Performance Evaluation Report

Central California Alliance for Health

July 1, 2009–June 30, 2010

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

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HSAG HEALTH SERVICES ADVISORY GROUP

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TABLE OF CONTENTS

1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] 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 the 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. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Central California Alliance for Health ("CCAH" or "the plan"), which delivers care in Merced, Monterey, and Santa Cruz counties, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

CCAH was previously known as Central Coast Alliance for Health. It is a full-scope managed care plan operating in Monterey, Santa Cruz, and Merced counties. CCAH became operational with the MCMC Program in Santa Cruz County in January 1996 and Monterey County in October 1999, and the plan expanded into Merced County in October 2009; however, information for Merced County is not included in this report because the plan did not have members in the plan long enough in 2009 to report valid data. The plan will report information for Merced County beginning in the next evaluation report. CCAH had 181,390 MCMC members in Merced, Monterey, and Santa Cruz counties as of June 30, 2010.[2]

CCAH serves members in all counties under a County Organized Health System (COHS) model. In a COHS model, the DHCS initiates contracts with county-organized and county-operated plans to provide managed care services to beneficiaries with designated, mandatory aid codes. In a COHS plan, beneficiaries can choose from a wide network of managed care providers. These beneficiaries do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the plan.

[2] *Medi-Cal Managed Care Enrollment Report—June 2010*. 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 that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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 and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division often work in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits are conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

HSAG reviewed the most current medical performance review reports available as of June 30, 2010, to assess the plan's compliance with State-specified standards. A&I conducted the most recent medical performance review in June 2009, covering the review period of April 1, 2008, through March 31, 2009. The DHCS also conducted a routine medical survey in June 2009, and the scope of that review focused on the areas of independent medical review, the online grievance process, and standing referrals for members with HIV. The DHCS issued final reports for both reviews in November 2009, and the findings were detailed in the 2008–2009 plan evaluation report.[3]

The audit findings showed that CCAH had at least one deficiency in each of the six evaluated categories of performance: Utilization Management, Continuity of Care, Availability and Accessibility, Members' Rights, Quality Management, and Administrative and Organizational Capacity. The plan developed a corrective action plan in November 2009 followed by a DHCS *Medical Audit Close-Out Report* dated April 19, 2010, indicating that all audit deficiencies were resolved by the plan. The next Medical Performance Audit is scheduled for June 1, 2012.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's 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, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These member rights reviews are conducted 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 member rights review of each plan approximately every two years and follow-up visits as 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, 2010.

The most current MRPIU review for CCAH was conducted in February 2009, covering the review period of January 1, 2008, through December 31, 2008. The MRPIU findings were addressed in the 2008–2009 plan evaluation report; however, MRPIU conducted a follow-up onsite review in May 2010 to determine whether the plan had corrected the deficiencies identified in the February 2009 review. MRPIU reviewed member grievances and prior-authorization notifications for the review period of November 1, 2009, through April 30, 2010.

[3] *Performance Evaluation Report – Central California Alliance for Health July 1, 2008 – June 30, 2009.* California Department of Health Care Services. October 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

The results of DHCS follow-up review indicated that CCAH took appropriate action to correct all member grievance findings that were identified in the MRPIU in February of 2009. However, it was noted that CCAH did not fully resolve issues regarding the notice of action (NOA) letters missing required citations and the timeliness of the letters being sent.

Strengths

The plan resolved all deficiencies noted on the previous medical performance review, suggesting that CCAH has sufficient programs and internal practices in place to support the provision of quality health care that is available and accessible to its members. CCAH showed substantial progress in addressing many of the MRPIU findings and resolving deficiencies related to the grievance process.

Opportunities for Improvement

While CCAH adequately addressed most of the MRPIU audit deficiencies, the plan did not implement mechanisms to ensure that all NOA letters contain citations supporting plan decisions and are sent to members within the required time frame; therefore, this continues to be an opportunity for improvement. The plan has an opportunity to develop and implement quality control mechanisms to ensure adherence to its established prior-authorization notification policies and procedures.

