Performance Evaluation Report

CenCal Health

July 1, 2013–June 30, 2014

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

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1. Introduction

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, CenCal Health ("CenCal" 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

CenCal 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.

CenCal became operational to provide MCMC services in Santa Barbara County in September 1983 and in San Luis Obispo in March 2008. As of June 30, 2014, CenCal had 91,771 MCMC members in Santa Barbara County and 44,494 members in San Luis Obispo County—for a total of 136,265 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 CenCal during the review period for this report. The most recent review with the MCP was conducted by DHCS's Member Rights/Program Integrity Unit (MR/PIU) in October 2011. In CenCal's 2011–12 and 2012–13 MCP-specific evaluation reports, HSAG included a summary of the review and the self-reported actions the MCP took to address HSAG's recommendations related to the findings.

Strengths

CenCal has no outstanding findings from the most recent MR/PIU review.

Opportunities for Improvement

Since CenCal has no outstanding findings from the most recent MR/PIU review, 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 CenCal Health* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that CenCal 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.

- CenCal continued to utilize incentives and bonuses to encourage accurate, complete, and timely data claim submissions by its providers.
- The auditor recommended that CenCal implement a formal policy to support the MCP's new claims audit process.
- CenCal was encouraged to develop methods to obtain and store source documentation for all cases entered into the MCP's diabetes registry for future use of the documentation.
- The auditor recommended that CenCal update the MCP's data security and back-up procedures.
- The auditor recommended that CenCal implement a thorough review process for DHCS-required rates prior to submission to ensure that the rates accurately reflect the MCP's performance.

[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 CenCal'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.

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
CenCal—San Luis Obispo 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	—	—	13.49%	12.28%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	65.82	63.56	58.78	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	343.58	346.43	334.76	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**82.95%**	**81.02%**	**80.16%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**82.35%**	84.20%	84.92%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	34.44%	33.33%	**14.46%**	**17.24%**	↔
Cervical Cancer Screening	Q,A	—	—	—	62.77%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	76.32%	76.39%	78.03%	77.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.17%	**95.31%**	96.78%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	87.31%	**86.21%**	89.60%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	88.32%	87.64%	90.47%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**86.08%**	86.69%	86.83%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	66.91%	67.64%	70.56%	65.94%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	60.83%	61.56%	58.39%	59.12%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	**73.72%**	81.02%	82.00%	84.18%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	51.34%	59.37%	61.31%	58.15%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	38.69%	41.36%	42.58%	40.15%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	75.43%	78.59%	79.56%	79.08%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	79.32%	84.67%	82.73%	85.40%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	41.12%	32.60%	31.14%	30.90%	↔
Controlling High Blood Pressure	Q	—	—	63.02%	54.43%	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	60.10%	71.65%	65.79%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**42.34%**	45.28%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	26.28%	26.77%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	70.42%	70.11%	71.04%	70.47%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	84.51%	82.76%	87.43%	87.13%	↔
Use of Imaging Studies for Low Back Pain	Q	78.38%	77.86%	75.69%	80.89%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	46.96%	62.29%	64.23%	77.13%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	57.91%	59.61%	61.31%	60.10%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	34.79%	47.69%	50.36%	51.82%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	**63.66%**	69.79%	67.97%	72.95%	↔

[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
CenCal—Santa Barbara 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	—	—	11.13%	13.15%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	48.37	52.16	51.43	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	346.64	335.52	301.90	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	86.89%	84.72%	85.79%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	**86.11%**	**84.85%**	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	87.25%	85.46%	86.74%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	31.61%	29.55%	19.13%	22.62%	↔
Cervical Cancer Screening	Q,A	—	—	—	74.45%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	82.31%	85.20%	85.84%	83.56%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	97.31%	97.84%	98.49%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	90.42%	91.16%	93.58%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	89.69%	90.88%	92.88%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	87.69%	89.29%	90.59%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	69.59%	69.10%	74.21%	72.02%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	70.32%	71.29%	70.56%	68.61%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	81.75%	92.21%	83.94%	86.37%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	61.56%	69.34%	59.61%	59.37%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	45.74%	50.12%	38.93%	40.39%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	76.89%	85.16%	80.54%	80.05%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	79.56%	87.35%	82.48%	84.91%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	28.95%	22.63%	33.58%	31.87%	↔
Controlling High Blood Pressure	Q	—	—	60.58%	60.25%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	70.07%	78.74%	80.90%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	47.38%	50.28%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	27.67%	26.70%	↔

