Performance Evaluation Report

Contra Costa Health Plan

July 1, 2013–June 30, 2014

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

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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 6
Opportunities for Improvement 6
3. PERFORMANCE MEASURES 7
Conducting the EQRO Review 7
Validating Performance Measures and Assessing Results 7
Performance Measure Validation 8
Performance Measure Validation Findings 8
Performance Measure Results 9
Seniors and Persons with Disabilities Performance Measure Results 12
Performance Measure Result Findings 15
Improvement Plans 16
Assessment of MCP's Improvement Plans 17
Strengths 18
Opportunities for Improvement 18
4. QUALITY IMPROVEMENT PROJECTS 19
Conducting the EQRO Review 19
Validating Quality Improvement Projects and Assessing Results 19
Quality Improvement Project Objectives 20
Quality Improvement Project Validation Findings 20
Quality Improvement Project Outcomes and Interventions 23
Strengths 24
Opportunities for Improvement 24
5. ENCOUNTER DATA VALIDATION 25
Conducting the EQRO Review 25
6. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS 26
Overall Findings Regarding Health Care Quality, Access, and Timeliness 26
Quality 26

Access 28
Timeliness 29
Follow-Up on Prior Year Recommendations 30
Recommendations 30

APPENDIX A. SPD TREND TABLE A-1

APPENDIX B. NON-SPD TREND TABLE 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 – Contra Costa Health Plan
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,

[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.

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

- MCP-specific evaluation reports (July 1, 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, Contra Costa Health Plan ("CCHP" 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

CCHP is a full-scope MCP delivering services to its MCMC members as a "Local Initiative" (LI) MCP under the Two-Plan Model (TPM). In TPM counties, MCMC beneficiaries may choose between two MCPs; typically, one MCP is an LI and the other a commercial plan (CP). DHCS contracts with both plans. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. MCMC beneficiaries may enroll in CCHP, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative CP.

CCHP became operational in Contra Costa County to provide MCMC services effective February 1997. As of June 30, 2014, CCHP had 124,185 MCMC members in Contra Costa County.[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-County Organized Health System (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.

Seniors and Persons with Disabilities Medical Survey

The most recent SPD medical survey for CCHP was conducted March 4, 2013, through March 6, 2013, covering the review period of December 1, 2011, through November 30, 2012. DMHC evaluated the following elements related to CCHP's delivery of care to the SPD population:

- Utilization Management
- Continuity of Care
- Access and Availability of Health Care Services
- Member Rights
- Quality Management

The survey report, issued to DHCS on August 6, 2013, indicated that DMHC identified the following potential deficiencies:

- In the area of Utilization Management, the MCP does not ensure that clinical decisions based on medical necessity are consistent with MCP criteria and guidelines.

- In the area of Access and Availability of Health Care Services, the MCP's website and provider directory do not indicate levels of access or medical equipment access.
- In the area of Member Rights:
  - The MCP's *Member Handbook and Evidence of Coverage* incorrectly implies that members may only file an appeal to a grievance decision in writing.
  - The MCP does not ensure that grievance forms distributed by Contra Costa Regional Medical Center to the MCP's members contain contractually required information.
- In the area of Quality Management:
  - The MCP's current reporting system does not produce adequate or accurate data that would allow the MCP to continuously review the quality of care provided to members and/or ensure that quality of care problems are identified and corrected.
  - The MCP is not ensuring that its largest delegate implements CAPs when deficiencies in care are revealed.

Audits & Investigation Division Medical Audit

The most recent A&I medical audit for CCHP was conducted March 4, 2013, through March 15, 2013, covering the review period of December 1, 2011, through November 30, 2012. The report was issued August 16, 2013, and DHCS sent a letter to the MCP dated September 9, 2013, which included a copy of the report. The letter indicated that CCHP was required to provide a CAP and respond to all deficiencies in the report. A&I reviewed the following areas:

- Utilization Management
- Continuity of Care
- Access and Availability to Care
- Member's Rights
- Quality Management
- Administrative and Organizational Capacity

A&I identified multiple findings in all review areas, resulting in the CAP requirement. Additionally, during the review A&I assessed CCHP's compliance with State Supported Services requirements. A&I determined that while CCHP made corrections to its provider manual to remove implications of any restriction or prior authorization requirement for abortion services, numerous policies and procedures continue to contain language that places limitations or conditions to receive abortion services. A&I indicated that this is a repeat finding for the MCP and recommended that, to be compliant with the requirements, the CCHP revise its policies and procedures.