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 provide 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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed a HEDIS Compliance Audit™ of CCAH in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[4] Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

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

Performance Measure Results

MCMC requires that contracted health plans 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 3.2 reflects combined reporting for those two counties. MCMC requires 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 beginning in 2011.

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. Table 3.1 displays a HEDIS performance measure name key.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
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*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of CCAH's HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan's HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

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

Table 3.2—2009–2010 Performance Measure Results for Central California Alliance for Health–Monterey and Santa Cruz Counties

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	30.3%	24.3%	★★	↓	20.2%	33.4%
AWC	Q,A,T	39.9%	51.8%	★★	↑	37.9%	59.4%
BCS	Q,A	62.0%	62.0%	★★	↔	45.0%	63.0%
CCS	Q,A	68.8%	74.7%	★★	↑	60.9%	79.5%
CDC–BP	Q	‡	70.8%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	51.8%	70.3%	★★	↑	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	58.6%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	36.3%	21.4%	★★★	↑	50.6%	29.2%
CDC–HT	Q,A	80.3%	90.3%	★★★	↑	76.5%	89.3%
CDC–LC (<100)	Q	36.1%	47.7%	★★★	↑	27.2%	44.7%
CDC–LS	Q,A	77.2%	85.2%	★★★	↑	71.5%	82.5%
CDC–N	Q,A	76.6%	86.6%	★★★	↑	73.4%	85.4%
CIS–3	Q,A,T	67.9%	81.5%	★★★	↑	62.4%	80.6%
LBP	Q	‡	82.7%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	77.9%	88.1%	★★	↑	78.5%	92.2%
PPC–Pst	Q,A,T	71.8%	77.9%	★★★	↑	57.9%	72.7%
URI	Q	94.5%	95.5%	★★★	↑	81.1%	94.5%
W34	Q,A,T	77.3%	82.5%	★★★	↑	64.0%	80.3%
WCC–BMI	Q	‡	50.6%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	58.6%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	34.1%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[5] Performance comparisons are based on the Chi-square 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 DHCS did not require plans to report this measure in 2009.
NA = The DHCS does not establish an MPL/HPL for first year measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.
Not Comparable = Performance could not be compared due to either significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, CCAH demonstrated above-average performance with substantial performance increases between 2009 and 2010. The plan had 13 measures with statistically significant increases in 2010 and only one measure with a statistically significant decrease. Nine out of 21 measures scored above the HPL in 2010.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline the steps it will take to improve care.

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing towards the MPL. In addition, HSAG assessed the plan's need for continuing existing improvement plans and/or developing new improvement plans.

In 2009, CCAH did not have any measures with rates below the MPL. Therefore, CCAH did not have to submit improvement plans.

Strengths

CCAH had a strong HEDIS 2010 performance; nine measures outperformed the national Medicaid 90th percentile. In 2010, 13 out of the 15 (87 percent) possible measures had statistically significant increases in performance from 2009.

Opportunities for Improvement

CCAH should focus on *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis,* as it was the only measure that had a statistically significant decline from 2009 to 2010.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Quality Improvement Projects Conducted

CCAH had two clinical QIPs in progress during the review period of July 1, 2009, through June 30, 2010. 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—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 that can 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 table below summarizes the validation results for both of CCAH's QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Central California Alliance for Health—Monterey and Santa Cruz Counties July 1, 2009, through June 30, 2010

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	62%	50%	*Partially Met*
	Resubmission 1	84%	60%	*Partially Met*
	Resubmission 2	100%	100%	*Met*
Internal QIPs				
Improving Effective Case Management	Annual Submission	41%	30%	*Not Met*
	Resubmission 1	65%	70%	*Partially Met*
	Resubmission 2	86%	100%	*Met*

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

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

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

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

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met, Partially Met,* or *Not Met*. In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that the initial submission by CCAH of both its *Reducing Avoidable Emergency Room Visits* and *Improving Effective Case Management* QIP received an overall validation status of *Partially Met* and *Not Met*, respectively. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. The plan resubmitted both QIPs and received a *Partially Met* validation status for the first resubmission. Based on the validation feedback, the plan resubmitted the QIPs for a second time and upon subsequent validation, achieved an overall *Met* validation status for both QIPs.

