

Performance Evaluation Report

CenCal Health

July 1, 2012–June 30, 2013

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

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Performance Evaluation Report – CenCal Health

July 1, 2012 – June 30, 2013

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 §438.364² 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, CenCal Health (“CenCal” 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

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

CenCal became operational to provide MCMC services in Santa Barbara County in September 1983 and in San Luis Obispo in March 2008. As of June 30, 2013, CenCal had 75,915 MCMC members in Santa Barbara County and 30,515 members in San Luis Obispo County—for a total of 106,430 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 CenCal'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.

DHCS did not conduct any audits or reviews with CenCal during the review period for this report. In the MCP's 2011–12 MCP-specific evaluation report, HSAG noted that the MCP had two findings from the October 2011 Member Rights/Program Integrity Unit (MR/PIU) review related to the area of Cultural and Linguistic Services. In the report, HSAG noted that CenCal appeared to have taken actions to address the findings. HSAG also recommended that the MCP provide a

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).

mechanism to formally assess and document whether provider education and monitoring have resulted in improved documentation of members' preferred language in the medical record and that member and provider education has resulted in all provider offices discouraging the use of family, friends, or minors as interpreters. As part of the process for producing CenCal's 2012–13 MCP-specific evaluation report, CenCal was asked to document actions the MCP had taken in response to each recommendation from the 2011–12 MCP-specific evaluation report. CenCal's self-report indicated that the MCP has a mechanism for monitoring medical record documentation and noted a 20-percentage-point increase in the medical record documentation of members' language needs from June 2011–12 to June 2012–13.

Strengths

CenCal provided documentation to HSAG that described the MCP's monitoring process for documentation of language preferences and use of family, friends, or minors as interpreters. Additionally, the MCP indicated that from June 2011–12 to June 2012–13, medical record documentation of language needs increased 20 percentage points.

Opportunities for Improvement

Since it appears that CenCal has fully addressed HSAG's recommendation from the MCP's 2011–12 MCP-specific evaluation report, HSAG does not have any recommendations for opportunities for improvement in the area of compliance.

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 AuditsTM⁷ 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 CenCal Health* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that CenCal followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A review of the MCP's HEDIS audit report revealed the following observations:

- ◆ CenCal continued to use provider incentives and bonuses to encourage accurate, complete, and timely claims submissions.
- ◆ CenCal's HEDIS team was exceptionally experienced and had a comprehensive grasp of reporting requirements, measures, and guidelines for all data sources. CenCal's HEDIS staff members worked closely with the MCP's information technology team to ensure that data element mapping was reviewed and updated according to the vendor's requirements.

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

⁷ NCQA HEDIS Compliance AuditTM is a trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

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

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

Performance Measure Abbreviation	Full Name of 2013 Reporting Year [†] Performance Measure
AAB	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
ACR	<i>All-Cause Readmissions</i> [‡]
AMB–ED	<i>Ambulatory Care—Emergency Department (ED) Visits</i>
AMB–OP	<i>Ambulatory Care—Outpatient Visits</i>
CAP–1224	<i>Children and Adolescents’ Access to Primary Care Practitioners (12–24 Months)</i>
CAP–256	<i>Children and Adolescents’ Access to Primary Care Practitioners (25 Months–6 Years)</i>
CAP–711	<i>Children and Adolescents’ Access to Primary Care Practitioners (7–11 Years)</i>
CAP–1219	<i>Children and Adolescents’ Access to Primary Care Practitioners (12–19 Years)</i>
CBP	<i>Controlling High Blood Pressure</i>
CCS	<i>Cervical Cancer Screening</i>
CDC–BP	<i>Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)</i>
CDC–E	<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>
CDC–H8 (<8.0%)	<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)</i>
CDC–H9 (>9.0%)	<i>Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)</i>
CDC–HT	<i>Comprehensive Diabetes Care—HbA1c Testing</i>
CDC–LC (<100)	<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>
CDC–LS	<i>Comprehensive Diabetes Care—LDL-C Screening</i>
CDC–N	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>
CIS–3	<i>Childhood Immunization Status—Combination 3</i>
IMA–1	<i>Immunizations for Adolescents—Combination 1</i>
LBP	<i>Use of Imaging Studies for Low Back Pain</i>
MMA–50	<i>Medication Management for People with Asthma—Medication Compliance 50% Total</i>
MMA–75	<i>Medication Management for People with Asthma—Medication Compliance 75% Total</i>
MPM–ACE	<i>Annual Monitoring for Patients on Persistent Medications—ACE</i>
MPM–DIG	<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>
MPM–DIU	<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>
PPC–Pre	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>
PPC–Pst	<i>Prenatal and Postpartum Care—Postpartum Care</i>
W-34	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
WCC–BMI	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>
WCC–N	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>
WCC–PA	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>

[†] 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 present a summary of CenCal’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
CenCal—San Luis Obispo 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	33.33%	14.46%	★	↓	18.98%	33.33%
ACR	Q, A	--	13.49%	--	Not Comparable	--	--
AMB–ED	‡	65.82	63.56	‡	Not Comparable	‡	‡
AMB–OP	‡	343.58	346.43	‡	Not Comparable	‡	‡
CAP–1224	A	96.17%	95.31%	★	↔	95.56%	98.39%
CAP–256	A	87.31%	86.21%	★	↔	86.62%	92.63%
CAP–711	A	88.32%	87.64%	★★	↔	87.56%	94.51%
CAP–1219	A	86.08%	86.69%	★★	↔	86.04%	93.01%
CBP	Q	--	63.02%	--	Not Comparable	--	--
CCS	Q,A	64.84%	65.00%	★★	↔	61.81%	78.51%
CDC–BP	Q	67.64%	70.56%	★★	↔	54.48%	75.44%
CDC–E	Q,A	61.56%	58.39%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	59.37%	61.31%	★★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	32.60%	31.14%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	81.02%	82.00%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	41.36%	42.58%	★★	↔	28.47%	46.44%

**Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
CenCal—San Luis Obispo 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
CDC-LS	Q,A	78.59%	79.56%	★★	↔	70.34%	83.45%
CDC-N	Q,A	84.67%	82.73%	★★	↔	73.48%	86.93%
CIS-3	Q,A,T	76.39%	78.03%	★★	↔	64.72%	82.48%
IMA-1	Q,A,T	60.10%	71.65%	★★	↑	50.36%	80.91%
LBP	Q	77.86%	75.69%	★★	↔	72.04%	82.04%
MMA-50	Q	--	42.34%	--	Not Comparable	--	--
MMA-75	Q	--	26.28%	--	Not Comparable	--	--
MPM-ACE	Q	82.95%	81.02%	★	↔	83.72%	91.33%
MPM-DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM-DIU	Q	82.35%	84.20%	★★	↔	83.19%	91.30%
PPC-Pre	Q,A,T	82.76%	87.43%	★★	↔	80.54%	93.33%
PPC-Pst	Q,A,T	70.11%	71.04%	★★	↔	58.70%	74.73%
W-34	Q,A,T	69.79%	67.97%	★★	↔	65.51%	83.04%
WCC-BMI	Q	62.29%	64.23%	★★	↔	29.20%	77.13%
WCC-N	Q	59.61%	61.31%	★★	↔	42.82%	77.61%
WCC-PA	Q	47.69%	50.36%	★★	↔	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
CenCal—Santa Barbara 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	29.55%	19.13%	★★	↓	18.98%	33.33%
ACR	Q, A	--	11.13%	--	Not Comparable	--	--
AMB-ED	‡	48.37	52.16	‡	Not Comparable	‡	‡
AMB-OP	‡	346.64	335.52	‡	Not Comparable	‡	‡
CAP-1224	A	97.31%	97.84%	★★	↔	95.56%	98.39%
CAP-256	A	90.42%	91.16%	★★	↔	86.62%	92.63%
CAP-711	A	89.69%	90.88%	★★	↑	87.56%	94.51%
CAP-1219	A	87.69%	89.29%	★★	↑	86.04%	93.01%
CBP	Q	--	60.58%	--	Not Comparable	--	--
CCS	Q,A	71.65%	72.51%	★★	↔	61.81%	78.51%
CDC-BP	Q	69.10%	74.21%	★★	↔	54.48%	75.44%
CDC-E	Q,A	71.29%	70.56%	★★★	↔	45.03%	69.72%
CDC-H8 (<8.0%)	Q	69.34%	59.61%	★★★	↓	42.09%	59.37%
CDC-H9 (>9.0%)	Q	22.63%	33.58%	★★	▼	50.31%	28.95%
CDC-HT	Q,A	92.21%	83.94%	★★	↓	78.54%	91.13%
CDC-LC (<100)	Q	50.12%	38.93%	★★	↓	28.47%	46.44%
CDC-LS	Q,A	85.16%	80.54%	★★	↔	70.34%	83.45%
CDC-N	Q,A	87.35%	82.48%	★★	↔	73.48%	86.93%
CIS-3	Q,A,T	85.20%	85.84%	★★★	↔	64.72%	82.48%
IMA-1	Q,A,T	70.07%	78.74%	★★	↑	50.36%	80.91%
LBP	Q	80.46%	80.57%	★★	↔	72.04%	82.04%
MMA-50	Q	--	47.38%	--	Not Comparable	--	--
MMA-75	Q	--	27.67%	--	Not Comparable	--	--
MPM-ACE	Q	86.89%	84.72%	★★	↔	83.72%	91.33%
MPM-DIG	Q	NA	86.11%	★	Not Comparable	87.93%	95.56%
MPM-DIU	Q	87.25%	85.46%	★★	↔	83.19%	91.30%
PPC-Pre	Q,A,T	80.74%	81.64%	★★	↔	80.54%	93.33%
PPC-Pst	Q,A,T	76.35%	73.44%	★★	↔	58.70%	74.73%
W-34	Q,A,T	76.01%	79.34%	★★	↔	65.51%	83.04%

**Table 3.3—Comparison of 2012 and 2013 Performance Measure Results
CenCal—Santa Barbara 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
WCC–BMI	Q	66.42%	70.56%	★★	↔	29.20%	77.13%
WCC–N	Q	67.88%	72.75%	★★	↔	42.82%	77.61%
WCC–PA	Q	44.77%	51.34%	★★	↔	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 CenCal's 2013 SPD measure results. Tables 3.4 and 3.6 presents 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
CenCal—San Luis Obispo County**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	6.70%	16.54%	▼	13.49%
CAP-1224	95.37%	NA	Not Comparable	95.31%
CAP-256	86.59%	73.87%	↓	86.21%
CAP-711	87.92%	83.22%	↔	87.64%
CAP-1219	87.58%	76.61%	↓	86.69%
CDC-BP	70.23%	72.67%	↔	70.56%
CDC-E	47.91%	57.27%	↑	58.39%
CDC-H8 (<8.0%)	47.44%	60.47%	↑	61.31%
CDC-H9 (>9.0%)	48.37%	34.01%	▲	31.14%
CDC-HT	75.81%	83.14%	↑	82.00%
CDC-LC (<100)	32.56%	45.35%	↑	42.58%
CDC-LS	73.95%	81.69%	↑	79.56%
CDC-N	72.09%	88.08%	↑	82.73%
MPM-ACE	74.84%	83.88%	↑	81.02%
MPM-DIG	NA	NA	Not Comparable	NA
MPM-DIU	78.57%	86.25%	↔	84.20%

