

Medi-Cal Managed Care External Quality Review Technical Report

July 1, 2014–June 30, 2015

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

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Commonly Used Abbreviations and Acronyms

Following is a list of abbreviations and acronyms used throughout this report.

- ◆ **A&I**—Audits and Investigations Division
- ◆ **ACR**—*All-Cause Readmissions*
- ◆ **AHRQ**—Agency for Healthcare Research and Quality
- ◆ **CAHPS®**—Consumer Assessment of Healthcare Providers and Systems¹
- ◆ **CANS**—Child and Adolescent Needs and Strengths
- ◆ **CAP**—corrective action plan
- ◆ **CFR**—Code of Federal Regulations
- ◆ **CMS**—Centers for Medicare & Medicaid Services
- ◆ **COHS**—County Organized Health System
- ◆ **CP**—commercial plan
- ◆ **DHCS**—California Department of Health Care Services
- ◆ **DMHC**—California Department of Managed Health Care
- ◆ **EAS**—External Accountability Set
- ◆ **EDV**—encounter data validation
- ◆ **EQR**—external quality review
- ◆ **EQRO**—external quality review organization
- ◆ **FFS**—fee-for-service
- ◆ **GMC**—Geographic Managed Care
- ◆ **HEDIS®**—Healthcare Effectiveness Data and Information Set²
- ◆ **HPL**—high performance level
- ◆ **HSAG**—Health Services Advisory Group, Inc.
- ◆ **IOM**—Institute of Medicine
- ◆ **IP**—improvement plan
- ◆ **IQIP**—internal quality improvement project
- ◆ **IS**—information systems
- ◆ **LI**—Local Initiative
- ◆ **MCMC**—Medi-Cal Managed Care

¹ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

² HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- ◆ **MCP**—Medi-Cal managed care health plan
- ◆ **MPL**—minimum performance level
- ◆ **MY**—measurement year
- ◆ **NCQA**—National Committee for Quality Assurance
- ◆ **Non-SPD**—Non-Seniors and Persons with Disabilities
- ◆ **PACES**—Post Adjudicated Claims and Encounters System
- ◆ **PCP**—primary care provider
- ◆ **PDSA**—Plan-Do-Study-Act
- ◆ **PIP**—performance improvement project
- ◆ **Roadmap**—HEDIS Record of Administration, Data Management, and Processes
- ◆ **RY**—reporting year
- ◆ **QIP**—quality improvement project
- ◆ **SFY**—State Fiscal Year
- ◆ **SPD**—Seniors and Persons with Disabilities
- ◆ **TOC**—Transitions of Care
- ◆ **TPM**—Two-Plan Model

Medi-Cal Managed Care External Quality Review Technical Report

July 1, 2014–June 30, 2015

1. EXECUTIVE SUMMARY

As required by the Code of Federal Regulations (CFR) at Title 42, Section (§) 438.364, the California Department of Health Care Services (DHCS) contracts with Health Services Advisory Group, Inc. (HSAG), 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 California's Medi-Cal Managed Care (MCMC) health plans (MCPs). This report provides an assessment of MCPs' strengths and weaknesses with respect to the quality and timeliness of and access to the health care services they furnished to California's Medicaid beneficiaries; provides recommendations for improvement; and assesses the degree to which MCPs addressed previous recommendations. The review period for this report is July 1, 2014, through June 30, 2015.

MCMC provides managed health care services to more than 9.6 million beneficiaries (as of June 2015)³ in the State of California through a combination of contracted full-scope and specialty MCPs. During the review period, DHCS contracted with 22 full-scope MCPs and three specialty MCPs to provide health care services in all 58 counties throughout California. Note: HSAG refers to Kaiser NorCal and Kaiser SoCal as two separate MCPs in this report; however, DHCS only holds one contract with Kaiser (KP Cal, LLC).

A summary of HSAG's assessment of performance for the July 1, 2014, through June 30, 2015, review period follows.

Medi-Cal Managed Care Quality Strategy Annual Assessment

DHCS's annual assessment, dated November 2015, focused on performance in three areas critical for the health of MCMC beneficiaries:

- ◆ Maternal and child health: timely postpartum care and immunizations of 2-year-olds
- ◆ Chronic disease management: hypertension control and diabetes care
- ◆ Prevention: tobacco cessation

³ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: January 24, 2016.