Strengths

DMHC identified no potential deficiencies in the area of Continuity of Care during the March 2013 SPD medical survey with CCHP.

Opportunities for Improvement

CCHP has the opportunity to address all potential deficiencies identified during the March 2013 SPD medical survey and findings from the March 2013 medical audit. The findings are in areas that affect the quality and timeliness of and access to care for MCMC members.

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 Contra Costa Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that CCHP followed the appropriate specifications to produce valid rates; however, there were issues of concern that caused minimal impact on the findings. A brief summary of the findings and opportunities for improvement is included below.

- CCHP had sufficient practices in place to process medical services data.
- CCHP resolved the claims backlogs noted in last year's audit.
- After a thorough review, CCHP determined that abstraction errors made by one reviewer were the primary reason for the noncompliant cases. The MCP developed an action plan to ensure accurate abstraction for future audits.
- The auditor recommended that CCHP:
  - Implement additional coding details to provide immediate feedback to the providers.

[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).

- Work with its vendor to obtain complete encounter data.
- Implement a formal HEDIS process to ensure consistency from year to year.
- Implement protocols to ensure that all sources of data are verified prior to loading into the database.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of CCHP'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 shows 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.

The reader should note the following regarding Table 3.1:

- 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
CCHP—Contra Costa 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	—	—	16.99%	12.95%	▲
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	59.47	60.94	53.25	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	274.88	217.23	246.81	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	85.62%	83.77%	86.52%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	**85.71%**	95.45%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**80.95%**	83.68%	85.11%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	29.56%	26.52%	43.27%	44.09%	↔
Cervical Cancer Screening	Q,A	—	—	—	**54.99%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	87.16%	85.40%	84.47%	74.70%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**93.97%**	**86.74%**	**94.62%**	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**84.54%**	**76.18%**	**86.07%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**84.07%**	**77.96%**	**86.71%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**83.25%**	**74.86%**	**83.44%**	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	55.11%	54.99%	59.37%	61.31%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	49.09%	52.80%	51.09%	51.34%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	86.86%	84.91%	85.40%	84.43%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	56.57%	53.04%	49.88%	48.18%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	40.69%	36.25%	41.61%	42.34%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Comprehensive Diabetes Care—LDL-C Screening	Q,A	77.74%	75.43%	82.00%	75.67%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	89.23%	87.35%	82.00%	83.94%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	33.94%	36.98%	40.39%	41.61%	↔
Controlling High Blood Pressure	Q	—	—	51.34%	53.28%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	59.85%	71.61%	73.24%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	56.90%	**43.46%**	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	33.95%	22.79%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	67.40%	64.96%	62.53%	60.34%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	81.75%	83.21%	86.86%	83.45%	↔
Use of Imaging Studies for Low Back Pain	Q	88.64%	88.58%	92.06%	87.85%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	61.07%	59.37%	56.20%	62.29%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	58.88%	55.72%	55.96%	59.37%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	46.47%	46.47%	46.23%	50.85%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	78.82%	77.86%	73.31%	74.45%	↔

[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).

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.

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 3.2 and Table 3.3, which present a summary of CCHP's 2014 SPD measure results. Table 3.2 presents 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 3.3 presents 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*

[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.

[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 3.2.

- *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*

Table 3.2—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CCHP—Contra Costa 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	9.53%	14.13%	▼	12.95%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.51%	87.41%	↑	86.52%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	95.00%	Not Comparable	95.45%
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.67%	85.24%	↔	85.11%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.62%	NA	Not Comparable	94.62%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	86.03%	87.47%	↔	86.07%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	86.72%	86.49%	↔	86.71%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	83.50%	82.72%	↔	83.44%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.37%	62.77%	↔	61.31%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	45.74%	52.55%	↔	51.34%
Comprehensive Diabetes Care—HbA1c Testing	79.32%	84.43%	↔	84.43%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	35.28%	54.01%	↑	48.18%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.12%	42.58%	↑	42.34%
Comprehensive Diabetes Care—LDL-C Screening	69.83%	75.91%	↑	75.67%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.94%	83.21%	↑	83.94%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	54.01%	36.98%	▲	41.61%

