Performance Evaluation Report

Central California Alliance for Health

July 1, 2012–June 30, 2013

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

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013.* This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and

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

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

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

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Central California Alliance for Health ("CCAH" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

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

CCAH became operational to provide MCMC services in Santa Cruz County in January 1996, in Monterey County in October 1999, and in Merced County in October 2009. As of June 30, 2013, CCAH had 76,341 MCMC members in Merced County, 94,802 members in Monterey County, and 40,317 members in Santa Cruz County—for a total of 211,460 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

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

This report section covers 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, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's 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.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits and Member Rights Reviews

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

Member Rights/Program Integrity Unit Routine Monitoring Review

The most recent routine monitoring review for CCAH was conducted from April 16, 2012, through April 19, 2012, covering the review period of January 1, 2011, through December 31, 2011. HSAG reported on the detailed findings from this review in CCAH's 2011–12 MCP-specific

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP 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 the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

evaluation report. The Member Rights/Program Integrity Unit (MR/PIU) identified findings in the areas of Member Grievances, Prior Authorization Notification, and Cultural and Linguistic Services. In a letter dated March 5, 2013, MR/PIU indicated that CCAH provided responses to the findings identified in the review and MR/PIU conducted a follow-up review on August 23, 2012. As part of the follow-up review, DHCS evaluated CCAH's level of progress in performing cultural awareness and sensitivity training required to meet the needs of SPDs and physical accessibility surveys.

The March 5, 2013, letter indicated that CCAH had taken appropriate action to correct all findings from the April 2012 review. Additionally, the letter indicated that MR/PIU found the MCP's progress on providing SPD sensitivity training and conducting physical accessibility review surveys to be satisfactory.

Strengths

CCAH fully resolved all findings from the April 2012 MR/PIU Routine Monitoring Review. Additionally, during the August 2012 follow-up review with CCAH, MR/PIU found the MCP's progress on providing SPD sensitivity training and conducting physical accessibility review surveys to be satisfactory.

Opportunities for Improvement

Since CCAH fully resolved all findings from the April 2012 MR/PIU Routine Monitoring Review, HSAG does not have any recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for Central California Alliance for Health* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that CCAH followed the appropriate specifications to produce valid rates and identified no issues of concern. A review of the MCP's HEDIS audit report revealed the following observation:

- CCAH implemented weekly audits of provider data in 2012. In addition, the MCP conducted quarterly reports for the provider data and monitored encounter data submissions from providers.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

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

Table 3.1—Name Key for Performance Measures in External Accountability Set

Performance Measure Abbreviation	Full Name of 2013 Reporting Year[†] Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions* [‡]
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient 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)*
CBP	*Controlling High Blood Pressure*
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*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MMA–75	*Medication Management for People with Asthma—Medication Compliance 75% Total*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
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*

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.
‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Tables 3.2 and 3.3 below present a summary of CCAH's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Tables 3.2 and 3.3 show the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

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 2012 and 2013 Performance Measure Results
CCAH—Merced County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	11.61%	16.23%	★	↑	18.98%	33.33%
ACR	Q, A	--	12.73%	--	Not Comparable	--	--
AMB–ED	‡	49.09	53.69	‡	Not Comparable	‡	‡
AMB–OP	‡	320.62	324.06	‡	Not Comparable	‡	‡
CAP–1224	A	96.92%	97.42%	★★	↔	95.56%	98.39%
CAP–256	A	91.25%	90.39%	★★	↓	86.62%	92.63%
CAP–711	A	89.54%	89.82%	★★	↔	87.56%	94.51%
CAP–1219	A	87.63%	90.19%	★★	↑	86.04%	93.01%
CBP	Q	--	52.80%	--	Not Comparable	--	--
CCS	Q,A	57.91%	63.77%	★★	↔	61.81%	78.51%
CDC–BP	Q	64.48%	64.96%	★★	↔	54.48%	75.44%
CDC–E	Q,A	56.20%	54.74%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	51.34%	46.72%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	37.23%	45.99%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	87.83%	84.91%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	37.96%	33.09%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	80.29%	80.54%	★★	↔	70.34%	83.45%
CDC–N	Q,A	82.48%	84.91%	★★	↔	73.48%	86.93%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
CCAH—Merced County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
CIS–3	Q,A,T	64.72%	64.74%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	50.12%	55.96%	★★	↔	50.36%	80.91%
LBP	Q	84.15%	79.33%	★★	↓	72.04%	82.04%
MMA–50	Q	--	48.30%	--	Not Comparable	--	--
MMA–75	Q	--	26.16%	--	Not Comparable	--	--
MPM–ACE	Q	86.41%	87.14%	★★	↔	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	87.31%	86.97%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	85.40%	83.92%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	59.61%	58.79%	★★	↔	58.70%	74.73%
W-34	Q,A,T	72.51%	74.33%	★★	↔	65.51%	83.04%
WCC–BMI	Q	58.88%	77.62%	★★★	↑	29.20%	77.13%
WCC–N	Q	64.23%	66.91%	★★	↔	42.82%	77.61%
WCC–PA	Q	44.28%	44.77%	★★	↔	31.63%	64.87%

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—Comparison of 2012 and 2013 Performance Measure Results
CCAH—Monterey/Santa Cruz Counties

