Performance Evaluation Report

Central California Alliance for Health

July 1, 2013–June 30, 2014

Managed Care Quality and Monitoring Division
California Department of Health Care Services

April 2015

TABLE OF CONTENTS

1. INTRODUCTION 1
Purpose of Report 1
Managed Care Health Plan Overview 2
2. MANAGED CARE HEALTH PLAN COMPLIANCE 3
Conducting the EQRO Review 3
Assessing the State's Compliance Review Activities 3
Readiness Reviews 3
Medical Audits and SPD Medical Surveys 3
Strengths 4
Opportunities for Improvement 4
3. PERFORMANCE MEASURES 5
Conducting the EQRO Review 5
Validating Performance Measures and Assessing Results 5
Performance Measure Validation 6
Performance Measure Validation Findings 6
Performance Measure Results 7
Seniors and Persons with Disabilities Performance Measure Results 11
Performance Measure Result Findings 15
Improvement Plans 17
Assessment of MCP's Improvement Plans 18
Strengths 19
Opportunities for Improvement 19
4. QUALITY IMPROVEMENT PROJECTS 20
Conducting the EQRO Review 20
Validating Quality Improvement Projects and Assessing Results 20
Quality Improvement Project Objectives 21
Quality Improvement Project Validation Findings 21
Quality Improvement Project Outcomes and Interventions 24
Strengths 25
Opportunities for Improvement 25
5. ENCOUNTER DATA VALIDATION 26
Conducting the EQRO Review 26
6. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS 27
Overall Findings Regarding Health Care Quality, Access, and Timeliness 27

Quality 27
Access 29
Timeliness 30
Follow-Up on Prior Year Recommendations 31
Recommendations 31

APPENDIX A. SPD TREND TABLES A-1

APPENDIX B. NON-SPD TREND TABLES B-1

APPENDIX C. SCORING PROCESS FOR THE DOMAINS OF CARE C-1

APPENDIX D. MCP'S SELF-REPORTED FOLLOW-UP ON EXTERNAL QUALITY REVIEW RECOMMENDATIONS FROM THE JULY 1, 2012–JUNE 30, 2013 PERFORMANCE EVALUATION REPORT D-1

Performance Evaluation Report – Central California Alliance for Health July 1, 2013 – June 30, 2014

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)[1] in the State of California through a combination of contracted full-scope and specialty managed care health plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and

[1] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.

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

encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2013–June 30, 2014). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Central California Alliance for Health ("CCAH" or "the MCP"), for the review period July 1, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Health Plan Overview

CCAH is a full-scope MCP delivering services to its MCMC members as a County Organized Health System (COHS). A COHS is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission.

CCAH became operational to provide MCMC services in Santa Cruz County in January 1996, in Monterey County in October 1999, and in Merced County in October 2009. As of June 30, 2014, CCAH had 102,566 MCMC members in Merced County, 117,859 in Monterey County, and 53,689 in Santa Cruz County—for a total of 274,114 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

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

This report section covers review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to evaluate key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

Medical Audits and SPD Medical Surveys

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were

conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

DHCS received authorization "1115 Waiver" from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-COHS counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary..

DHCS conducted no compliance reviews with CCAH during the review period for this report. The most recent routine monitoring review for CCAH was conducted April 16, 2012, through April 19, 2012, covering the review period of January 1, 2011, through December 31, 2011. DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit (MR/PIU) conducted a follow-up review on August 23, 2012. As part of the follow-up review, MR/PIU evaluated CCAH's progress performing cultural awareness and sensitivity training required to meet the needs of the SPD population and conducting physical accessibility surveys. HSAG included summaries of the reviews in CCAH's 2011–12 and 2012–13 MCP-specific evaluation reports.

Strengths

CCAH has no outstanding findings from the most recent reviews conducted by DHCS.

Opportunities for Improvement

Since CCAH has no outstanding deficiencies from the most recent DHCS reviews, HSAG has no recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[4] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

Performance Measure Validation

DHCS's 2014 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 32. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[6] of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for Central California Alliance for Health* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that CCAH followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the findings and opportunities for improvement is included below.

- CCAH successfully transitioned its Healthy Families Program population into MCMC with no impact on member operations (i.e., processes related to enrollment, customer service, member outreach, etc.).
- CCAH should explore ways to capture rendering provider/specialist information in automated ways to reduce the burden of medical record review.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 and Table 3.2 present a summary of CCAH's performance measure results for 2011–14. Note that data may not be available for all four years.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 and Table 3.2 show the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

DHCS based the MPLs and HPLs on the NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *CDC–H9 (>9.0 percent)* measure. For the *CDC–H9 (>9.0 percent)* measure, a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

Note: While DHCS generally requires MCPs to report county-level data, DHCS made an exception and allowed CCAH to continue to report Monterey and Santa Cruz counties as one combined rate.

The reader should note the following regarding Table 3.1 and Table 3.2:

- The *All-Cause Readmissions* measure is a non-HEDIS measure used for the ACR collaborative QIP; therefore, no MPL or HPL is established for this measure.
- For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- The *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures. No MPL or HPL is established for a utilization measure. Additionally, HSAG did not compare performance for these measures.
- Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for 2014:
  - All four *Children and Adolescents' Access to Primary Care* measures.
  - *Cervical Cancer Screening*. Note: MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008; however, due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014. Consequently, HSAG did not include or make comparisons to previous years' rates in this report.