* 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 3.3—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
CCHP—Contra Costa County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
223.77	48.06	342.49	74.83

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

Performance Measure Result Findings

The rates were above the HPLs for the following measures:

- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Use of Imaging Studies for Low Back Pain* for the fourth consecutive year

The rates for the following measures were significantly better in 2014 when compared to 2013:

- *All-Cause Readmissions*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- All four *Children and Adolescents' Access to Primary Care Practitioners* measures (Note: The rates remained below the MPLs for the third consecutive year.)

The rate improved by more than 9 percentage points for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure. Although not statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the HPL in 2014.

In addition to the rates being below the MPLs for all four *Children and Adolescents' Access to Primary Care Practitioners* measures, the rate was below the MPL for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure.

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

- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—LDL-C Screening*
- Both *Medication Management for People with Asthma—Medication Compliance* measures, resulting in the rate for the *Medication Compliance 50% Total* measure moving from above the MPL in 2013 to below the MPL in 2014

- *Use of Imaging Studies for Low Back Pain* (Note: The rate remained above the HPL for the fourth consecutive year.)

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for six measures. The better rates in 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 better monitoring of care. The SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure, meaning that significantly more SPD members (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than were non-SPD members.

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 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 Plan-Do-Study-Act 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

CCHP had one new IP in 2013 for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure. The MCP identified the following barriers to the rate being above the MPL:

- Providers not having reminder systems in place to prompt them to order the tests.
- Patients lacking awareness of the need to be tested.

To address the barriers, CCHP implemented the following interventions:

- Developed a list of members on Digoxin who needed to receive the test and sent the list to providers.
- Sent reminder letters to members who needed to be tested.

CCHP's efforts resulted in the rate for this measure improving by more than 9 percentage points and moving from below the MPL to above the HPL. The MCP will not be required to continue this IP in 2014.

New Improvement Plans for 2014

Based on 2014 rates and the measures for which DHCS held MCPs accountable to meet the MPLs, CCHP will be required to submit an IP for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure in 2014.

Strengths

During the 2014 HEDIS audit with CCHP, HSAG auditors determined that the MCP followed the appropriate specifications to produce valid performance measure rates.

The rates for three measures were above the HPLs, and the rates improved significantly from 2013 to 2014 for six measures. CCHP's IP was successful at moving the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure from below the MPL in 2013 to above the MPL in 2014. Although the SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure, the MCP reported having many successful interventions (see Appendix D) that resulted in the SPD rate improving significantly from 2013 to 2014 (see Appendix A).

Opportunities for Improvement

During the HEDIS 2014 process, the auditor indicated that CCHP has the opportunity to improve the audit process by:

- Implementing additional coding details to provide immediate feedback to the providers.
- Working with its vendor to obtain complete encounter data.
- Implementing a formal HEDIS process to ensure consistency from year to year.
- Implementing protocols to ensure that all sources of data are verified prior to loading into the database.

CCHP has the opportunity to assess the factors leading to the rates being below the MPLs for six measures in 2014 and implement strategies to improve the rates. Additionally, for measures with rates that declined significantly from 2013 to 2014 but were still above the MPLs, CCHP should assess the factors leading to the decline to ensure the rates for the measures remain above the MPLs. Finally, the MCP has the opportunity to continue implementing interventions that are contributing to a reduction in hospital readmissions for members in the SPD population.

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 CCHP'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

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

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

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Improving Perinatal Access and Care	Clinical	Q, A, T

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.

CCHP's *Improving Perinatal Access and Care* QIP focused on improving the care women receive during and post pregnancy. Being able to maintain regular prenatal care visits throughout a pregnancy may help identify and treat any problems that may arise. Providing postpartum care may lead to a successful health outcome.