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	27.95%	22.27%	★★	↓	18.98%	33.33%
ACR	Q, A	--	12.06%	--	Not Comparable	--	--
AMB–ED	‡	51.95	52.10	‡	Not Comparable	‡	‡
AMB–OP	‡	320.58	318.74	‡	Not Comparable	‡	‡
CAP–1224	A	97.42%	98.49%	★★★	↑	95.56%	98.39%
CAP–256	A	91.05%	91.29%	★★	↔	86.62%	92.63%
CAP–711	A	89.57%	90.89%	★★	↑	87.56%	94.51%
CAP–1219	A	88.93%	91.00%	★★	↑	86.04%	93.01%
CBP	Q	--	55.96%	--	Not Comparable	--	--
CCS	Q,A	73.24%	71.65%	★★	↔	61.81%	78.51%
CDC–BP	Q	76.64%	71.05%	★★	↔	54.48%	75.44%
CDC–E	Q,A	67.40%	63.02%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	61.80%	51.09%	★★	↓	42.09%	59.37%
CDC–H9 (>9.0%)	Q	28.22%	36.98%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	91.97%	87.35%	★★	↓	78.54%	91.13%
CDC–LC (<100)	Q	47.20%	39.66%	★★	↓	28.47%	46.44%
CDC–LS	Q,A	84.91%	78.83%	★★	↓	70.34%	83.45%
CDC–N	Q,A	79.81%	79.32%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	84.18%	83.84%	★★★	↔	64.72%	82.48%
IMA–1	Q,A,T	63.99%	77.60%	★★	↑	50.36%	80.91%
LBP	Q	85.12%	88.00%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	49.96%	--	Not Comparable	--	--
MMA–75	Q	--	24.42%	--	Not Comparable	--	--
MPM–ACE	Q	88.31%	85.86%	★★	↓	83.72%	91.33%
MPM–DIG	Q	87.93%	89.47%	★★	↔	87.93%	95.56%
MPM–DIU	Q	88.95%	85.58%	★★	↓	83.19%	91.30%
PPC–Pre	Q,A,T	86.13%	81.76%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	77.62%	70.27%	★★	↓	58.70%	74.73%
W-34	Q,A,T	83.21%	82.08%	★★	↔	65.51%	83.04%
WCC–BMI	Q	79.08%	81.89%	★★★	↔	29.20%	77.13%

Table 3.3—Comparison of 2012 and 2013 Performance Measure Results CCAH—Monterey/Santa Cruz Counties

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
WCC–N	Q	80.29%	81.63%	★★★	↔	42.82%	77.61%
WCC–PA	Q	61.31%	66.58%	★★★	↔	31.63%	64.87%

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[8] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in

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

measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Tables 3.4 through 3.7, which present a summary of CCAH's 2013 SPD measure results. Tables 3.4 and 3.6 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Tables 3.5 and 3.7 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.4 and 3.6.

**Table 3.4—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
CCAH—Merced County**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.86%	14.40%	▼	12.73%
CAP–1224	97.51%	90.32%	↓	97.42%
CAP–256	90.37%	91.17%	↔	90.39%
CAP–711	89.76%	90.89%	↔	89.82%
CAP–1219	90.30%	88.74%	↔	90.19%
CDC–BP	69.34%	61.80%	↓	64.96%
CDC–E	49.88%	53.28%	↔	54.74%
CDC–H8 (<8.0%)	45.26%	48.66%	↔	46.72%
CDC–H9 (>9.0%)	45.50%	43.80%	↔	45.99%
CDC–HT	84.18%	84.67%	↔	84.91%
CDC–LC (<100)	33.58%	33.33%	↔	33.09%
CDC–LS	81.75%	79.32%	↔	80.54%
CDC–N	82.00%	86.13%	↔	84.91%
MPM–ACE	86.26%	87.83%	↔	87.14%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	84.96%	88.28%	↔	86.97%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

**Table 3.5—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
CCAH—Merced County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
299.06	51.12	536.12	75.54

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

Table 3.6—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
CCAH—Monterey/Santa Cruz Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.78%	14.47%	▼	12.06%
CAP–1224	98.50%	96.67%	↔	98.49%
CAP–256	91.26%	92.76%	↔	91.29%
CAP–711	90.86%	91.46%	↔	90.89%
CAP–1219	91.17%	88.47%	↓	91.00%
CDC–BP	76.16%	65.21%	↓	71.05%
CDC–E	61.56%	63.99%	↔	63.02%
CDC–H8 (<8.0%)	48.42%	51.58%	↔	51.09%
CDC–H9 (>9.0%)	39.90%	36.98%	↔	36.98%
CDC–HT	85.64%	86.37%	↔	87.35%
CDC–LC (<100)	38.20%	40.88%	↔	39.66%
CDC–LS	79.81%	76.16%	↔	78.83%
CDC–N	76.16%	81.02%	↔	79.32%
MPM–ACE	80.15%	89.32%	↑	85.86%
MPM–DIG	NA	89.13%	Not Comparable	89.47%
MPM–DIU	78.84%	88.86%	↑	85.58%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

Table 3.7—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
CCAH—Monterey/Santa Cruz Counties

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
293.93	49.10	543.55	79.25

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

Performance Measure Result Findings

Consistent with previous years, Monterey/Santa Cruz counties performed better than Merced County; however, in 2013, Monterey/Santa Cruz counties had a decline in performance. In 2012, Monterey/Santa Cruz counties had 14 measures with rates above the HPLs, while in 2013, only 6 measures had rates above the HPLs. Additionally, in 2012, Monterey/Santa Cruz counties had three measures with rates that improved significantly from the prior year and one measure with a significant decline in its rate. In 2013, these counties had four measures with rates that improved significantly from 2012 and nine measures with rates what were significantly worse.

Merced County's performance in 2013 also declined. In 2012, this county had one measure with a rate above the HPL and two measures with rates below the MPLs. Six measures in 2012 had rates that improved significantly from 2011 and no measures that declined significantly. In 2013, Merced County had one measure with a rate above the HPL and one measure with a rate below the MPL. Three measures had rates with statistically significant improvement from 2012 to 2013, and three measures had rates that were significantly worse in 2013 when compared to 2012.