- *Comprehensive Diabetes Care—LDL-C Control.* (This measure is being eliminated for HEDIS 2015.)
- *Comprehensive Diabetes Care—LDL-C Screening.* (This measure is being eliminated for HEDIS 2015.)

Table 3.1—Performance Measure Results
CCAH—Merced County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	12.73%	12.78%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	49.09	53.69	52.70	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	320.62	324.06	321.41	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	86.41%	87.14%	86.87%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	**83.33%**	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	87.31%	86.97%	86.43%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	**15.09%**	**11.61%**	**16.23%**	18.62%	↔
Cervical Cancer Screening	Q,A	—	—	—	65.63%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	**55.23%**	64.72%	64.74%	68.68%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.92%	97.42%	97.63%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	91.25%	90.39%	91.65%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	89.54%	89.82%	90.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	87.63%	90.19%	88.46%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	67.15%	64.48%	64.96%	62.53%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	41.61%	56.20%	54.74%	53.53%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	86.13%	87.83%	84.91%	83.94%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	46.72%	51.34%	46.72%	44.28%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	36.01%	37.96%	33.09%	32.85%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	80.05%	80.29%	80.54%	78.59%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	86.37%	82.48%	84.91%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	44.04%	37.23%	45.99%	45.74%	↔
Controlling High Blood Pressure	Q	—	—	52.80%	53.66%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Immunizations for Adolescents—Combination 1	Q,A,T	—	50.12%	55.96%	64.86%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	48.30%	54.14%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	26.16%	29.04%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	63.02%	59.61%	58.79%	60.35%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	88.32%	85.40%	83.92%	82.79%	↔
Use of Imaging Studies for Low Back Pain	Q	79.87%	84.15%	79.33%	82.49%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	46.72%	58.88%	77.62%	82.24%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	62.29%	64.23%	66.91%	68.13%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	40.39%	44.28%	44.77%	43.07%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.97%	72.51%	74.33%	76.32%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.2—Performance Measure Results
CCAH—Monterey/Santa Cruz Counties

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	12.06%	11.58%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	51.95	52.10	46.64	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	320.58	318.74	303.75	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	88.31%	85.86%	87.34%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	87.93%	89.47%	87.76%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	88.95%	85.58%	87.02%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	26.36%	27.95%	22.27%	28.07%	↔
Cervical Cancer Screening	Q,A	—	—	—	72.22%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	82.73%	84.18%	83.84%	82.48%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	97.42%	98.49%	98.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	91.05%	91.29%	92.11%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	89.57%	90.89%	93.18%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	88.93%	91.00%	90.94%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	71.78%	76.64%	71.05%	75.18%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	65.94%	67.40%	63.02%	56.45%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	89.05%	91.97%	87.35%	86.86%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	56.45%	61.80%	51.09%	51.82%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	45.74%	47.20%	39.66%	35.77%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	84.43%	84.91%	78.83%	79.81%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	82.48%	79.81%	79.32%	79.32%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	33.33%	28.22%	36.98%	38.20%	↔
Controlling High Blood Pressure	Q	—	—	55.96%	59.46%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	63.99%	77.60%	80.29%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	49.96%	52.98%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**24.42%**	30.21%	↑

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	75.43%	77.62%	70.27%	69.83%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	93.43%	86.13%	81.76%	93.10%	↑
Use of Imaging Studies for Low Back Pain	Q	86.06%	85.12%	88.00%	85.20%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	69.83%	79.08%	81.89%	81.02%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	72.26%	80.29%	81.63%	78.59%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	61.31%	61.31%	66.58%	65.21%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	83.45%	83.21%	82.08%	80.29%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[7] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

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

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

The final selected SPD measures are listed below. Following the list of measures are Table 3.3 through Table 3.6, which present a summary of CCAH's 2014 SPD measure results. Table 3.3 and Table 3.4 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[8] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.5 and Table 3.6 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[8] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.3 and Table 3.4.

Table 3.3—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CCAH—Merced County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.00%	15.78%	▼	12.78%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.92%	90.10%	↑	86.87%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	83.33%
Annual Monitoring for Patients on Persistent Medications—Diuretics	79.91%	91.17%	↑	86.43%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.66%	NA	Not Comparable	97.63%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.67%	91.03%	↔	91.65%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.11%	94.07%	↑	90.31%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.58%	86.86%	↔	88.46%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	50.85%	43.31%	↓	62.53%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	49.64%	51.82%	↔	53.53%
Comprehensive Diabetes Care—HbA1c Testing	85.16%	88.32%	↔	83.94%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	36.01%	39.42%	↔	44.28%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	25.06%	28.47%	↔	32.85%
Comprehensive Diabetes Care—LDL-C Screening	78.35%	81.02%	↔	78.59%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.83%	86.86%	↑	81.27%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	57.18%	52.07%	↔	45.74%

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

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

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

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

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.4—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CCAH—Monterey/Santa Cruz Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.69%	13.89%	▼	11.58%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.28%	89.63%	↑	87.34%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	87.80%	Not Comparable	87.76%
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.85%	90.06%	↑	87.02%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.32%	NA	Not Comparable	98.31%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	92.06%	95.29%	↑	92.11%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	93.21%	92.34%	↔	93.18%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	91.08%	87.52%	↓	90.94%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.29%	59.85%	↔	75.18%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	51.09%	62.04%	↑	56.45%
Comprehensive Diabetes Care—HbA1c Testing	81.27%	88.08%	↑	86.86%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	40.15%	51.82%	↑	51.82%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	31.39%	37.96%	↑	35.77%
Comprehensive Diabetes Care—LDL-C Screening	73.97%	81.75%	↑	79.81%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	75.67%	82.97%	↑	79.32%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	50.36%	40.88%	▲	38.20%

