Performance Evaluation Report

CenCal Health
(Santa Barbara San Luis Obispo Health Authority)

July 1, 2008–June 30, 2009

Medi-Cal Managed Care Division
California Department of
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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.6 million beneficiaries (as of June 2009) 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.

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. This report is unique to the Medi-Cal managed care program's plan, CenCal Health, contracting as the Santa Barbara San Luis Obispo Health Authority ("CenCal" or "the plan"), which delivers care in San Luis Obispo and Santa Barbara counties. This report covers the review period July 1, 2008 to June 30, 2009. Actions taken by the plan subsequent to June 30, 2009, regarding findings identified in 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.

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 MPL 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.

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

CenCal achieved rates above the MPLs for all of its performance measures in Santa Barbara County. CenCal exceeded the HPLs for six measures impacting childhood immunizations, appropriate treatment for acute bronchitis, and postpartum care, and for three measures related to diabetes care. The plan began services in San Luis Obispo County in March 2008; therefore, it was only able to report rates for six of the 18 DHCS-required indicators during the review period based on the continuous enrollment requirements for most measures. Of the six reported rates, San Luis Obispo achieved four rates above the MPLs and exceeded the HPLs for the two prenatal and postpartum care measures.

Performance measure results in both counties demonstrated an effort to provide quality care, which was a strength of the plan. Results suggested that the plan and the plan's provider network provided care consistent with recommended practice guidelines. Additionally, the plan has demonstrated its ability to improve in targeted areas of low performance. In Santa Barbara County, CenCal exceeded the MPL in 2009 for *Appropriate Treatment for Children With Upper*

Respiratory Infection (URI) after submitting the DHCS-required HEDIS®[1] improvement plan for performance below the MPL in 2008. The plan achieved statistically significant improvement between 2008 and 2009.

While none of the plan's 2009 performance measure rates were below the MPL, CenCal's performance for *Adolescent Well-Care Visits* (*AWC*) in San Luis Obispo County was only 4.1 percentage points above the MPL. Similarly, in 2009, CenCal demonstrated statistically significant decreases in Santa Barbara County for two *Comprehensive Diabetes Care* indicators, which suggests an opportunity for improvement for the plan.

The plan demonstrated real improvement for two of its three study indicators for its *Proper Antibiotic Use* QIP. The plan had statistically significant and sustained improvement in appropriate treatment to adults with acute bronchitis. The plan also improved appropriate treatment for children with pharyngitis. Despite the success of its QIPs, HSAG noted that the plan had an opportunity to improve its documentation of both QIPs to be in compliance 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 will achieve real and sustained improvement of health outcomes.

Joint audit findings showed that CenCal was fully compliant in the area of quality management. The plan had an adequate structure and enough resources to support its quality improvement program. Findings showed improvement by the plan to better address areas of deficiency noted from the last review period and minimized repeat areas of concern. Oversight and involvement of the medical director related to clinical issues and quality improvement was improved.

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

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

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

For the access domain of care, CenCal demonstrated average performance based on its 2009 performance measure rates that related to access, QIP outcomes that addressed access, and compliance review standards related to the availability of and access to care.

The plan's 2009 performance measure rates related to access fell primarily between the MPLs and HPLs. CenCal performed best on the *Prenatal and Postpartum Care: Postpartum Care (PPC–Pst)* measure. The plan exceeded the HPL for this measure in both San Luis Obispo and Santa Barbara counties.

Audit results showed that CenCal demonstrated strength in the area of continuity of care. The plan had good processes in place to ensure that members had coordinated care across settings, which supported access to medically necessary care. The plan had standards for access to care for routine, after-hours, and emergent care, and it monitored these standards through complaints and grievances, member satisfaction, and facility site reviews. The plan was compliant with referral tracking and follow-up care for members. The joint audit found CenCal to be compliant with all standards reviewed related to cultural and linguistic services; however, the more recent review conducted by the Member Rights/Program Integrity Unit (MRPIU) found that provider offices did not discourage the use of family or friends as language interpreters, which can compromise the accurate communication of medical information.

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, CenCal demonstrated average performance in the timeliness domain of care. CenCal performed within the MCMC-established thresholds for well-child visits, above the HPL for postpartum care in both San Luis Obispo and Santa Barbara counties, and above the HPL for childhood immunizations in Santa Barbara County.