* 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
CenCal—San Luis Obispo County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
303.89	57.42	599.51	100.09

* 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
CenCal—Santa Barbara County**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	5.54%	13.88%	▼	11.13%
CAP-1224	97.87%	NA	Not Comparable	97.84%
CAP-256	91.26%	86.40%	↓	91.16%
CAP-711	91.01%	87.97%	↔	90.88%
CAP-1219	89.25%	89.83%	↔	89.29%
CDC-BP	71.78%	68.61%	↔	74.21%
CDC-E	64.96%	68.37%	↔	70.56%
CDC-H8 (<8.0%)	56.45%	61.07%	↔	59.61%
CDC-H9 (>9.0%)	38.69%	31.39%	▲	33.58%
CDC-HT	81.51%	84.91%	↔	83.94%
CDC-LC (<100)	36.25%	42.09%	↔	38.93%
CDC-LS	76.16%	81.27%	↔	80.54%
CDC-N	80.54%	85.89%	↑	82.48%
MPM-ACE	80.90%	86.86%	↑	84.72%
MPM-DIG	NA	87.10%	Not Comparable	86.11%
MPM-DIU	78.97%	88.10%	↑	85.46%

* 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
CenCal—Santa Barbara County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
308.44	46.35	566.20	101.65

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

Performance Measure Result Findings

CenCal's overall performance on reported measures was average in 2013, compared to above average in 2012. Although Santa Barbara County performed better than San Luis Obispo County for the fourth consecutive year, Santa Barbara County had a decline in performance on measures from 2012 to 2013. In 2013, Santa Barbara County had three measures with rates above the HPLs and one measure with a rate below the MPL compared to nine measures with rates above the HPLs and no measures with rates below the MPLs in 2012. In 2013, San Luis Obispo County had one measure with a rate above the HPL and four measures with rates below the MPLs compared to two measures with rates above the HPLs and no measures with rates below the MPLs in 2012.

The rate for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)* measure was above the HPL in San Luis Obispo County for the second consecutive year and above the HPL in Santa Barbara County for the third consecutive year.

The rates for the following measures were above the HPLs in Santa Barbara County for the fifth consecutive year:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Childhood Immunization Status—Combination 3*

The rates for the *Immunizations for Adolescents—Combination 1* measure improved significantly from 2012 to 2013 in both of CenCal's counties. Additionally, the rates for the following measures improved significantly in Santa Barbara County from 2012 to 2013:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*

The rates for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure declined significantly from 2012 to 2013 in both of CenCal's counties; and in San Luis Obispo County, the decline moved the rate from above the MPL in 2012 to below the MPL in 2013. Additionally, the following measures had rates below the MPLs in 2013:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* in San Luis Obispo County
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* in San Luis Obispo County
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE* in San Luis Obispo County
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin* in Santa Barbara County

Finally, the following measures in Santa Barbara County had rates that were significantly worse in 2013 when compared to 2012:

- ◆ *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)*

Seniors and Persons with Disabilities Findings

Across both counties, the SPD rates for 12 measures were significantly better than the non-SPD rates. San Luis Obispo County had eight measures with SPD rates that were significantly better, and Santa Barbara County had four measures with SPD rates that were significantly better. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

Both counties had SPD rates that were significantly higher than the non-SPD rates for the *All-Cause Readmissions* measure, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population. Additionally, both counties had SPD rates that were significantly lower than the non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners (25Months–6 Years)* measure, meaning significantly fewer SPD members aged 25 months to 6 years were seen by their primary care practitioner than non-SPD members in the same age range. Finally, the SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* measure in San Luis Obispo County was significantly worse than the non-SPD rate, meaning that in San Luis Obispo County significantly fewer SPD members in this age range were seen by their primary care practitioner than non-SPD members in the same age range.

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

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to

develop a set of strategies that will improve 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.

Since CenCal did not have any measures with rates below the MPLs in 2012, no IPs were required. The MCP will be required to submit IPs for the following measures with rates below the MPLs in 2013:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Luis Obispo County
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE* in San Luis Obispo County
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin* in Santa Barbara County

Although CenCal's rates on the *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* and *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* measures in San Luis Obispo County were below the MPLs in 2013, the MCP will not be required to submit IPs for these measures. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact.

Strengths

The rate for one measure in San Luis Obispo County was above the HPL for the second consecutive year. The rates for two measures in Santa Barbara County were above the HPLs for the fifth consecutive year, and the rate for one measure in this county was above the HPL for the third consecutive year. The rate for one measure in San Luis Obispo County improved significantly from 2012 to 2013, and the rates for three measures in Santa Barbara County improved significantly from 2012 to 2013.

Opportunities for Improvement

CenCal has the opportunity to improve performance on five measures with rates below the MPLs in 2013. By identifying the factors that have caused the rates for these measures to fall below the MPLs, the MCP can identify strategies to improve the rates. Additionally, CenCal has the opportunity to identify the factors leading to six measures having rates that were significantly worse in 2013 when compared to 2012 so the MCP can develop strategies to prevent further decline on the rates. Finally, for measures with SPD rates that were significantly worse than the non-SPD rates, CenCal 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 protocol¹⁰ 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 CenCal's validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

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

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

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

QIP	Counties	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	San Luis Obispo and Santa Barbara	Clinical	Q, A
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children & Adolescents</i>	San Luis Obispo and Santa Barbara	Clinical	Q
<i>Annual Monitoring for Patients on Persistent Medications</i>	San Luis Obispo and Santa Barbara	Clinical	Q

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

Prior to initiation of the statewide collaborative QIP, CenCal had a 30-day readmission rate of 14.68 percent for San Luis Obispo County and 13.12 percent for Santa Barbara County among Medi-Cal beneficiaries. CenCal also found that the readmission rate for the SPD population was higher in both San Luis Obispo and Santa Barbara counties (17.25 percent and 14.94 percent, respectively) than for the non-SPD population (8.94 percent and 9.49 percent, respectively).