The following measures in Monterey/Santa Cruz counties had rates above the HPLs in 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Childhood Immunization Status—Combination 3*
- *Use of Imaging Studies for Low Back Pain*
- All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

Additionally, the rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* measure in Merced County was above the HPL in 2013.

Although the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was below the MPL in Merced County for the third consecutive year, the rate for this measure improved significantly from 2012, which indicates that the MCP is making progress on improving performance for this measure.

Seniors and Persons with Disabilities Findings

The SPD rates for the following measures in Monterey/Santa Cruz counties were significantly better than the non-SPD rates:

- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The SPD rates for the following measures were significantly worse than the non-SPD rates:

- *All-Cause Readmissions* measure in Merced and Monterey/Santa Cruz counties
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* measure in Merced County
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* in Monterey/Santa Cruz counties
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* in Merced and Monterey/Santa Cruz counties

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however, rates should be interpreted with caution because high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures, and HSAG does not provide comparative analysis.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

CCAH was required to submit IPs for two measures with rates below the MPLs in Merced County in 2012. Below is a summary of each IP and HSAG's analysis of the progress the MCP made on improving performance on these measures from 2012 to 2013.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

CCAH identified the following barriers to the MCP performing above the MPL on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Merced County:

- Variations in prescribing patterns for antibiotic treatment.
- A lack of educational materials for members on avoidance of antibiotic use.

To address the barriers, CCAH implemented the following interventions:

- Targeted education to low-performing providers and monitored provider performance monthly. The MCP provided feedback to providers and published the data through the provider portal quarterly.
- Provider and member education regarding the importance of avoiding antibiotic use for bronchitis.
- Shared best practices from Monterey/Santa Cruz counties with the provider network through provider committees and forums.

Although the rate for this measure remained below the MPL in 2013, the rate improved significantly from 2012 to 2013, showing that the MCP's efforts are resulting in fewer instances of antibiotics being prescribed for adults with acute bronchitis and improved performance on this measure. The MCP will be required to continue the IP for this measure in Merced County.

Cervical Cancer Screening

CCAH identified several barriers to the MCP performing above the MPL on the *Cervical Cancer Screening* measure in Merced County, including:

- Not having a consistent way to inform providers when cervical cancer screening is due.
- Members getting screening in clinics other than where their primary care physician works.
- Limited ability to frequently monitor cervical cancer screening rates.
- Provider and member lack of knowledge on cervical cancer screening clinical guidelines.

CCAH implemented several interventions to address the barriers, including:

- Conducted telephone outreach calls to members who did not have their cervical cancer screening.
- Provided a list of members due for their cervical cancer screening to providers through the provider portal.
- Implemented a provider incentive program.
- Provided targeted education to low-performing providers on the *Cervical Cancer Screening* measure.

Although not statistically significant, the rate for this measure improved more than 5 percentage points for Merced County from 2012 to 2013, moving the rate from below the MPL in 2012 to above the MPL in 2013. CCAH will not be required to continue this IP.

Strengths

Across all counties, seven measures had rates above the HPLs in 2013, and seven measures had rates that improved significantly from 2012 to 2013. CCAH's IP for the *Cervical Cancer Screening* measure was successful at bringing the rate for this measure from below the MPL in 2012 to above the MPL in 2013 for Merced County. Although the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Merced County was below the MPL in 2013, the MCP's IP for this measure resulted in the rate for this measure improving significantly from 2012 to 2013.

Opportunities for Improvement

CCAH has the opportunity to build on the successful interventions being implemented in Merced County to improve the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure from below the MPL to above the MPL. Additionally, the MCP has the opportunity to assess the factors leading to the rates for several measures declining significantly from 2012 to 2013 and identify interventions to implement to prevent further decline on the rates. Finally, for measures with SPD rates that were significantly worse than the non-SPD rates, CCAH has the opportunity to assess the factors leading to the rates being significantly worse for the SPD population and identify strategies to ensure the MCP is meeting this population's needs.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[10] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

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

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

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

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

Quality Improvement Project Objectives

CCAH participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2012–June 30, 2013.

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

Table 4.1—Quality Improvement Projects for CCAH
July 1, 2012, through June 30, 2013

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

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

Prior to initiation of the statewide collaborative QIP, CCAH had a 30-day readmission rate of 11.99 percent for Merced County and 10.94 percent for Santa Cruz/Monterey counties among Medi-Cal beneficiaries. CCAH also found that the readmission rate for the SPD population was 14.81 percent for Merced County and 14.39 percent for Santa Cruz/Monterey counties which was higher than the 7.88 percent rate for Merced County and 5.71 percent rate for Santa Cruz/Monterey counties for the non-SPD population.

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

Quality Improvement Project Validation Findings

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

Table 4.2—Quality Improvement Project Validation Activity
CCAH—Merced and Santa Cruz/Monterey Counties
July 1, 2012, through June 30, 2013

Name of Project/Study	Counties	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	Counties received the same score—Merced and Santa Cruz/Monterey	Study Design Submission	90%	100%	*Met*
Internal QIPs					
Improving Asthma Health Outcomes	Counties received the same score—Merced and Santa Cruz/Monterey	Study Design Submission	45%	0%	*Not Met*
	Counties received the same score—Merced and Santa Cruz/Monterey	Study Design Resubmission 1	59%	43%	*Not Met*
	Counties received the same score—Merced and Santa Cruz/Monterey	Study Design Resubmission 2	55%	40%	*Not Met*
	Counties received the same score—Merced and Santa Cruz/Monterey	Study Design Resubmission 3	91%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that CCAH's *All-Cause Readmissions* QIP study design resubmission received an overall validation status of *Met* with 100 percent of critical elements and 90 percent of evaluation elements met. The *Improving Asthma Health Outcomes* QIP study design submission received a *Not Met* validation status. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. CCAH had to resubmit the QIP three times before achieving an overall *Met* validation status, with 100 percent of the critical elements and 91 percent of the evaluation elements being met.