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	77.57%	76.35%	73.44%	76.83%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.49%	80.74%	81.64%	85.98%	↔
Use of Imaging Studies for Low Back Pain	Q	80.67%	80.46%	80.57%	81.72%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	59.12%	66.42%	70.56%	74.21%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	72.51%	67.88%	72.75%	72.99%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	39.17%	44.77%	51.34%	57.66%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	74.39%	76.01%	79.34%	80.65%	↔

[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.
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[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.

[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 CenCal'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 CenCal—San Luis Obispo 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	6.71%	14.96%	▼	12.28%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	71.79%	83.97%	↑	80.16%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	72.97%	90.28%	↑	84.92%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.86%	NA	Not Comparable	96.78%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.04%	76.07%	↓	89.60%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.91%	83.22%	↓	90.47%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.41%	79.72%	↓	86.83%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	67.71%	68.56%	↔	65.94%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.81%	61.47%	↔	59.12%
Comprehensive Diabetes Care—HbA1c Testing	83.85%	83.85%	↔	84.18%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	50.00%	61.76%	↑	58.15%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.85%	45.04%	↑	40.15%
Comprehensive Diabetes Care—LDL-C Screening	77.60%	80.74%	↔	79.08%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.73%	88.39%	↑	85.40%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	35.94%	27.76%	▲	30.90%

* 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 CenCal—Santa Barbara 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	7.29%	16.41%	▼	13.15%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	79.54%	89.25%	↑	85.79%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	83.33%	Not Comparable	84.85%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.53%	89.19%	↑	86.74%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.48%	NA	Not Comparable	98.49%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	93.63%	90.99%	↔	93.58%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	92.99%	90.32%	↔	92.88%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	90.65%	89.52%	↔	90.59%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	71.53%	67.64%	↔	72.02%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	66.18%	66.18%	↔	68.61%
Comprehensive Diabetes Care—HbA1c Testing	84.18%	87.10%	↔	86.37%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.20%	63.50%	↑	59.37%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.98%	45.01%	↑	40.39%
Comprehensive Diabetes Care—LDL-C Screening	79.56%	79.32%	↔	80.05%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.02%	86.13%	↑	84.91%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	33.33%	26.76%	▲	31.87%

* 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
CenCal—San Luis Obispo County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
296.02	53.41	598.85	95.46

*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
CenCal—Santa Barbara County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
272.79	46.42	596.56	102.10

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

Performance Measure Result Findings

Consistent with previous years, Santa Barbara County performed better than San Luis Obispo County. The rate for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure exceeded the HPL for San Luis Obispo County, and the rates for the following measures exceeded the HPLs for Santa Barbara County:

- *Childhood Immunization Status—Combination 3* for the fourth consecutive year
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for the fourth consecutive year
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* for the fourth consecutive year
- *Prenatal and Postpartum Care—Postpartum Care*

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 San Luis Obispo and Santa Barbara counties, with the improvement in San Luis Obispo County resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* for San Luis Obispo and Santa Barbara counties

- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* for Santa Barbara County
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* for San Luis Obispo County

The rates for the following measures for San Luis Obispo County improved from 2013 to 2014. Although not statistically significant, the improvement resulted in the rates moving from below the MPLs in 2013 to above the MPLs in 2014: (Note: DHCS did not hold the MCP's accountable to meet the MPLs for these measures in 2013.)

- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Medication Management for People with Asthma—50% Total*

The rates for the following measures were below the MPLs:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* for San Luis Obispo County for the third consecutive year
- *Annual Monitoring for Patients on Persistent Medications—Digoxin* for Santa Barbara County
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* for San Luis Obispo County

The rate for the *Controlling High Blood Pressure* measure for San Luis Obispo County declined significantly from 2013 to 2014.

