Performance Evaluation Report

Central California Alliance for Health

July 1, 2010–June 30, 2011

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

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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS California Department of HealthCareServices

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 million beneficiaries (as of June 2011)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to the domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Central California Alliance for Health ("CCAH" or "the plan"), which delivers care in Merced, Monterey, and Santa Cruz counties, for the review period July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

CCAH was previously known as Central Coast Alliance for Health. It is a full-scope managed care plan operating in Monterey, Santa Cruz, and Merced counties. CCAH became operational with the MCMC Program in Santa Cruz County in January 1996 and Monterey County in October 1999, and the plan expanded into Merced County in October 2009. HSAG included the plan's performance measure rates and QIP information for Merced County in this report for the first time since this is the first year information has been available. CCAH had 186,838 MCMC members in Merced, Monterey, and Santa Cruz counties as of June 30, 2011.[2]

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

[2] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about CCAH's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

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

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

As the 2008–2009 performance evaluation report indicated, CCAH had at least one deficiency in each of the six evaluated categories of performance, and recommendations were made in each area.

CCAH submitted a corrective action plan in September 2009. The DHCS *Medical Audit Close-Out Report* dated April 19, 2010, indicated that all audit deficiencies were resolved by the plan.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These member rights reviews are conducted before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2011. The most current MRPIU review for CCAH was a follow-up monitoring review conducted in May 2010, covering the review period of November 1, 2009, through April 30, 2010. Finding from this audit were detailed in the 2008–2009 plan evaluation report.[3]

The results of the DHCS follow-up review indicated that CCAH took appropriate action to correct all member grievance findings that were previously identified in the MRPIU in February 2009. However, it was noted that CCAH did not resolve issues related to the notice of action (NOA) letter

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

missing a required citation and the timeliness of the letters being sent. The report also recommended that CCAH develop and implement quality controls to ensure adherence to policies concerning prior-authorization notification.

Strengths

The plan fully resolved all deficiencies noted on the previous medical performance review. CCAH showed substantial progress in addressing many of the MRPIU findings and resolving deficiencies related to the grievance process.

Opportunities for Improvement

While CCAH adequately addressed most of the MRPIU audit deficiencies, the plan did not implement mechanisms to ensure that all NOA letters contain citations supporting plan decisions and are sent to members within the required time frame; therefore, this continues to be an opportunity for improvement. The plan has an opportunity to implement an internal review process to ensure that corrective action plans are fully implemented and effective.

Conducting the Review

The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provide a standardized method for objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about CCAH's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[4] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of CCAH in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. Audit results showed that the plan was fully compliant with the information standards to report valid rates.

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

Performance Measure Results

MCMC requires that contracted health plans calculate and report HEDIS rates at the county level unless otherwise approved by the DHCS; however, exceptions to this requirement were approved several years ago for COHS health plans operating in certain counties. CCAH was one of the COHS health plans approved for combined county reporting for Monterey and Santa Cruz counties; therefore, Table 3.2 reflects combined reporting for those two counties. MCMC requires that all existing health plans expanding into new counties report separate HEDIS rates for each county once membership exceeds 1,000; therefore, the DHCS required CCAH to report performance measure rates for Merced County separately from the reporting of Monterey and Santa Cruz counties.

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Tables 3.2 and 3.3.

Table 3.1—HEDIS® 2011 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2011 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Tables 3.2 and 3.3 present a summary of CCAH's HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. The table shows the plan's HEDIS 2011 performance compared to the MCMC-established MPLs and HPLs.

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

Table 3.2—2010–2011 Performance Measure Results for Central California Alliance for Health—Monterey and Santa Cruz Counties

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	24.3%	26.4%	★★	↔	19.7%	35.9%
AWC	Q,A,T	51.8%	46.5%	★★	↔	38.8%	63.2%
BCS	Q,A	62.0%	61.6%	★★	↔	46.2%	63.8%
CCS	Q,A	74.7%	71.3%	★★	↔	61.0%	78.9%
CDC–BP	Q	70.8%	71.8%	★★	↔	53.5%	73.4%
CDC–E	Q,A	70.3%	65.9%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	58.6%	56.4%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	21.4%	33.3%	★★	↓	53.4%	27.7%
CDC–HT	Q,A	90.3%	89.1%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	47.7%	45.7%	★★★	↔	27.2%	45.5%
CDC–LS	Q,A	85.2%	84.4%	★★★	↔	69.3%	84.0%
CDC–N	Q,A	86.6%	82.5%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	81.5%	82.7%	★★★	↔	63.5%	82.0%
LBP	Q	82.7%	86.1%	★★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	88.1%	93.4%	★★★	↑	80.3%	92.7%
PPC–Pst	Q,A,T	77.9%	75.4%	★★★	↔	58.7%	74.4%
URI	Q	95.5%	95.0%	★★★	↔	82.1%	94.9%
W34	Q,A,T	82.5%	83.5%	★★★	↔	65.9%	82.5%
WCC–BMI	Q	50.6%	69.8%	★★★	↑	13.0%	63.0%
WCC–N	Q	58.6%	72.3%	★★★	↑	34.3%	67.9%
WCC–PA	Q	34.1%	61.3%	★★★	↑	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.