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

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

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

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

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.5—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
CCAH—Merced County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
297.38	50.05	539.90	76.83

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

Table 3.6—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
CCAH—Monterey/Santa Cruz Counties

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
282.10	44.17	549.69	74.76

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

Performance Measure Result Findings

The following measures had rates above the HPLs:

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* for Monterey/Santa Cruz counties
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Monterey/Santa Cruz counties
- *Use of Imaging Studies for Low Back Pain* for Merced and Monterey/Santa Cruz counties, with the rate being above the HPL in Monterey/Santa Cruz counties for the fourth consecutive year
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* for Merced and Monterey/Santa Cruz counties, with the rate being above the HPL in Monterey/Santa Cruz counties for the fourth consecutive year
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* for Monterey/Santa Cruz counties for the fourth consecutive year
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* for Monterey/Santa Cruz counties for the fourth consecutive year

The rates for the following measures improved significantly from 2013 to 2014:

- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* for Merced and Monterey/Santa Cruz counties

- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* for Monterey/Santa Cruz counties
- *Immunizations for Adolescents—Combination 1* for Merced County
- *Medication Management for People with Asthma—Medication Compliance 50% Total* for Merced County
- *Medication Management for People with Asthma—Medication Compliance 75% Total* for Monterey/Santa Cruz counties, resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014 (Note: DHCS did not hold the MCPs accountable to meet the MPL for this measure in 2013 since 2013 was the first year the measure was reported.)
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Monterey/Santa Cruz counties

The rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure for Merced County improved by more than 2 percentage points. Although not statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014.

Monterey/Santa Cruz counties had no measures with rates below the MPLs, and Merced County had one measure with a rate below the MPL—*Annual Monitoring for Patients on Persistent Medications—Digoxin*.

As part of the process for developing this report, CCAH provided information about actions the MCP took to address 12 rates being significantly worse in 2013 when compared to 2012 (see Appendix D). The MCP's actions appear to have been successful, as the rate for only one measure (*Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*) declined significantly from 2013 to 2014. Additionally, as noted above, seven rates improved significantly from 2013 to 2014.

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for four measures for Merced County and 10 measures for Monterey/Santa Cruz counties. The better rates for the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to more monitoring of care. The SPD rates were significantly worse than the non-SPD rates for the following measures:

- *All-Cause Readmissions* for Merced and Monterey/Santa Cruz counties
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 29 Years* for Monterey/Santa Cruz counties
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* for Merced County

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however rates should be interpreted with

caution as high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures and HSAG does not provide comparative analysis.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act (PDSA) cycle. DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates (measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid cycle approach (including the PDSA cycle) to strengthen these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

Assessment of MCP's Improvement Plans

CCAH was required to continue its IP for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure for Merced County in 2013. The MCP identified several barriers to the rate for the measure being above the MPL, including:

- Variations existed in prescribing patterns for antibiotic treatment.
- Educational efforts in 2012 were passive (i.e., newsletters).
- Members' insistence on receiving antibiotics was high.
- Monthly monitoring of provider performance was resource intensive and not effective.
- Antibiotic prescribing for acute bronchitis in the ED was high.

The following new interventions were implemented by CCAH to address the barriers:

- Conducted a member survey of 30 members from each county who were given antibiotics, and provided education when the members' responses showed lack of knowledge about the appropriate use of antibiotics.
- Sent a letter (to members linked to low-performing providers) that included a brochure from the Antibiotic Resistance Education Program and the Centers for Disease Control and Prevention with information on the use of antibiotics for bronchitis.

In addition to the IP for this measure, DHCS required CCAH to submit a PDSA cycle related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure. The PDSA cycle focused on identifying the provider with the highest prescribing rate for antibiotics for acute bronchitis in Merced County. Once the provider was identified, the MCP developed a report that showed the provider's performance against benchmarks, peer-to-peer comparison, and member details. Additionally, CCAH conducted a targeted in-service with the provider to share the results, provide available resources, and disseminate educational materials.

CCAH's efforts were successful at improving the rate for the measure by more than 2 percentage points, which resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014. The MCP will not be required to continue the IP for this measure in 2014.

New Improvement Plans for 2014

CCAH will not be required to submit any IPs for 2014.

Strengths

HSAG auditors determined that CCAH followed the appropriate specifications to produce valid performance measure rates, and no issues of concern were identified.

CCAH had eight measures with rates above the HPLs, and seven rates improved significantly from 2013 to 2014. The MCP's IP was successful at improving the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure from below the MPL in 2013 to above the MPL in 2014. Additionally, the rate for the *Medication Management for People with Asthma—Medication Compliance 75% Total* measure improved from below the MPL in 2013 to above the MPL in 2014. Finally, the MCP had only one measure with a rate that declined significantly from 2013 to 2014, compared to 12 rates that were significantly worse in 2013 when compared to 2012.

CCAH continued to be a high-performing MCP and in 2014 was given the DHCS Honorable Mention Quality Award for its HEDIS performance.

Opportunities for Improvement

The HSAG auditor indicated that CCAH has the opportunity to explore ways to capture rendering provider/specialist information to reduce the burden of medical record review during the HEDIS audit process.