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for six measures for each county. The SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure for both counties, and the SPD rates were significantly worse than the non-SPD rates for San Luis Obispo County for the following measures:

- *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—2 to 19 Years*

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

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Based on 2013 rates, CenCal was required to submit an IP for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* for San Luis Obispo County. The MCP identified the following barriers to the rate being above the MPL:

- Provider lack of compliance with clinical guidelines
- Miscoding by providers
- Member pressure on providers for antibiotics treatment
- Member lack of knowledge regarding disease self-management

To address the barriers, CenCal implemented the following interventions:

- Educated providers using the Alliance Working for Antibiotic Resistance Education (AWARE) program.
- Conducted face-to-face meetings with high-volume providers to discuss barriers and coding practices.
- Included educational information in member newsletters.
- Disseminated to providers toolkits from the AWARE program which included viral treatment prescription pads and patient handouts for use during flu season.

In addition to the IP, CenCal submitted information to DHCS regarding rapid-cycle improvement strategies that the MCP had implemented. The MCP provided information on the clinical guidelines to high-volume, low-performing providers and emergency room providers. Additionally, the MCP implemented a nurse advice line for members.

The MCP's efforts resulted in the rate for the measure improving by more than 2 percentage points from 2013 to 2014; however, the improvement did not result in the rate moving to above the MPL. CenCal will be required to continue the IP for this measure in 2014.

Annual Monitoring for Patients on Persistent Medications

The rates for San Luis Obispo County for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure and Santa Barbara County for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure were below the MPLs in 2013. Since CenCal had an existing QIP for the measures, DHCS did not require the MCP to submit IPs. Instead, the MCP was required to continue to work on improving the rates through the QIP. While information on the *Annual Monitoring for Patients on Persistent Medications* QIP is included in the Quality Improvement Projects section of this report, HSAG provides a summary below.

CenCal identified the following barriers to the rates being above the MPLs:

- Provider lack of knowledge regarding clinical practice guidelines
- Member lack of knowledge regarding disease self-management
- Providers not having an effective way to track members in need of testing
- Monitoring for members on persistent medications not being a priority for providers
- Providers being over-burdened
- Being monitored not being a priority for members
- Member lack of follow-through after the provider orders the tests
- Members lost to follow-up

To address the barriers, the MCP implemented several interventions, including:

- Provided information on the clinical guidelines to providers, emphasizing the importance of medication monitoring.
- Provided tools to providers to assist them with tracking and following up with patients.
- Provided members with information on the importance of monitoring for adverse effects and of keeping regular appointments with their providers.
- Provided members with assistance in making appointments and understanding health care benefits.

Although not statistically significant, the rates for both measures declined slightly from 2013 to 2014, resulting in the rates remaining below the MPLs. The MCP will continue the QIP in 2014.

Strengths

To encourage accurate, complete, and timely data claims submissions by its providers, CenCal continued to use incentives and bonuses, which appeared to be an effective approach to improving the quality of claims submissions.

San Luis Obispo County had one measure with a rate above the HPL, and the rates for five measures for Santa Barbara County were above the HPLs. The rates for three measures for Santa Barbara County were above the HPLs for the fourth consecutive year. Across both counties, six rates improved significantly from 2013 to 2014, and the rates for three measures improved from below the MPLs in 2013 to above the MPLs in 2014.

Opportunities for Improvement

To improve the HEDIS audit process, the auditor indicated that the MCP has opportunities for improvement related to its claims audit process, documentation in the MCP's diabetes registry, data security and back-up procedures, and review process for required performance measure rates.