Table 3.3—2010–2011 Performance Measure Results for Central California Alliance for Health—Merced County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	NA	15.1%	★	NC	19.7%	35.9%
AWC	Q,A,T	NA	37.2%	★	NC	38.8%	63.2%
BCS	Q,A	NA	NA*	NA	NC	46.2%	63.8%
CCS	Q,A	NA	53.0%	★	NC	61.0%	78.9%
CDC–BP	Q	NA	67.2%	★★	NC	53.5%	73.4%
CDC–E	Q,A	NA	41.6%	★★	NC	41.4%	70.1%
CDC–H8 (<8.0%)	Q	NA	46.7%	★★	NC	38.7%	58.8%
CDC–H9 (>9.0%)	Q	NA	44.0%	★★	NC	53.4%	27.7%
CDC–HT	Q,A	NA	86.1%	★★	NC	76.0%	90.2%
CDC–LC (<100)	Q	NA	36.0%	★★	NC	27.2%	45.5%
CDC–LS	Q,A	NA	80.0%	★★	NC	69.3%	84.0%
CDC–N	Q,A	NA	86.4%	★★★	NC	72.5%	86.2%
CIS–3	Q,A,T	NA	55.2%	★	NC	63.5%	82.0%
LBP	Q	NA	79.9%	★★	NC	72.0%	84.1%
PPC–Pre	Q,A,T	NA	88.3%	★★	NC	80.3%	92.7%
PPC–Pst	Q,A,T	NA	63.0%	★★	NC	58.7%	74.4%
URI	Q	NA	90.1%	★★	NC	82.1%	94.9%
W34	Q,A,T	NA	74.0%	★★	NC	65.9%	82.5%
WCC–BMI	Q	NA	46.7%	★★	NC	13.0%	63.0%
WCC–N	Q	NA	62.3%	★★	NC	34.3%	67.9%
WCC–PA	Q	NA	40.4%	★★	NC	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

NA = The DHCS does not establish an MPL/HPL for first year measures.

NA* = The plan did not have enough members meeting the measure criteria to report a valid rate.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

NC = Not compared. Indicates instances when one or both of the comparison years had no rate to compare, or significant changes to the measure's methodology impacted the ability to compare rates between years.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

CCAH had above-average performance with substantial improvement in 2011 for Monterey and Santa Cruz counties and average performance for Merced County. The combined county rates for Monterey and Santa Cruz counties had four measures with statistically significant increases in 2011 and only one measure with a statistically significant decrease. Eleven out of 21 measures scored above the HPLs in 2011 in Monterey and Santa Cruz counties. However, four measures performed below the MPLs in Merced County, and only one measure performed above the HPL.

HEDIS Improvement Plans

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

For plan measure rates that required a 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with the plan's 2011 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans. The plan did not have any rates that fell below the MPL in 2010; therefore, it was not required to do any HEDIs improvement plans for HEDIS year 2011.

Strengths

CCAH had a strong HEDIS 2011 performance just as it did in 2010 for Monterey and Santa Cruz counties with 11 measures outperforming the HPLs in 2011 compared to nine in 2010. Another indicator of the plan's exceptional performance for Monterey and Santa Cruz counties was that four measures had a statistically significant increase over 2010's results.

Opportunities for Improvement

In Monterey and Santa Cruz counties, CCAH should focus on improving its *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)* measure, as it was the only measure that had a statistically significant decline from 2010 to 2011. In Merced County, CCAH will need to focus on improving the four measures that fell below the MPLs: *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis, Adolescent Well-Care Visits, Cervical Cancer Screening,* and *Childhood Immunization Status—Combination 3*.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Quality Improvement Projects Conducted

CCAH had two clinical QIPs in progress during the review period of July 1, 2010–June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. CCAH's second project, an internal QIP, sought to increase effective case management of members by reducing hospital admissions for uncontrolled diabetes and reducing discharges for congestive heart failure (CHF). Both QIPs fell under the quality and access domains of care.