Managed Care Health Plan Compliance

- ◆ For compliance review findings reported on in the previous review period, DHCS followed up on all outstanding findings and MCPs resolved the findings, resulting in DHCS closing any open corrective action plans (CAPs) from the reviews.
- ◆ HSAG assessed whether DHCS had conducted compliance reviews with all full-scope and specialty MCPs within the three-year period of the review dates for this report and found that DHCS conducted reviews with all but one specialty MCP. As part of the process for completing this report, DHCS provided information to HSAG indicating that it implemented a policy change to ensure that DHCS conducts comprehensive reviews of all MCPs at least every other year and follow-up audits in off years.
- ◆ As in previous review periods, while MCPs experienced challenges meeting all requirements assessed by DHCS through the compliance reviews, MCPs generally had appropriate resources and written policies and procedures to support their quality improvement programs. Findings were MCP-specific, and HSAG identified no specific areas for improvement across all MCPs.
- ◆ HSAG noted that DHCS issued final reports several months or longer after the related on-site audits or surveys.

Performance Measure Validation

The full-scope MCP performance measure results for reporting year (RY) 2015, which represent calendar year 2014 data, indicate overall improvement across the State. DHCS held 43 MCP reporting units accountable to meet the minimum performance levels (MPLs) in RY 2015 and 44 MCP reporting units accountable in RY 2014 for 22 measures each year. In RY 2015, 81 percent of the reporting unit rates for which a comparison could be made to the MPLs were above the MPLs as compared to RY 2014 when 80 percent of the reporting unit rates were above the MPLs. Further, in RY 2015, 11 percent of the reporting unit rates were above the high performance levels (HPLs); this is an improvement from the prior year.

Notable Performance Measures—Full-scope Managed Care Health Plans

Full-scope MCPs' performance was best for the following measures:

- ◆ *Use of Imaging Studies for Low Back Pain*
- ◆ *All three Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measures*

HSAG identified several measures for DHCS to consider as priority areas for improvement based on declining performance and the number of rates below the DHCS-established MPLs, which are set as the national Medicaid 25th percentiles. Some rates below the MPLs were for

counties/regions reporting rates for the first time. DHCS does not hold MCPs accountable to meet MPLs in the first reporting year because the first year serves as a baseline.

HSAG identified the following measures as having the most opportunities for improvement:

- ◆ *All-Cause Readmissions*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics*
- ◆ *Cervical Cancer Screening*
- ◆ All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- ◆ Both *Medication Management for People with Asthma* measures
- ◆ Both *Prenatal and Postpartum Care* measures
- ◆ *Child Immunization Status—Combination 3*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

HSAG identified potential areas for improvement related to the Seniors and Persons with Disabilities (SPD) population based on rates for performance measures stratified by the SPD and non-SPD populations. For the third consecutive year, the SPD population had a significantly higher rate of hospital readmissions than the non-SPD population. While a higher rate of hospital readmissions is expected for the SPD population, in the MCP-specific evaluation reports HSAG recommended that MCPs with significantly higher SPD readmissions rates assess the factors leading to the higher readmissions, such as beneficiary level of acuity, to ensure that they are meeting the needs of the SPD population.

Performance Measure Results—Specialty Managed Care Health Plans

The three specialty MCPs (AIDS Healthcare Foundation, Family Mosaic Project, and SCAN Health Plan) had mixed performance measure results. Notable results include:

- ◆ AIDS Healthcare Foundation's rate for the *Colorectal Cancer Screening* measure improved significantly from RY 2014 to RY 2015, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015. The MPL for this measure is based on the national commercial 25th percentile as no Medicaid benchmarks exist for this measure.
- ◆ SCAN Health Plan's rate for the *Breast Cancer Screening* measure improved significantly from RY 2014 to RY 2015 and remained above the HPL (which is based on the national Medicaid 90th percentile) for the third consecutive year.

Quality Improvement Projects

During the reporting period, 45 statewide *All-Cause Readmissions (ACR)* quality improvement projects (QIPs) and 25 internal (MCP-specific) QIPs (IQIPs) progressed to the Outcomes stage.

- ◆ Only six *ACR* QIPs and three IQIPs achieved statistically significant improvement over baseline for at least one of the QIP study indicators.
- ◆ Three QIPs progressed to the point of being assessed for sustained improvement, and all three achieved sustained improvement by maintaining or increasing the statistically significant improvement over baseline achieved in the previous measurement period.