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

Table 4.3—Quality Improvement Project Average Rates*
CCAH—Merced and Santa Cruz/Monterey Counties
(Number = 5 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	80%	20%	0%
	II: Clearly Defined, Answerable Study Question(s)	80%	20%	0%
	III: Clearly Defined Study Indicator(s)	64%	36%	0%
	IV: Correctly Identified Study Population	40%	60%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	80%	15%	5%
Design Total		**72%**	**26%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	25%	25%	50%
	VIII: Appropriate Improvement Strategies	0%	0%	100%
Implementation Total**		**17%**	**17%**	**67%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.
**The stage and/or activity totals may not equal 100 percent due to rounding.

HSAG validated Activities I through VI for CCAH's *All-Cause Readmissions* QIP and Activities I through VIII for the MCP's *Improving Asthma Health Outcomes* QIP study design submissions.

CCAH demonstrated a thorough application of Activities I through VI for the *All-Cause Readmissions* QIP. The only activity receiving a lowered score was Activity VI because CCAH did not describe the MCP's data analysis plan for this QIP.

CCAH struggled with providing adequate documentation for the Design stage (Activities I through VI) for the *Improving Asthma Health Outcomes* QIP. The MCP had to resubmit this QIP three times before achieving a *Met* validation status. The areas requiring resubmission included providing historical data for all study indicators, adequately defining the study questions, providing all required information on the study indicators, including information on how the study indicator rates would be compared to the goals/benchmarks, and indicating what statistical test would be

used. Since CCAH experienced so many challenges with achieving a *Met* validation status, HSAG provided technical assistance to the MCP's QIP staff members to provide guidance on how to design a sound QIP and meet all documentation requirements.

When submitting the *Improving Asthma Health Outcomes* QIP, CCAH included some documentation for Activities VII and VIII (the Implementation stage). Although the QIP had not progressed to the Implementation stage, since the MCP provided documentation in these activities, HSAG validated the information. HSAG designated several elements as *Not Applicable* and scored the elements for which CCAH provided information. The QIP will have progressed to the Implementation stage at the next annual submission, and HSAG will provide a more thorough assessment of the MCP's application of the Implementation stage in CCAH's 2013–14 MCP-specific evaluation report.

Quality Improvement Project Outcomes and Interventions

Since the *All-Cause Readmissions* and *Improving Asthma Health Outcomes* QIPs did not progress to the Implementation or Outcomes stage during the reporting period, no intervention or outcome information for these QIPs is included in this report.

Strengths

CCAH demonstrated an excellent application of the QIP Design stage for the *All-Cause Readmissions* QIP. The MCP achieved a *Met* validation status for this QIP on the first submission.

Opportunities for Improvement

As in previous years, CCAH had challenges meeting the QIP validation requirements. While in 2011–12 the MCP only needed one resubmission for two of its QIPs before achieving *Met* validation statuses, in 2012–13, CCAH was required to submit its *Improving Asthma Health Outcomes* QIP three times before achieving a *Met* status. As has been recommended previously, CCAH should refer to the QIP Completion Instructions prior to submitting QIPs to ensure completeness of the data. Additionally, the MCP should ensure all comments in the QIP Validation Tool are addressed prior to the next QIP submission; and if the MCP is not clear on how to address the comments, it should request technical assistance from the EQRO.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

CCAH's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about CCAH's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

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

CAHPS Global Rating Measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

CAHPS Composite Measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

Table 5.1—CAHPS Measures Domains of Care

Measure	Domains of Care
Rating of Health Plan	Q
Rating of All Health Care	Q
Rating of Personal Doctor	Q
Rating of Specialist Seen Most Often	Q
Getting Needed Care	Q, A
Getting Care Quickly	Q, T
How Well Doctors Communicate	Q
Customer Service	Q
Shared Decision Making	Q

National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

Star Rating	Adult and Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or above the 75th and below the 90th percentiles
★★★ Good	At or above the 50th and below the 75th percentiles
★★ Fair	At or above the 25th and below the 50th percentiles
★ Poor	Below the 25th percentile

Table 5.3 through Table 5.6 present the star ratings for the global ratings and composite measures for CCAH's adult and child Medicaid populations.[15]

Table 5.3—Medi-Cal Managed Care Adult County-Level Global Ratings
CCAH—Merced and Monterey/Santa Cruz Counties

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Merced	★	★	★★★★	★★+
Monterey/Santa Cruz	★★★	★★★★★	★★★★★	★★★★★

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.

[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.

[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.

[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

Table 5.4—Medi-Cal Managed Care Child County-Level Global Ratings
CCAH—Merced and Monterey/Santa Cruz Counties

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Merced	★	★	★	★★★★★+
Monterey/Santa Cruz	★★★	★	★★★★	★★★★★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Table 5.5—Medi-Cal Managed Care Adult County-Level Composite Measures
CCAH—Merced and Monterey/Santa Cruz Counties

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Merced	★★	★	★★	★★★★+
Monterey/Santa Cruz	★★★★	★★★	★★★★★	★★★★★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Table 5.6—Medi-Cal Managed Care Child County-Level Composite Measures
CCAH—Merced and Monterey/Santa Cruz Counties

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Merced	★+	★+	★+	★★+
Monterey/Santa Cruz	★★	★	★	★

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Strengths

Overall, Monterey/Santa Cruz Counties had higher ratings when compared to Merced County. Monterey/Santa Cruz counties received an *Excellent* rating on the following measures:

- *Rating of All Health Care*—adult population
- *Rating of Personal Doctor*—adult population
- *Rating of Specialist Seen Most Often*—adult and child populations[16]

[16] Since Monterey/Santa Cruz counties had fewer than 100 respondents for the child *Rating of Specialist Seen Most Often* measure, caution should be exercised when evaluating these results.

