the plan overcame these challenges in the next reporting period.

HSAG noted that CCAH has an opportunity to improve its documentation of both QIPs to comply with federal requirements for conducting a QIP. Following the Centers for Medicare & Medicaid Services (CMS) protocol for conducting a QIP increases the likelihood that the plan can achieve real and sustained improvement of health outcomes.

CCAH has an opportunity to ensure that quality of care issues are reviewed by the medical director and appropriately investigated and documented. Additionally, CCAH should ensure that quality improvement activities such as delegated entity oversight and monitoring are reported through its committee structure and documented in the meeting minutes. Results from a non-joint, routine medical survey by the Department of Managed Health Care (DMHC) found that CCAH was not sending notice of action modification letters to members as a result of staffing issues. The plan has an opportunity to address lack of plan resources or provide additional staff training to increase compliance with State and federal standards.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members.

The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess plans' compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Many performance measures fall under more than one domain. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines. Based on its 2009 performance measure rates that relate to access, QIP outcomes that address access, and compliance review standards that relate to the availability of and access to care, CCAH demonstrated average performance for the access domain of care.

Performance measure results for 2009 related to access fell primarily between the MPLs and HPLs. CCAH was above the HPLs for breast cancer screening and timeliness of postpartum care.

All seven of CCAH's statistically significant declines in performance fall under the access domain of care, as well as the quality domain of care. These performance decreases are in the areas of adolescent and well-child visits and immunizations, cervical cancer screening, diabetic eye exams, diabetic hemoglobin A1c testing, and timeliness of prenatal care. These declines may indicate an access to care issue. While the plan demonstrated that it monitors many aspects of care within its evaluation and work plan, CCAH did not include measures and monitoring access and availability of services as part of this evaluation.

For the statewide collaborative ER QIP, a member health education campaign, implemented statewide, attempts to educate members on contacting their providers before going to the emergency room (ER) for many common, nonurgent conditions. CCAH will need to gain provider support and participation to meet the collaborative campaign goal of treating patients and ensuring access to care in an outpatient setting rather than referring them to the ER for the intervention to be effective.

CCAH had standards in place and monitoring for availability and accessibility of services. The plan has an opportunity to increase access to care by improving care coordination for members eligible for CCS and early start and developmental disabilities services.

Timeliness

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

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Based on 2009 performance measure rates for providing timely care and compliance review standards related to timeliness, CCAH demonstrated average performance in the timeliness domain of care—performing within the MCMC-established thresholds for all performance measures under this domain.

Review findings revealed several deficiencies pertaining to CCAH's member grievance system and prior authorization notifications. Not all files reviewed contained the required member rights information. The plan did not meet the required time frame for sending a prior authorization notice of action (NOA) to members and did not use the approved NOA letter for all files reviewed. DHCS requires that plans notify members, via an NOA, for a denial, termination, or

modification in benefits. The DHCS's review team found that CCAH was not sending modification letters to members for denials, terminations, or modifications.

Conclusions and Recommendations

Overall, CCAH demonstrated average to above-average performance in providing quality care to its MCMC members and average performance for accessible and timely health care services.

Although CCAH's performance measure rates were primarily between the established MPLs and HPLs, the plan exceeded the HPLs for its *Breast Cancer Screening (BCS)*, *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)*, and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*. The plan demonstrated statistically significant improvement for its *Breast Cancer Screening (BCS)* rate, which HSAG identified as an area for improvement for the MCMC Program as a whole.[1] Opportunities exist to address areas that showed a performance decline.

CCAH was fully compliant with audit compliance standards for marketing and enrollment programs and program integrity. Opportunities for improvement exist across areas for member rights and grievances, availability and accessibility of services, utilization management, quality management, and administrative and organizational capacity.