CCAH has the opportunity to assess the factors leading to the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure for Merced County being below the MPL and the rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure declining significantly from 2013 to 2014.

To ensure that the needs of the SPD population are being met, the MCP has the opportunity to continue to assess the factors leading to four SPD rates being significantly worse than the non-SPD rates. Although CCAH provided HSAG with documentation of actions the MCP has taken to address some 2013 SPD rates being significantly worse than the non-SPD rates (see Appendix D), the MCP has the opportunity to continue to assess if and which efforts are making a positive impact since four SPD rates continued to be significantly worse than the non-SPD rates.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[9] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

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

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

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

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

Quality Improvement Project Objectives

CCAH participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2013–June 30, 2014.

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

Table 4.1—Quality Improvement Projects for CCAH
July 1, 2013, through June 30, 2014

QIP	Counties	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Merced and Monterey/Santa Cruz	Clinical	Q, A
Improving Asthma Health Outcomes	Merced and Monterey/Santa Cruz	Clinical	Q, A

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

CCAH's *Improving Asthma Health Outcomes* QIP attempted to improve the quality of care delivered to beneficiaries with asthma aged 5 to 64 years by reducing asthma exacerbations. Inadequate medication control and asthma exacerbations resulting in emergency room (ER) visits and hospital inpatient stays are indicators of suboptimal care. These visits and stays may also indicate ineffective case management of chronic diseases.

Quality Improvement Project Validation Findings

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

Table 4.2—Quality Improvement Project Validation Activity
CCAH—Merced and Monterey/Santa Cruz Counties
July 1, 2013, through June 30, 2014

Name of Project/Study	Counties	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	All counties received the same score	Annual Submission	94%	100%	*Met*
Internal QIPs					
Improving Asthma Health Outcomes	All counties received the same score	Annual Submission	88%	86%	*Partially Met*
	All counties received the same score	Annual Resubmission 1	100%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that CCAH's annual submission of its *All-Cause Readmissions* QIP achieved an overall validation status of *Met*, with 94 percent of evaluation elements and 100 percent of critical elements receiving a met score. The *Improving Asthma Health Outcomes* QIP annual submission received an overall validation status of *Partially Met*. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, CCAH resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of evaluation elements (critical and noncritical) receiving a met score.

Table 4.3 summarizes the aggregated validation results for CCAH's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
CCAH—Merced and Monterey/Santa Cruz Counties
(Number = 6 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	75%	8%	17%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**83%**	**6%**	**11%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

HSAG validated Activities I through VIII for CCAH's *All-Cause Readmissions* and *Improving Asthma Health Outcomes* QIPs annual submissions.

CCAH demonstrated a strong application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs.

Both QIPs progressed to the Implementation stage during the reporting period. The MCP demonstrated an adequate application of the Implementation stage, meeting 83 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *All-Cause Readmissions* QIP, CCAH did not document if there were any factors that threatened the internal or external validity of the findings, resulting in a lower score for Activity VII. In the initial submission of the *Improving Asthma Health Outcomes* QIP, CCAH did not document if there were any factors that threatened the internal or external validity of the findings and did not provide accurate data, resulting in a lower score for Activity VII. The MCP corrected the deficiencies in the *Improving Asthma Health Outcomes* QIP resubmission, resulting in the QIP achieving an overall *Met* validation status.

Quality Improvement Project Outcomes and Interventions

Neither QIP progressed to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP's interventions for each QIP:

All-Cause Readmissions QIP

Alliance Telephonic Care Transitions Program

- Conduct telephonic assessment post-discharge with all members in Santa Cruz and Merced counties who have a diagnosis of heart failure, myocardial infarction, diabetes, asthma, or pneumonia. The call includes verification of a primary care physician (PCP) follow-up appointment within 14 days after discharge, medication inventory, an advance care plan, and a member satisfaction survey.
  - A second telephone call is made after the 14-day follow-up appointment to conduct a medication inventory and assess for any additional needs.

Alliance Home Visit Care Transitions Pilot Program

- Readmitted members discharged from Monterey County hospitals with a diagnosis of heart failure, myocardial infarction, diabetes, asthma, or pneumonia are visited by a home care nurse within 72 hours of the hospital discharge. The nurse verifies that the member has a follow-up visit scheduled with his/her PCP within 14 days of the discharge, completes a medication reconciliation, completes an advance care plan, and conducts a member satisfaction survey.
- Conduct a second home visit after the PCP visit to perform a second medication reconciliation and assess for any additional needs.
- Implemented a process to send a fax to the PCP when a member has an inpatient admission. The fax includes the member's 90-day readmission history and a reminder that the member will need a follow-up appointment within 14 days.

Improving Asthma Health Outcomes QIP

- Redesign the asthma action plan (AAP) template into an electronic and paper form. The forms will be used by providers to help guide discussions with members regarding their asthma condition. The forms will include the following:
  - A place for member and/or parent to sign an attestation acknowledging understanding of what to do to keep asthma symptoms under control.
  - A place for member to indicate to the provider the severity of his/her asthma. If the member has persistent asthma and the provider does not complete the form correctly, the MCP will contact the provider to review how to correctly complete the form.