- *How Well Doctors Communicate*—adult population
- *Customer Service*—adult population[17]

Merced County received an *Excellent* rating on the child *Rating of Specialist Seen Most Often* measure; however, since this county had fewer than 100 respondents, caution should be exercised when evaluating these results.

The following measures received a *Very Good* rating:

- *Rating of Personal Doctor*—Merced County for the adult population and Monterey/Santa Cruz counties for the child population
- *Getting Needed Care*—Monterey/Santa Cruz counties for the adult population
- *Customer Service*—Merced County for the adult population[18]

Across all counties, the child composite measures had the worst ratings; however, Merced County had fewer than 100 respondents for all four child composite measures.

Monterey/Santa Cruz counties improved their ratings on the following measures from 2010 to 2013:

- *Rating of Health Plan*—adult population
- *Rating of All Health Care*—adult population
- *Rating of Personal Doctor*—adult population
- *Getting Needed Care*—adult population
- *Getting Care Quickly*—adult population
- *How Well Doctors Communicate*—adult population
- *Customer Service*—adult population

Since CCAH did not begin providing services to Medi-Cal beneficiaries in Merced County until October 2009, Merced County was not included in the 2010 CAHPS survey.

Please note that across both Merced and Monterey/Santa Cruz counties, CCAH had fewer than 100 respondents for the *Rating of Specialist Seen Most Often* and *Customer Service* measures. Also, CCAH had fewer than 100 respondents for all composite measures in Merced County. Caution should be exercised when evaluating these results.

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[17] Since Monterey/Santa Cruz counties had fewer than 100 respondents for the adult *Customer Service* measure, caution should be exercised when evaluating these results.

[18] Since Merced County had fewer than 100 respondents for the adult *Customer Service* measure, caution should be exercised when evaluating these results.

Opportunities for Improvement

Overall, CCAH's CAHPS results showed average performance. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as CCAH's highest priorities: *Getting Care Quickly, Rating of All Health Plan*, and *Rating of All Health Care*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 CCAH CAHPS MCP-Specific Report.* Areas for improvement spanned the quality and timeliness domains of care.

Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[19] completed by the MCPs during their NCQA HEDIS Compliance Audit. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[19] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

CCAH's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

Encounter Data Validation Findings

Review of Encounter Systems and Processes

The information provided in CCAH's Roadmap and supplemental questionnaire demonstrate that the MCP has sound procedures in place for the creation, validation, correction, and ongoing monitoring of encounter data.

Record Completeness

For CCAH, long-term care (LTC) records were included under the Hospital/Inpatient claim type for the comparative analysis. Therefore, there are no LTC claim results for CCAH.

Overall, CCAH had fairly low record omission and record surplus rates for the Medical/Outpatient, Hospital/Inpatient, and Pharmacy claim types, indicating fairly complete data when comparing DHCS's data to the encounter data extracted from CCAH's system for this study. The record surplus rates were all below 2 percent, and the record omission rates were below 3 percent for the Medical/Outpatient and Pharmacy claim types. The Hospital/Inpatient claim type had a record omission rate of 6.7 percent. All of CCAH's record omission and record surplus rates were better than the respective statewide rates, with notable performance for the Pharmacy claim type. For this claim type, CCAH's rates were better than their respective statewide record omission and surplus rates by more than 11 percentage points. At the county level, performance was fairly consistent for all three counties.

Data Element Completeness

CCAH had high performance for data element completeness with element omission rates of 0.2 percent or less and element surplus rates of 0.8 percent or lower for all key data elements except one element. The *Referring/Prescribing/Admitting Provider Number* field in the Pharmacy claim type had a very poor element surplus rate of 97.6 percent, which was worse than the statewide rate by 91.3 percentage points. CCAH indicated that not receiving the *Referring/Prescribing/Admitting Provider Number* information from the pharmacy benefit manager (PBM) caused the poor element surplus rate. For the remaining data elements, CCAH's performance was better than or similar to the statewide rates across all claim types. The counties performed fairly consistently with rates that were within 2 percentage points of CCAH's rates.

Data Element Accuracy

CCAH had fairly high element accuracy with rates of 98 percent or higher for the majority of the key data elements across the three claim types except three rates listed below.

- In the Medical/Outpatient and Hospital/Inpatient claim types, the *Billing/Reporting Provider Number* had data element accuracy rates of 77.0 percent and 49.2 percent, respectively. For both claim types, more than 86 percent of the records with mismatched values contained a Medi-Cal provider number in DHCS's data and an NPI in the MCP's data. CCAH indicated that the inaccuracy was due to changes made in January 2012 in how it reports this data element.

- In the Pharmacy claim type, the *Referring/Prescribing/Admitting Provider Number* had an element accuracy rate of 43.0 percent. However, this only indicated that 247 records had mismatched values for this data element. Please use caution when interpreting this element accuracy rate.

The three rates mentioned above were below the statewide rates by more than 13 percentage points. For the remaining element accuracy rates, CCAH's rates were better than or similar to the respective statewide rates. CCAH's three counties performed fairly consistently on the element accuracy rates for all key data elements except the *Billing/Reporting Provider Number*, which had noticeable county-level variation with a range of 10.2 percentage points for the Medical/Outpatient claim type and 27.3 percentage points for the Hospital/Inpatient claim type.