Table 4.2 summarizes the validation results for both of CCAH's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Central California Alliance for Health—Monterey and Santa Cruz Counties (Number = 2 QIPs, 2 QIP Topics) July 1, 2009, through June 30, 2010

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	83%	0%	17%
Implementation Total		**94%**	**0%**	**6%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	94%	6%	0%
	IX: Real Improvement Achieved†	63%	38%	0%
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		**83%**	**17%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.
‡ No QIPs were assessed for this activity/evaluation element.
† The sum may not equal 100 percent due to rounding.

CCAH submitted Remeasurement 1 data for both of its QIPs; therefore, HSAG validated Activity I through Activity IX. CCAH demonstrated an accurate application of the Design and Implementation stages, scoring 100 percent on all evaluation elements for five of the six applicable activities. Activity VII was scored down for the plan's lack of discussion regarding revising or implementing new interventions based on the study indicator outcomes for its *Improving Effective Case Management* QIP. For the Outcomes stage, CCAH was scored lower in Activity VIII

for the plan's lack of interpretation of the baseline results for its *Improving Effective Case Management* QIP. Additionally, one of two study indicators for the *Improving Effective Case Management* QIP did not demonstrate improvement; therefore, CCAH received a score of 63 percent for Activity IX.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods. Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Table 4.3––Quality Improvement Project Outcomes for Central California Alliance for Health—Monterey and Santa Cruz Counties July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement**
Percentage of ER visits that were avoidable	23.2%	19.0%*	‡	‡
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**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement**
Percentage of members 18–75 years of age with a hospitalization for uncontrolled diabetes	0.82%	0.89%	‡	‡
Percentage of members over 21 years of age with a hospital discharge for congestive heart failure	71.1%	39.8%*	‡	‡

‡ The QIP did not progress to this phase during the review period and could not be assessed.
* Designates statistically significant difference over the prior measurement period (*p* value <0.05).

In the *Reducing Avoidable ER Visits* QIP, CCAH reported a decrease in the percentage of avoidable ER visits. The decrease was statistically significant and probably not due to chance. A decrease for this measure reflects an improvement in performance. CCAH implemented several plan-specific interventions including reports to primary care providers regarding their members' ER usage and a Web-based reporting system that allows providers to check their members' ER usage in real time. Additionally, the plan has a financial incentive program that rewards primary care providers for

providing preventive care and services to their members. Since collaborative interventions were not initiated until early 2009, HSAG could not evaluate the effectiveness of those interventions.

For the *Improving Effective Case Management* QIP, the percentage of members hospitalized for uncontrolled diabetes increased from baseline to Remeasurement 1, demonstrating a decline in performance; however, the increase was not statistically significant and the rate remained below one percent. The percentage of members who were discharged from a hospitalization for congestive heart failure decreased by 31.3 percentage points from baseline to Remeasurement 1. The decrease was statistically significant and demonstrated an increase in performance. The plan implemented stepped interventions. First, the plan combined some of the duties of the chronic disease case managers with the child case managers. Second, the two sets of case managers were moved into physical proximity to each other. Then the plan provided laptops so that the case managers would be able to enter data in real time and access utilization data.

Strengths

CCAH demonstrated good application of the QIP process for QIP topic selection, development of study questions, and definition of the study population. Additionally, CCAH implemented accurate data collection methods and appropriate improvement strategies. CCAH's actions 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 were educated on the availability of these tools.

Opportunities for Improvement

CCAH has shown challenges with meeting QIP validation requirements with the initial QIP submission. CCAH should incorporate the recommendations provided in the QIP Validation Tool when it resubmits QIPs to avoid the necessity of a second resubmission.

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 18 members were admitted with uncontrolled diabetes and only 78 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.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan surveys.[5]

The administration of the CAHPS surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS surveys be administered to both adult members and the parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

The Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about CCAH's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures as follows:

CAHPS Global Rating Measures:

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

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

CAHPS Composite Measures:

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

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance (NCQA)'s HEDIS® benchmarks and thresholds or NCQA's national Medicaid data, when applicable. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 5.1.