For MCPs testing Plan-Do-Study-Act (PDSA) cycles as part of their rapid-cycle quality improvement strategies, HSAG made the following observations:

- ◆ A majority of the 13 *ACR* PDSA cycles did not meet their goals.
- ◆ A majority of the 14 IQIP PDSA cycles did achieve their goals.
- ◆ MCPs indicated that they adopted more than half of the interventions tested through PDSA cycles for both *ACR* and IQIP topics.
- ◆ Overall, MCPs provided adequate documentation regarding the PDSA cycles, but still have the opportunity to improve the level of detail provided for describing PDSA cycle activities and reporting lessons learned.

Consistent with last year's review, the validation results suggest that many interventions MCPs implemented through the QIP process did not result in positive outcomes. Thus, DHCS made a decision to transition to HSAG's rapid-cycle performance improvement project (PIP) approach starting July 1, 2015. HSAG's redesigned PIP approach places greater emphasis on improving both health care outcomes and processes through the integration of quality improvement science. As a result, all QIPs were closed as of June 30, 2015; and MCPs will no longer submit QIPs to HSAG for validation and, instead, will submit PIP documentation to HSAG.

Encounter Data Validation

The results and analyses for the State Fiscal Year (SFY) 2013–14 encounter data validation (EDV) study were not available when HSAG produced the 2013–14 external quality review (EQR) technical and MCP-specific evaluation reports. Therefore, HSAG provides a summary of the SFY 2013–14 and SFY 2014–15 EDV studies in this report.

The goal of the SFY 2013–14 EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by MCPs through a review of the medical records. For SFY 2014–15, HSAG assisted DHCS in understanding operational and infrastructure changes

implemented by MCPs in support of DHCS's transition to the new Post Adjudicated Claims and Encounters System (PACES).

SFY 2013–14 Encounter Data Validation Study

For the SFY 2013–14 EDV study, HSAG evaluated MCMC encounter data completeness and accuracy via the review of medical records for physician services rendered in calendar year 2012.

HSAG identified the following related to encounter data completeness:

- ◆ DHCS encounters were moderately supported by the documentation in beneficiaries' medical records.
- ◆ While DHCS encounters included supporting documentation in the medical records at a moderate level, not all services documented in the medical records were submitted to DHCS (encounter data omission).
- ◆ Omissions identified in the medical records (services located in the encounter data but not supported in the medical record) and omissions in the encounter data (services located in the medical record but not in the encounter data) illustrated discrepancies in the completeness of DHCS's encounter data. Data completeness at the MCP-level varied considerably.

HSAG identified the following related to encounter data accuracy:

- ◆ Among the data elements evaluated for accuracy, the following were supported by medical record documentation identified in the electronic encounter data:
 - 83.6 percent of diagnosis codes
 - 77.6 percent of procedure codes
 - 99.5 percent of procedure code modifiers
 - 63.0 percent of rendering provider names
 - 68.6 percent of billing provider names
- ◆ Less than 5 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries' medical records.

SFY 2014–15 Encounter Data Validation Study

In SFY 2014–15, DHCS began transitioning its encounter data system, with the goal that most MCPs would be actively submitting to PACES by early 2015. As a component of EDV, HSAG assisted DHCS in understanding operational and infrastructure changes implemented by MCPs in support of the transition to the new PACES.

From HSAG’s desk review of MCPs’ information systems (IS) and encounter data processing and submission, HSAG determined that transition to PACES has addressed some concerns HSAG identified in prior EDV studies regarding areas of inconsistency in the encounter data processes among MCPs. DHCS has addressed the recommendations from the SFY 2012–13 Encounter Data Validation study regarding moving to standardized data formats and requiring MCPs to notify DHCS of system changes. However, MCPs approached the PACES transition process in different ways; and some MCPs had a more difficult transition process, based on the data systems and procedures available at the beginning of the transition.

Recommendations Across All Assessed Activities

Based on its assessment, HSAG provides the following recommendations for DHCS:

- ◆ Establish a specific time frame for DHCS to produce and deliver all compliance review reports to ensure that MCPs are able to take action to resolve all findings as soon as possible to be fully compliant with federal and State requirements.
- ◆ Issue CAPs to MCPs demonstrating poor performance on multiple measures over consecutive years. Rather than require MCPs to address poor performance on all measures at once, work with MCPs to prioritize areas in need of improvement to increase the likelihood of positive outcomes.
- ◆ Assess whether DHCS should add any measures to the list of priority areas in the Medi-Cal Managed Care Program Quality Strategy moving forward. Following are measures HSAG recommends for DHCS’s consideration:
 - *All-Cause Readmissions*, including focusing on reducing readmissions for the SPD population
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics*
 - *Cervical Cancer Screening*
 - *Both Medication Management for People with Asthma* measures
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- ◆ To support accurate and complete encounter data from MCPs, review the *Encounter Data Validation Study Aggregate Report—July 1, 2013–June 30, 2014* and *Encounter Data Validation Study Aggregate Report—July 1, 2014–June 30, 2015* and identify strategies to address recommendations not already addressed by DHCS to ensure accuracy and completeness of encounter data.