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* QIP targeted members 3 to 17 years of age. CenCal’s objective was to increase these rates by implementing provider improvement strategies. By increasing the documentation of body mass index (BMI) and nutrition and physical activity referrals, the MCP would have a better assessment of the obesity issues for the targeted age group.

CenCal’s *Annual Monitoring for Patients on Persistent Medications* QIP is focused on monitoring Medi-Cal beneficiaries’ use of angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), digoxin, and diuretic medications. By monitoring the use of these

medications, CenCal can ensure better compliance and effectiveness of the medications and monitor the potential side effects.

Quality Improvement Project Validation Findings

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

**Table 4.2—Quality Improvement Project Validation Activity
CenCal—San Luis Obispo and Santa Barbara Counties
July 1, 2012, through June 30, 2013**

Name of Project/Study	County	Type of Review ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Overall Validation Status ⁴
Statewide Collaborative QIP					
<i>All-Cause Readmissions</i>	Counties received the same score— San Luis Obispo and Santa Barbara	Study Design Submission	100%	100%	<i>Met</i>
Internal QIPs					
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children & Adolescents</i>	San Luis Obispo	Annual Submission	100%	100%	<i>Met</i>
	Santa Barbara	Annual Submission	97%	100%	<i>Met</i>
<i>Annual Monitoring for Patients on Persistent Medications</i>	Counties received the same score— San Luis Obispo and Santa Barbara	Study Design Submission	70%	100%	<i>Partially Met</i>
	Counties received the same score— San Luis Obispo and Santa Barbara	Study Design Resubmission 1	90%	100%	<i>Met</i>

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 the study design submission by CenCal of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical and evaluation elements met. CenCal received an overall validation status of *Met* for the MCP’s *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* QIP for both counties, with 100 percent of critical and evaluation elements being met for San Luis Obispo County and 100 percent of critical elements and 97 percent of evaluation elements being met for Santa Barbara County.

For the *Annual Monitoring for Patients on Persistent Medications* QIP study design submission, CenCal received a *Partially 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. Based on the validation feedback, CenCal resubmitted the study design; and upon subsequent validation, the QIP achieved an overall *Met* validation status with 100 percent of the critical elements and 90 percent of the evaluation elements being met for both counties.

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

**Table 4.3—Quality Improvement Project Average Rates*
CenCal—San Luis Obispo and Santa Barbara Counties
(Number = 4 QIP Submissions, 3 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	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	78%	0%	22%
Design Total		92%	0%	8%
Implementation	VII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		100%	0%	0%
Outcomes	IX: Real Improvement Achieved**	88%	13%	0%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		90%	10%	0%
*The activity average rate represents the average percentage of applicable elements with a <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> 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 CenCal's *All-Cause Readmissions* QIP and *Annual Monitoring for Patients on Persistent Medications* QIP study design submissions and Activities I through X for the MCP's *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* QIP annual submission.

CenCal demonstrated a strong application of the Design stage, meeting 92 percent of the requirements for all applicable evaluation elements within the stage for all three QIPs. The MCP met 100 percent of the requirements for all applicable evaluation elements in Activities I through VI for the *All-Cause Readmissions* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* QIPs. CenCal did not provide all required documentation in Activity VI for the *Annual Monitoring for Patients on Persistent Medications* QIP, resulting in a lower score for this activity for both counties. CenCal corrected the deficiencies in the resubmission, and the QIP achieved an overall *Met* validation status.

Only the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* QIP progressed to the Implementation and Outcomes stages during the reporting period. The MCP met 100 percent of the requirements for all applicable evaluation elements in Activities VII and VIII for both counties. Since one of the study indicators in Santa Barbara County did not demonstrate improvement in Remeasurement 3, the QIP received a lower score for Activity IX for this county. Since all indicators had previously achieved improvement over baseline, HSAG assessed the indicators for sustained improvement (Activity X). All study indicators achieved sustained improvement over the life of the project. Please note that since this QIP was initiated prior to HSAG implementing its new scoring methodology that requires statistically significant improvement over baseline, the previous definition of sustained improvement was used. (Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.)

Quality Improvement Project Outcomes and Interventions

Table 4.4 summarizes QIP study indicator results and displays whether improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the improvement was maintained or improved for at least one subsequent measurement period).

The *All-Cause Readmissions* QIP and the *Annual Monitoring for Patients on Persistent Medications* QIP did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information for these QIPs are included in the table or report.