Table 5.1—Star Ratings Crosswalk

Stars	Adult Percentiles	Child Percentiles
★★★★★	≥ 90th percentile	≥ 80th percentile
★★★★	75th percentile–89th percentile	60th percentile–79th percentile
★★★	50th percentile–74th percentile	40th percentile–59th percentile
★★	25th percentile–49th percentile	20th percentile–39th percentile
★	< 25th percentile	< 20th percentile

Table 5.2—Central California Alliance for Health—Monterey and Santa Cruz Counties Medi-Cal Managed Care County-Level Global Ratings

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

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Table 5.3—Central California Alliance for Health—Monterey and Santa Cruz Counties Medi-Cal Managed Care County-Level Composite Ratings

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Adult	★★★	★	★★★	★★★+	★★
Child	★★	★	★★	★+	★★★★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Strengths

CCAH ranked high in many categories across the adult and child spectrums. At the global ratings level, CCAH performed best in the child categories: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*, scoring above the 80th percentile. The adult category of *Specialist Seen Most Often* scored higher than the 90th percentile. At the composite rating level in the adult category, *Getting Needed Care*, *How Well Doctors Communicate* and *Customer Service* scored above 50th percentile. The *Shared Decision Making* rating in the child category scored above the 60th percentile.

Opportunities for Improvement

At the global ratings level, CCAH's CAHPS results showed the opportunity for the most improvement in the *Rating of Health Plan* category for adults and *Rating of All Health Care* for the child category. At the composite rating level, the *Getting Care Quickly* category has the most potential for improvement, with scores below the 25th and 20th percentile for the adult and child categories respectively.

HSAG conducted a key-drivers-of-satisfaction analysis that focused on the top three highest priorities based on the plan's CAHPS results. The purpose of the key-drivers-of-satisfaction analysis was to help decision makers identify specific aspects of care most likely to benefit from quality improvement (QI) activities. Based on the key-driver analysis, HSAG identified the following measures as CCAH's highest priorities: *Rating of All Health Care, Customer Service, and Getting Care Quickly*. The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program – 2010 Central California Alliance for Health CAHPS Plan-Specific Report*. Areas for improvement spanned the quality, access, and timeliness domains of care.

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 the results of performance measures and quality improvement projects (QIPs) to assess care delivered to members by a plan in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, 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.

The plan showed above-average performance in the quality domain. This assessment was based on CCAH's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

The plan improved scores on the 2010 quality-related HEDIS measures. CCAH had substantial performance increases between 2009 and 2010, and nine measures related to quality scored above the HPL in 2010.

QIP results showed that the plan did well at documenting the QIP study design and implementation phases. Additionally, CCAH's interventions to address identified causes/barriers and system interventions are likely to induce permanent change.

The plan did demonstrate improvement in the area of compliance, as it was able to address all quality-related issues that were identified in the DHCS *Medical Audit Close-Out Report.*

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 a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

The plan demonstrated above-average performance in the access domain. This assessment was based on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results.

Timeliness

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

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.

CCAH had average performance in the timeliness domain of care based on its 2010 performance measure rates for providing timely care, medical performance review standards related to timeliness, and member satisfaction results related to timeliness. While CCAH showed substantial progress in addressing grievance deficiencies identified in the February 2009 review and fully resolved these deficiencies as part of the May 2010 reevaluation, the plan had not adequately addressed deficiencies related to prior-authorization files. The May 2010 reevaluation showed that

out of 102 prior-authorization files reviewed, there were 15 instances in which the plan had sent out the notice of action (NOA) letter to the member after the maximum time frame had passed, and 13 instances in which the NOA letter did not have a supporting citation for the plan's decision. These deficiencies could have an impact on members' ability to access services timely as well as limit their rights to appeal denials.

Performance measure rates related to timeliness showed that the plan performed above the HPL for: *Childhood Immunization Status—Combination 3; Postpartum Care; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life,* suggesting that members are receiving care within the appropriate time frame after a need for preventive services is identified.

Member satisfaction results showed that the plan demonstrated poor performance in the *Getting Care Quickly* category for both adult and child populations. This suggests that members perceive that they do not always receive care in a timely manner.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. CCAH's self-reported responses are included in Appendix A.