  - A place for the member to indicate what triggers his/her asthma.
- Enhance the MCP's current Healthy Breathing for Life (HBL) monthly report.
- Revise the HBL identification criteria to match HEDIS/NCQA identification criteria.
- Establish asthma health education in Merced County.
- For Monterey County providers, generate provider-specific reports on *Medication Management for People with Asthma* rate, ED use, hospital admissions, and AAP submission rate.
- Administer educational outreach programs for members admitted to the hospital for asthma.
- Perform process improvements including health educators approving AAPs in workflow and providing both provider and member newsletters regarding improved asthma management and utilization for asthma health education benefit.

Outcome information for each QIP will be included in CCAH's 2014–15 MCP-specific evaluation report.

Strengths

CCAH demonstrated an excellent application of the QIP Design stage. The MCP met all requirements for all applicable evaluation elements within the Design stage for both its *All-Cause Readmissions* and *Improving Asthma Health Outcomes* QIPs. The MCP was also able to achieve a *Met* validation status for the *All-Cause Readmissions* QIP on the first submission.

In response to HSAG's recommendations in CCAH's 2012–13 MCP-specific evaluation report, CCAH implemented a process to ensure that staff referred to the QIP Completion Instructions and QIP validation tools prior to the MCP submitting the QIP (see Appendix D). Implementation of the new process resulted in fewer QIP resubmissions during the review period for this report when compared to the 2012–13 reporting period.

Opportunities for Improvement

Although CCAH improved its QIP submissions, the MCP should continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

Conducting the EQRO Review

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Please note that when a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[10]

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

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

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

CCAH's quality improvement program description provides details of the MCP's monitoring and evaluation processes, which are designed to ensure that quality care is provided to members. CCAH's quality improvement work plan goals are mostly related to the MCP's performance on measures, and most of the measures fall into the quality domain of care. CCAH's evaluation of the work plan activities indicated that the MCP has made progress toward improving performance on the measures.

The following quality performance measures had rates above the HPLs:

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* for Monterey/Santa Cruz counties
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Monterey/Santa Cruz counties
- *Use of Imaging Studies for Low Back Pain* for Merced and Monterey/Santa Cruz counties, with the rate being above the HPL in Monterey/Santa Cruz counties for the fourth consecutive year
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* for Merced and Monterey/Santa Cruz counties, with the rate being above the HPL in Monterey/Santa Cruz counties for the fourth consecutive year
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* for Monterey/Santa Cruz counties for the fourth consecutive year
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* for Monterey/Santa Cruz counties for the fourth consecutive year

The following quality measures had rates that improved significantly from 2013 to 2014:

- *Immunizations for Adolescents—Combination 1* for Merced County
- *Medication Management for People with Asthma—Medication Compliance 50% Total* for Merced County
- *Medication Management for People with Asthma—Medication Compliance 75% Total* for Monterey/Santa Cruz counties, resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014 (Note: DHCS did not hold the MCPs accountable to meet the MPL for this measure in 2013 since 2013 was the first year the measure was reported.)
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Monterey/Santa Cruz counties

The rate for Merced County for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, which falls into the quality domain of care, improved from 2013 to 2014. Although not statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014.

The rate for Merced County for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure, which falls into the quality domain of care, was below the MPL.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care. The SPD rates were significantly better than the non-SPD rates for three of the measures for Merced County and nine measures for Monterey/Santa Cruz counties. The better rates for the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to more monitoring of care. The SPD rates were significantly worse than the non-SPD rates for the following measures:

- *All-Cause Readmissions* for Merced and Monterey/Santa Cruz counties
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* for Merced County

Both of CCAH's QIPs fell into the quality domain of care. Since neither QIP progressed to the Outcomes stage, HSAG was not able to assess the QIPs' success at improving the quality of care delivered to the MCP's MCMC members.

Overall, CCAH showed above-average performance related to the quality domain of care.

Access

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

CCAH's quality improvement program description indicates that the MCP has policies designed to ensure members' access to needed health care services. Additionally, as indicated above, CCAH's quality improvement work plan goals are mostly related to the MCP's performance on measures. Some measures in the work plan fall into the access domain of care, and CCAH's evaluation of the work plan activities indicated that the MCP has made progress toward improving performance on the measures.

The rate for one access performance measure, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, was above the HPL for Monterey/Santa Cruz counties. The following access measures had rates that improved significantly from 2013 to 2014:

- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* for Merced and Monterey/Santa Cruz counties
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* for Monterey/Santa Cruz counties
- *Immunizations for Adolescents—Combination 1* for Merced County
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Monterey/Santa Cruz counties

No access measures had rates below the MPLs, and the rate for one access measure for Merced County, *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*, declined significantly from 2013 to 2014.

Nine of the performance measures stratified for the SPD population fall into the access domain of care. The SPD rates were significantly better than the non-SPD rates for two of the measures for Merced County and five measures for Monterey/Santa Cruz counties. As indicated above, the better rates for the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to more monitoring of care. The SPD rates were significantly worse than the non-SPD rates for the following measures:

- *All-Cause Readmissions* for Merced and Monterey/Santa Cruz counties
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* for Monterey/Santa Cruz counties

Both of CCAH's QIPs fell into the access domain of care. Since neither QIP progressed to the Outcomes stage, HSAG was not able to assess the QIPs' success at improving access to care for the MCP's MCMC members.

Overall, CCAH showed average performance related to the access domain of care.

Timeliness

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

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas

such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

CCAH's quality improvement program description provides information on the MCP's structure, which supports the provision of timely care to members.