CenCal has the opportunity to assess the factors leading to the rates for three measures continuing to be below the MPLs and determine if current improvement strategies should be discontinued or modified or if new strategies should be implemented to improve outcomes. Additionally, to prevent further decline in the measure's rate, the MCP should assess the factors leading to the rate for the *Controlling High Blood Pressure* measure for San Luis Obispo County declining significantly from 2013 to 2014. Finally, although CenCal provided documentation of actions the MCP has taken to address some SPD rates being significantly worse than non-SPD rates (see Appendix D), five SPD rates were significantly worse than the non-SPD rates in 2014. CenCal has the opportunity to assess if the MCP's efforts are working or if the MCP needs to implement new strategies to ensure that the needs of the SPD population are being met.

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 CenCal'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

CenCal 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 CenCal's QIPs and indicates the county 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 CenCal
July 1, 2013, through June 30, 2014

QIP	Counties	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	San Luis Obispo and Santa Barbara	Clinical	Q, A
Annual Monitoring for Patients on Persistent Medications	San Luis Obispo and Santa Barbara	Clinical	Q

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.

CenCal's *Annual Monitoring for Patients on Persistent Medications* QIP is focused on monitoring Med-Cal beneficiaries' use of angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), digoxin, and diuretic medications. By monitoring the use of these medications, CenCal can ensure better compliance and effectiveness of the medications and monitor the potential side effects.

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
CenCal—San Luis Obispo and Santa Barbara Counties
July 1, 2013, through June 30, 2014

Name of Project/Study	County	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	Both counties received the same score	Annual Submission	88%	86%	*Partially Met*
		Annual Resubmission 1	100%	100%	*Met*
Internal QIPs					
Annual Monitoring for Patients on Persistent Medications	Both counties received the same score	Annual Submission	94%	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 CenCal's annual submission of its *All-Cause Readmissions* QIP received an overall validation status of *Partially Met* for both counties. 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, CenCal resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of evaluation elements (critical and noncritical) receiving a met score. The *Annual Monitoring for Patients on Persistent Medications* QIP annual submission achieved an overall validation status of *Met* for both counties, with 94 percent of the evaluation elements and 100 percent of the critical elements receiving a met score.

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

Table 4.3—Quality Improvement Project Average Rates*
CenCal—San Luis Obispo and Santa Barbara 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**	83%	8%	8%
	VIII: Appropriate Improvement Strategies	83%	17%	0%
Implementation Total		**83%**	**11%**	**6%**
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.

**The stage and/or activity totals may not equal 100 percent due to rounding.

HSAG validated Activities I through VIII for CenCal's *All-Cause Readmissions* QIP and *Annual Monitoring for Patients on Persistent Medications* QIPs annual submissions.

CenCal 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. In the initial submission of the *All-Cause Readmissions* QIP, CenCal did not document if there were any factors that threatened the internal or external validity of the findings, did not describe the team and process used to identify the barriers and interventions, and did not include an evaluation plan for each intervention, resulting in lower scores for Activities VII and VIII. CenCal corrected the

deficiencies in its resubmission, resulting in the QIP achieving an overall *Met* validation status. For the *Annual Monitoring for Patients on Persistent Medications* QIP, CenCal did not provide a description of the study indicator rates, resulting in a lower score for Activity VII.

Quality Improvement Project Outcomes and Interventions

The *All-Cause Readmissions* and *Annual Monitoring for Patients on Persistent Medications* QIPs 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 each QIP:

All-Cause Readmissions QIP

- Implemented a primary care physician (PCP) incentive payment process to reimburse providers for the extra time needed to accommodate access to timely (within 72 hours) appointments for discharged members.
- Developed intradepartmental collaboration to facilitate PCP appointment scheduling for members requiring assistance, letter notification for members unable to be reached by telephone, provider services promotion and training of PCPs, and claims reports and payments.
- Established readmissions agreement with a large federally qualified health center (FQHC) PCP clinic system to perform outreach to its members, and provided an incentive to the clinic for reducing its readmissions rates.
- Developed a fax/e-mail process to notify PCPs within 24 hours of their members being discharged from hospitals so the PCPs can perform outreach and increase access to timely appointments. Discharge summaries are provided to PCPs as part of this process.
- Conducted weekly utilization management/case management departmental meetings to discuss high-risk cases and monthly utilization management/case management metrics meetings to discuss readmissions rates, community-based resources, and resource voids (e.g., being homeless, lacking mental health services).
- Hired a full-time health services representative to work with community providers and external agencies on behalf of CenCal in matters pertaining to high-risk members. The staff member is based primarily at a high-volume, mid-county hospital.
- Refined the process to identify members discharged from in- and out-of-area hospitals and to monitor cases using case management software.