The plan's ER and CHF QIPs covered in this report included members from Santa Cruz and Monterey counties but did not include members from Merced County as the DHCS requires that plans initiate QIP projects for counties after the plan has been operational for one year. CCAH has indicated it will include Merced County in its next QIP proposal due in November 2011. Additionally, the plan will include Merced County in the next collaborative QIP.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a PCP in an office or clinic setting. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

Hospital admissions for uncontrolled diabetes and discharges for CHF are indicators of suboptimal care. These admissions and discharges may also indicate ineffective case management of chronic diseases. CCAH's project attempted to improve the quality of care delivered to members with diabetes and CHF.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for both of CCAH's QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Central California Alliance for Health—Monterey and Santa Cruz Counties July 1, 2010, through June 30, 2011

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	82%	100%	*Met*
Internal QIPs				
Improving Effective Case Management	Annual Submission	79%	90%	*Partially Met*
	Resubmission 1	84%	90%	*Partially Met*
	Resubmission 2	87%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that the initial submission of CCAH's *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. For its *Improving Effective Case Management* QIP, the plan did not address a *Point of Clarification* for a critical element from the prior year's validation instructing the plan to revise its study questions; therefore, the score was lowered from a *Met* score with a *Point of Clarification* to a *Partially Met* score. As of July 1, 2009, the DHCS began requiring plans to resubmit their QIPs until they achieved an overall *Met* validation status. The plan resubmitted the *Improving Effective Case Management* QIP without correcting its study questions, so the validation score

remained a *Partially Met*. The plan finally made the correction in the second resubmission and the plan received a *Met* validation status.

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

Table 4.2—Quality Improvement Project Average Rates* for Central California Alliance for Health—Monterey and Santa Cruz Counties (Number = 2 QIPs, 2 QIP Topics) July 1, 2010, through June 30, 2011

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	0%	100%	0%
	VI: Accurate/Complete Data Collection	90%	10%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**88%**	**12%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation†	88%	13%	0%
	IX: Real Improvement Achieved	25%	25%	50%
	X: Sustained Improvement Achieved	0%	50%	50%
Outcomes Total		**62%**	**19%**	**19%**

*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 sum may not equal 100 percent due to rounding.

CCAH submitted Remeasurement 2 data for both of its QIPs; therefore, HSAG validated Activity I through Activity X. CCAH demonstrated an accurate application of the design and implementation stages, scoring 100 percent on all evaluation elements for five of the seven activities. Although CCAH did not use sampling in its *Improving Effective Case Management* QIP, the plan was scored down in Activity V for not addressing a prior *Point of Clarification*. The plan was instructed to document that sampling was not used instead of leaving Activity V blank. Similarly in Activity VI for both QIPs, the plan was scored down for not addressing a prior *Point of Clarification* to provide the timeline for each measurement period.

For the outcomes stage, once again, CCAH was given a *Partially Met* score in Activity VIII for not addressing a prior *Point of Clarification* to provide a complete interpretation of the study indicator results for its *Improving Effective Case Management* QIP. The correction was not made in either resubmission. One of two study indicators for the *Improving Effective Case Management* QIP and the

outcome for the *Reducing Avoidable Emergency Room Visits* QIP did not demonstrate improvement; therefore, CCAH received a score of 25 percent for Activity IX. For Activity X, the plan did not achieve sustained improvement for its *Reducing Avoidable Emergency Room Visits* QIP outcome and for one of its *Improving Effective Case Management* QIP outcomes. Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

Table 4.3 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3––Quality Improvement Project Outcomes for Central California Alliance for Health—Monterey and Santa Cruz Counties July 1, 2010, through June 30, 2011

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable	23.2%	19.0%*	22.2%*	Yes
QIP #2—Improving Effective Case Management				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement¥**
Percentage of members 18–75 years of age with a hospitalization for uncontrolled diabetes	0.82%	0.89%	0.91%	No
Percentage of members over 21 years of age with a hospital discharge for congestive heart failure	71.1%	39.8%*	38.0%	Yes