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
CCHP—Contra Costa County
July 1, 2013, through June 30, 2014

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Annual Submission	75%	100%	*Partially Met*
	Annual Resubmission 1	100%	100%	*Met*
Internal QIPs				
Improving Perinatal Access and Care	Study Design Submission	95%	88%	*Partially Met*
	Study Design Resubmission 1	95%	88%	*Partially Met*
	Study Design Resubmission 2	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 CCHP's annual submission of its *All-Cause Readmissions* QIP received an overall validation status of *Partially Met.* As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, CCHP resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of evaluation elements (critical and noncritical) receiving a met score. The *Improving Perinatal Access and Care* QIP annual submission received an overall validation status of *Partially Met.* CCHP resubmitted the QIP and, after the second resubmission, 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 CCHP's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
CCHP—Contra Costa County
(Number = 5 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)	100%	0%	0%
	VI: Accurate/Complete Data Collection	92%	8%	0%
Design Total		**97%**	**3%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	75%	0%	25%
	VIII: Appropriate Improvement Strategies	80%	20%	0%
Implementation Total		**78%**	**11%**	**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 CCHP's *All-Cause Readmissions* QIP annual submission and Activities I through VI for *Improving Perinatal Access and Care* QIP study design submission.

CCHP demonstrated a strong application of the Design stage, meeting 97 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP did not provide all stated attachments and did not fully describe the data analysis plan for the *All-Cause Readmissions* QIP, resulting in a lower score for Activity VI. CCHP met 100 percent of the requirements for all applicable evaluation elements within the Design stage for the *Improving Perinatal Access and Care* QIP.

Only the *All-Cause Readmissions* QIP progressed to the Implementation stage during the reporting period. CCHP demonstrated an adequate application of the Implementation stage, meeting 78 percent of the requirements for all applicable evaluation elements within the study stage for this

QIP. In the initial submission of the *All-Cause Readmissions* QIP, CCHP did not document if any factors threatened the internal or external validity of the findings and did not provide an interpretation of the baseline data, resulting in a lower score for Activity VII. CCHP corrected the deficiencies in the resubmission, resulting in the QIP achieving an overall *Met* validation status.

Although the *Improving Perinatal Access and Care* QIP did not progress to the Implementation stage, CCHP provided documentation regarding the planned interventions; therefore, HSAG validated Activity VIII for this QIP. In the initial submission, CCHP did not provide the causal/barrier analysis and did not include an evaluation plan for each intervention, resulting in a lower score for Activity VIII. The MCP corrected the deficiencies in the resubmissions, resulting in the QIP achieving an overall *Met* validation status.

Quality Improvement Project Outcomes and Interventions

While the *Improving Perinatal Access and Care* QIP did not progress to the Implementation stage, since CCHP provided intervention information, HSAG includes a summary of the interventions for the QIP below:

- Worked with outside hospitals to set up a process to schedule appropriately timed postpartum appointments prior to discharge.
- Developed a system to call new mothers to ensure appointments are scheduled and remind them of their appointments.
- Worked with Contra Costa Regional Medical Center to develop a system that ensures providers will address the requirements of a postpartum visit.
- Worked with its largest provider network to improve the provision of contraception.

Additional Implementation stage information will be included in CCHP's 2014–15 MCP-specific evaluation report.

The *All-Cause Readmissions* QIP did not progress 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 the *All-Cause Readmissions* QIP:

- Established a call center with a nurse available during weekdays to assist discharge staff at area hospitals with ensuring that all required services and follow-up care were arranged before the member was discharged.
- Had a nurse call members post-discharge from the county hospital to ensure that all care needs were met.
- Implemented a new initiative to provide a family nurse practitioner to visit members in skilled nursing facilities and to be available to skilled nursing facilities when a potential need to prevent a readmission was identified.

Outcome information for the *All-Cause Readmissions* QIP will be included in CCHP's 2014–15 MCP-specific evaluation report.

Strengths

CCHP demonstrated an excellent application of the QIP process for the *All-Cause Readmissions* and *Improving Perinatal Access and Care* QIPs. The MCP met all requirements for all applicable evaluation elements within the Design stage for the *Improving Perinatal Access and Care* QIP.

Opportunities for Improvement

In response to HSAG's recommendations in CCHP's 2012–13 MCP-specific evaluation report, CCHP indicated that the QIP Completion Instructions are reviewed prior to QIP submissions (see Appendix D). Although the MCP has implemented this process, CCHP continued to provide incomplete or inaccurate documentation for its QIPs and continued to demonstrate opportunities for improving its QIP documentation. 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.