Audit findings from the joint audit review and MRPIU showed deficiencies in performance on some timeliness standards. The joint audit noted deficiencies related to prior-authorization decisions and member notification. MRPIU noted that member notification of prior-authorization decisions exceeded timelines. The plan did not meet required time frames for payment of clean claims. These delays, which can disrupt care for members, present an opportunity for improvement for the plan.

Conclusions and Recommendations

Overall, CenCal demonstrated above-average performance in providing quality care to members. The above average performance is evidenced by CenCal's high-performance measure rates and QIP outcomes. CenCal is one of four plans that HSAG designated as a high-performer in the *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program* based on the plan achieving six or more performance measures above the HPLs.[2] The plan was fully compliant with quality management standards and demonstrated improvement in the delivery of the quality management program compared with the previous joint audit report.

CenCal demonstrated average performance for providing access to care and timely health care services to its MCMC members. The plan had strong performance in coordinating care for members. The plan had opportunities to improve compliance by provider offices with language translation requirements and the timeliness of prior-authorization and claims payment.

Based on the overall assessment of CenCal in the areas of quality and timeliness of and access to care, HSAG recommends that the plan:

- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance that will increase compliance with the CMS protocol for conducting QIPs.
- Explore factors that contributed to statistically significant declines in 2009 in Santa Barbara County for two diabetes care indicators.
- Terminate the *Proper Antibiotic Use* QIP with the next remeasurement period and select a new area of focus for the next QIP.
- Reeducate provider offices on language translation requirements.
- Implement a process to monitor prior-authorization notification timeliness.
- Monitor timeliness of payment of clean claims, identify barriers to improvement in this area, and implement appropriate interventions.

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

[2] California Department of Health Services. *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program*. July 2010.

Plan Overview

CenCal contracted with the DHCS as the Santa Barbara Health Authority in 1983 to serve the Medi-Cal managed care population in Santa Barbara County. In March 2008, the plan, contracting as the Santa Barbara San Luis Obispo Health Authority, expanded its service area to include San Luis Obispo County. CenCal serves members as a full-scope Medi-Cal managed care plan in those two central California counties. As of June 30, 2009, CenCal had 80,888 MCMC members in both of the contracted counties combined.[3]

CenCal serves members in both counties as a County Organized Health System (COHS). In a COHS model, the DHCS contracts with one county organized and operated plan in a county to provide managed care services to all Medi-Cal beneficiaries in that county, with very few exceptions. Members can choose from a wide network of managed care providers. Beneficiaries in COHS plan counties do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the DHCS.

[3] *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 a plan's 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 CenCal'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

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. A joint audit is conducted for each MCMC plan approximately once every three years. In addition, A&I periodically conducts non-joint medical audits of five MCMC plans; however, CenCal was not among those plans designated for a non-joint medical audit.

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. The most recent joint audit for CenCal was conducted in November 2008, covering the review period of November 1, 2007, through October 31, 2008. The audit reviewed both Santa Barbara and San Luis Obispo counties. The scope of the audit covered utilization management (UM), continuity of care, availability and accessibility, member

rights, quality management, and administrative and organizational capacity. Results from this audit revealed that CenCal was compliant with many areas covered under the scope of the audit but had some areas of noncompliance.

Under the UM category, the plan demonstrated implementation of a UM program that met program requirements. The plan monitored under- and overutilization across several clinical areas and incorporated findings in its internal "Compliance and Quality Dashboard." Additionally, the plan trended and analyzed its performance measure data annually. Audit findings in this area related to prior-authorization review requirements. Both pharmacy and nonpharmacy denial notifications did not include the reason for the denial or the telephone number of the professional responsible for the determination, both of which are required. Additionally, the contract requires that a physician review all prior-authorization denials, and a review of pharmacy denials showed that CenCal was not compliant in this area. This was a repeat finding from the previous audit. The plan was compliant with appeal procedures and demonstrated adequate oversight of its delegated entities.

In the areas of continuity and coordination of care, the plan was fully compliant. CenCal designated the primary care physician as the coordinator and case manager of all services, including a process that ensured that patients had coordinated care across settings. CenCal demonstrated the ability to identify members eligible for California Children's Services, early intervention services, and services for persons with disabilities. By entering into memorandum of understanding agreements with local regional centers related to tracking and coordinating care, the plan demonstrated good processes for monitoring and ensuring that all members were receiving medically necessary diagnostic, preventive, and treatment services. This demonstrated CenCal's improvement in this area since this was a deficiency noted in the previous audit report. The plan also was compliant with referral tracking and follow-up care for members.