The rate for one timeliness performance measure, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, was above the HPL for Monterey/Santa Cruz counties; and the following timeliness measures had rates that improved significantly from 2013 to 2014:

- *Immunizations for Adolescents—Combination 1* for Merced County
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Monterey/Santa Cruz counties

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

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2012–13 MCP-specific evaluation report. CCAH's self-reported responses are included in Appendix D.

Recommendations

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

- Explore ways to capture rendering provider/specialist information to reduce the burden on medical record review during the HEDIS audit process.
- Assess the factors leading to the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure for Merced County being below the MPL, and identify strategies to improve the measure's rate.
- Assess the factors leading to the rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure declining significantly from 2013 to 2014, and identify strategies to prevent further decline on the rate.

- Assess actions already taken (see Appendix D) to determine if and which efforts are making a positive impact to ensure the MCP is meeting the SPD population's needs, since four SPD rates continued to be significantly worse than the non-SPD rates.
- Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

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

Table A.1 and Table A.2 provide two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the tables:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table A.1—HEDIS 2014 SPD Trend Table
CCAH—Merced County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	14.40%	15.78%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	75.54	76.83	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	536.12	539.90	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.83%	90.10%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.28%	91.17%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	90.32%	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.17%	91.03%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.89%	94.07%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.74%	86.86%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	61.80%	43.31%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.28%	51.82%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.67%	88.32%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.66%	39.42%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.33%	28.47%	↔
Comprehensive Diabetes Care—LDL-C Screening	79.32%	81.02%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.13%	86.86%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	43.80%	52.07%	▼

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

Table A.2—HEDIS 2014 SPD Trend Table
CCAH—Monterey/Santa Cruz Counties

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	14.47%	13.89%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	79.25	74.76	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	543.55	549.69	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.32%	89.63%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	89.13%	87.80%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.86%	90.06%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.67%	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	92.76%	95.29%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	91.46%	92.34%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.47%	87.52%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	65.21%	59.85%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	63.99%	62.04%	↔
Comprehensive Diabetes Care—HbA1c Testing	86.37%	88.08%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	51.58%	51.82%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	40.88%	37.96%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.16%	81.75%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.02%	82.97%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	36.98%	40.88%	↔

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

Table B.1 and Table B.2 provide two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the tables:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table B.1—HEDIS 2014 Non-SPD Trend Table
CCAH—Merced County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.86%	8.00%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	51.12	50.05	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	299.06	297.38	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.26%	82.92%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.96%	79.91%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.51%	97.66%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.37%	91.67%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.76%	90.11%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	90.30%	88.58%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	69.34%	50.85%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	49.88%	49.64%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.18%	85.16%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.26%	36.01%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.58%	25.06%	↓
Comprehensive Diabetes Care—LDL-C Screening	81.75%	78.35%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.00%	78.83%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	45.50%	57.18%	▼

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

Table B.2—HEDIS 2014 Non-SPD Trend Table
CCAH—Monterey/Santa Cruz Counties

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.78%	7.69%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	49.10	44.17	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	293.93	282.10	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.15%	83.28%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.84%	80.85%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.50%	98.32%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.26%	92.06%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.86%	93.21%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	91.17%	91.08%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	76.16%	62.29%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	61.56%	51.09%	↓
Comprehensive Diabetes Care—HbA1c Testing	85.64%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.42%	40.15%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.20%	31.39%	↓
Comprehensive Diabetes Care—LDL-C Screening	79.81%	73.97%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.16%	75.67%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	39.90%	50.36%	▼

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

Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[11] This process allows HSAG to evaluate each MCP's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.1 and Table 3.2)

Quality Domain

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

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

Access and Timeliness Domains

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

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Some, but not all, study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

APPENDIX D. MCP'S SELF-REPORTED FOLLOW-UP ON EXTERNAL QUALITY REVIEW RECOMMENDATIONS FROM THE JULY 1, 2012–JUNE 30, 2013 PERFORMANCE EVALUATION REPORT

for Central California Alliance for Health

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with CCAH's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table D.1—CCAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

2012–13 External Quality Review Recommendation Directed to CCAH	Actions Taken by CCAH During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Build on the successful interventions being implemented to improve the rate for the Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis measure in Merced County to move the rate from below the MPL to above the MPL.	Provider level reports were developed and distributed to the providers in Merced county with high antibiotic use for acute bronchitis. Inservices were performed and resources were made available (i.e., Center for Disease Control and Prevention [CDC] handouts, posters, prescription pads for symptom management) to the providers. The measure and recommendations for improvement were discussed at the Joint Operating Committee (JOC), which includes members from CCAH and hospital staff. In addition, the member newsletter and provider bulletins (September and December 2013) incorporated information on avoiding antibiotics for acute bronchitis. Member outreach was done by telephone to assess values and knowledge related to antibiotic use; Just in Time education was provided. This measure has also been incorporated as a new quality measure for the Alliance Care Based Incentives program for 2015.
2. Since CCAH had 12 measures with rates that were significantly lower in 2013 when compared to 2012, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.	As part of the Quality and Performance Improvement Plan, an annual work plan is developed at the end of the year to prioritize areas for improvement. The recommendations from the performance evaluation report and those measures that declined significantly are discussed at the quality improvement committee meetings and incorporated in the work plan. This was demonstrated by focused interventions on the measures that fell below the minimum performance levels (i.e., *Avoidance of Antibiotics for Acute Bronchitis* and *Cervical Cancer Screening*). For HEDIS 2013, abstraction and medical record review was done by a vendor. To ensure the highest level of accuracy and review for all hybrid measures, it was determined that CCAH would discontinue use of vendor for abstraction in HEDIS 2014. In addition, a HEDIS debrief is performed at the end of the season, to identify lessons learned and develop actions for improvement. This includes a review of the measures with statistically significant improvement or decline from the previous year. To improve processes, a HEDIS Process Redesign was a priority for the Alliance and focused on improving administrative data capture for all measures.