Purpose of Report

In the State of California, DHCS administers the Medicaid program (Medi-Cal) through its fee-for-service (FFS) and managed care delivery systems. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its MCPs, making improvements to care and services and ensuring that contracted MCPs comply with federal and State standards.

As required by 42 CFR §438.364,⁴ DHCS contracts with HSAG, an EQRO, to prepare an annual, independent, technical report that analyzes and evaluates aggregated information of the health care services provided by California's Medi-Cal MCPs. The technical report provides an assessment of MCPs' strengths and weaknesses with respect to the quality and timeliness of and access to the health care services the MCPs furnished to enrolled Medi-Cal beneficiaries, provides recommendations for improvement, and assesses the degree to which MCPs addressed any previous recommendations.

HSAG's performance evaluation centers on federal and State-specified criteria that fall into one or more domains of care: quality, access, and timeliness—for each part of the compliance review, performance measure, and QIP. While not required, the State may elect to include optional EQR activities such as EDV results.

This report provides:

- ◆ A description of MCMC.
- ◆ A description of MCMC's assessment of its quality strategy and quality improvement objectives.
- ◆ A description of the scope of EQR activities for the period of July 1, 2014, through June 30, 2015, including the methodology used for data collection and analysis and a description of the data for each activity.
- ◆ An aggregate assessment of health care timeliness, access, and quality across organizational structure and MCP compliance based on performance measures and QIPs. The report also assesses encounter data validation, an optional EQR monitoring activity that helps evaluate MCPs' infrastructure to collect and report on services received so that these data may be used to inform quality improvement activities.

⁴ 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.

- ◆ MCP-specific evaluation reports are included in the technical report as appendices (see appendices A through Z). Each MCP-specific evaluation report provides an assessment of the MCP's strengths and opportunities for improvement regarding the quality and timeliness of, and access to, health care services, as well as recommendations to the MCP for improving quality of health care services for its beneficiaries.

The technical report and MCP-specific evaluation reports all align to the same review period—July 1, 2014, through June 30, 2015. The reports include summaries and assessments of results from State compliance reviews, performance measure validation, QIP validation, and encounter data validation.

Medi-Cal Managed Care Overview

MCMC provides managed health care services to more than 9.6 million beneficiaries (as of June 30, 2015)⁵ in the State of California through a combination of contracted full-scope and specialty MCPs. During the review period, DHCS contracted with 22 full-scope MCPs and three specialty MCPs to provide health care services in all 58 counties throughout California. DHCS operates MCMC through a service delivery system that encompasses six models of managed care for its full-scope services, as well as a model for specialty MCPs. DHCS monitors MCP performance across model types. A link to the Medi-Cal managed care county map, which depicts the location of each model type, may be found at <http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx>.

Following is a description of each model type.

County Organized Health System (COHS) model. A COHS is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission. A COHS model has been implemented in 22 counties and operates in each as a single, county-operated health plan. This model does not offer FFS Medi-Cal. As of June 30, 2015, the COHS model was serving about 2.08 million MCMC beneficiaries through six health plans in 22 counties; six of those counties were added in 2013.⁵

Two-Plan Model (TPM). Under TPM, beneficiaries may choose between two MCPs; typically, one MCP is a local initiative (LI) and the other a commercial plan (CP). DHCS contracts with both plans. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. As of June 30, 2015, the TPM was serving about 6.17 million MCMC

⁵ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: January 24, 2016.

beneficiaries through 12 health plans in 14 counties.⁵ Note that Anthem Blue Cross Partnership Plan serves as an LI in Tulare County and a CP in all other TPM counties.

