Performance Evaluation Report

Central California Alliance for Health

July 1, 2011–June 30, 2012

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

June 2013

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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans 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 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 designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more 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.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[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.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, 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.

This report is specific to DHCS'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, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, 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. CCAH is a full-scope managed care plan operating in Monterey, Santa Cruz, and Merced counties. CCAH serves members in all counties under a County Organized Health System (COHS) model. In a COHS model, DHCS initiates contracts with county-organized and county-operated plans to provide managed care services to beneficiaries with designated, mandatory aid codes. In a COHS plan, beneficiaries can choose from a wide network of managed care providers. These beneficiaries do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the plan.

CCAH became operational in Santa Cruz County to provide MCMC services in January 1996 and in Monterey County in October 1999. CCAH expanded into Merced County in October 2009. As of June 31, 2012, CCAH had 189,907 MCMC members in Merced, Monterey, and Santa Cruz counties, collectively.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period 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.

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 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from 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. DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of DHCS's Medi-Cal Managed Care Division (MMCD) have historically worked in conjunction with the Department of Managed Health Care to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or the Department of Managed Health Care. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

The most recent medical performance review was conducted in June 2009, covering the review period of April 1, 2008, through March 31, 2009. 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 human immunodeficiency virus (HIV). DHCS issued final reports for both reviews in November 2009, and the findings were detailed in CCAH's 2008–2009 plan-specific evaluation report.[4] The plan's 2010–2012 plan-specific evaluation report indicated that the DHCS Medical Audit Close-Out Report dated April 19, 2010, found that all audit deficiencies were resolved by the plan.

Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current medical performance reviews and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

The most recent MR/PIU review was conducted in April 2012 for the review period of January 1, 2011, through December 31, 2011. The MR/PIU report dated July 12, 2012, indicated that the plan was fully compliant in the area of program integrity, and MR/PIU noted five findings from

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

the review. CCAH was not required to respond to the findings. MR/PIU will follow up with the plan on the findings during its next review. Listed below are the findings:

Member Grievances

MR/PIU reviewed 55 member grievance files and found:

- One case where CCAH did not resolve a member grievance within the 30-day time frame requirement.
- One case where CCAH did not provide the member with notification of the status of the grievance or its estimated date of resolution.

Prior Authorization Notification

MR/PIU reviewed 80 prior authorization notification case files and found:

- Eleven files where the notice of action (NOA) letter for denial or modification was not sent within the required 14-day time frame.
- Three files where the NOA letter was not mailed to the member within the three-business-day requirement.

Cultural and Linguistic Services

- Staff members in one of nine provider officers visited did not discourage the use of family, friends, or minors as interpreters for members. This is not compliant with the requirement that plans must not require or suggest to limited English proficient (LEP) members that they must provide their own interpreters, since use of family, friends, and particularly minors may compromise the reliability of medical information, and LEP members may be reluctant to reveal personal and confidential information to family members, friends, or minors.

Please note that while the MR/PIU report was issued outside the July 1, 2011, through June 30, 2012, review period for this plan-specific evaluation report, since the MR/PIU review was conducted within the review period, HSAG included the findings from the review. Based on the timing of the MR/PIU letter and the time frame for this report, information regarding the actions the plan has taken to address the findings were not available. HSAG will report on CCAH's actions to address the findings in the next plan-specific evaluation report.

Strengths

MR/PIU's review of CCAH's Anti-Fraud and Abuse Program determined that the plan has policies and procedures in place to adequately prevent, detect, investigate, and report instances of suspected fraud and/or abuse. Although MR/PIU identified five findings during its review,

CCAH is not required to submit a corrective action plan. Instead, MR/PIU indicated that it will follow up with the plan to ensure the identified findings have been resolved.

Opportunities for Improvement

The plan has the following opportunities for improvement based on the results of the MR/PIU review:

CCAH should take all necessary actions to ensure that the plan's established policies and procedures are consistently applied to ensure that:

- All member grievances are resolved within the required time frame.
- Members are notified in writing of the status of their grievances and provided with an estimated completion date for resolution when grievances cannot be resolved within the required 30-day time frame.
- Members receive NOA letters for denial or modification within the required 14-day time frame.
- All NOA letters are mailed to members within three business days after a decision has been made.
- Provider offices are appropriately trained to ensure that LEP members are discouraged from using family, friends, or minors as interpreters when being seen by a provider or interacting with other health care professionals.

Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). 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 DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by DHCS for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the plan's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of CCAH in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

Performance Measure Validation Findings

No concerns were identified by the HSAG audit team during CCAH's HEDIS Compliance Audit, and all rates were valid.

Performance Measure Results

MCMC requires that contracted plans calculate and report HEDIS rates at the county level unless otherwise approved by 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 plans MCMC approved for combined county reporting for Monterey and Santa Cruz counties; therefore, Table 3.3 reflects combined reporting for these 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 members; therefore, DHCS required CCAH to report performance measure rates for Merced County separate from Monterey and Santa Cruz counties.

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

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions (internally developed measure)*
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
AWC	*Adolescent Well-Care Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
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*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*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 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the All-Cause Readmissions (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

DHCS based the MPLs and HPLs on the National Committee for Quality Assurance's (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.

Table 3.2—Comparison of 2011 and 2012 Performance Measure Results for Central California Alliance for Health—Merced County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	15.1%	11.6%	★	↔	18.8%	31.6%
AMB–ED	‡	--	49.1	--	Not Comparable	--	--
AMB–OP	‡	--	320.6	--	Not Comparable	--	--
AWC	Q,A,T	37.2%	48.9%	★★	↑	39.6%	64.1%
CAP–1224	A	--	96.9%	--	Not Comparable	--	--
CAP–256	A	--	91.2%	--	Not Comparable	--	--
CAP–711	A	--	89.5%	--	Not Comparable	--	--
CAP–1219	A	--	87.6%	--	Not Comparable	--	--
CCS	Q,A	53.0%	57.9%	★	↔	64.0%	78.7%
CDC–BP	Q	67.2%	64.5%	★★	↔	54.3%	76.0%
CDC–E	Q,A	41.6%	56.2%	★★	↑	43.8%	70.6%
CDC–H8 (<8.0%)	Q	46.7%	51.3%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	44.0%	37.2%	★★	↑	52.1%	29.1%
CDC–HT	Q,A	86.1%	87.8%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	36.0%	38.0%	★★	↔	27.3%	45.9%
CDC–LS	Q,A	80.0%	80.3%	★★	↔	70.4%	84.2%
CDC–N	Q,A	86.4%	82.5%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	55.2%	64.7%	★★	↑	64.4%	82.6%
IMA–1	Q,A,T	--	50.1%	--	Not Comparable	--	--
LBP	Q	79.9%	84.1%	★★★	↑	72.3%	82.3%
MPM–ACE	Q	--	86.4%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	87.3%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	88.3%	85.4%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	63.0%	59.6%	★★	↔	59.6%	75.2%
W-34	Q,A,T	74.0%	72.5%	★★	↔	66.1%	82.9%
WCC–BMI	Q	46.7%	58.9%	★★	↑	19.7%	69.8%
WCC–N	Q	62.3%	64.2%	★★	↔	39.0%	72.0%
WCC–PA	Q	40.4%	44.3%	★★	↔	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS'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] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Table 3.3—Comparison of 2011 and 2012 Performance Measure Results for Central California Alliance for Health—Monterey/Santa Cruz Counties