2012–13 External Quality Review Recommendation Directed to CCAH	Actions Taken by CCAH During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
3. For measures with SPD rates that were significantly worse than the non-SPD rates in 2013, assess the factors leading to the rates being significantly worse for the SPD population and identify interventions to implement to ensure the MCP is meeting the SPD population's needs.	A contributing factor to the rates being significantly worse for the SPD population may be the methodology between 2012 and 2013. In 2012, the methodology for the SPD measures was fairly new, and standardization of the SPD methodology was further refined in 2013 by the vendor. For the measures that were significantly worse, the following interventions were implemented: • *All Cause Readmission* interventions: In February 2013, the Alliance Telephonic Care Transitions Program was implemented. Telephonic assessment and care coordination were conducted for all members for a period of 30 days post-discharge (including SPD) in Santa Cruz, Monterey, and Merced Counties for specific chronic conditions post-discharge: asthma, heart failure, acute myocardial infarction, pneumonia, diabetes. This included verification of primary care physician (PCP) follow-up appointment within 14 days after discharge, medication inventory, advanced care planning/physician orders for life-sustaining treatment (POLST), and a member question related to satisfaction. For those members who need additional support after 30 days, a referral is made to the Alliance Care Management Program. In addition, in May 2014, the Care Transitions Home Visit Pilot Project was initiated in Monterey County. The program consists of an in-hospital visit and two home visits by a home health registered nurse to selected high-risk patients that are not otherwise receiving home health services. During visits, the nurse will discuss discharge summary, reconcile medication, perform a home safety assessment, facilitate the PCP visit appointment after discharge, provide education on disease management, discuss advanced care planning, and assess any additional needs. • For *Children and Adolescents' Access to Primary Care Practitioners* (CAP) interventions: Annual Well-Child Visit reminder letters for children 3 to 6 years of age and adolescents 12 to 19 years of age are sent to the member's home during their birth month; third quarter reminder letters are sent to members that have not had a well-child exam for the current year; and immunization reminder postcards are sent at 3 and 9 months. In addition, the Care-Based Incentive program incentivizes providers for the well-child and adolescent well-child visit (AWC) measures, for members 3 to 6 and 12 to 21 years of age. A monthly list of non-compliant members is available to each provider on the provider portal. • *Comprehensive Diabetes Care* (*CDC*) interventions: *CDC* SPD abstraction for HEDIS 2014 was given additional focus for the 2013 measurement year. A quarterly list of *CDC* screenings that have not been completed on diabetic members is available to the providers in the provider portal. The Alliance diabetes education program "Live Better with Diabetes" provides individual or group training for members with diabetes to understand diabetes and disease management. In 2013, the Alliance Health Programs team implemented a peer-to-peer, evidence-based program following

<table>
<tr><th>2012–13 External Quality Review Recommendation Directed to CCAH</th><th>Actions Taken by CCAH During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation</th></tr>
<tr><td></td><td>Stanford University's Chronic Disease Self-Management Program (CDSMP). The Alliance has two master trainers and seven leaders to facilitate the face-to-face workshops within our service area. Classes started in September 2013. In February 2014 the Alliance hired a registered dietitian to provided additional education about chronic disease.</td></tr>
<tr><td>4. Refer to the QIP Completion Instructions prior to submitting QIPs to ensure completeness of the data. Additionally, the MCP should ensure all comments in the QIP Validation Tool are addressed prior to the next QIP submission; and if the MCP is not clear on how to address the comments, it should request technical assistance from the EQRO.</td><td>As part of the QIP submissions, a work plan was developed for both asthma and readmission which included timelines for internal approval processes and reminders to utilize the QIP Completion Instructions and QIP Validation Tool as checklists prior to submission. During the QIP process this year, technical assistance was requested at a greater frequency to address sampling and validation issues.

For asthma, the QIP metrics have been monitored on a quarterly basis and documented on the work plan. The results were discussed at the Asthma Performance Improvement meetings to allow feedback for root causes of the results. A schedule has been created to stay on track for the QIP submission as follows:

<table>
<tr><th>Task</th><th>Due Date</th></tr>
<tr><td>Data Analysis</td><td>May 30, 2014</td></tr>
<tr><td>Initial Outline</td><td>June 27, 2014</td></tr>
<tr><td>First Draft using QIP Completion Instructions/QIP Validation Tool</td><td>July 14′ 2014</td></tr>
<tr><td>Review with Leadership</td><td>July 18,2014</td></tr>
<tr><td>Corrections , Final Review, Assistance from EQRO if needed</td><td>August 1′ 2014</td></tr>
<tr><td>QIP Submission to the State</td><td>August 29′ 2014</td></tr>
</table>
</td></tr>
<tr><td>5. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the Getting Care Quickly, Rating of Health Plan, and Rating of All Health Care priority areas.</td><td>A detailed analysis of the CAHPS survey results was done and presented at the Clinical Quality Committee meetings and other leadership forums.