CCHP's quality and performance improvement program description includes brief summaries of the MCP's quality program organizational structure. The document also indicates that the MCP tracks issues related to quality of care and services and identifies priority opportunities for improvement. Note: In CCHP's previous MCP-specific evaluation reports, HSAG recommended that the MCP consider revising its quality documents to include more robust information. CCHP's self-report indicated that the MCP added more explicit content to its quality program documents and that all quality documents received all possible points during the MCP's NCQA accreditation process (see Appendix D).

DMHC identified two potential deficiencies in the area of Quality Management during the March 2013 SPD medical survey for CCHP, and A&I identified findings in the areas of Quality Management and Administrative and Organizational Capacity during the March 2013 medical audit for the MCP. Deficiencies in these areas could affect the quality of care delivered to the MCP's MCMC members.

The rates were above the HPLs for the following quality performance measures:

- *Annual Monitoring for Patients on Persistent Medications—Digoxin* (Note: The rate for this measure moved from below the MPL in 2013 to above the HPL in 2014.)
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Use of Imaging Studies for Low Back Pain* for the fourth consecutive year, despite the rate declining significantly from 2013 to 2014

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

- *All-Cause Readmissions*

Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs In addition to the rate declining significantly from 2013 to 2014 for the *Use of Imaging Studies for Low Back Pain* measure, the rates declined significantly from 2013 to 2014 for the following quality measures:

- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—LDL-C Screening*
- Both *Medication Management for People with Asthma* measures, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014 for the *Medication Compliance 50% Total* measure

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and six SPD rates were significantly better than the non-SPD rates. The better rates in 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 better monitoring of care. The SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure, meaning that significantly more SPD members (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than were non-SPD members. Note that the SPD rate for the *All-Cause Readmissions* measure improved significantly from 2013 to 2014 (see Appendix A).

Both of CCHP'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, CCHP showed 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.

As part of the process for producing this report, HSAG reviewed CCHP's available quality improvement information. In the MCP's evaluation document, CCHP indicated that two of the MCP's contracted provider networks met the access and availability goals; however, one of the provider networks frequently fell short of meeting the goals. The MCP indicated that the provider is constructing additional clinic space and redesigning its health care processes to address the barriers to meeting the access and availability goals.

DMHC identified one potential deficiency in the area of Access and Availability of Health Care Services during the March 2013 SPD medical survey for CCHP, and A&I identified findings in the area of Access and Availability to Care during the March 2013 medical audit for the MCP. Deficiencies in these areas could affect access to care for the MCP's MCMC members.

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

- *All-Cause Readmissions*
- All four *Children and Adolescents' Access to Primary Care Practitioners* measures (Note: The rates remained below the MPLs for the third consecutive year.

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

- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—LDL-C Screening*

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and two SPD rates were significantly better than the non-SPD rates. As indicated above, the better rates in 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 better monitoring of care. As indicated above, the SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure, meaning that significantly more SPD members (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than were non-SPD members. Also as noted above, the SPD rate for the *All-Cause Readmissions* measure improved significantly from 2013 to 2014 (see Appendix A).

Both of CCHP'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, CCHP showed below-average performance related to the access domain of care.

Timeliness

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

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

CCHP's evaluation document indicated that the MCP worked during the year to ensure timely processing of appeals and denials to help the MCP meet NCQA's accreditation standards. The

CCHP's quality and performance improvement program description includes information on the MCP's utilization management activities and grievance processes, which affect the timeliness of care delivered to members.

DMHC identified one potential deficiency in the area of Utilization Management and two potential deficiencies in the area of Member Rights during the March 2013 SPD medical survey for CCHP, and A&I identified findings in the areas of Utilization Management, Continuity of Care, and Member's Rights during the March 2013 medical audit for the MCP. Deficiencies in these areas could affect the timeliness of care delivered to the MCP's MCMC members.

The rate declined significantly from 2013 to 2014 for the *Childhood Immunization Status—Combination 3* measure, which falls into the timeliness domain of care. The rates were above the MPLs for all timeliness performance measures.

The *Improving Perinatal Access and Care* QIP fell into the timeliness domain of care. Since the QIP did not progress to the Outcomes stage, HSAG was not able to assess the QIPs' success at improving timeliness of care for the MCP's MCMC members.