¥ Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

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

In the *Reducing Avoidable ER Visits* QIP, CCAH reported a decrease in the percentage of avoidable ER visits from Remeasurement 1 to Remeasurement 2. The increase was statistically significant and probably not due to chance. A decrease for this measure reflects improvement in

performance. From baseline to Remeasurement 1, CCAH had implemented several plan-specific interventions including reports to primary care providers regarding their members' ER usage and a Web-based reporting system that allows providers to check their members' ER usage in real time. Additionally, the plan had a financial incentive program that rewards primary care providers for providing preventive care and services to their members. Although these interventions were continued, the plan demonstrated a statistically significant decline in performance from Remeasurement 1 to Remeasurement 2. Although the Remeasurement 2 rate was not improved over the Remeasurement 1 rate, it was still improved over the baseline rate. Therefore, the plan did achieve sustained improvement from baseline to Remeasurement 2. Collaborative interventions were initiated in early 2009; however, these interventions were not directly associated with an improved outcome.

For the *Improving Effective Case Management* QIP, the percentage of members hospitalized for uncontrolled diabetes increased from Remeasurement 1 to Remeasurement 2, demonstrating a decline in performance; however, the increase was not statistically significant, and the rate remained below 1 percent. The plan did not demonstrate any improvement from baseline to Remeasurement 2 and, therefore, did not achieve sustained improvement for this outcome. The percentage of members who were discharged from a hospitalization for congestive heart failure decreased from Remeasurement 1 to Remeasurement 2 and reflected an increase in performance. Although the change was not statistically significant, the plan demonstrated sustained improvement from baseline to Remeasurement 2. The plan continued its stepped interventions. First, the plan combined some of the duties of the chronic disease case managers with the child case managers. Second, the two sets of case managers were moved into closer physical proximity to each other. Then the plan provided laptops so that the case managers would be able to enter access utilization data in real time.

Strengths

CCAH demonstrated good application of the QIP process for QIP topic selection, development of study indicators, and definition of the study population. Additionally, CCAH implemented accurate data collection methods and appropriate improvement strategies. CCAH's actions to address identified causes/barriers and system interventions are likely to induce permanent change.

CCAH's case management QIP has the potential to impact the plan's chronic disease management. System interventions selected by CCAH to decrease diabetes admissions and CHF discharges included software tools to provide timely access to claims and hospital data. These interventions have the potential to coordinate care between case management, disease management, and utilization management. Additionally, PCPs were educated on the availability of these tools.

Opportunities for Improvement

CCAH has shown challenges with meeting QIP validation requirements with the initial QIP submission. CCAH should incorporate the recommendations, including *Points of Clarification,* provided in the prior year's QIP Validation Tool to avoid being scored down in the next annual submission. Additionally, all recommendations should be addressed before the plan resubmits the QIPs to avoid the necessity of multiple resubmissions.

CCAH should incorporate a method to evaluate the effectiveness of its interventions, especially when multiple interventions are implemented. The plan should conduct an annual barrier analysis, at a minimum, to ensure that ongoing interventions are still targeting relevant barriers. Additionally, for the case management QIP, the plan should address the variability of the results since only a very small proportion of the plan's overall Medi-Cal managed care population is included in the study.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for Medi-Cal managed care members through the provision of health care services and the plan's structural and operational characteristics.

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

The plan showed average performance in the quality domain. This assessment was based on CCAH's 2011 performance measure rates (which reflect 2010 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

In the 2011 quality-related HEDIS measures, CCAH Monterey, Santa Cruz, and Merced counties had 12 measures score above the HPLs and four measures with statistically significant increases. However, Merced County did not perform as well with four quality related measures falling below the MPLs.

The plan demonstrated improvement in the area of compliance, as it was able to address most quality-related issues that were identified in the medical performance review, as well as the MRPIU review. The MRPIU recommended that CCAH develop and implement quality controls to ensure adherence to policies concerning prior-authorization notification.

CCAH demonstrated good application of the QIP process for QIP topic selection, development of study indicators, and definition of the study population. However, CCAH has shown challenges with meeting QIP validation requirements with the initial QIP submission.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the Medi-Cal Managed Care Program.

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

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

In the 2011 access-related HEDIS measures, CCAH had six measures score above the HPLs for Monterey, Santa Cruz, and Merced counties and one measure with a statistically significant increase. The plan demonstrated improvement in the area of compliance, as it was able to address all access-related issues that were identified in the medical performance review, as well as the MRPIU review.