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	26.4%	28.0%	★★	↔	18.8%	31.6%
AMB–ED	‡	--	51.9	--	Not Comparable	--	--
AMB–OP	‡	--	320.6	--	Not Comparable	--	--
AWC	Q,A,T	46.5%	64.7%	★★★	↑	39.6%	64.1%
CAP–1224	A	--	97.4%	--	Not Comparable	--	--
CAP–256	A	--	91.1%	--	Not Comparable	--	--
CAP–711	A	--	89.6%	--	Not Comparable	--	--
CAP–1219	A	--	88.9%	--	Not Comparable	--	--
CCS	Q,A	71.3%	73.2%	★★	↔	64.0%	78.7%
CDC–BP	Q	71.8%	76.6%	★★★	↔	54.3%	76.0%
CDC–E	Q,A	65.9%	67.4%	★★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	56.4%	61.8%	★★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	33.3%	28.2%	★★★	↔	52.1%	29.1%
CDC–HT	Q,A	89.1%	92.0%	★★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	45.7%	47.2%	★★★	↔	27.3%	45.9%
CDC–LS	Q,A	84.4%	84.9%	★★★	↔	70.4%	84.2%
CDC–N	Q,A	82.5%	79.8%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	82.7%	84.2%	★★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	64.0%	--	Not Comparable	--	--
LBP	Q	86.1%	85.1%	★★★	↔	72.3%	82.3%
MPM–ACE	Q	--	88.3%	--	Not Comparable	--	--
MPM–DIG	Q	--	87.9%	--	Not Comparable	--	--
MPM–DIU	Q	--	89.0%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	93.4%	86.1%	★★	↓	80.3%	93.2%
PPC–Pst	Q,A,T	75.4%	77.6%	★★★	↔	59.6%	75.2%
W-34	Q,A,T	83.5%	83.2%	★★★	↔	66.1%	82.9%
WCC–BMI	Q	69.8%	79.1%	★★★	↑	19.7%	69.8%
WCC–N	Q	72.3%	80.3%	★★★	↑	39.0%	72.0%
WCC–PA	Q	61.3%	61.3%	★★★	↔	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS'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] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
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★★★ = 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, CCAH had above-average performance in 2012. Monterey/Santa Cruz counties had 14 measures above the HPLs, while Merced County had average performance with one measure performing above the HPL and two measures performing below the MPLs (*Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* and *Cervical Cancer Screening*). Monterey/Santa Cruz counties had three measures with statistically significant improvement and one measure (*Prenatal and Postpartum Care—Timeliness of Prenatal Care*) with statistically significant decline in performance. Merced County had six measures with statistically significant improvement over the previous year.

HEDIS Improvement Plans

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

HSAG compared the plan's 2011 IP (if one was required) with the plan's 2012 HEDIS rate for that measure 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.

Although four measures in Merced County performed below the MPLs in 2011, CCAH was not required to submit IPs for these measures in 2012 because 2011 was the first year the plan reported rates for Merced County. In 2012, the rates for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Cervical Cancer Screening* measures fell below the MPLs in Merced County; therefore, CCAH will be required to implement improvement plans for these measures.

Strengths

CCAH continues to perform above average overall on performance measures. Monterey/Santa Cruz counties had exceptionally strong performance, with 14 measures performing above the HPLs. Merced County had statistically significant improvement on six measures, two of which improved from performing below the MPLs in 2011 to average performance in 2012 (*Adolescent Well-Care Visits* and *Childhood Immunization Status—Combination 3*).

Opportunities for Improvement

CCAH has the following opportunities for improvement:

- In Merced County, CCAH should focus on improving performance on the following measures:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*—Performance on this measure was below the MPL in 2011 and 2012 and did not show improvement between years. The plan should conduct barrier analysis and implement interventions that will improve the rate above the MPL.
  - *Cervical Cancer Screening*—Performance on this measure was below the MPL in 2011 and 2012; and although not statistically significant, performance improved from 2011 to 2012. The plan should continue to monitor that performance on this measure continues to move upward to achieve the MPL.
- In Monterey/Santa Cruz counties, the plan should find out the factors that led to a statistically significant decline in performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and identify and implement interventions to prevent further decline and consequently improve the performance on this measure.

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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* 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 plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). 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 Project Objectives

CCAH—Monterey/Santa Cruz counties had one clinical QIP and two clinical QIP proposals and CCAH—Merced had two clinical QIP proposals in progress during the review period of July 1, 2010–June 30, 2011. The plan's *Reducing Avoidable Emergency Room Visits* QIP covered in this report included members from Santa Cruz and Monterey counties but did not include members from Merced County as DHCS requires that plans initiate QIP projects for counties after the plan has been operational for one year. Following DHCS requirements, CCAH included Merced County in its *Improving Asthma Health Outcomes* and *All-Cause Readmissions* QIP proposals.