**Table 4.4—Quality Improvement Project Outcomes
CenCal—San Luis Obispo and Santa Barbara Counties
July 1, 2012, through June 30, 2013**

QIP #1—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents					
Study Indicator 1: Percentage of members 3 to 17 years of age who had a BMI percentile documented					
County	Baseline Period 1/1/08–12/31/08	Remeasurement 1 1/1/09–12/31/09	Remeasurement 2 1/1/10–12/31/10	Remeasurement 3 1/1/11–12/31/11	Sustained Improvement[‡]
San Luis Obispo	NR	33.2%	47.0%*	62.3%*	Yes
Santa Barbara	37.5%	55.0%*	59.1%	66.4%*	Yes
Study Indicator 2: Percentage of members 3 to 17 years of age who had a documentation or referral for nutrition education					
County	Baseline Period 1/1/08–12/31/08	Remeasurement 1 1/1/09–12/31/09	Remeasurement 2 1/1/10–12/31/10	Remeasurement 3 1/1/11–12/31/11	Sustained Improvement[‡]
San Luis Obispo	NR	50.8%	57.9%*	59.6%	Yes
Santa Barbara	44.7%	65.9%*	72.5%*	67.9%	Yes
Study Indicator 3: Percentage of members 3 to 17 years of age who had a documentation or a referral for physical activity counseling					
County	Baseline Period 1/1/08–12/31/08	Remeasurement 1 1/1/09–12/31/09	Remeasurement 2 1/1/10–12/31/10	Remeasurement 3 1/1/11–12/31/11	Sustained Improvement[‡]
San Luis Obispo	NR	20.0%	34.8%*	47.7%*	Yes
Santa Barbara	9.7%	11.6%	39.2%*	44.8%	Yes
NR—San Luis Obispo’s baseline data corresponds to the same time period as Santa Barbara’s Remeasurement 1 data.					
‡ Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Note: This QIP was initiated prior to HSAG implementing its new scoring methodology that requires statistically significant improvement over baseline; therefore, the previous definition of sustained improvement was used.					
* Statistically significant improvement over the prior measurement period (p value < 0.05).					

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents QIP

For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* QIP, both counties demonstrated sustained improvement for all three study indicators throughout the course of the QIP. A review of the MCP’s QIP Summary Forms and QIP Validation Tools revealed the following observations:

- ◆ CenCal completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process. The analysis revealed that in addition to providers lacking the knowledge or time to document weight assessment activities, providers transitioning to electronic health records may not be accurately capturing weight assessment and intervention activities in the electronic records.
- ◆ The MCP continued to implement successful interventions. To address the barrier related to electronic medical records, the MCP worked with providers to ensure that during the transition to electronic medical records, the providers addressed needed process changes to capture the weight assessment and intervention activities.
- ◆ The study indicators demonstrated improvement over baseline which was consistent with the planned and implemented interventions. Additionally, the improvement was sustained during subsequent measurement periods. Due to the success of the QIP, HSAG recommended that the QIP be closed.

Strengths

Overall, CenCal demonstrated proficiency with the QIP process for all three stages. CenCal was successful at developing and implementing interventions that positively affected the rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents* HEDIS measures. CenCal used the QIP process to fully understand and improve the MCP's performance on these measures.

Opportunities for Improvement

Although CenCal demonstrated proficiency with the QIP process, the MCP has the opportunity to ensure all required documentation is included in the QIP Summary Form. CenCal should reference the QIP Completion Instructions to ensure that all required information is included for each QIP submission.

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.

CenCal'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 CenCal'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).

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

Tables 5.3 through 5.6 present the star ratings for the global ratings and composite measures for CenCal's adult and child Medicaid populations.¹⁵

**Table 5.3—Medi-Cal Managed Care Adult County-Level Global Ratings
CenCal—San Luis Obispo and Santa Barbara Counties**

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
San Luis Obispo	★	★★★★★	★★★☆☆	★★★★★ ⁺
Santa Barbara	★★	★★	★★★★★	★★★★★

+ 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
CenCal—San Luis Obispo and Santa Barbara Counties**

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
San Luis Obispo	★	★	★	★ ⁺
Santa Barbara	★★★★	★★★★	★★★★	★★★★★ ⁺

+ 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
CenCal—San Luis Obispo and Santa Barbara Counties**

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
San Luis Obispo	★★★★	★★★★★	★★	★★★★★ ⁺
Santa Barbara	★★★	★★★	★★★★	★★★★ ⁺

+ 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
CenCal—San Luis Obispo and Santa Barbara Counties**

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
San Luis Obispo	★ ⁺	★ ⁺	★	★ ⁺
Santa Barbara	★★	★	★	★★★★

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

Strengths

Overall, CenCal had average ratings on the CAHPS measures. The MCP received an *Excellent* rating on the adult *Getting Care Quickly* measure in San Luis Obispo County. Additionally, the MCP received an *Excellent* rating on the child *Rating of Specialist Seen Most Often* measure in Santa Barbara County; however, since the MCP had fewer than 100 respondents for this measure in Santa Barbara County, caution should be used when interpreting these results.

CenCal received *Very Good* ratings on the following measures for the adult population in San Luis Obispo County:

- ◆ *Rating of All Health Care*

- ◆ *Getting Needed Care*
- ◆ *Customer Service*¹⁶

CenCal received *Very Good* ratings on the following measures in Santa Barbara County:

- ◆ *Rating of Personal Doctor*—adult population
- ◆ *Rating of Specialist Seen Most Often*—adult population
- ◆ *Rating of Personal Doctor*—child population
- ◆ *How Well Doctors Communicate*—adult population
- ◆ *Customer Service*—child population

The MCP improved its ratings on the following measures in Santa Barbara County from 2010 to 2013:

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

San Luis Obispo County was not surveyed in 2010.

Opportunities for Improvement

Across both counties, CenCal's CAHPS results showed average performance for the child and adult global ratings and composite measures. 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 CenCal's highest priorities: *Rating of Health Plan*, *Rating of All Health Care*, and *How Well Doctors Communicate*. 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 CenCal CAHPS MCP-Specific Report*. Areas for improvement spanned the quality domain of care.

¹⁶ Since the MCP had fewer than 100 respondents for this measure in San Luis Obispo County, caution should be exercised when evaluating these results.