Based on the overall assessment of CCAH in the areas related to quality and timeliness of and access to care, HSAG recommends the following:

- Explore factors that led to a statistically significant decline for seven of its 2009 performance measures. The plan should evaluate potential issues with its hybrid data collection process, since all impacted measures were hybrid.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance toward increasing compliance with the CMS protocol for conducting QIPs.
- Address staffing issues to ensure that notice of action letters are sent to members for denials, terminations, or modifications to increase compliance with State and federal standards.
- Implement a process to monitor for timeliness of prior authorization decisions and notifications to members.
- Streamline quality improvement activity reporting by ensuring reporting and documentation within the committee structure.
- Implement a process to investigate and review all quality of care concerns.
- Implement procedures to ensure care coordination for members eligible for CCS and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

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

[1] California Department of Health Care Services. *2009 HEDIS Aggregate Report. July 2010.*

Plan Overview

Central California Alliance for Health was previously known as Central Coast Alliance for Health. It is a full-scope Medi-Cal managed care plan operating in Monterey and Santa Cruz counties and delivers care to members in both counties as a County Organized Health System (COHS). CCAH became operational with the MCMC Program in Santa Cruz County in January 1996 and Monterey County in October 1999. The plan expanded into Merced County in October 2009; however, information for Merced County is not included in this report since the review period ended June 30, 2009. CCAH had 99,291 MCMC members in the Monterey and Santa Cruz counties as of June 30, 2009. [2]

In a COHS model, the DHCS contracts with a county-organized and county-operated plan to provide managed care services to all Medi-Cal beneficiaries in the county, except for individuals in a few select aid codes. These Medi-Cal beneficiaries with mandatory aid codes do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the DHCS. Beneficiaries enrolled in the COHS plan can choose from a wide range of managed care providers in the plan's network.

[2] *Medi-Cal Managed Care Enrollment Report, June 2009*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about CCAH's performance in providing quality, accessible, and timely health care services to its MCMC members. Compliance monitoring standards primarily fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Joint Audit Review

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. In most instances, the DHCS's Audits and Investigations Division (A&I) works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. These medical audits assess plans' compliance with contract requirements and State and federal regulations. The most recent audit for CCAH was conducted by A&I in June 2009 as a non-joint medical performance audit for the period of April 1, 2008, through March 31, 2009.

The A&I audit evaluated six categories of performance: Utilization Management, Continuity of Care, Availability and Accessibility, Members' Rights, Quality Management, and Administrative and Organizational Capacity. Results from this audit identified strengths as well as opportunities for improvement.

Under the utilization management (UM) category of review, CCAH had a UM program in place that used written criteria to determine medical necessity. The UM program measured for under- and over-utilization of services and included a referral tracking system. Review of a sample of treatment authorization requests revealed that the plan did not send members a deferral letter when it could not process denied authorizations timely. Additionally, the decision letter for the treatment authorization request, which notifies the member of the authorization decision, did not contain clear and concise reasons for denying or modifying the request. The audit also showed that the plan's quality improvement committee minutes did not reflect discussion of UM problems related to delegated entities.

For continuity of care, the plan had policies and procedures in place for member care coordination provided both in- and out-of-network. Findings under this category included lack of care coordination for members eligible for CCS to ensure that members received medically necessary covered services. In addition, the plan did not maintain coordination between the plan, regional centers, and primary care physicians for members receiving EPSDT Program services. During the period covered by this report, the plan noted it was actively negotiating a Memorandum of Understanding (MOU) with a regional center related to care coordination. The next annual performance evaluation report will reflect whether this MOU and other related activities improved plan performance in this area.

Under the availability and accessibility of services category, CCAH had policies and procedures for access and availability of routine care, urgent care, emergency care, and routine specialty care. The plan maintained procedures for triaging member calls and providing access to care after hours. Findings under this category included the plan's lack of monitoring access to prenatal care, lack of formal committee review of the plan's accessibility report, and lack of monitoring access to ensure members receive an adequate supply of medically necessary medication in an emergency situation.

In the member rights category, the audit found that the plan had a grievance system in place. Findings under this area were the lack of documentation by a medical director or associate medical director for quality of care issues and that the plan did not obtain medical records to properly assess clinical issues for all reviewed grievances.

Under the quality management review area, the plan demonstrated implementation of a quality management program that monitors, evaluates, and takes action to address needed improvements. CCAH had policies and procedures in place for credentialing and recredentialing of providers. The plan had one finding related to the lack of monitoring of delegated entities through the plan's committee structure.

In the administrative and organizational capacity area, the plan had appropriate staffing and structure to support the quality program. The plan was compliant with fraud, waste, and abuse requirements. The plan had one deficiency for not conducting new provider training within the required 10 days of the provider's active status date.

The plan's corrective action plan (issued in November 2009) and the DHCS's close-out letter results (issued April 2010) will be included in the next annual report.

Member Rights and Program Integrity Monitoring Review

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

As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2009.