CCAH—Monterey/Santa Cruz counties' first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of DHCS's statewide collaborative QIP. CCAH's second project, an internal QIP, sought to improve asthma health outcomes of Monterey, Santa Cruz, and Merced County members aged 5 to 64 years by reducing

asthma exacerbations. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative which focused on reducing readmissions for members aged 21 years and older in Monterey, Santa Cruz, and Merced counties. All three QIP topics fell under the quality and access domains of care.

The current statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. At the initiation of the QIP, CCAH—Monterey/Santa Cruz counties had identified 8,877 ER room visits that were avoidable, which was 23.2 percent of its ER visits. The plan's objective was to reduce this rate by 5 percent with the use of member, provider, and system improvement strategies. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

The new statewide collaborative proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members leading to improved health outcomes.

CCAH's *Improving Asthma Health Outcomes* QIP attempted to improve the quality of care delivered to members with asthma. Inadequate medication control and asthma exacerbations resulting in ER visits and hospital inpatient stays are indicators of suboptimal care. These visits and stays may also indicate ineffective case management of chronic diseases.

Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Central California Alliance for Health—Merced, Monterey, and Santa Cruz Counties July 1, 2011, through June 30, 2012

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 (Monterey and Santa Cruz counties only)	Annual Submission	79%	90%	*Not Met*
	Resubmission	97%	100%	*Met*
*All-Cause Readmissions** (Monterey/Santa Cruz counties and Merced County received the same score)	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIPs				
Improving Asthma Health Outcomes (Monterey/Santa Cruz counties and Merced County received the same scores)	Proposal	70%	75%	*Partially Met*
	Proposal Resubmission	96%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a 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 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*.

*During the review period, the *All-Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that the annual submission by CCAH of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Not Met*. Similarly, its *Improving Asthma Health Outcomes* QIP received an overall validation status of *Partially Met*. As of July 1, 2009, DHCS began requiring plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted both of these QIPs and upon subsequent validation, achieved an overall *Met* validation status. For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

Due to unique, one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

Table 4.2 summarizes the aggregate validation results for 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—Merced, Monterey, and Santa Cruz Counties (Number = 6 QIP Submissions, 2 QIP Topics) July 1, 2011, through June 30, 2012

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	94%	0%	6%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population**	63%	25%	13%
Design Total		**92%**	**4%**	**4%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	0%	0%	100%
	VI: Accurate/Complete Data Collection	63%	30%	7%
	VII: Appropriate Improvement Strategies	83%	17%	0%
Implementation Total		**65%**	**27%**	**8%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	75%	6%	19%
	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total**		**85%**	**4%**	**12%**

*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.

CCAH submitted Remeasurement 3 data for its *Reducing Avoidable ER Visits* QIP; therefore, HSAG validated Activities I through X. For the two QIP proposals, the plan progressed through Activity VI. CCAH demonstrated an adequate understanding of the design stage, scoring 92 percent of all applicable evaluation elements *Met*. Activity IV was initially scored down in the *Improving Asthma Heath Outcomes* QIP since the plan did not completely define the study population.

In the implementation stage, CCAH scored 65 percent of the applicable evaluation elements *Met*. The plan did not appropriately complete Activity V in its *Reducing Avoidable ER Visits* QIP as recommended in the two prior years resulting in a *Not Met* score. In its resubmission, the plan

corrected the deficiency and correctly identified that sampling was not used; therefore, the activity received a *Not Applicable* score. In Activity VI, CCAH did not include a timeline for the data collection in either QIP. Furthermore, this deficiency was not addressed in the resubmissions. Also in Activity VI, the plan did not attach the HEDIS specifications for its *Improving Asthma Heath Outcomes* QIP or the final audit report in its *Reducing Avoidable ER Visits* QIP. Both of these deficiencies were corrected in the resubmissions. In its *Reducing Avoidable ER Visits* QIP resubmission, the plan included its improvement strategy for the last remeasurement period that had been omitted in its annual submission.