Annual Monitoring for Patients on Persistent Medications QIP

Interventions targeting providers included:

- Provided annual performance profiles to the providers based on HEDIS results. The MCP performed on-site visits for high-volume, low-performing providers and called or mailed a summary to low-volume or high-performing clinics.
- Published a provider bulletin article regarding the importance of monitoring patients on persistent medications.
- Mailed the providers a list of eligible members who did not receive the required tests.

Interventions targeting members included:

- Implemented member outreach program including mailing eligible members informational flyers.
- Published a newsletter outlining the same information from the targeted mailing.

Strengths

CenCal 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 *Annual Monitoring for Patients on Persistent Medications* QIPs. Additionally, the *Annual Monitoring for Patients on Persistent Medications* QIP achieved a *Met* validation status on the first submission.

Opportunities for Improvement

Although in response to HSAG's QIP recommendation in the MCP's 2012–13 MCP-specific evaluation report the MCP indicated it would ensure all required information is included in its QIP submissions (see Appendix D), the MCP continues to have opportunities for improving QIP documentation. The MCP should implement strategies, including referencing the QIP Completion Instructions and previous QIP validation tools, to ensure that all required documentation is included in the QIP Summary Form.

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.

CenCal's quality improvement program description provides details of the processes the MCP uses to continuously improve the quality of care delivered to members. Rather than identify one individual or department as responsible for the MCP's quality functions, CenCal implemented a quality committee structure that uses the expertise of staff and practitioners from multiple disciplines. The MCP indicates that its multidisciplinary approach has resulted in both enhanced communication throughout the organization and integrated processes.

The rate for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, which falls into the quality domain of care, exceeded the HPL for San Luis Obispo County; and the rates for the following measures exceeded the HPLs for Santa Barbara County:

- *Childhood Immunization Status—Combination 3* for the fourth consecutive year
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for the fourth consecutive year
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* for the fourth consecutive year
- *Prenatal and Postpartum Care—Postpartum Care*

The rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* measure, which falls into the quality domain of care, improved significantly from 2013 to 2014 for San Luis Obispo County.

The rates were below the MPLs for the following quality measures:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* for San Luis Obispo County for three consecutive years
- *Annual Monitoring for Patients on Persistent Medications—Digoxin* for Santa Barbara County
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* for San Luis Obispo County

The rate for the *Controlling High Blood Pressure* measure, which falls into the quality domain of care, declined significantly from 2013 to 2014 for San Luis Obispo County.

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 six measures for each county. The better rates in the SPD population are likely a result of this population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. For both counties, the SPD rates were significantly worse than the non-SPD rates for the *All-Cause Readmissions* measure, which falls into the quality domain of care.

Both of CenCal'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 MCMC members.

Overall, CenCal 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.

HSAG reviewed CenCal's available quality improvement information and found that the MCP included access-related goals in its work plan. Additionally, CenCal's work plan evaluation indicated that the MCP's monitoring of compliance with access standards demonstrated that all access standard measures were met in 2013, despite the large influx of members into Medi-Cal. Finally, the MCP's work plan evaluation indicated that the MCP has various processes in place to assess and monitor member access to care.