MRPIU conducted a routine monitoring review of CCAH in February 2009, covering the review period of January 1, 2008, through December 31, 2008. The MRPIU noted eight review findings under member grievances and prior authorization notifications.

Under member grievances, not all of the 34 files reviewed contained the brochure that informs members how to file a State fair hearing request. Additionally, none of the files included the member's right to represent himself or herself or to be represented by legal counsel, a friend, or other spokesperson at the fair hearing.

Under prior authorization notifications, one file reviewed lacked a specific citation supporting the plan's decision within the Notice of Action (NOA) letter. CCAH did not meet the required time frame for sending a prior authorization NOA to members for 18 of the 34 prior authorization notification denial letters reviewed. The review also showed that the plan did not use the approved NOA letter for five files reviewed, all of which related to prior authorization for wheelchairs. DHCS requires that plans notify members, via an NOA, for a denial, termination, or modification in benefits. The MRPIU found that, as a result of staffing issues, CCAH was not sending modification letters to members.

One provider's office reviewed did not discourage the use of family, friends, or minors as interpreters, which can compromise the reliability of medical information.

Strengths

CCAH's quality improvement evaluation and work plan from 2008 showed ongoing monitoring of its performance measure rates, a complex case management program, and quality improvement projects, all of which demonstrated a structure that supports quality care.[3]

Additionally, the plan was in compliance with all standards reviewed for marketing and enrollment programs and for program integrity.

Opportunities for Improvement

CCAH has an opportunity to implement a mechanism to better monitor its compliance with prior authorization notifications, including notice of action letter requirements, information related to member rights, as well as timeliness of decisions and notifications to members.

While the plan has an adequate quality improvement committee structure in place, CCAH needs to improve reporting of quality improvement activities—such as its availability analysis and delegated entity oversight actions—to the committee and document the discussion. Additionally, the plan must ensure that quality of care issues are reviewed and appropriately documented.

The plan should implement procedures to ensure care coordination for members eligible for CCS and the EPSDT Program.

[3] Central California Alliance for Health. 2008 Quality Improvement Work Plan and Evaluation.

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about CCAH's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Performance Measure Validation

HSAG performed a HEDIS® Compliance Audit™[4] of CCAH in 2009. HSAG found all measures to be reportable and that CCAH's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

Recommendations from the audit involved pursuing methods to gather data for outside services provided to members. The plan should also consider additional steps to capture more complete encounter data. CCAH could improve encounter timeliness by examining the plan's existing approach and making appropriate changes.

[4] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS Compliance Audit™ is a trademark of the NCQA.

Performance Measure Results

Table 4.1 presents a summary of CCAH's HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measures results (based on calendar year 2007 data). In addition, the table shows the plan's HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs.

The MCMC Program requires contracted health plans to calculate and report HEDIS rates at the county level unless otherwise approved by the DHCS; however, exceptions to this requirement were approved several years ago for COHS health plans operating in certain counties. CCAH was one of the COHS health plans approved for combined county reporting for Monterey and Santa Cruz counties; therefore, Table 4.1 reflects combined reporting for those two counties. The MCMC Program is requiring that all existing health plans expanding into new counties report separate HEDIS rates for each county once membership exceeds 1,000. CCAH will be required to do county-level reporting for Merced County, which it expanded into as of October 2009.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the NCQA's national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—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 Medicaid 10th percentile.

Due to significant methodology changes for the *Comprehensive Diabetes Care—HbA1c Control (< 7.0 Percent)* measure for 2009, the MCMC Program was unable to compare 2008 and 2009 performance results for this measure.

Appendix A includes a performance measure name key with abbreviations contained in the following table.

Table 4.1—2008–2009 Performance Measure Results for Central California Alliance for Health—Monterey and Santa Cruz Counties