In the areas of availability of and accessibility to care, the audit showed that CenCal had standards for access to care for routine, after-hours, and emergent care. The plan monitored these standards through complaints and grievances, member satisfaction, and facility site reviews. Time and distance standards for ensuring an adequate number of primary care physicians were met. However, the review found that the plan did not meet its clean claim payment goals of 90 percent within 30 days and 100 percent within 45 days.

Review in the area of member rights found that CenCal had a member grievance system in place. A review of 26 grievances showed that the plan met requirements for timely acknowledgment and resolution. Two of the 26 grievances contained potential quality-of-care issues that were not reviewed by a physician; however, this occurred during a time of staff transition with an interim medical director. All grievances reviewed after the hire date of the permanent medical director had appropriate documentation. The plan met all requirements in the areas of cultural and linguistic services and confidentiality standards.

CenCal was fully compliant with quality management requirements. The plan had a written description of its quality program, appropriate clinical oversight, and qualified staff and providers to deliver covered services.

The audit also showed that the plan had adequate administrative and organizational capacity to carry out its quality program. The audit noted two areas of deficiency. Six of 10 provider offices did not receive training regarding the MCMC Program within contractual time frames. Also, the plan's fraud and abuse procedures did not include the required notification of the DHCS within 10 days.

A DHCS *Medical Audit Close-Out Report* dated September 29, 2009, noted that all of the above deficiencies were adequately addressed by the plan's corrective action plan.

Member Rights and Program Integrity Monitoring Review

The Member Rights/Program Integrity Unit (MRPIU) in DHCS's Medi-Cal Managed Care Division 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 CenCal, covering both Santa Barbara and San Luis Obispo counties, in May 2009, covering the review period of November 8, 2008, through April 30, 2009. MRPIU noted four findings related to member grievances, prior authorization notifications, and cultural and linguistic services:

- In the member grievances area, 1 of 20 plan grievances files reviewed exceeded the 30-day time frame.
- The plan's policy and procedure for filing an appeal showed 180 days, which was not compliant with the 90-day State and federal requirement.
- For prior authorization notifications, 4 of 19 prior authorization files reviewed exceeded the 14-day time frame for sending a notice of action.

- Under cultural and linguistic services requirements, the review revealed that not all providers' offices discouraged the use of family and friends as interpreters.

Strengths

CenCal demonstrated full compliance in the areas of continuity and care, quality management, and marketing and enrollment. Joint audit findings showed that the plan had made significant improvements in care coordination processes since the last review to ensure that members receive medically necessary services. By the time the *Medical Audit Close-Out Report* was issued, the plan had adequately addressed all areas noted as deficiencies from the joint audit report.

Opportunities for Improvement

Although the DHCS indicated that the plan had corrected areas of deficiency from the joint audit, the plan had an opportunity to conduct internal, periodic monitoring to ensure ongoing compliance. The MRPIU review showed that the plan needed to implement a process for monitoring the timeliness of prior-authorization notification. Also, the plan should continue to monitor the timeliness of clean claim payments and identify and address barriers that result in delayed payment. The plan should reeducate provider offices regarding language translation requirements, including discouraging the use of family and friends as interpreters.

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 of 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. This 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 CenCal'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 CenCal in 2009. HSAG found all measures to be reportable for Santa Barbara County. Because CenCal did not have members in San Luis Obispo County until March 2008, the plan could report rates only for measures for which it could meet the appropriate continuous enrollment criteria. For measures that could not be reported, the plan received an audit result of *Not Applicable (NA)*. CenCal'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 tracking and trending encounter data from vendors and formalizing a process for updating submission threshold levels for comparative purposes. In

[4] HEDIS Compliance Audit™ is a trademark of the NCQA.

addition, the plan should consider formalizing its follow-up process with vendors that do not meet the encounter data threshold, as the current process is conducted on an ad hoc basis. These actions would strengthen CenCal's process for ensuring complete encounter data.

Performance Measure Results

Tables 4.1 and 4.2 present a summary of CenCal's county-level 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 bases its MPLs and HPLs for all but one measure on the National Committee for Quality Assurance (NCQA) national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>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.

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. Additionally, HSAG was not able to compare 2008 and 2009 performance results for San Luis Obispo County since 2009 was the first year the plan could report rates for some of the performance measures for its new membership that became effective as of March 2008.