While the Medical/Outpatient claim type had an all-element accuracy rate that was 8.4 percentage points higher than the statewide rate, the all-element accuracy rate for the Hospital/Inpatient claim type fell below the statewide result by 15.7 percentage points due to element inaccuracy with the data element *Billing/Reporting Provider Number*. Because of the poor element surplus rate for the *Referring/Prescribing/Admitting Provider Number*, the Pharmacy claim type had an all-element accuracy rate worse than the statewide rate by 76.7 percentage points. There was notable variation at the

county level for both the *Billing/Reporting Provider Number* element accuracy rates in the Medical/Outpatient and Hospital/Inpatient claim types.

Recommendations

Based on its review, HSAG recommends the following:

- CCAH indicated that not receiving the *Referring/Prescribing/Admitting Provider Number* information from its PBM caused the poor element surplus rate in the Pharmacy claim type. CCAH should consider requesting values from its PBM and storing them in the MCP's data system for the data element *Referring/Prescribing/Admitting Provider Number* in the Pharmacy data.
- For the Hospital/Inpatient claim type, both data sources were missing values for the data elements *Primary Surgical Procedure Code* and *Secondary Surgical Procedure Code*. CCAH stated that the MCP did not store these data elements in its data system. CCAH should work with DHCS to determine if it should collect and submit data to DHCS for these data elements in the future.
- Although it appears that the change CCAH made in January 2012 in how it reports the data element was the cause for the relatively low element accuracy rates for the *Billing/Reporting Provider Number* in the Medical/Outpatient and Hospital/Inpatient claim types, CCAH should further investigate the reason(s) and take necessary actions to prevent similar issues from reoccurring.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[20]

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

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

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

HSAG reviewed CCAH's quality improvement documents as part of the process for producing this MCP-specific evaluation report. HSAG found that CCAH's organizational structure and quality improvement activities support the provision of quality care to the MCP's members.

The following quality measures in Monterey/Santa Cruz counties had rates above the HPLs in 2013:

- *Childhood Immunization Status—Combination 3*
- *Use of Imaging Studies for Low Back Pain*
- All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

The rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* measure was also above the HPL in Merced County.

Across all counties, three quality measures had rates with significant improvement from 2012 to 2013. The rate for one of these measures in Merced County, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, was below the MPL in 2013, despite the significant improvement. Eleven quality measures had rates that were significantly worse in 2013 when compared to 2012.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care. The SPD rates for the following quality measures in Monterey/Santa Cruz counties were significantly better than the non-SPD rates:

- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The SPD rates for the following quality measures were significantly worse than the non-SPD rates:

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

All CAHPS measures fall into the quality domain of care. The results were mixed across all counties, with 7 measures receiving an *Excellent* rating, 4 measures receiving a *Very Good* rating, 3 measures receiving a *Good* rating, 5 measures receiving a *Fair* rating, and 13 measures receiving a *Poor* rating.

Both of CCAH's QIPs fall into the quality domain of care. Neither of the QIPs progressed to the Implementation or Outcomes stage, so HSAG was not able to assess the QIPs' success at improving the quality of care delivered to the MCP's Medi-Cal members.

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

Access

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

As indicated above, HSAG reviewed CCAH's quality improvement documents as part of the process for producing this MCP-specific evaluation report. It appears that CCAH has policies and procedures in place to ensure members' access to care.

Two access measures in Monterey/Santa Cruz counties had rates above the HPLs in 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Childhood Immunization Status—Combination 3*

Across all counties, five access measures had rates with statistically significant improvement from 2012 to 2013, and no access measures had rates below the MPLs in 2013. The following measures falling into the access domain of care had rates that declined significantly from 2012 to 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* in Merced County
- *Comprehensive Diabetes Care—HbA1c Testing* in Monterey/Santa Cruz counties
- *Comprehensive Diabetes Care—LDL-C Screening* in Monterey/Santa Cruz counties
- *Prenatal and Postpartum Care—Postpartum Care* in Monterey/Santa Cruz Counties

Nine of the performance measures stratified for the SPD population fall into the access domain of care. None of the access measures' SPD rates were significantly better than the non-SPD rates.

The following access measures had SPD rates that were significantly worse than the non-SPD rates:

- *All-Cause Readmissions* in Merced and Monterey/Santa Cruz counties
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* in Merced County
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* in Monterey/Santa Cruz counties

CCAH had mixed results for the *Getting Needed Care* CAHPS measure, which falls into the access domain of care. Merced County received a *Fair* rating for the adult population and a *Poor* rating for the child population, while Monterey/Santa Cruz counties received a *Very Good* rating for the adult population and a *Fair* rating for the child population.

Both of CCAH's QIPs fall into the access domain of care. Neither of the QIPs progressed to the Implementation or Outcomes stage so HSAG was not able to assess the QIPs' success at improving access to care for the MCP's Medi-Cal members.

Overall, CCAH showed above-average performance in the access domain of care.

Timeliness

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

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

The rate for one timeliness measure, *Childhood Immunization Status—Combination 3* was above the HPL in Monterey/Santa Cruz counties. No timeliness measures had rates below the MPLs. The rate for the *Immunizations for Adolescents—Combination 1* measure, which falls into the timeliness domain of care, increased significantly from 2012 to 2013 in Monterey/Santa Cruz counties. The rate for one timeliness measure, *Prenatal and Postpartum Care—Postpartum Care*, declined significantly from 2012 to 2013 in Monterey/Santa Cruz counties.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. This measure received a *Poor* rating in Merced County for the adult and child populations, a *Good* rating in Monterey/Santa Cruz counties for the adult population, and a *Poor* rating in Monterey/Santa Cruz counties for the child population.