Only the *Reducing Avoidable ER Visits* QIP progressed through the outcomes stage. For this QIP, the plan initially did not indicate whether there were factors that affected the validity or comparability of the data. Additionally, the plan incorrectly documented the outcome and provided an incomplete interpretation of the results and the success of the project, all of which were addressed in its resubmission. In Activities IX and X, the plan reported both statistically significant and sustained improvement. 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 and Interventions

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—Merced and Monterey/Santa Cruz Counties July 1, 2011, through June 30, 2012

QIP #1—Reducing Avoidable Emergency Room Visits (Monterey/Santa Cruz Counties[1])					
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**	**Remeasurement 3 1/1/10–12/31/10**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable^	23.2%	19.0%*	22.2%*	21.0%*	Yes
QIP #2—Improving Asthma Health Outcomes					
QIP Study Indicator	**Baseline Period 1/1/11–12/31/11**	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**		**Sustained Improvement¥**
Percentage of members with a controller to asthma medication ratio of 0.5 or higher	‡	‡	‡		‡
Percentage of ER visits for members with persistent asthma^	‡	‡	‡		‡
Percentage of inpatient discharges for members with persistent asthma^	‡	‡	‡		‡

[1] CCAH did not expand into Merced County until October 2009; therefore, only Monterey and Santa Cruz counties were included in the QIP.

^A lower percentage indicates better performance.

¥ 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.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, CCAH set an overall objective to decrease the rate of ER visits designated as avoidable by 5 percent. For this project outcome, a lower rate demonstrates improved performance. The plan met its overall objective; it reduced the percentage of avoidable ER visits by a statistically significant amount from baseline to the first remeasurement period (4.2 percentage points) and then again from the second to the third remeasurement period (1.2 percentage points). The third remeasurement period rate remained below the baseline rate, demonstrating sustained improvement for the project.

While the plan achieved statistically significant improvement for two remeasurement periods, there was a statistically significant decline in performance from the first to the second remeasurement period. A critical analysis of the plan's improvement strategy allowed for the following observations:

- The plan conducted a planning session to identify barriers and develop interventions. The plan did not provide any specific results of the barrier analysis or any data-driven rationale for the selection of the interventions.
- The plan implemented several strong plan-specific interventions including reports to PCPs 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 PCPs for providing preventive care and services to their members and reducing ER use. These interventions were implemented early in the project with slight modifications being made after the plan performed annual analyses. The plan did not report any evaluation plans for the interventions and was unable to obtain specific data to support the interventions' effectiveness. The plan was not able to evaluate why the decline occurred from the first to the second remeasurement period, and the same interventions were in place for both measurement periods. .
- The plan participated in the collaborative interventions, initiated in early 2009; however, the plan did not report its hospital collaborative intervention results. Additionally, the interventions were not directly associated with an improved outcome.

The plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine whether to modify or discontinue existing interventions, or implement new ones, thereby reducing the likelihood of achieving project objectives and improving performance.

Improving Asthma Health Outcomes QIP

The plan's *Improving Asthma Health Outcomes* QIP had not progressed to the point of reporting results or implementing interventions.

Strengths

CCAH demonstrated an acceptable application of the QIP design stage.

The plan was able to reduce the percentage of avoidable ER visits and sustain that improvement through the final remeasurement period in Monterey/Santa Cruz counties.

Opportunities for Improvement

CCAH had challenges meeting QIP validation requirements with the initial QIP submissions. CCAH should incorporate the recommendations provided in the prior year's QIP Validation Tool to avoid being scored down in the subsequent annual submission. Additionally, all recommendations should be addressed before the plan resubmits a QIP to avoid the necessity of multiple resubmissions.

CCAH should conduct an annual barrier analysis, at minimum. The plan should improve the documentation of the barrier analysis, providing the data, the identified barriers, and the rationale for how the barriers are prioritized. CCAH should ensure that the barrier analyses are performed to evaluate whether different barriers exist for Merced County than for Monterey/Santa Cruz counties and develop improvement strategies accordingly.

The interventions implemented should address the high-priority barriers. A method to evaluate the effectiveness of each intervention should be documented, as well as the results of the intervention's evaluation for each measurement period.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care. A more detailed description of HSAG's scoring process is included in Appendix A.

Quality

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

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries 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, 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.