Geographic Managed Care (GMC) model. Under a GMC model, DHCS allows Medi-Cal beneficiaries to select from several MCPs within a specified geographic area (county). As of June 30, 2015, the GMC model had seven health plans serving about 1.02 million MCMC beneficiaries in Sacramento and San Diego counties.⁵

Regional model. This model consists of three commercial health plans that provide services to beneficiaries in the rural counties of the State, primarily in northern and eastern California. The Regional model was implemented in November 2013, bringing MCMC to counties that historically offered only FFS Medi-Cal. As of June 30, 2015, the Regional model was serving close to 300,000 MCMC beneficiaries in 18 counties.⁵

Imperial model. This model operates in Imperial County with two commercial health plans. As of June 30, 2015, this model was serving close to 70,000 MCMC beneficiaries.⁵

San Benito model. This model operates in San Benito County and provides services to beneficiaries through a CP and FFS Medi-Cal. As of June 30, 2015, the San Benito model was serving more than 7,000 MCMC beneficiaries.⁵ San Benito is California's only county where enrollment in managed care is not mandatory.

Specialty Managed Care Health Plans. Specialty MCPs provide health care services to specialized populations. During the review period, DHCS held contracts with three specialty MCPs:

- ◆ AIDS Healthcare Foundation—provides services in Los Angeles County primarily to beneficiaries living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). As of June 30, 2015, AIDS Healthcare Foundation was serving 852 MCMC beneficiaries.⁵
- ◆ Family Mosaic Project—provides intensive case management and wraparound services in San Francisco County for MCMC children and adolescents at risk of out-of-home placement. As of June 30, 2015, Family Mosaic Project was serving 37 MCMC beneficiaries.⁵
- ◆ SCAN Health Plan—is a Medicare Advantage Special Needs Plan that provides services for the dual-eligible Medicare/Medi-Cal population subset residing in Los Angeles, Riverside, and San Bernardino counties. According to DHCS, as of June 30, 2015, SCAN Health Plan was serving 10,706 MCMC beneficiaries.

Table 2.1 shows participating MCPs by model type.

Table 2.1—Medi-Cal Managed Care Health Plans by Model Type as of December 31, 2014

Model Type		MCP Name	Counties
Two-Plan	Commercial	Anthem Blue Cross Partnership Plan	Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara
		Health Net Community Solutions, Inc.	Kern, Los Angeles, San Joaquin, Stanislaus, Tulare
		Molina Healthcare of California Partner Plan, Inc.	Riverside, San Bernardino
	Local Initiative	Alameda Alliance for Health	Alameda
		Anthem Blue Cross Partnership Plan	Tulare
		CalViva Health	Fresno, Kings, Madera
		Contra Costa Health Plan	Contra Costa
		Health Plan of San Joaquin	San Joaquin, Stanislaus
		Inland Empire Health Plan	Riverside, San Bernardino
		Kern Health Systems	Kern
		LA Care Health Plan	Los Angeles
		San Francisco Health Plan	San Francisco
Santa Clara Family Health Plan	Santa Clara		
Geographic Managed Care	Anthem Blue Cross Partnership Plan	Sacramento	
	Health Net Community Solutions, Inc.		
	KP Cal, LLC Kaiser NorCal (Kaiser NorCal)*		
	Molina Healthcare of California Partner Plan, Inc.		
	Care1st Partner Plan	San Diego	
	Community Health Group Partnership Plan		
	Health Net Community Solutions, Inc.		
	KP Cal, LLC Kaiser SoCal (Kaiser SoCal)		
Molina Healthcare of California Partner Plan, Inc.			
County-Organized Health System	CalOptima	Orange	
	CenCal Health	San Luis Obispo, Santa Barbara	
	Central California Alliance for Health	Merced, Monterey, Santa Cruz	
	Gold Coast Health Plan	Ventura	
	Health Plan of San Mateo	San Mateo	
	Partnership HealthPlan of California	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo	
Imperial	Molina Healthcare of California Partner Plan, Inc.	Imperial	
	California Health & Wellness		
San Benito	Anthem Blue Cross Partnership Plan	San Benito	

Model Type	MCP Name	Counties
Regional	Anthem Blue Cross Partnership Plan	Butte, Colusa, Glenn, Plumas, Sierra, Sutter, Tehama (MCPs will report a single, multi-county rate for these counties, which are collectively referred to as Region 1.)
	California Health & Wellness Plan	
	Anthem Blue Cross Partnership Plan	Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, Yuba (MCPs will report a single, multi-county rate for these counties, which are collectively referred to as Region 2.)
	California Health & Wellness Plan	
	Kaiser NorCal*	Amador, El Dorado, Placer
Specialty MCPs	AIDS Healthcare Foundation	Los Angeles
	Family Mosaic Project	San Francisco
	SCAN Health Plan	Los Angeles, Riverside, San Bernardino

* Kaiser NorCal provides Medi-Cal services in Sacramento County as a GMC model type and in Amador, El Dorado, and Placer counties as a Regional model type; however, the MCP reports performance measure rates for all counties combined. DHCS's decision to have the MCP report the combined rates ensures that Kaiser NorCal has a sufficient sample size to compute accurate performance measure rates that represent the availability and quality of care provided for the population in the region and assists Kaiser NorCal with maximizing operational and financial efficiencies by reducing the number of encounter data validation, improvement plans, QIPs, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)⁶ survey activities. Since RY 2015 is the first year that Kaiser NorCal is reporting a rate for the combined counties, no comparisons to previous years' rates can be made.