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

Table 4.1—2008–2009 Performance Measure Results for CenCal Health—San Luis Obispo County

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	- -	NA	Not Comparable	Not Comparable	20.6%	35.4%
ASM	Q	- -	NA	Not Comparable	Not Comparable	86.1%	91.9%
AWC	Q,A,T	- -	40.0%	★★	Not Comparable	35.9%	56.7%
BCS	Q,A	- -	NA	Not Comparable	Not Comparable	44.4%	61.2%
CCS	Q,A	- -	63.2%	★★	Not Comparable	56.5%	77.5%
CDC–E	Q,A	- -	NA	Not Comparable	Not Comparable	39.7%	67.6%
CDC–H7 (<7.0%)	Q	- -	NA	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	- -	NA	Not Comparable	Not Comparable	52.5%	32.4%
CDC–HT	Q,A	- -	NA	Not Comparable	Not Comparable	74.2%	88.8%
CDC–LC (<100)	Q	- -	NA	Not Comparable	Not Comparable	25.1%	42.6%
CDC–LS	Q,A	- -	NA	Not Comparable	Not Comparable	66.7%	81.8%
CDC–N	Q,A	- -	NA	Not Comparable	Not Comparable	67.9%	85.4%
CIS–3	Q,A,T	- -	NA	Not Comparable	Not Comparable	59.9%	78.2%
PPC–Pre	Q,A,T	- -	93.7%	★★★	Not Comparable	76.6%	91.4%
PPC–Pst	Q,A,T	- -	73.1%	★★★	Not Comparable	54.0%	70.6%
URI	Q	- -	89.2%	★★	Not Comparable	79.6%	94.1%
W15	Q,A,T	- -	NA	Not Comparable	Not Comparable	44.5%	73.7%
W34	Q,A,T	- -	68.8%	★★	Not Comparable	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.
NA = Not applicable due to the plan's new membership not meeting continuous enrollment requirements during the measurement period.
Not Comparable = Performance could not be compared due either to significant methodology changes between years or because the rate was not reported.

Table 4.2—2008–2009 Performance Measure Results for CenCal Health—Santa Barbara County

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	46.7%	45.4%	★★★	↔	20.6%	35.4%
ASM	Q	90.3%	91.5%	★★	↔	86.1%	91.9%
AWC	Q,A,T	35.9%	42.4%	★★	↔	35.9%	56.7%
BCS	Q,A	56.7%	57.4%	★★	↔	44.4%	61.2%
CCS	Q,A	67.4%	67.4%	★★	↔	56.5%	77.5%
CDC–E	Q,A	79.0%	79.9%	★★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	52.4%	42.0%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	23.5%	29.5%	★★★	↓	52.5%	32.4%
CDC–HT	Q,A	88.6%	84.2%	★★	↓	74.2%	88.8%
CDC–LC (<100)	Q	46.4%	48.8%	★★★	↔	25.1%	42.6%
CDC–LS	Q,A	81.8%	81.0%	★★	↔	66.7%	81.8%
CDC–N	Q,A	80.4%	77.5%	★★	↔	67.9%	85.4%
CIS–3	Q,A,T	84.6%	81.7%	★★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	85.1%	80.4%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	77.9%	76.6%	★★★	↔	54.0%	70.6%
URI	Q	78.2%	84.4%	★★	↑	79.6%	94.1%
W15	Q,A,T	63.9%	59.7%	★★	↔	44.5%	73.7%
W34	Q,A,T	71.7%	72.2%	★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the full name of each HEDIS measure.
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↓ = 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, CenCal demonstrated average to above-average performance, falling between the MPLs and HPLs for most of its reported performance measures in 2009. More importantly, at least one-third of the reportable measures for both counties exceeded the Medi-Cal managed care HPLs. The plan did not perform below-average for any measure.

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 required CenCal in Santa Barbara County to submit one improvement plan to the DHCS for *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*. The improvement plan indicated that CenCal focused interventions on both members and providers, with priority focus on interventions that addressed primary care providers (PCPs) with high volumes of members diagnosed with URI and who were prescribed antibiotics. The plan had a statistically significant improvement of its *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* rate, which increased above the MPL for HEDIS 2009. Based on CenCal's 2009 performance, the DHCS did not require an improvement plan for either county since none of the performance measures fell below the MPLs.