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)¹⁷ 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

¹⁷ 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.

CenCal'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 CenCal's Roadmap and questionnaire demonstrates that the MCP has sound procedures in place for the creation, validation, correction, and ongoing monitoring of encounter data. The MCP has performance and compensation strategies to encourage its capitated providers to submit complete and timely encounters, and under which providers are compared to their peers and performance standards are established by each provider's peer group.

Record Completeness

Overall, CenCal had low record omission and record surplus rates for the Pharmacy claim type, indicating relatively complete Pharmacy data when comparing DHCS's data and the encounter data extracted from CenCal's data system for this study. The record omission rates for the Medical/Outpatient and Hospital/Inpatient claim types were worse than the statewide results by 18.3 percentage points and 7.5 percentage points, respectively. For both claim types, nearly 48 percent of the records omitted from DHCS's data had *Adjudication Dates* in November 2010. In addition, the invalid *Procedure Codes* of "001" and "002" may have contributed to the record omissions for the Medical/Outpatient claim type. The record surplus rates were less than 4 percent for all claim types and performed better than the respective statewide rates. At the county level, the record omission and record surplus rates were comparable, although Santa Barbara County generally had slightly lower rates.

Data Element Completeness

CenCal had fairly good performance, with element omission and element surplus rates of less than 1 percent for all key data elements across the three claim types, except for two elements. The *Secondary Diagnosis Code* data element had element omission rates of 71.8 percent and 48.2 percent in the Hospital/Inpatient and Medical/Outpatient claim types, respectively. These element omission rates were worse than the statewide rates by more than 45 percentage points. The *Provider Type* data element had element surplus rates of 46.7 percent in Medical/Outpatient encounters, 58.8 percent in Hospital/Inpatient encounters, and 99.9 percent in Pharmacy encounters. The element surplus rates for the *Provider Type* were worse than the statewide rates by at least 45 percentage points for every claim type. The two counties had fairly consistent element omission and element surplus rates. The only notable discrepancy was that Santa Barbara County's element omission rate for the data element *Secondary Diagnosis Code* in the Hospital/Inpatient claim type was 19.8 percentage points better than San Luis Obispo County's rate.

Data Element Accuracy

CenCal had accuracy rates that were greater than 90 percent for the majority of the key data elements, although there were a number of fields with accuracy rates of less than 10 percent. The *Provider Type* data element had a low accuracy rate (less than 10 percent) in the Medical/Outpatient and the Hospital/Inpatient claim types. The *Provider Type* low accuracy rate was due to differing values between the MCP and DHCS data, including alphanumeric values that were only found in the MCP file. The *Primary Diagnosis Code* also had a low element accuracy rate (less than 3 percent) for both of these claim types because more than 95 percent of the DHCS *Primary Diagnosis Codes* were populated with an invalid value of "12345." For the Pharmacy claim type, the *Billing/Reporting Provider Number* and *Referring/Prescribing/Admitting Provider Number* had accuracy rates of less than 10 percent because they had different lengths in the two data sources. All of these fields had accuracy rates that fell below the respective statewide rates by more than 80 percentage points.

The poor element accuracy and element completeness caused CenCal to have all-element accuracy rates of 0.1 percent or lower for all three claim types. These all-element accuracy rates fell below the statewide rates by at least 63 percentage points. The county-level performance for the element and all-element accuracy rates was fairly consistent between the two counties.

Recommendations

Based on its review, HSAG recommends the following:

- ◆ CenCal should clarify why the majority of the claim control numbers (CCNs) in the MCP's Pharmacy data and in DHCS's Pharmacy data were not comparable.

- ◆ CenCal should investigate the high record omission rates for the Medical/Outpatient and Hospital/Inpatient claim types and create strategies for improvement.
- ◆ Overall, more than 95 percent of DHCS's Medical/Outpatient and Hospital/Inpatient records were missing values for the *Secondary Diagnosis Code*. Based on the data CenCal extracted from its system for this study, CenCal had additional secondary diagnoses codes in its system and should submit them to DHCS.
- ◆ Although the missing values for the *Provider Type* in the MCP's data were probably caused by error(s) during the data extraction for this EDV study, CenCal should investigate the high element surplus rates for the *Provider Type* across all claim types and apply appropriate quality control procedures to avoid similar issues from occurring in future data submissions.
- ◆ CenCal should investigate the low element accuracy for the *Provider Type* in the Medical/Outpatient and Hospital/Inpatient claim types.
- ◆ CenCal should investigate why the invalid *Primary Diagnosis Code* value of "12345" was populated in the DHCS file and improve its processes and procedures to prevent this issue from occurring in the future.
- ◆ For the Pharmacy claim type, CenCal should investigate the differing lengths for the *Billing/Reporting Provider Number* and *Referring/Prescribing/Admitting Provider Number* data elements between the MCP and DHCS files so that it can improve the accuracy rates for these two data elements.
- ◆ The lower data element accuracy rates for the data elements *Procedure Code Modifiers 2* should be reviewed. For these elements, CenCal's data had values with a length of two characters, while the DHCS file had values with a length of one character.
- ◆ Although CenCal had element accuracy rates between 89 and 93 percent for the data elements current procedural terminology/Healthcare Common Procedure Coding System codes (*CPT/HCPCS Codes*) and *Header Service To Date* in the Medical/Outpatient claim type and for *Revenue Code* in the Hospital/Inpatient claim type, CenCal should review the inaccuracy for these data elements to improve its rates in the future.

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.¹⁸

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

¹⁸ This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

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

CenCal submitted quality documents for HSAG's review as part of the process for producing this MCP-specific evaluation report. CenCal's quality improvement program description, work plan, and work plan evaluation documents describe processes, goals, and accomplishments that provide evidence the MCP has a structure in place to support the provision of quality care to the MCP's Medi-Cal members.