For enrollment information on each county, go to

<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>.

Medi-Cal Expansion

As part of the expansion authority under Section 1115 of the Social Security Act,⁷ MCMC expanded into all rural counties of California effective November 1, 2013. Anthem Blue Cross Partnership Plan and California Health & Wellness Plan contracted with DHCS to provide MCMC services for 18 rural counties—Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba. Anthem Blue Cross Partnership Plan also expanded into San Benito County to provide MCMC services, and California Health & Wellness Plan contracted with DHCS to provide MCMC services in Imperial County. Also as part of the expansion authority, Kaiser NorCal contracted with DHCS to provide MCMC services in Amador, El Dorado, and Placer counties beginning November 1, 2013; Molina Healthcare of California Partner Plan, Inc., contracted with DHCS to

⁶ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

⁷ Information on Section 1115 of the Social Security Act can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>.

provide MCMC services in Imperial County beginning September 1, 2013; and Partnership HealthPlan of California contracted with DHCS to provide MCMC services in Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties beginning September 1, 2013.

Domains of Care

The Centers for Medicare & Medicaid Services (CMS) chose the domains of quality, access, and timeliness as keys to evaluating the performance of MCPs. HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCPs in each of these domains.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its beneficiaries 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.⁸

Access

In the preamble to the CFR,⁹ CMS discusses access to and the availability of services to Medicaid beneficiaries as the degree to which health plans implement the standards set forth by the state to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that reflects the needs and characteristics of the enrollees served by the plan.

Timeliness

The National Committee for Quality Assurance (NCQA) defines timeliness relative to utilization decisions as follows: “The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.”¹⁰ NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and

⁸ 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. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: January 24, 2016.

⁹ Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

¹⁰ National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.

that require timely response by the MCP—e.g., processing expedited appeals and providing timely follow-up care. The Agency for Healthcare Research and Quality (AHRQ) indicates “timeliness is the health care system’s capacity to provide health care quickly after a need is recognized.”¹¹ Timeliness includes the interval between identifying a need for specific tests and treatments and actually receiving those services.¹²

Table 2.2 shows HSAG’s assignment of the compliance review standards, performance measures, and QIPs into the domains of quality, timeliness, and access. Unless indicated otherwise, all full-scope MCPs report all performance measures listed in Table 2.2.

Table 2.2—Assignment of Activities to Performance Domains

Compliance Review Standards*	Quality	Timeliness	Access
Enrollee Rights and Protections Standards		√	√
Access Standards		√	√
Structure and Operations Standards		√	√
Measurement and Improvement Standards	√		
Grievance System Standards		√	√
Performance Measures	Quality	Timeliness	Access
<i>All-Cause Readmissions (Statewide Collaborative QIP Measure)</i>	√		√
<i>Ambulatory Care—Emergency Department (ED) Visits[‡]</i>	**	**	**
<i>Ambulatory Care—Outpatient Visits[‡]</i>	**	**	**
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	√		
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	√		
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	√		
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	√		
<i>Breast Cancer Screening (specialty MCP measure)</i>	√		√
<i>Cervical Cancer Screening</i>	√		√
<i>Childhood Immunization Status—Combination 3</i>	√	√	√
<i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months</i>			√
<i>Children and Adolescents’ Access to Primary Care Practitioner—25 Months to 6 Years</i>			√
<i>Children and Adolescents’ Access to Primary Care Practitioners—7 to 11 Years</i>			√
<i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i>			√
<i>Colorectal Cancer Screening (specialty MCP measure)</i>	√		√

¹¹ Agency for Healthcare Research and Quality. *National Healthcare Quality Report 2007*. AHRQ Publication No. 08-0040. February 2008.

¹² Ibid.