Strengths

CenCal performed above the MCMC goal on both prenatal and postpartum care measures in San Luis Obispo County. These measures spanned the domains of quality, access, and timeliness.

CenCal performed above the HPLs for six measures in Santa Barbara County:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC–E)*
- *Comprehensive Diabetes Care—HbA1c Poor Control > 9.0 Percent (CDC–H-9)*
- *Comprehensive Diabetes Care—LDL-C Control (CDC–LC)*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)*
- *Childhood Immunization Status—Combination 3 (CIS–3)*
- *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)*

These results demonstrated an effort to provide quality care.

Opportunities for Improvement

CenCal's performance for the *Adolescent Well-Care Visits* measure was only 4.1 percentage points above the MPL in San Luis Obispo County. Similarly, CenCal demonstrated statistically significant decreases for two *Comprehensive Diabetes Care* measures in Santa Barbara County. While none of these measures scored below the MPLs, they present an opportunity for improvement. CenCal's performance in these areas may point to potential issues with health care quality, access, and/or timeliness.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and/or 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 CenCal'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

CenCal was not required to submit QIPs in San Luis Obispo County for the review period of July 1, 2008, through June 30, 2009, due to the plan's effective date. The plan will include San Luis Obispo County in its next individual QIP proposal to the DHCS and begin reporting rates for the statewide QIP on reducing avoidable emergency room visits during the next review period.

CenCal had two clinical QIPs in progress in Santa Barbara County during the review period of July 1, 2008, through June 30, 2009. Both QIPs fell under the quality domain of care.

The first QIP targeted the reduction of avoidable emergency room visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP project. For its second QIP, CenCal conducted an internal QIP in Santa Barbara County designed to improve the proper use of antibiotics by providing appropriate treatment for children with upper respiratory infections, providing appropriate testing for children with pharyngitis, and avoiding antibiotic treatment for adults with acute bronchitis.

The statewide collaborative QIP sought to reduce emergency room visits that could have been more appropriately managed by and/or referred to a 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. CenCal's Santa Barbara County QIP on *Proper Antibiotic Use* attempted to improve the quality of care for children with upper respiratory infection and adults with acute bronchitis by encouraging providers to reduce the prescribing of antibiotics for viral infections, which can lead to antibiotic resistance. Additionally, the QIP aimed to increase the percentage of children with a diagnosis of pharyngitis and prescribed antibiotics who also had received a group A streptococcal (strep) test. For this QIP, the plan focused on physician intervention.

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.

The table below summarizes the validation results for CenCal's Santa Barbara County QIP across CMS protocol activities during the review period.

Table 5.1—QIP Validation Results for CenCal Health—Santa Barbara County (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	100%	0%	0%
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	62%	23%	15%
IV.	Correctly Identified Study Population	0%	33%	67%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	42%	33%	25%
VII.	Appropriate Improvement Strategies	71%┼	14%┼	14%┼
VIII.	Sufficient Data Analysis and Interpretation	63%┼	19%┼	19%┼
IX.	Real Improvement Achieved	38%┼	25%┼	38%┼
X.	Sustained Improvement Achieved	0%	100%	0%
Percentage Score of Applicable Evaluation Elements *Met*		**54%**		
Validation Status		***Not Applicable****		

* QIPs were not given an overall validation status during the review period.
┼ The sum may not equal 100 percent due to rounding.

CenCal submitted baseline data for the Santa Barbara County emergency room (ER) QIP during the review period; therefore, the QIP had not progressed to the point of remeasurement and

HSAG could not assess for real improvement. The plan submitted remeasurement data for its *Proper Antibiotic Use* QIP and was assessed for real and 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 CenCal's Santa Barbara County QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided CenCal, 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 CenCal's data for its Santa Barbara County QIPs. For CenCal's ER collaborative QIP in Santa Barbara County, the goal was to reduce the overall rate of members who used the emergency room, with a 5 percent reduction in its avoidable ER visit rate. The plan submitted its first remeasurement data in late 2010. HSAG validated the data; however, for consistency in reporting collaborative data, HSAG will present Remeasurement 1 results in the next plan-specific evaluation report. For CenCal's Santa Barbara County QIP on *Proper Antibiotic Use*, HSAG assessed for statistically significant improvement for each measurement period and for sustained improvement for two of the three study indicators.