The following quality measures had rates above the HPLs in 2013:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Santa Barbara County
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)* in both counties
- ◆ *Childhood Immunization Status—Combination 3* in Santa Barbara County

The rates for the *Immunizations for Adolescents—Combination 1* measure, which falls into the quality domain of care, improved significantly in both counties from 2012 to 2013.

The rates for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, which falls into the quality domain of care, declined significantly from 2012 to 2013 in both counties; and in San Luis Obispo County, the decline moved the rate from above the MPL in 2012 to below the MPL in 2013. Additionally, the following quality measures in Santa Barbara County had rates that were significantly worse in 2013 when compared to 2012:

- ◆ *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)*

In addition to the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure being below the MPL in San Luis Obispo County, the rates for the following quality measures were below the MPLs in 2013:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE* in San Luis Obispo County
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Santa Barbara County

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and the SPD rates for four of these measures in San Luis Obispo County were significantly better than the non-SPD rates, while the SPD rates for eight of these measures in Santa Barbara County were significantly better than the non-SPD rates. The better rates in the

SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

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

- ◆ *All-Cause Readmissions* in both counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (25Months–6 Years)* in both counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* in San Luis Obispo County

All CAHPS measures fall into the quality domain of care. Overall, CenCal had average ratings on the CAHPS measures, with most measures receiving a *Good*, *Fair*, or *Poor* rating.

All three of CenCal's QIPs fall into the quality domain of care. Since the *All-Cause Readmissions* and *Annual Monitoring for Patients on Persistent Medications* QIPs did not progress to the Outcomes stage, HSAG was not able to assess the QIPs' success at improving the quality of care delivered to the MCP's members. The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* QIP progressed to the Outcomes stage. Both counties demonstrated sustained improvement for all three study indicators throughout the course of the QIP, reflecting an improvement in the quality of care for members aged 3 to 17 years related to weight assessment activities.

Overall, CenCal showed average performance related to the quality domain of care.

Access

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

When reviewing the quality documents CenCal submitted as part of the process for producing this MCP-specific evaluation report, HSAG found descriptions of activities and goals with a focus on ensuring members' access to needed care.

The rates for two access measures were above the HPLs in Santa Barbara County for the fifth consecutive year:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Childhood Immunization Status—Combination 3*

The rates for the following access measures improved significantly from 2012 to 2013:

- ◆ *Children and Adolescents’ Access to Primary Care Practitioners (7–11 Years)* in Santa Barbara County
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners (12–19 Years)* in Santa Barbara County
- ◆ *Immunizations for Adolescents—Combination 1* in both counties

The rates for two access measures in San Luis Obispo County were below the MPLs in 2013:

- ◆ *Children and Adolescents’ Access to Primary Care Practitioners (12–24 Months)*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners (25 Months–6 Years)*

The rate for the *Comprehensive Diabetes Care—HbA1c Testing* measure, which falls into the access domain of care, declined significantly in Santa Barbara County from 2012 to 2013.

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and the SPD rates for the following access measures were significantly better than the non-SPD rates:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in San Luis Obispo County
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* in San Luis Obispo County
- ◆ *Comprehensive Diabetes Care—LDL-C Screening* in San Luis Obispo County
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in both counties

As indicated above, the better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The *Getting Needed Care* CAHPS measure falls into the access domain of care. CenCal received mixed results on this measure. The MCP received a *Very Good* rating for the adult measure in San Luis Obispo County; however, the MCP received a *Poor* rating on the child measure in this county. Note that CenCal had fewer than 100 respondents for the child measure in San Luis Obispo County; therefore, caution should be exercised when interpreting these results. The MCP received a *Good* rating for the adult measure in Santa Barbara County and a *Fair* rating on the child measure in this county.

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

Overall, CenCal showed average performance related to the access domain of care.

Timeliness

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

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

CenCal's quality improvement program description, work plan, and work plan evaluation documents describe processes that support the provision of timely care to the MCP's Medi-Cal members.

The rate for one timeliness measure, *Childhood Immunization Status—Combination 3*, was above the HPL in Santa Barbara County for the fifth consecutive year. The rate for the *Immunizations for Adolescents—Combination 1* measure, which also falls into the timeliness domain of care, improved significantly in both counties from 2012 to 2013. No timeliness measures had rates below the MPLs or rates that declined significantly from 2012 to 2013.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. The MCP received a *Poor* rating on the child measure in both counties; however, the MCP had fewer than 100 respondents for this measure in San Luis Obispo County. The MCP received an *Excellent* rating on the adult measure in San Luis Obispo County and a *Good* rating on the adult measure in Santa Barbara County.

Overall, CenCal showed average performance related to the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-specific evaluation report. CenCal’s self-reported responses are included in Appendix B.