Performance Measures	Quality	Timeliness	Access
<i>Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)</i>	√		
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	√		√
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)</i>	√		
<i>Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)</i>	√		
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	√		√
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	√		√
<i>Controlling High Blood Pressure (full-scope and specialty MCP measure)</i>	√		
<i>Immunizations for Adolescents—Combination 1</i>	√	√	√
<i>Medication Management for People with Asthma—Medication Compliance 50% Total</i>	√		
<i>Medication Management for People with Asthma—Medication Compliance 75% Total</i>	√		
<i>Osteoporosis Management in Women Who Had a Fracture (specialty MCP measure)</i>	√	√	
<i>Out-of-Home Placements (specialty MCP measure)</i>	√		√
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	√	√	√
<i>Prenatal and Postpartum Care—Postpartum Care</i>	√	√	√
<i>School Attendance (specialty MCP measure)</i>	√		
<i>Use of Imaging Studies for Low Back Pain</i>	√		
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	√	√	√
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	√		
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	√		
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	√		
Quality Improvement Projects	Quality	Timeliness	Access
<i>All-Cause Readmissions</i>	√		√
Internal QIPs	Domain varied by MCP QIP. This information is included in appendices A through Z in the QIP section of each MCP-specific evaluation report.		

†This is a utilization measure, which measures the volume of services used.

*The compliance review standards related to managed care health plans are defined at 42 CFR 438.

**Domains of care are not assigned to utilization measures.

Medi-Cal Managed Care Quality Strategy Annual Assessment

42 CFR §438.200 and §438.202 require that state Medicaid agencies develop and implement a written quality strategy for assessing and improving the quality of health care services offered to their beneficiaries. The written strategy must describe the standards the state and its contracted plans must meet. The state must conduct periodic reviews to examine the scope and content of its managed care quality strategy, evaluate the strategy's effectiveness, and update it as needed.

In November 2015, DHCS submitted to CMS its annual assessment update of the baseline report, *2012 Medi-Cal Managed Care Program Quality Strategy Report*. The annual assessment provides DHCS's evaluation of MCPs' performance, updates progress toward measurable objectives for key indicators, assesses past interventions to improve future performance, includes future interventions, describes changes in service delivery and contractual standards, and outlines enhancements in DHCS's oversight and monitoring of MCMC. The annual assessment focused on performance in three areas critical for the health of MCMC beneficiaries:

- ◆ Maternal and child health: timely postpartum care and immunizations of 2-year-olds
- ◆ Chronic disease management: hypertension control and diabetes care
- ◆ Prevention: tobacco cessation

Throughout the November 2015 annual assessment document, DHCS identified opportunities to engage in quality improvement activities with MCPs and the EQRO to ensure that quality, accessible, and timely health care is delivered to MCMC beneficiaries.

The detailed annual assessment may be found through the following link:

<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx>.

Note: Although the November 2015 annual assessment was released outside the review dates for this report, HSAG references information from the report at the request of DHCS and because the information was available at the time this report was produced.

Follow-up on Prior Year's Recommendations

In the *2013–14 Medi-Cal Managed Care Technical Report*, HSAG recommended that DHCS report outcomes achieved through strategies outlined in the *2014 Medi-Cal Managed Care Program Quality Strategy Report* and indicate whether strategies will be expanded, modified, or eliminated to achieve improvement in key focus areas. As part of the process for producing the *2014–15 Medi-Cal*

Managed Care Technical Report, DHCS provided the following information on the actions it took to address this recommendation:

- ◆ DHCS submitted its *2015 Medi-Cal Managed Care Quality Strategy Report Annual Assessment* to CMS on November 5, 2015. This report is available online: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx>. The report outlines in detail outcomes achieved through strategies from the *2014 Medi-Cal Managed Care Program Quality Strategy Report Annual Assessment*. In evaluating the performance of MCPs, the report updates progress toward measurable objectives for key indicators, assesses past interventions to improve performance, includes future interventions, describes changes in service delivery and contractual standards, and outlines enhancements in DHCS oversight and monitoring of the MCMC program and its MCPs.

DHCS provided in its November 2015 annual assessment detailed outcomes information and documentation of strategies that DHCS intends to implement to ensure that quality, accessible, and timely care is provided to MCMC beneficiaries. Therefore, HSAG has no recommendations for DHCS related to its implementation and assessment of the Medi-Cal Managed Care Program Quality Strategy.

Compliance Standards

According to 42 CFR §438.358, 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 beneficiary 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.