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

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-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 MCP:

- Build on the successful interventions being implemented to improve the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Merced County to move the rate from below the MPL to above the MPL.
- Since CCAH had 12 measures with rates that were significantly lower in 2013 when compared to 2012, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.
- For measures with SPD rates that were significantly worse than the non-SPD rates in 2013, assess the factors leading to the rates being significantly worse for the SPD population and identify interventions to implement to ensure the MCP is meeting the SPD population's needs.
- Refer to the QIP Completion Instructions prior to submitting QIPs to ensure completeness of the data. Additionally, the MCP should ensure all comments in the QIP Validation Tool are addressed prior to the next QIP submission; and if the MCP is not clear on how to address the comments, it should request technical assistance from the EQRO.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Getting Care Quickly, Rating of Health Plan,* and *Rating of All Health Care* priority areas.
- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[21] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Tables 3.2 and 3.3)

Quality Domain

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

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

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

Access and Timeliness Domains

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

CAHPS Survey Measures

(Refer to Tables 5.3 through 5.6)

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

Quality Domain

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

Access Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

Timeliness Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Not all study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

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 and Medi-Cal Managed Care Division reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures, CAHPS measures, and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the encounter data validation (EDV) study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

Appendix B. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

for **Central California Alliance for Health**

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with CCAH's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table B.1—CCAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	CCAH's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. 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:	
a. All member grievances are resolved within the required time frame.	This finding was a result of incorrect application of a standard using business days, rather than calendar days. Staff education was conducted to ensure all grievance coordinators resolve grievance cases within required time frames. Additionally, the Grievance Team was restructured and moved under the Compliance Department to align grievance handling with other regulatory work. A new position of grievance coordinator 3 was created to ensure case load is shared appropriately across the Grievance Team and to assist the grievance supervisor in monitoring deadlines for cases.
b. 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.	This finding was a result of incorrect application of a standard using business days, rather than calendar days. Staff education was conducted to ensure all grievance coordinators resolve grievance cases within required timeframes. Additionally, the Grievance Team was restructured and moved under the Compliance Department to align grievance handling with other regulatory work. A new position of grievance coordinator 3 was created to ensure case load is shared appropriately across the Grievance Team and to assist the grievance supervisor in monitoring deadlines for cases.
c. Members receive notice of action (NOA) letters for denial or modification within the required 14-day time frame.	In response to these findings, CCAH has implemented an automated NOA generation, approval, and printing process in its Alliance Care Tracking (ACT) system, which significantly reduced the amount of staff time required to manually create and process NOAs. CCAH continues to develop and implement a compliance clock to integrate the regulatory time frames for letter generation, including notification of staff of the NOA requirement. In addition, a NOA

2011–12 External Quality Review Recommendation	CCAH's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	coordinator has been assigned to audit and monitor all NOAs for timeliness.
d. All NOA letters are mailed to members within three business days after a decision has been made.	In response to these findings, CCAH has implemented an automated NOA generation, approval, and printing process in its Alliance Care Tracking (ACT) system, which significantly reduced the amount of staff time required to manually create and process NOAs. CCAH continues to develop and implement a compliance clock to integrate the regulatory time frames for letter generation, including notification of staff of the NOA requirement. In addition, a NOA coordinator has been assigned to audit and monitor all NOAs for timeliness.
e. Provider offices are trained to ensure that limited English proficiency (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.	The Alliance has taken concrete actions to ensure that network provider offices are properly trained about policies and procedures to serve LEP members, including discouraging members from using anyone other than a qualified interpreter when being seen by a provider or interacting with other health care professionals. In an effort to address HSAG's recommendation made to ensure that LEP and deaf or hard of hearing members have access to qualified interpreter services when accessing Alliance covered services, the following activities/interventions were implemented during the period of July 1, 2012, through June 30, 2013: On August 6, 2012, a letter was mailed to a provider who was identified during the audit for using unqualified interpreters. Provider was informed about the State and federal laws, as well as the Alliance's policies requiring the use of trained and qualified foreign language and sign language interpreters for patient communications, and to not use patients' friends, family members, or other unqualified individuals as interpreters. Additional supporting materials were provided at this time as well, including *Alliance Interpreter Services Provider Quick Reference Guide, Point to your Language* 9'' x 12'' Language Identification easel for counter tops and *I Speak* 2'' x 3.5'' patient language identification cards. Office staff attended one of the workshops as listed below and they were adequately trained on how to access the Alliance Interpreter Services. Two provider workshops were delivered on 9/15/12 and10/17/12 titled, "Connecting with Your Diverse Patient Population: Practical Tips and Tools to Increase Awareness About and Improve Communication with Limited English Proficiency (LEP) Patients; Patients with Visible and Hidden Disabilities; and Senior Patients." Alliance providers have received continuous communication and reinforcing materials regarding accessing trained and qualified interpreter services offered by the Alliance via articles published in the Provider Bulletin. The following Provider Bulletin articles provide detailed procedures on how to access a qualified interpreter: March 2012, "New Telephone Interpreter Vendor for the Alliance"; June 2012, "Reminder: New Telephone Interpreter Service for the Alliance"; March 2013, "How to Access Free Interpreter Services for