CCAH's overall performance was above average in the quality domain of care. Across all three counties, 15 measures that fall into the quality domain of care performed above the HPLs. Two measures in Merced County falling into the quality domain of care performed below the MPLs. The plan also showed sustained improvement for the *Reducing Avoidable Emergency Room Visits* QIP that was implemented in Monterey/Santa Cruz counties.

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 MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and 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. Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

CCAH's overall performance was above average in the access domain of care. The plan's MR/PIU review identified findings in the areas of Prior Authorization Notification and Cultural and Linguistic Services; however, the plan was informed by MR/PIU that no corrective action plan was required. MR/PIU will instead follow up with the plan to ensure findings have been addressed. Across all three counties, six measures falling into the access domain of care had performance above the HPLs; and four measures had statistically significant improvement. One measure in Merced County falling into the access domain of care performed below the MPL. The *Reducing Avoidable Emergency Room Visits* QIP fell into the access domain of care and, as stated above, the plan showed sustained improvement on this QIP in Monterey/Santa Cruz counties.

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.

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's overall performance was above average in the timeliness domain of care. The plan's MR/PIU review identified two findings in the area of grievances; however, the plan was informed by MR/PIU that no corrective action plan was required. MR/PIU will instead follow up with the

plan to ensure findings have been addressed. Across all counties, four measures falling into the timeliness domain of care performed above the HPLs. Two timeliness measures in Merced County that performed below the MPLs in 2011 improved to above the MPLs in 2012 (*Adolescent Well-Care Visits* and *Childhood Immunization Status—Combination 3*).

Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. CCAH's self-reported responses are included in Appendix B.

Recommendations

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

- Ensure that all findings identified in the April 2012 MR/PIU review are fully resolved. Specifically, take all necessary actions so that the plan's established policies and procedures are consistently applied to ensure that:
  - All member grievances are resolved within the required time frame.
  - Members are notified in writing of the status of their grievances and provided with an estimated completion date for resolution when grievances cannot be resolved within the required 30-day time frame.
  - Members receive NOA letters for denial or modification within the required 14-day time frame.
  - All NOA letters are mailed to members within three business days after a decision has been made.
  - Provider offices are trained to ensure that LEP members are discouraged from using family, friends, or minors as interpreters when being seen by a provider or interacting with other health care professionals.
- In Merced County, focus on improving performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Cervical Cancer Screening* measures, since 2012 rates were below the MPLs.
- In Monterey/Santa Cruz counties, assess the factors that led to a statistically significant decline in performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and identify and implement interventions that will prevent further decline in performance on this measure.

- Incorporate the recommendations provided in the prior year's QIP Validation Tool to avoid being scored down in the subsequent annual submission. Additionally, address all recommendations before resubmitting a QIP to avoid the necessity of multiple resubmissions.
- Conduct an annual barrier analysis, at minimum. Additionally, improve the documentation of the barrier analysis, providing the data, the identified barriers, and the rationale for how the barriers are prioritized. Finally, ensure that the barrier analyses are performed to evaluate whether different barriers exist for Merced County than for Monterey/Santa Cruz counties and develop improvement strategies accordingly.
- Ensure that the QIP interventions implemented address the high-priority barriers. Additionally, document a method to evaluate the effectiveness of each intervention, as well as the results of the intervention's evaluation for each measurement period.

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

Quality, Access, and Timeliness

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

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Tables 3.2 and 3.3)

Quality Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) greater than negative three, if there are two or less measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than three.
3. To be considered ***Below Average***, a plan will have three or more measures below the MPLs than it has above the HPLs.

Access Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus and the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Timeliness Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

- **Validation** *(Table 4.1)*: For each QIP submission and subsequent resubmission(s), if applicable.
  - **Above Average** is not applicable.
  - **Average** = *Met* validation status.
  - **Below Average** = *Partially Met* or *Not Met* validation status.
- **Outcomes** *(Table 4.3)*: Activity IX, Element 4—**Real Improvement**
  - **Above Average** = All study indicators demonstrated statistically significant improvement.
  - **Average** = Not all study indicators demonstrated statistically significant improvement.
  - **Below Average** = No study indicators demonstrated statistically significant improvement.