CCAH implemented accurate data collection methods and appropriate improvement strategies. CCAH's actions to address identified causes/barriers and system interventions are likely to induce permanent change. CCAH should incorporate a method to evaluate the effectiveness of its interventions, especially when multiple interventions are implemented.

Timeliness

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

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits,

and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

CCAH had above-average performance in the timeliness domain of care based on its 2011 performance measure rates for providing timely care and medical performance review standards related to timeliness. In the 2011 access-related HEDIS measures, CCAH had four measures score above the HPLs and one measure with a statistically significant increase for Monterey, Santa Cruz, and Merced counties. The plan demonstrated improvement in the area of compliance, as it was able to address most of the timeliness-related issues that were identified in the medical performance review, as well as the MRPIU review. There was one outstanding issue of the timeliness of an NOA letter being sent.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 plan-specific evaluation report. CCAH's self-reported responses are included in Appendix A.

Conclusions and Recommendations

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

In Monterey and Santa Cruz counties, CCAH showed an increase in its 2011 performance measure rates compared with 2010 rates. The plan was generally compliant with procedural requirements across performance measures, QIPs, and State and federal requirements.

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

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

- Ensure that all NOA letters contain citations supporting plan decisions and are sent to members within the required time frame.
- Implement an internal review process to ensure that corrective action plans are fully implemented and effective.
- Focus on improving its *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)* measure in Monterey and Santa Cruz counties, as it was the only measure that had a statistically significant decline from 2010 to 2011.
- Emulate the practices and processes from Monterey and Santa Cruz counties into the Merced County relating to performance measures.

- Incorporate the recommendations, including *Points of Clarification*, provided in the prior year's QIP Validation Tool to avoid being scored down in the next annual submission.
- Address all recommendations before resubmitting QIPs to avoid the necessity of multiple resubmissions.
- Incorporate a method to evaluate the effectiveness of its interventions, especially when multiple interventions are implemented.
- Conduct an annual barrier analysis, at a minimum, to ensure that ongoing interventions are still targeting relevant barriers.
- Address the variability of the results since only a very small proportion of the plan's overall Medi-Cal managed care population are included in the study.

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

Appendix A. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

for Central California Alliance for Health

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with Central California Alliance for Health's self-reported actions that address the recommendations. Neither Health Services Advisory Group, Inc. (the external quality review organization for Medi-Cal Managed Care) nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table A.1—Grid of CCAH's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	CCAH's Self-Reported Actions That Address the EQR Recommendation
Develop and implement quality control mechanisms to ensure adherence to established prior-authorization notification policies and procedures.	As of the first Quarter of 2010, the Alliance UM Department ensured that a Notice of Action (NOA) letter was sent to all members whose authorization requests were approved as modified or denied authorization requests. The NOAs are mailed to the member within 3 days of the decision to modify or deny the requested services. The NOA letters are reviewed for quality of content along with the compliance timeline by several UM staff/supervisors for ongoing process improvement as needed. The UM Department reports the percentage of NOAs for denials that are sent within 3 days of the determination in the Health Services Alliance Quality Indicator (AQI) quarterly report. When the goal (95% goal until mid-2011/then 100% goal in remainder of 2011 and 2012) is not reached, then an analysis of the findings is conducted by the UM Management Team and reported to the Alliance Management Team along with steps for future compliance.
Explore factors that contributed to the decline in performance for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, which had a statistically significant decrease from 2009 to 2010.	CCAH has explored the decrease with some root cause analysis. The AAB measure is on our HEDIS watch list and we will be monitoring the rates on a quarterly basis. The rate did increase from 2010 to 2011 by 2% and we are looking forward to seeing that in your next report.
Incorporate the recommendations provided by HSAG in the QIP validation tool when it resubmits QIPs to avoid the necessity of a second resubmission.	CCAH continues to work closely with HSAG on understanding and ensuring that recommendations are accurately incorporated into either resubmissions, if necessary, or future submissions.
Ensure that future QIP topics are reflective of a need that can have a greater impact on a larger portion of the Medi-Cal managed care population.	CCAH closed out the Complex Case Management QIP in 2011. While complex and chronic disease are very relevant to the seniors and persons with disabilities (SPD) population, we will work closely with the EQRO before launching a QIP aimed at the SPD population in order to find or develop measures which have a larger denominator and greater impact.
Review the 2010 plan-specific CAHPS results report and develop strategies to address the following priority areas: Rating of Health Plan and Rating of All Health Care.	CCAH will report, analyze, and do barrier analysis on all CAHPS results and review them through our internal and external quality committee structure.