San Luis Obispo County had no access measures with rates above the HPLs, and the rates for the following access measures were above the HPLs for Santa Barbara County:

- *Childhood Immunization Status—Combination 3* for the fourth consecutive year
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for the fourth consecutive year
- *Prenatal and Postpartum Care—Postpartum Care*

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

- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* for San Luis Obispo and Santa Barbara counties, resulting in the rate for San Luis Obispo County moving from below the MPL in 2013 to above the MPL in 2014

- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* for San Luis Obispo and Santa Barbara counties
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* for Santa Barbara County

Nine of the performance measure stratified for the SPD population fall into the access domain of care. The SPD rate for one of the measures, *Comprehensive Diabetes Care—Medical Attention for Nephropathy*, was significantly better than the non-SPD rate for both counties. The SPD rates were significantly worse than the non-SPD rates for the following measures:

- *All-Cause Readmissions* for San Luis Obispo and Santa Barbara counties
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* for San Luis Obispo County
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* for San Luis Obispo County
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* for San Luis Obispo County

The MCP's *All-Cause Readmissions* QIP fell into the access domain of care. Since the QIP did not progress to the Outcomes stage, HSAG was not able to assess the QIP's success at improving access to care for the MCP's MCMC members.

Overall, CenCal showed above-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.

Based on HSAG's review of CenCal's quality improvement documents, it appears the MCP has a structure to support timeliness of care to MCMC members. Additionally, CenCal provided a

detailed description of the MCP's Utilization Management Program, which includes details regarding the MCP's processes to ensure timely utilization management decisions.

San Luis Obispo County had no timeliness measures with rates above the HPLs, and the rates were above the HPLs for the following timeliness measures for Santa Barbara County:

- *Childhood Immunization Status—Combination 3* for the fourth consecutive year
- *Prenatal and Postpartum Care—Postpartum Care*

Overall, CenCal 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. CenCal's self-reported responses are included in Appendix D.

Recommendations

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

- To improve the HEDIS audit process:
  - Implement a formal policy to support the MCP's new claims audit process.
  - Develop methods to obtain and store source documentation for all cases entered into the MCP's diabetes registry for future use of the documentation.
  - Update the MCP's data security and back-up procedures.
  - Implement a thorough review process for DHCS-required rates prior to submission to ensure that the rates accurately reflect the MCP's performance.
- Assess the factors leading to the rates for the following measures continuing to be below the MPLs, and determine if current improvement strategies should be discontinued or modified or if new strategies should be implemented to improve outcomes:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* for San Luis Obispo County
  - *Annual Monitoring for Patients on Persistent Medications—Digoxin* for Santa Barbara County
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* for San Luis Obispo County
- Assess the factors leading to the rate for the *Controlling High Blood Pressure* measure for San Luis Obispo County declining significantly from 2013 to 2014 to prevent further decline in the measure's rate.

- Assess if the MCP needs to implement new strategies to ensure that the needs of the SPD population are being met.
- Implement strategies, including referencing the QIP Completion Instructions and previous QIP validation tools, to ensure that all required documentation is included in the QIP Summary Form.

In the next annual review, HSAG will evaluate CenCal'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
CenCal—San Luis Obispo County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	16.54%	14.96%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	100.09	95.46	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	599.51	598.85	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.88%	83.97%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.25%	90.28%	↔
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	73.87%	76.07%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	83.22%	83.22%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	76.61%	79.72%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	72.67%	68.56%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.27%	61.47%	↔
Comprehensive Diabetes Care—HbA1c Testing	83.14%	83.85%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	60.47%	61.76%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	45.35%	45.04%	↔
Comprehensive Diabetes Care—LDL-C Screening	81.69%	80.74%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	88.08%	88.39%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	34.01%	27.76%	↔

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

Table A.2—HEDIS 2014 SPD Trend Table
CenCal—Santa Barbara County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	13.88%	16.41%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	101.65	102.10	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	566.20	596.56	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.86%	89.25%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	87.10%	83.33%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.10%	89.19%	↔
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	86.40%	90.99%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	87.97%	90.32%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	89.83%	89.52%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	68.61%	67.64%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	68.37%	66.18%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.91%	87.10%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	61.07%	63.50%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	42.09%	45.01%	↔
Comprehensive Diabetes Care—LDL-C Screening	81.27%	79.32%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.89%	86.13%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	31.39%	26.76%	↔