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	34.1%	30.3%	★★	↔	20.6%	35.4%
ASM	Q	88.7%	90.8%	★★	↔	86.1%	91.9%
AWC	Q,A,T	47.2%	39.9%	★★	↓	35.9%	56.7%
BCS	Q,A	59.1%	62.0%	★★★	↑	44.4%	61.2%
CCS	Q,A	80.5%	68.8%	★★	↓	56.5%	77.5%
CDC–E	Q,A	71.3%	51.8%	★★	↓	39.7%	67.6%
CDC–H7 (<7.0%)	Q	46.2%	39.9%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	31.6%	36.3%	★★	↔	52.5%	32.4%
CDC–HT	Q,A	85.6%	80.3%	★★	↓	74.2%	88.8%
CDC–LC (<100)	Q	38.2%	36.1%	★★	↔	25.1%	42.6%
CDC–LS	Q,A	80.3%	77.2%	★★	↔	66.7%	81.8%
CDC–N	Q,A	81.0%	76.6%	★★	↔	67.9%	85.4%
CIS–3	Q,A,T	75.7%	67.9%	★★	↓	59.9%	78.2%
PPC–Pre	Q,A,T	84.2%	77.9%	★★	↓	76.6%	91.4%
PPC–Pst	Q,A,T	71.3%	71.8%	★★★	↔	54.0%	70.6%
URI	Q	94.5%	94.5%	★★★	↔	79.6%	94.1%
W15	Q,A,T	77.9%	49.9%	★★	↓	44.5%	73.7%
W34	Q,A,T	78.1%	77.3%	★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the full name of each HEDIS measure.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.
[4] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[5] Performance comparisons are based on the *z* test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
† The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.
Not Comparable = Performance could not be compared due either to significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, CCAH demonstrated average to above-average performance, falling between the MPLs and HPLs for most of its reported performance measures in 2009. The plan exceeded MCMC goals (HPLs) for *Breast Cancer Screening (BCS)*, *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)*, and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*. The plan did not have below-average performance in any area. CCAH had statistically significant decreases in performance between 2008 and 2009 for 7 of the 17 comparable measures and a statistically significant increase for breast cancer screening.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. Plans that have rates below these minimum levels must submit an improvement plan to the DHCS for each area of deficiency, outlining the steps they will take to improve care.

In 2008, the DHCS did not require CCAH to submit any improvement plans. Based on its 2009 performance, the DHCS again did not require CCAH to submit any improvement plans, since none of its measures fell below the MPLs.

Strengths

CCAH performed above the HPLs on the *Breast Cancer Screening (BCS)*, *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)*, and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* measures, and it showed a statistically significant increase over the prior year for breast cancer screening. These measures span the domains of quality, access, and timeliness. The plan continued to perform above the MPLs for all measures reported in 2008 and 2009.

Opportunities for Improvement

Seven out of 17 of CCAH's comparable measures had statistically significant declines in performance. Of these, the rates for *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* are now only slightly above the MPL (4.0 and 1.3 percentage points, respectively). These areas present an opportunity for improvement.

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about CCAH's performance in providing quality, accessible, and timely care and services to its MCMC members. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Quality Improvement Projects Conducted

CCAH had two clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. CCAH's second project, an internal QIP, sought to increase effective case management of members by reducing hospital admissions for uncontrolled diabetes and reducing discharges for congestive heart failure (CHF). Both QIPs fell under the quality and access domains of care.

The plan's ER and CHF QIPs covered in this report included members from Santa Cruz and Monterey counties but did not include members from Merced County. The DHCS requires that plans initiate QIP projects for counties after the plan has been operational for one year; therefore, CCAH will be required to initiate QIP projects for Merced County beginning in October 2010. The statewide collaborative QIP sought to reduce ER visits that could have been managed more appropriately by and/or referred to a primary care provider (PCP) in an office or clinic setting.

Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

Hospital admissions for uncontrolled diabetes and discharges for CHF are indicators of suboptimal care. These admissions and discharges may also indicate ineffective case management of chronic diseases. CCAH's project attempted to improve the quality of care delivered to members with diabetes and CHF.

Quality Improvement Project Validation Findings

The DHCS contracted with HSAG as its new EQRO in the second half of 2008. HSAG began validation for QIPs submitted by the plans after July 1, 2008.

Table 5.1 summarizes the validation results for both of CCAH's QIPs across CMS protocol activities during the review period.

Table 5.1—Quality Improvement Project Validation Results for Central California Alliance for Health—Monterey and Santa Cruz Counties (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	83%┼	8%┼	8%┼
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	46%┼	38%┼	15%┼
IV.	Correctly Identified Study Population	0%	33%	67%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	33%	17%	50%
VII.	Appropriate Improvement Strategies	100%	0%	0%
VIII.	Sufficient Data Analysis and Interpretation	25%	25%	50%
IX.	Real Improvement Achieved	25%	0%	75%
X.	Sustained Improvement Achieved	‡		
Percentage Score of Applicable Evaluation Elements *Met*		**43%**		
Validation Status		***Not Applicable****		

‡ The QIP did not progress to this activity during the review period and could not be assessed.
* QIPs were not given an overall validation status during the review period.
┼ The sum may not equal 100 percent due to rounding.