Table 5.2—QIP Outcomes for CenCal Health—Santa Barbara County

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	Remeasurement Period 1 1/1/08–12/31/08	Remeasurement Period 2 1/1/09–12/31/09	Sustained Improvement
Percentage of ER visits that were avoidable	19.2%	‡	‡	‡
‡The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Proper Antibiotic Use^						
QIP Study Indicator	Baseline Period 7/1/02–6/30/03	Remeasurement Period 1 7/1/03–6/30/04	Remeasurement Period 2 7/1/04–6/30/05	Remeasurement Period 3 7/1/05–6/30/06	Remeasurement Period 4 7/1/06–6/30/07	Sustained Improvement
1) Percentage of eligible members 2–18 years of age that were not dispensed an antibiotic within 3 days of URI diagnosis	77.0%	68.4%¥	75.0%*	71.5%¥	78.2%*	‡
2) Percentage of members 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test	10.24%	9.6%¥	14.2%*	13.7%	13.9%	No
3) Percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	27.6%	29.8%	50.2%*	46.7%	┼	Yes
^ The third study indicator was added to the QIP in July 2003; therefore, every measurement period is one year later than what is provided. * Designates statistically significant improvement over the prior measurement period. ¥ Designates statistically significant decline over the prior measurement period. ‡ 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. ┼ No rate was reported for this year by the plan.						

For the first study indicator, the plan experienced mixed performance with a statistically significant decrease between the baseline and first remeasurement period, followed by a statistically significant increase the next period, then another statistically significant decline and, finally, another statistically significant increase. Despite efforts, the plan has had little success achieving an increase above the baseline period. Although the QIP has not shown steady

improvement, HSAG noted that the plan's *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* performance measure for the 2008 and 2009 measurement periods demonstrated improvement with a rate of 84.4 percent. CenCal initiated an intervention that involved having high-volume providers meet with CenCal's Chief Medical Officer to review proper coding and guidelines for the treatment of viral URI, which appears to have made a strong impact on the plan's Santa Barbara County rate after the QIP remeasurement periods. HSAG will recommend that the plan terminate this QIP with the next remeasurement period and continue to monitor its efforts internally.

The plan's second indicator measured whether member 2–18 years of age who were diagnosed with pharyngitis and were dispensed an antibiotic also had a strep test to help ensure that providers determined a bacterial infection before prescribing an antibiotic. The plan had a statistically significant decline between the baseline and first remeasurement period but then demonstrated a statistically significant increase and has managed to improve its baseline rate from 10.24 percent to 13.9 percent. The plan achieved a *Partially Met* score for sustained improvement. The plan offered an incentive to providers from October 2007 through March 2008 for the performance of streptococcal testing. This intervention shows promise for achieving improvement in the plan's next and final remeasurement period.

The plan was able to demonstrate statistically significant and sustained improvement for its third indicator, which measured the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. The plan increased its baseline rate of 27.6 percent to 46.7 percent.

Strengths

CenCal demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data.

CenCal implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits. From member and provider surveys, CenCal found that 40 percent of members with avoidable ER visits went to the ER after hours or on weekends. To address this significant finding, the plan introduced financial incentives to encourage PCPs to offer expanded or weekend hours in all of the densely populated regions of CenCal's service area. The plan's PCP incentive program, therefore, was refined to directly target one of the plan's key identified barriers. Member interventions included educating members on which providers offered after-hour care and how to access these appointments. These interventions directly link to barriers and have the ability to impact the plan's rates of avoidable ER visits.

For its *Proper Antibiotic Use* QIP, CenCal demonstrated statistically significant and sustained improvement for its appropriate treatment of adults with acute bronchitis study indicator. The plan also showed improvement in the appropriate treatment for children with pharyngitis study indicator.

Both QIPs are designed to improve the quality of care delivered to members. The ER collaborative QIP helps to ensure that members have access to the most appropriate treatment setting, and the *Proper Antibiotic Use* QIP helps to ensure that providers are practicing according to clinical guidelines.

Opportunities for Improvement

CenCal's greatest opportunity for improvement is improving 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 CMS protocol activities.

CenCal identified several access-related barriers cited by members as reasons for using the ER, such as a lack of after-hours alternatives to the ER. Plan-specific interventions were not implemented until January 2009. CenCal will need to evaluate these interventions annually to determine if members continue to have difficulty accessing care.

The plan should terminate its *Proper Antibiotic Use* QIP to allow the plan the opportunity to address other areas of low performance. The plan will need to initiate a QIP for San Luis Obispo County during the next review period.

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

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—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*