*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
CenCal—San Luis Obispo County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	6.70%	6.71%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	57.42	53.41	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	303.89	296.02	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	74.84%	71.79%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.57%	72.97%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.37%	96.86%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	86.59%	90.04%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	87.92%	90.91%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.58%	87.41%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	70.23%	67.71%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.91%	57.81%	↑
Comprehensive Diabetes Care—HbA1c Testing	75.81%	83.85%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	47.44%	50.00%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.56%	33.85%	↔
Comprehensive Diabetes Care—LDL-C Screening	73.95%	77.60%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.09%	80.73%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	48.37%	35.94%	▲

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

Table B.2—HEDIS 2014 Non-SPD Trend Table
CenCal—Santa Barbara County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	5.54%	7.29%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	46.35	46.42	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	308.44	272.79	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.90%	79.54%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.97%	81.53%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.87%	98.48%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.26%	93.63%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	91.01%	92.99%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	89.25%	90.65%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	71.78%	71.53%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	64.96%	66.18%	↔
Comprehensive Diabetes Care—HbA1c Testing	81.51%	84.18%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.45%	56.20%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.25%	36.98%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.16%	79.56%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.54%	81.02%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	38.69%	33.33%	↔

*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 **CenCal Health**

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with CenCal'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—CenCal'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 CenCal	Actions Taken by CenCal During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Assess the factors leading to the rates for the following measures falling below the MPLs in 2013 and identify strategies to improve the rates:	
a. *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Luis Obispo County	Poor provider compliance with treatment guidelines for treatment of viral illness and lack of time to educate patients about viral illness are major factors in providers prescribing antibiotics for adults with acute bronchitis. Provider education visits are performed by plan clinical staff to reinforce the clinical practice recommendations and provide readily available patient resources so patients have a better understanding of the steps they can take to feel better without the use of antibiotics.
b. *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* in San Luis Obispo County	Factors potentially affecting rates were Blue Cross Healthy Families members transitioning to CenCal Health's Medi-Cal, which uses a different provider network. Also a large contracted primary care physician (PCP) group in San Luis Obispo closed a few pediatric locations with several thousand members, which required moving those members to new locations. Implementation of electronic health record systems at several provider network locations may have also affected access. These issues combined likely caused reductions to CenCal Health's CAP rate. CenCal Health initiated automated call outreach to members to encourage annual exams. CenCal Health also began sharing the listing of members contacted with providers so they could schedule appointments.
c. *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* in San Luis Obispo County	CenCal Health's interventions to improve this aspect of care achieved statistically significant improvement from HEDIS 2013 to HEDIS 2014. In addition to the barriers described above for *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months),* for members aged 4 to 6 years, if providers mistakenly only followed Child Health and Disability Prevention (CHDP) periodicity for appointment scheduling, every other year members would not have appointments to count towards this measure.