Overall, CCHP showed average performance related to 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. CCHP's self-reported responses are included in Appendix D.

Recommendations

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

- Address all potential deficiencies identified during the March 2013 SPD medical survey in the areas of:
  - Utilization Management
  - Access and Availability of Health Care Services
  - Member Rights
  - Quality Management
- Address all findings from the March 2013 medical audit in the areas of:
  - Utilization Management
  - Continuity of Care

  - Access and Availability to Care
  - Member's Rights
  - Quality Management
  - Administrative and Organizational Capacity
- Revise the MCP's policies and procedures to be compliant with State Supported Services abortion services requirements.
- To improve the HEDIS audit process:
  - Implement additional coding details to provide immediate feedback to the providers.
  - Work with the MCP's vendor to obtain complete encounter data.
  - Implement a formal HEDIS process to ensure consistency from year to year.
  - Implement protocols to ensure that all sources of data are verified prior to loading into the database.
- Continue to implement the strategies that resulted in the rates improving significantly from 2013 to 2014 for all four *Children and Adolescents' Access to Primary Practitioners* measures, because the rates for all four measures continued to be below the MPLs.
- Assess the factors leading to the rate declining significantly for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014, and identify strategies to improve the rate.
- For the following measures with rates that declined significantly from 2013 to 2014 but were still above the MPLs, assess the factors leading to the decline and implement strategies to ensure that the rates for the measures remain above the MPLs:
  - *Childhood Immunization Status—Combination 3*
  - *Medication Management for People with Asthma—Medication Compliance 75% Total*

  Note: While the rate declined significantly from 2013 to 2014 for the *Use of Imaging Studies for Low Back Pain* measure, the rate was above the HPL. Therefore, HSAG does not recommend that the MCP allocate resources to address the decline in this measure's rate.
- Continue implementing interventions that are contributing to a reduction in hospital readmissions for members in the SPD population.
- 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 CCHP's progress with these recommendations along with its continued successes.

Table A.1 provides 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 table:

– = 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
CCHP—Contra Costa County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	19.48%	14.13%	▲
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	83.56	74.83	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	299.06	342.49	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.68%	87.41%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	86.54%	95.00%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.83%	85.24%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	74.13%	87.47%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	82.34%	86.49%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	79.63%	82.72%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	56.20%	62.77%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	54.50%	52.55%	↔
Comprehensive Diabetes Care—HbA1c Testing	88.56%	84.43%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	55.96%	54.01%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	43.55%	42.58%	↔
Comprehensive Diabetes Care—LDL-C Screening	84.43%	75.91%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.13%	83.21%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	33.82%	36.98%	↔

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

Table B.1 provides 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 table:

– = 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
CCHP—Contra Costa County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	12.72%	9.53%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	55.98	48.06	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	199.28	223.77	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	78.37%	83.51%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	77.84%	84.67%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	86.81%	94.62%	↑
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	76.24%	86.03%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	77.74%	86.72%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	74.46%	83.50%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.85%	59.37%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	49.88%	45.74%	↔
Comprehensive Diabetes Care—HbA1c Testing	81.27%	79.32%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	40.88%	35.28%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.58%	32.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.16%	69.83%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	75.91%	74.94%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	51.34%	54.01%	↔

*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)