2011–12 External Quality Review Recommendation	CCAH's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	Alliance Members"; June 2013, "Do you Speak Your Patient's Language?" In the Provider Manual, Section 14: Cultural and Linguistic Services Program, outlines the Alliance's Language Assistance Program/Interpreter Services, including policy background and how to access a qualified interpreter. Alliance providers also receive a comprehensive orientation during the New Provider Training, with specific information on Cultural and Linguistic Services. The Alliance continues to provide tools and information on cultural competence and health literacy to providers and members via the Alliance's Web site. The following are some examples of cultural competence and health literacy tools available on the Alliance's Web site: 1. Provider Tools to Care for Diverse Populations 2. Provider Tools to Care for Seniors and Persons with Disabilities 3. English/Spanish/Hmong Managed Care Glossary of Terms The Alliance has also been proactive in educating members about their right to a qualified and trained interpreter when interacting with health care professionals who do not speak their primary language. Such information is provided to members via the Alliance's Web site, new member welcome packet and orientation, and Member Newsletter. The following Member Newsletter article provided information about the Alliance's Interpreter Services Program: • December 2012, "*Does your doctor speak your language?*"
2. 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.	Cervical Cancer Screening: Improvements noted for CCS in Merced: HEDIS 2011: 53 percent; HEDIS 2012: 57.9 percent; HEDIS 2013: 63.7 percent achieving a rate above the MPL. Merced joined the Alliance in October 2009. It did not have a managed care health plan in place prior to joining the Alliance and this was the first time it reported rates for the HEDIS measures. In addition, the plan did not have access to three complete years of claims data to perform the three year look-back for cervical cancer screening (CCS). Actions taken: 1. In May and November 2012, a Womens Health Member letter of screenings due was sent out to members. 2. In March 2013, telephone outreach was done for members who did not have a CCS. Appointments were encouraged and reinforced importance of CCS. 3. Quarterly CCS trended reports by provider was developed and available on the provider portal (2nd Qtr, 2013). 4. Targeted education given to providers on CCS measure (2nd Qtr, 2013). 5. Quarterly Provider Portal Quality Reports available to providers

<table>
<tr><th>2011–12 External Quality Review Recommendation</th><th>CCAH's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation</th></tr>
<tr><td></td><td>to indicate which of their members are due for a CCS.
6. Incentive given to providers for completion of CCS through the Care Based Incentive program.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis: Rates below MPL HEDIS 2011: 15.1 percent; HEDIS 2012: 11.61 percent; HEDIS 2013: 16.23 percent.
1. Starting in March 2013, targeted education was done through site visits, promoted evidence-based guidelines from the Centers for Disease Control, and provided handouts/posters.
2. Shared best practices and discussed barriers at the provider committees (i.e., Clinical Quality Improvement Committee, Physician Advisory Committee) to raise awareness.
3. Provider-level reports were created and distributed to providers (2nd Qtr, 2013).
4. Chart review performed by QI nurse to determine any trends with AAB prescribing patterns (2nd Qtr, 2013).
5. Reinforce AAB measure during facility site reviews.</td></tr>
<tr><td>3. 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.</td><td><table><tr><td>HEDIS</td><td>ADM 2011</td><td>HYBRID 11</td><td>ADM 2012</td><td>HYBRID 12</td></tr><tr><td>SC_MT PPC-Pre</td><td>66.88</td><td>93.43</td><td>67.40</td><td>86.13</td></tr><tr><td>SC_MT PPC-Post</td><td>58.89</td><td>75.43</td><td>58.85</td><td>77.62</td></tr><tr><td>Merced PPC-Pre</td><td>76.52</td><td>88.32</td><td>66.34</td><td>85.40</td></tr><tr><td>Merced PPC-Post</td><td>55.94</td><td>63.02</td><td>55.67</td><td>59.61</td></tr></table>When comparing Adm rates between years, it is noted that there was a 10.18 percentage point drop in Prenatal Merced rate from HEDIS 2011 to HEDIS 2012 due to unknown causes. Though Hybrid rates dropped in Santa Cruz/Monterey for Prenatal and in Merced for Prenatal and Postpartum from 2011 to 2012, all rates were above the MPL range. Continued efforts to improve our Hybrid efforts were attempted through employing Verisk Health as our abstractor vendor for the HEDIS 2013 season. Monthly member letters are sent to new female Medi-Cal members and members that have a new prenatal vitamin prescription educating them about our Members Rewards program that started January 1, 2011, and is still active. This program rewards a member with a gift card if she is seen within the first three months of her pregnancy and another gift card if she returns for a postpartum exam 21–56 days after giving birth.</td></tr>
<tr><td>4. 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.</td><td>HSAG and DHCS have held ongoing technical assistance calls that have provided a detailed understanding of what validation elements are critical in meeting the study with a "Met" score. From the PowerPoints and information obtained from the technical assistance calls, the Alliance has educated the QIP work group teams about all previous recommendations and aspects of the annual submission tool. Furthermore, prior to each submission, there is a thorough review process in place that ensures all elements of the validation tool are met.</td></tr>
</table>

2011–12 External Quality Review Recommendation	CCAH's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
5. 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.	The Alliance has developed work group teams dedicated to conducting ongoing barrier analysis with current processes and interventions. Each barrier analysis uses the submission tool provided by HSAG/DHCS as a reference and a mechanism for documentation. The work group teams follow a Plan-Do-Study-Act (PDSA) model for improvement which provides phases for data mining, identifying barriers, and prioritizing barriers. We have incorporated brainstorming, cause and effect diagrams, identifying root causes, and prioritizing strategies for improvement. By adhering to the sequential steps of the submission tool, we ensure that a systematic approach is followed when making improvements. During the data analysis process, each county's data are drilled down to identify different barriers that exist. This has been documented through a flow chart within the submission tool. From the specific drill down, improvement strategies are developed accordingly.
6. 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.	Each barrier is prioritized by the QIP work group teams. Prioritization is based on the level of effect the barrier has on the customer (member or provider). The interventions developed directly address the barriers that are prioritized. Measureable outcomes are established for each measure. The goals, barriers, and outcomes are documented in each intervention's project charter. Evaluation of the interventions are done on a quarterly basis through qualitative and quantitative analysis and reported to the QIP work groups and at the Clinical Quality Improvement Workgroup. The work groups are exploring methods to automate reporting of the measures on a more frequent and consistent basis.