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d. *Annual Monitoring for Patients on Persistent Medications—ACE* in San Luis Obispo County	In studying provider-level data, staff identified no PCP outliers. Network-wide, providers cite difficulty with patients that "no-show" for appointments or fail to follow through with referrals for lab tests. CenCal Health implemented interventions addressing possible provider and member knowledge deficits and noncompliance of members. CenCal Health performed more direct interventions during 2013 by providing lists of noncompliant members to PCPs to enable them to follow up with members and order monitoring tests. This did not occur until Q3 of 2013. Interventions currently underway include providing lists of noncompliant members to a large multi-site federally qualified health center (FQHC) to enable them to call and schedule appointments with noncompliant members.
e. Annual Monitoring for Patients on Persistent Medications—Digoxin in Santa Barbara County	In addition to the barriers described above for ACE/ARB, this aspect of care is problematic to measure because very few members are prescribed digoxin on a long-term basis. During 2013 and 2014 the number of members in each year numbered 36 and 33, respectively. Therefore, the measurements are prone to significant year-to-year variability. Nevertheless, the same interventions described above are underway to improve lab monitoring of members on long-term digoxin therapy.
2. Assess the factors leading to the rates for the following measures being significantly worse in 2013 when compared to 2012 and identify strategies to prevent further decline on the rates:	
a. Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis in San Luis Obispo and Santa Barbara counties	The decline in performance from 2012 to 2013 may have been due to ongoing regional pertussis outbreaks and members with respiratory illness prescribed antibiotics on a precautionary basis. This trend is reversing with intensified interventions, including prescriber visits by CenCal Health clinical staff. Ongoing provider and member education appear to be reversing the prior negative trend.
b. Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent) in Santa Barbara County	Performance for this indicator for the past 5 years ranged from 59% to 62%. However, HEDIS 2012 was an exceptional year when CenCal Health achieved 69%. Current performance for HEDIS 2014 ranks among the top 10% of Medicaid plans nationally.
c. Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent) in Santa Barbara County	Performance for this indicator for the past 5 years ranged from 29% to 34%. However, HEDIS 2012 was an exceptional year when only 23% of our diabetes population had poor A1c control (> 9.0%). Current performance for HEDIS 2014 is less than 1 percentage point from ranking among the top 10% of Medicaid plans nationally.
d. Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL) in Santa Barbara County	Performance for this indicator for the past 5 years ranged from 39% to 46%. However, HEDIS 2012 was an exceptional year when the plan achieved 50%. Current performance for HEDIS 2014 ranks among the top 25% of Medicaid plans nationally.
e. Comprehensive Diabetes Care—HbA1c Testing in Santa Barbara County	Performance for this indicator for the past 5 years ranged from 81% to 86%. However, HEDIS 2012 was an exceptional year, when the plan achieved 92%. Current performance for HEDIS 2014 improved from 2013.

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3. Assess the factors leading to the SPD rates for the following measures being significantly worse than the non-SPD rates and identify strategies to ensure the MCP is meeting the needs of the SPD population:	
a. *All-Cause Readmissions* in San Luis Obispo and Santa Barbara counties	The SPD population has higher utilization and readmissions due to increased age, disability, and multiple comorbidities. CenCal Health staff reviews needs assessments of all newly enrolled SPD members and, when clinically indicated, develops interventions and care plans to assure the needs of this high risk population are addressed. CenCal Health also implemented a Pay-for-Performance program to financially reward PCPs that successfully intervene to improve 30-day readmissions.
b. *Children and Adolescents' Access to Primary Care Practitioners (25 Months –6 Years)* in San Luis Obispo and Santa Barbara counties	For Santa Barbara, the SPD population numbers only 222; therefore, the difference between the SPD and non-SPD level of performance is not statistically significant due to the small SPD pediatric population. The difference in performance for San Luis Obispo County is statistically significant. The pediatric clinic closures described above likely affected access for all pediatric members, including those with disability. CenCal Health's clinical staff evaluates risk assessments and, when clinically indicated, performs care management for SPD members.
c. *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* in San Luis Obispo County	The pediatric clinic closures described above likely affected access for all pediatric members, including adolescents with disability. CenCal Health's clinical staff evaluates risk assessments and, when clinically indicated, performs care management for SPD members.
4. Reference the QIP Completion Instructions to ensure that all required information is included on the QIP Summary Form for each QIP submission.	CenCal Health will ensure that all required information is included on future QIP submission forms for each QIP submission.
5. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the *Rating of Health Plan, Rating of All Health Care,* and *How Well Doctors Communicate* priority areas.	CenCal Health received the 2013 MCP-specific CAHPS results report in March 2014. An analysis was completed to review scores, external factors with potential impact on satisfaction during the survey time frame, and recommendations from HSAG to focus improvement efforts on the overall ratings of "Health Plan," "Health Care," and the composite measure, "How Well Doctors Communicate". Analysis of national ratings supported CenCal Health's need to focus on those measures for the pediatric population in San Luis Obispo County. Results have been reported through CenCal Health's quality committee structure, including committees with representatives from CenCal Health's provider network, and also to the plan's Community Advisory Board and Board of Directors. Development and implementation of interventions are ongoing.
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.	CenCal and DHCS will work together to address the findings of the encounter data validation study report as part of the transition from the current encounter data system and formats to the new system and national standard transaction types.

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