Recommendations

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

- ◆ Assess the factors leading to the rates for the following measures falling below the MPLs in 2013 and identify strategies to improve the rates:
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Luis Obispo County
 - *Children and Adolescents’ Access to Primary Care Practitioners (12–24 Months)* in San Luis Obispo County
 - *Children and Adolescents’ Access to Primary Care Practitioners (25 Months–6 Years)* in San Luis Obispo County
 - *Annual Monitoring for Patients on Persistent Medications—ACE* in San Luis Obispo County
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin* in Santa Barbara County
- ◆ Assess the factors leading to the rates for the following measures being significantly worse in 2013 when compared to 2012 and identify strategies to prevent further decline on the rates:
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Luis Obispo and Santa Barbara counties
 - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)* in Santa Barbara County
 - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Santa Barbara County
 - *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* in Santa Barbara County
 - *Comprehensive Diabetes Care—HbA1c Testing* in Santa Barbara County
- ◆ Assess the factors leading to the SPD rates for the following measures being significantly worse than the non-SPD rates and identify strategies to ensure the MCP is meeting the needs of the SPD population:
 - *All-Cause Readmissions* in San Luis Obispo and Santa Barbara counties
 - *Children and Adolescents’ Access to Primary Care Practitioners (25 Months–6 Years)* in San Luis Obispo and Santa Barbara counties

- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* in San Luis Obispo County
- ◆ Reference the QIP Completion Instructions to ensure that all required information is included on the QIP Summary Form for each QIP submission.
- ◆ Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Rating of Health Plan*, *Rating of All Health Care*, and *How Well Doctors Communicate* 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 CenCal'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.¹⁹ 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 Table 3.2 through 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.

¹⁹ 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>.

- 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

- 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.
- 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.
- 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)

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

- To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
- To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
- 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 **CenCal Health**

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with CenCal’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—CenCal’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	CenCal’s Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation															
<p>1. Provide a mechanism to formally assess and document whether provider education and monitoring have resulted in improved documentation of members’ preferred language in the medical record and that member and provider education has resulted in all provider offices discouraging the use of family, friends, or minors as interpreters.</p>	<p>Monitoring Mechanisms: CenCal Health monitors the quality and content of medical record documentation related to language preferences and use of family, friends, or minors as interpreters. CenCal Health licenses proprietary software (Healthy Data Systems) to track Facility Site Review (FSR) and Medical Record Review (MRR) results, including findings related to the assessment of language and interpreter medical record documentation. The Healthy Data Systems software allows monitoring of individual audit criteria. Current results show significant improvement in providers’ documentation of language preferences as illustrated below:</p> <table border="1" data-bbox="695 1234 1404 1549"> <tr> <td colspan="3" data-bbox="703 1245 1396 1350">Primary language and linguistic service needs of non- or limited English proficient (LEP) or hearing-impaired persons are prominently noted. (MRR Criteria I. H.)</td> </tr> <tr> <td data-bbox="703 1356 808 1398"></td> <td data-bbox="808 1356 1109 1398">6/2011–6/2012</td> <td data-bbox="1109 1356 1396 1398">6/2012–6/2013</td> </tr> <tr> <td data-bbox="703 1404 808 1446">Yes</td> <td data-bbox="808 1404 1109 1446">59.7%</td> <td data-bbox="1109 1404 1396 1446">79.9%</td> </tr> <tr> <td data-bbox="703 1453 808 1495">No</td> <td data-bbox="808 1453 1109 1495">5.58%</td> <td data-bbox="1109 1453 1396 1495">1.15%</td> </tr> <tr> <td data-bbox="703 1501 808 1543">NA</td> <td data-bbox="808 1501 1109 1543">34.6%</td> <td data-bbox="1109 1501 1396 1543">18.9%</td> </tr> </table> <p>This shows a 20-percentage-point increase in the medical record documentation of language needs and a significant decrease in the percentage of charts that do not document current language/linguistic service needs. During this period, an increase in interpreter services was observed from 1,640 requests during 6/1/11–5/31/12 to 2,020 requests during 6/1/12–5/31/13, or a 24 percent increase. This increase may be attributed to several interventions completed by CenCal Health that addressed the availability and use of interpreter resources.</p>	Primary language and linguistic service needs of non- or limited English proficient (LEP) or hearing-impaired persons are prominently noted. (MRR Criteria I. H.)				6/2011–6/2012	6/2012–6/2013	Yes	59.7%	79.9%	No	5.58%	1.15%	NA	34.6%	18.9%
Primary language and linguistic service needs of non- or limited English proficient (LEP) or hearing-impaired persons are prominently noted. (MRR Criteria I. H.)																
	6/2011–6/2012	6/2012–6/2013														
Yes	59.7%	79.9%														
No	5.58%	1.15%														
NA	34.6%	18.9%														

2011–12 External Quality Review Recommendation	CenCal's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
<p>2. Focus efforts on the Prenatal and Postpartum Care—Timeliness of Prenatal Care measure in Santa Barbara County and implement interventions to prevent the measure from performing below the MPL since the measure's rate of 80.7 percent is just slightly above the MPL of 80.3 percent.</p>	<p>CenCal Health met with its largest high-volume providers of prenatal care during January and March 2013 and an expedited appointment process was implemented for new CenCal Health members that are pregnant and late-term at 26 or more weeks. This new process is to ensure expectant mothers have access to prenatal care as soon as possible. CenCal Health also developed an automated greeting to female members of child-bearing age 18 to 45. This greeting provides an opportunity for women to directly link to CenCal Health's call center to receive immediate assistance to select an Ob-Gyn and secure an appointment and transportation if needed. The new greeting and assistance service will be active by November 1, 2013.</p>
<p>3. Develop a method to evaluate each QIP intervention before implementing the interventions. Additionally, using the interventions' evaluation results, CenCal should determine and document the effectiveness of each intervention. The evaluation results should be the basis for any changes to the plan's improvement strategy.</p>	<p>CenCal Health's QIP interventions are reviewed internally at a quality improvement workgroup, barriers are defined, and interventions developed specifically to address those barriers. This internal quality workgroup was established to collaboratively evaluate the effectiveness of strategies using recent data. Barriers are often explored directly with providers during profiling visits conducted by CenCal Health's clinical staff and through outreach to members. These activities are conducted on an ongoing basis, and revisions to the process are initiated when efforts do not demonstrate expected improvements in rates.</p>