CCAH submitted baseline data for one project and remeasurement data for the other. Therefore, the QIPs have not progressed to the point of a second remeasurement period, and HSAG could not assess for sustained improvement.

During the period covered by this report, HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the MCMC plans. As a result, many plans had difficulty complying fully with these requirements during the first cycle of QIP validations by

HSAG. This was the case with the plan's QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided CCAH, as well as other plans, with an overall validation status of "Not Applicable" for both QIPs. This allowed time for plans to receive technical assistance and training with HSAG's validation requirements without holding up the ongoing progress of QIPs that were already underway.

Quality Improvement Project Outcomes

Table 5.2 shows CCAH's data for its QIPs. For the ER collaborative QIP, CCAH's goal was to reduce the overall rate of members who use the emergency room, with a five percent reduction in its avoidable ER visit rate. The plan submitted data through Remeasurement 1 and HSAG validated the data; however, to maintain consistency in reporting collaborative data the results are not presented in Table 5.2. HSAG will present Remeasurement 1 results in the next plan-specific evaluation report, at which time HSAG will assess for real improvement.

For its *Improving Effective Case Management* QIP, CCAH set a Remeasurement 1 goal to decrease by five percent the baseline rate of hospital admissions for uncontrolled diabetes per 100,000 members and the rate of discharges for CHF per thousand members.

Table 5.2—Quality Improvement Project Outcomes for Central California Alliance for Health—Monterey and Santa Cruz Counties

QIP #1—Reducing Avoidable Emergency Room Visits				
		Remeasurement Period		
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	1* 1/1/08–12/31/08	2 1/1/09–12/31/09	Sustained Improvement
Percentage of ER visits that were avoidable	23.2%	‡	‡	‡
*Data reported for Remeasurement 1 will not be presented until next year, maintaining the collaborative timeline. ‡The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Improving Effective Case Management			
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Sustained Improvement
Hospital admissions for uncontrolled diabetes per 100,000 member months	13.01	‡	‡
Discharges for CHF per thousand member months	0.47	‡	‡
‡ The QIP did not progress to this phase during the review period or did not meet the criteria for assessment and therefore could not be assessed.			

Strengths

CCAH demonstrated a good understanding of documenting support for its QIP topic selections by providing plan-specific data. In addition, CCAH's interventions to address identified causes/barriers and system interventions are likely to induce permanent change.

CCAH implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits. CCAH identified early in 2008 that its data systems provided limited access to useful data. The plan focused on providing a Web-based reporting system to help identify utilization patterns and characteristics of its MCMC members who use the ER. In addition, the plan has provided reports of member ER utilization to PCPs and has tied the results to financial incentives.

CCAH's case management QIP has the potential to impact the plan's chronic disease management. System interventions selected by CCAH to decrease diabetes admissions and CHF discharges included software tools to provide timely access to claims and hospital data. These interventions have the potential to coordinate care between case management, disease management, and utilization management. Additionally, PCPs will be educated on the availability of these tools.

Opportunities for Improvement

CCAH can improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with the DHCS requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the activities included in the CMS protocol.

CCAH should evaluate the effectiveness of its interventions annually to ensure that the targeted interventions impact the identified barriers. Additionally, for the case management QIP, only 11 members were admitted with uncontrolled diabetes and only 40 members were identified as CHF discharges; therefore, the results will be more variable and impact a very small proportion of the plan's overall Medi-Cal managed care population.

The statewide collaborative member health education campaign attempts to educate members on contacting their providers before going to the ER for many common, non-urgent conditions. CCAH will need to gain provider support and participation to meet the collaborative campaign goal of treating patients in an outpatient setting rather than referring them to the ER.

The table below provides abbreviations of HEDIS performance measures used throughout this report.

Table A.1—HEDIS® Performance Measures Name Key

Abbreviation	Full Name of HEDIS® Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ASM	*Use of Appropriate Medications for People With Asthma*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–E	*Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed*
CDC–H7	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)*
CDC–H9	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC	*Comprehensive Diabetes Care—LDL-C Control*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W15	*Well-Child Visits in the First 15 Months of Life (Six or More Visits)*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*