In the CAHPS survey report, key recommendations were noted and implemented as stated below:

Getting Care Quickly:
Access to Care
The organization prioritized initial health assessments (IHAs) as an integral part of PCP care. Providers and members were educated on the importance of the IHA and the requirement for completing an initial exam in a timely manner. The education was completed through the provider portal, provider workshops, provider</td></tr>
</table>

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

2012–13 External Quality Review Recommendation Directed to CCAH	Actions Taken by CCAH During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	newsletters, and member newsletters in September 2013, December 2013, and March 2014. The interventions focused on completion of the IHA within 120 days, promotion of the patient-centered medical home (PCMH) by choosing a PCP, and ensuring access to care upon enrollment. In addition, a Rapid Dramatic Performance Improvement (DPI) pilot program was implemented starting in March 2013, which focused on the PCMH model and decreased emergency department (ED) use by creating team-based quality care, expanding access for patients, and improving system efficiencies. The program was implemented in eight Alliance provider clinics. Five clinics started March–April 2013, and two started in May–August 2013. Dashboards at the clinic site monitored no-show rate, third next available appointment, provider productivity measures (visits/hour, visits/session, and missed opportunities), cycle time, and confirmation calls. In the clinics that participated in the rapid DPI program, there was an overall decrease in ED visit use of 6 percent year over year compared to all other providers. Preliminary data presented on members switching providers showed a slight decrease overall, a proxy measure for member satisfaction. The following Care Based Incentives (CBI) measures related to access were continually promoted as opportunities for improvement: avoidable ED visits, ambulatory care sensitive admissions, well-child care visits, adolescent well-child visits, and extended office hours. Provider education on current CBI was done through the provider workshops, provider portal, and provider bulletins. Facility site reviews are conducted routinely by the quality improvement nurses. During these reviews the nurses monitor provider compliance to the accessibility standards outlined in Policy 401-1509—Accessibility. These standards ensure provider availability for members. In addition, during these site reviews compliance to the initial health assessment guidelines outlined in the Policy 401-1511—Initial Health Assessment are evaluated and feedback provided as needed. **Rating of Health Plan:** *Alternatives to One-On-One Visits* The Alliance is working on increasing referrals to the Alliance Approved Asthma Educators for members. Asthma education consists of group and individual classes for members, including self-management techniques. This allows members to have more resources available for asthma management. In addition during the efforts of this project, the Alliance recruited a new asthma educator in Merced county. This is the first Alliance-approved asthma educator in Merced.

<table>
<tr><th>2012–13 External Quality Review Recommendation Directed to CCAH</th><th>Actions Taken by CCAH During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation</th></tr>
<tr><td></td><td>
Chronic Disease Self-Management Workshops were initiated by Alliance Health Programs in late 2013 and continued in 2014. This series of six classes is an avenue for members with chronic diseases to come together in a group setting with their peers to learn about self-management techniques, goal setting to improve disease management and outcomes, and the value of peer support in managing stress reduction and chronic disease management.

Promote Quality Improvement Initiatives
Several quality improvement initiatives have been promoted quarterly to continually engage the member in health plan activities. Provider bulletins (P) and member newsletter (M) articles published included the following:
<table>
<tr><th>Publication Month and Year</th><th>Promoted Quality Improvement Initiative</th></tr>
<tr><td>September 2013</td><td>Asthma Education Benefit (P)
New Patient Exams (Initial Health Assessment) (M)</td></tr>
<tr><td>September 2013</td><td>Staying Healthy Assessment and Initial Health Assessment (P)</td></tr>
<tr><td>September 2013</td><td>Avoidance of Antibiotics for Acute Bronchitis (P)</td></tr>
<tr><td>December 2013</td><td>Staying Healthy Assessment and Initial Health Assessment (P)
Advanced Care Planning (M)</td></tr>
<tr><td>December 2013</td><td>Care Based Incentives (P)</td></tr>
<tr><td>December 2013</td><td>PEARLS [Partnership, Empathy, Apology, Respect, Legitimation and Support] for Reducing Inappropriate Antibiotic Use (P)</td></tr>
<tr><td>December 2013</td><td>Immunizations (P)</td></tr>
<tr><td>March 2014</td><td>Best Practices During Facility Site Reviews (P), Avoidance of Antibiotics (M)</td></tr>
<tr><td>March 2014</td><td>Staying Healthy Assessment and Initial Health Assessment (P)</td></tr>
<tr><td>June 2014</td><td>Avoidable Emergency Department Visits (P and M), Cervical Cancer Screening (M)</td></tr>
</table>

Rating of All Health Care:
Shared Decision Making
The importance of shared decision making was presented at the Clinical Quality Improvement Committee meeting (October 29, 2013). Attendees of this meeting included members, providers, and Alliance staff. A video from the Institute for Healthcare Improvement (IHI) on shared decision making was shared and best practices promoted.
</td></tr>
</table>

2012–13 External Quality Review Recommendation Directed to CCAH	Actions Taken by CCAH During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
6. Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.	• To address the billing/reporting provider number issue, the Alliance redesigned our provider subsystem and claim adjustment subsystem on January 7, 2012. As of January 2012, data are consistent going forward as a result. • For the issue related to referring/prescribing/admitting provider number in the pharmacy data, the Alliance changed pharmacy benefit managers (PBMs) in January 2013, and the new PBM receives and stores these data. This issue is now resolved. • For the hospital/inpatient claim type related to primary surgical procedure codes and secondary surgical procedure codes, the Alliance is converting to a new core system in 2015 and will be able to store and submit these data elements. The Alliance will continue to work with DHCS on interim solutions as necessary.