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 Contra Costa Health Plan

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with CCHP'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—CCHP'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 CCHP	Actions Taken by CCHP During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Consider revising the MCP's quality documents to include more robust information, using headings to denote the various important content areas (i.e., results, barriers, strengths, and next steps, as appropriate) and ensure that activities cover all domains of care (i.e., quality, access, timeliness).	We have added more explicit content to the documents. They earned all possible points when the National Committee for Quality Assurance accredited us in March 2014. We have also directed those reporting to the Quality Council to specifically include sections on Summary of Analysis/Conclusions, Actions Completed, and Follow-Up Actions. We've also suggested a barriers section if not making good progress.
2. Consider making improvements that will positively affect the MCP's HEDIS audit process, including:	
a. Taking proactive steps to avoid claims backlogs to ensure the MCP's ability to report HEDIS rates.	Our Claims backlog was the result of big problems in converting to an Epic electronic health record [system]. Claims are currently being paid on time.
b. Ensuring vendor audits are performed in accordance with the MCP's policies and procedures.	Our vendor audits are performed in accordance with our policies and procedures. We are not sure what the finding referred to.
c. Making changes to the MCP's transactional system to resolve issues with coding detail and health insurance claim numbers.	Resolved.
d. Promptly contracting with a certified software vendor to avoid placing undue burden on the MCP's HEDIS staff and the HEDIS auditor(s).	We are two years into a three-year contract with a certified vendor. We are considering bringing their software engine in-house, rather than having the vendor host it. This will speed things up and allow us to test the data more extensively.
3. Engage in the following efforts to improve performance related to required measures:	
a. Assess the factors leading to all four *Children and Adolescents' Access to Primary Care Practitioners* measures having statistically significant decline from 2012 to 2013 and the rates to be below the MPLs, and identify strategies to implement to prevent further decline in the rates.	The decline was primarily due to Epic implementation difficulties at our largest network. They were unable to see as many patients as normal. The 2014 rates are above both 2012 and 2013!

2012–13 External Quality Review Recommendation Directed to CCHP	Actions Taken by CCHP During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
b. Assess the factors leading to the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure being below the MPL in 2013, and identify interventions to implement to bring the rate for this measure above the MPL.	Barriers were evaluated and interventions implemented. As a result, our 2014 rate is above the national 90th percentile.
c. Assess the factors leading to the rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure declining significantly from 2012 to 2013 to ensure the rate for this measure remains above the MPL.	Adjusting to the new system in our largest network was a cause of the decline. The 2014 rate is higher than the Medi-Cal mean for 2013 and is quite close to the HPL.
d. Assess the factors leading to the SPD rate for the *All-Cause Readmissions* measure being significantly higher than the non-SPD rate and identify strategies to ensure the MCP is meeting the SPD population's needs.	It is no surprise that SPD readmission rates are higher than for non-SPDs. This is true across all plans because the SPDs are much sicker. We have many interventions in place and they have proven successful. The 2014 rate for SPDs improved by 33 percent.
4. Engage in the following efforts to improve performance related to QIPs:	
a. Review the QIP Completion Instructions prior to submitting QIPs to ensure all required documentation is included in the QIP Summary Form.	We now do this regularly.
b. Ensure that the MCP has an evaluation plan for each QIP intervention so that it can determine whether to modify or discontinue existing interventions, or implement new ones, to increase the likelihood of achieving positive project outcomes.	We have evaluation plans for most interventions. Some interventions cannot be evaluated because the impact is impossible to isolate. We include these when expert opinion suggests the intervention could be helpful.
c. Since the study indicator related to documentation of nutrition counseling for the *Reducing Childhood Obesity* QIP did not achieve sustained improvement at Remeasurement 2, conduct a new barrier analysis and assess if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.	We performed the barrier analysis and instituted new interventions through our Pediatric Obesity Program. Our 2014 rate is the highest the measure has ever been.

2012–13 External Quality Review Recommendation Directed to CCHP	Actions Taken by CCHP During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
d. Although not statistically significant, since the rates for the BMI and physical fitness counseling indicators for the *Reducing Childhood Obesity* QIP declined at Remeasurement 2, consider assessing the factors leading to a decline in the rates for these indicators to determine if modifications need to be made to existing strategies to avoid further decline in the rates.	We performed the barrier analysis and instituted new interventions through our Pediatric Obesity Program. Our 2014 rate is the highest the measure has ever been.
5. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the *Getting Needed Care, Getting Care Quickly,* and *Rating of All Health Care* priority areas.	After analysis of the CAHPS report, we added strategies to our ongoing work to improve access. We were disappointed that the CAHPS data were so old by the time we received them.
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.	We reviewed the report and believe that many of the issues identified have been resolved (see below) and with a transition to 837 file format for encounter data reporting starting October 1, 2014, the data quality will be significantly different. Examples of issues addressed: 1. Provider specialty "HO"/"CH"/"LA": This was coming from our legacy system. Claims with service dates after July 1, 2012, should not have this specialty as we transition to a new claims processing system. 2. Provider type of "26": We are receiving this from Kaiser and we have informed them. 3. Provider type of "16" had a rendering provider number; it is being set to blank starting January 1, 2014.

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