Conclusions and Recommendations

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

CCAH showed an increase in its performance measures rates in 2010 compared with 2009 rates. The plan was generally compliant with documentation requirements across performance measures, QIPs, and State and federal requirements.

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

- Develop and implement quality control mechanisms to ensure adherence to established prior-authorization notification policies and procedures.
- Explore factors that contributed to the decline in performance for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, which had a statistically significant decrease from 2009 to 2010.
- Incorporate the recommendations provided by HSAG in the QIP validation tool when it resubmits QIPs to avoid the necessity of a second resubmission.
- Ensure that future QIP topics are reflective of a need that can have a greater impact on a larger portion of the Medi-Cal managed care population.

- Review the 2010 plan-specific CAHPS results report and develop strategies to address the following priority areas: *Rating of Health Plan* and *Rating of All Health Care*.

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

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
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.	In 2009 Central California Alliance for Health added two new lines of business that added approximately 88,000 new members. We acquired 18,000 Healthy Families members in Monterey County due to the sudden withdrawal of Anthem Blue Cross and also expanded into Merced County October 2009 adding an additional 70,000. These projects depleted the resources both financially and in terms of personnel usually devoted to HEDIS (both in terms of IT support and nurses available for chart abstraction). Because of this, less effort was focused on chart pursuit and abstraction. Despite this, Alliance HEDIS rates for 2009 exceeded all Minimum Performance Levels and surpassed rates submitted by the majority of Medi-Cal Managed Care Plans within California. During the period of July 30, 2009–June 30, 2010 additional staff have been added and the Alliance was able to effectively resume our former rate of chart pursuit. As a result of these efforts the Alliance was awarded the Silver Award for Excellence in HEDIS from the State of California for our 2010 rates.
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance toward increasing compliance with the CMS protocol for conducting QIPs	During the period in question the Alliance switched to the Health Services Advisory Group QIP Summary Forms. State contracted with Health Services Advisory Group as EQRO necessitating the change in forms formerly used by prior vendor.
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.	Utilization Management (UM) reports this metric quarterly for an internal quality reporting that is completed organization wide. Each quarter, the staffing issues (if any) are addressed to better manage this requirement. For the past six quarters, (since January 2010) the compliance rate has been greater than or equal to 90%. For the first two quarters of 2011, 97% and 100% respectively of the NOAs have been sent within the compliance standards of three working days of decision. Health Services/Utilization Management has an Alliance Quality Indicator (AQI) that is measured and reported quarterly regarding the timely completion and mailing of notice of action (NOA) letters to members for notification of denials or modifications of services in compliance with State and federal standards.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
Implement a process to monitor for timeliness of prior-authorization decisions and notifications to members.	Utilization Management (UM) reports this metric quarterly for an internal quality reporting that is completed organization wide. As stated in the previous section, there is a process in place for monitoring timeliness of prior-authorization decisions and notifications to members. For the first two quarters of 2011, 86.8% and 91% respectively of the authorization requests have been completed within the compliance standards of five (5) working days of receipt. Health Services has an Alliance Quality Indicator (AQI) that is measured and reported quarterly regarding the timely completion of investigation and review of all quality of care concerns.
Streamline quality improvement activity reporting by ensuring reporting and documentation within the committee structure.	During the period in question internal and external committees were restructured ensuring a smooth and orderly flow of information from committee level to Board of Directors. Information is now flowing smoothly from committee level to Board of Directors in a timely fashion.
Implement a process to investigate and review all quality of care concerns.	There is a process already in place: See PQI policy #401-1301 Health Services has an Alliance Quality Indicator (AQI) that is measured and reported quarterly regarding the timely completion of investigation and review of 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.	Each of the three Alliance counties (Santa Cruz, Monterey, and Merced) has a CCS case manager to ensure coordination of care for members with CCS conditions. Each authorization request received by the UM department is reviewed for CCS eligible conditions and then care is coordinated with CCS and PCP to ensure all necessary services are provided. The Alliance works closely with the Children's Health and Disability Program (CHDP) (California's EPSDT Program) and California Children's Services (CCS) departments (we have MOUs with each of them in each county) including quarterly meetings to ensure that all of the children receive all of the services required for each age group.