- **Sustained Improvement** *(Table 4.3)*: Activity X—**Achieved Sustained Improvement**
  - **Above Average =** All study indicators achieved sustained improvement.
  - **Average =** Not all study indicators achieved sustained improvement.
  - **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 performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity 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.

Appendix B. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

for Central California Alliance for Health

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with CCAH's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table B.1—Grid of CCAH's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	CCAH's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Ensure that all NOA letters contain citations supporting plan decisions and are sent to members within the required time frame.	Monitored compliance of this recommendation in the reporting year, July 1, 2011, to June 30, 2012; ranged from a low of 91.9% to a high of 100%, with the annual average rate of 95.8%. The goal is 100% and process improvement was initiated to change the process from a manual process to an automated process. Prior authorization staff worked closely with the Associate Medical Director to develop approved citations or "snippets" specific to authorization type for insertion into the NOA letter. In 2Q12, the NOA letter templates embedded into the UM prior authorization software (ACT) were significantly improved by the standardization of NOA letter generation, resulting in a more timely and thorough review of citations supporting plan decisions and approval by the associate medical director at the time of medical determination decisions. In addition to the electronic generation of NOA letters in ACT for timely letter mailing compliance, a compliance time clock methodology is slated to be implemented by 1Q2013. This will ensure that all decision correspondence is timely. Tracking and reporting of NOA citation accuracy, letter generation, and mailing will be monitored daily and reported quarterly through an Administrative Quality Indicator (AQI) in 2013 to ensure continued compliance.
Implement an internal review process to ensure that corrective action plans are fully implemented and effective.	The Alliance has delegated the Compliance Department responsibility to monitor and report on all corrective action plans from surveys and audits. Additionally, all audit recommendations are tracked for improvement through internal administrative quality indicators reported on a quarterly basis.
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.	2010 had exceptionally low HbA1c poor control rates. Based on historical data, the average rate is 30.18 and the median is 31.63. In 2011, the Alliance began incentivizing members to obtain all 4 key diabetic screenings, and physicians were provided quarterly reports of compliance. This allowed the physician and member an opportunity to improve compliance over the calendar year. As a result, the HbA1c poor control rates decreased from 2011 (33.33%) to 2012 (28.22%). It is anticipated this improvement will continue in 2013.
Emulate the practices and processes from Monterey and Santa Cruz counties into Merced County relating to performance measures.	By emulating the practices and process from Monterey and Santa Cruz counties, the Alliance is demonstrating gradual and sustained improvement with Merced HEDIS rates. As noted in 2011, there were four measures under the MPL; in 2012, not only was there improvement in all 4 of those measures, only two measures fell under the MPL. One of those measures is CCS which is a three-year look back, and the Alliance has only been reporting Merced HEDIS rates for the last two years. It is anticipated that Merced HEDIS compliance rates will continue to improve as Merced providers and members become more exposed to Alliance incentives and interventions.

Table B.1—Grid of CCAH's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	CCAH's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
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.	Effective 2Q12, all QIPs were reviewed by leadership prior to submission to ensure all Points of Clarification were responded to. The Alliance developed a QIP checklist that will be completed before submission of QIPS to ensure Points of Clarification, recommendations, and findings are addressed prior to submission.
Address all recommendations before resubmitting QIPs to avoid the necessity of multiple resubmissions.	The Alliance developed a QIP checklist that will be completed before submission of QIPs to ensure recommendations and findings are addressed prior to submission. Additionally, leadership will review all QIPs prior to submission to ensure compliance.
Incorporate a method to evaluate the effectiveness of its interventions, especially when multiple interventions are implemented.	QIPs are now designed with individual interventions identified and tracked down to the member to demonstrate impact.
Conduct an annual barrier analysis, at a minimum, to ensure that ongoing interventions are still targeting relevant barriers.	All current QIPs are reported and evaluated for barriers and interventions on a quarterly basis to the internal Quality Work Group and to the external Clinical Quality Committee.
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.	QIPs are now identified utilizing historical data, to ensure relevance and adequacy of population. The Individual QIP (IQIP) that was being monitored in 2010–2011, has ended and has been closed out. The two QIPs currently in process (Asthma and Hospital Readmissions) address larger relevant populations.