Conducting the Review

The *2015 Medi-Cal Managed Care Quality Strategy Report Annual Assessment* is DHCS's most recent update to its *Medi-Cal Managed Care Program Baseline Quality Report—April 2012*. The quality strategy report describes the standards and processes DHCS uses to evaluate the operational structure and procedures MCPs use as required by the CFR. Contracts between DHCS and MCPs include provisions for the standards—including the frequency of reporting, monitoring, and enforcement of corrective actions.

For this review period, DHCS performed multiple assessments including, DHCS Audits & Investigations Division (A&I) medical performance audits, A&I State Supported Services audits, and California Department of Managed Health Care (DMHC) 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Surveys (referred to in this report as “SPD medical surveys”). While some areas of these reviews are similar, the results are separate and distinct.

Medical Audits and SPD Medical Surveys

Historically, DHCS conducted medical audits of MCPs once every three years—sometimes in collaboration with DMHC. These medical audits assessed MCPs' compliance with contract requirements and State and federal regulations.

DHCS received an authorization “1115 Waiver” from the federal government to conduct mandatory enrollment of SPD beneficiaries into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. DMHC entered into an interagency agreement with DHCS to conduct health plan medical surveys (DMHC SPD medical surveys) every three years to ensure that beneficiaries affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment began in June 2011.

In January 2015, California Welfare and Institutions Code § 14456 became law. This regulation mandates annual audits for full-service MCPs. Through June 2015, DHCS audited approximately half of the MCPs. Additionally, by June 2015, DHCS had scheduled comprehensive audits for all contracted full-service MCPs. These audits were scheduled to be conducted before August 2016. Ongoing, a comprehensive audit of MCPs will occur every other year. In the off year, DHCS will conduct a focused audit of the full-service MCP.

Under the monitoring protocols, until MCPs achieve full resolution, DHCS actively and continuously monitors deficiencies identified in A&I medical audits, DMHC SPD medical surveys, and other monitoring-related MCP examinations. Some deficiencies are provisionally closed in order to ensure that all issues are correctly ameliorated. Monitoring activities include follow-up communications with MCPs augmented by DHCS technical assistance to MCPs to develop meaningful CAPs to address all deficiencies. The CAP is not satisfied and remains provisionally closed until all issues are resolved. At that time, DHCS issues a final closeout letter to the MCP.

Objectives

DHCS's primary objective of monitoring organizational assessment and structure performance standards is to assess MCPs' compliance with federal regulations and State-specified standards.

Methodology

During the review period for this report, DHCS conducted monitoring of MCPs' compliance with federal and State-specified standards through the various types of audits and surveys listed below (with review areas indicated for each type of audit and survey):

DHCS A&I Medical Performance Audits

- ◆ Access and Availability of Care
- ◆ Case Management and Coordination of Care
- ◆ Member's Rights
- ◆ Administrative and Organizational Capacity
- ◆ Quality Management
- ◆ Utilization Management

DHCS A&I State Supported Services Audits

DHCS's A&I conducts audits of each MCP that holds a State Supported Services contract to determine if the MCP is meeting the terms of its contract, which covers contracted abortion services.

DMHC Triannual SPD and Rural Medical Surveys

- ◆ Availability and Accessibility
- ◆ Continuity of Care
- ◆ Member Rights
- ◆ Quality Management
- ◆ Utilization Management

MCP-specific Focus Area Medical Reviews

DHCS A&I conducted a focused medical review of CalOptima that included assessment of the following areas:

- ◆ Delegation of Utilization Management
- ◆ Fraud and Abuse Program
- ◆ Grievances and Appeals
- ◆ Pharmaceutical Services
- ◆ Prior Authorization Procedures
- ◆ Referral Tracking System
- ◆ Utilization Management

Specialty Plan reviews included the following:

- ◆ DHCS's Long-Term Care Division evaluated Nursing Facility Level of Care certifications completed by SCAN Health Plan.
- ◆ DHCS completed a Program Oversight and Compliance Branch review of Family Mosaic Project. The following areas were assessed:
 - Access
 - Authorization
 - Beneficiary Protection
 - Funding, Reporting, and Contracting Requirements
 - Target Populations and Array of Services
 - Interface with Physical Health Care
 - Provider Relations
 - Program Integrity
 - Quality Improvement
 - Mental Health Services Act
 - Chart Review—Non-Hospital Services

Assessment of MCP Monitoring

HSAG organized, aggregated, and analyzed results from DHCS's compliance monitoring reviews to assess whether DHCS conducted a comprehensive audit with all MCPs at least once within three years of the review dates for this report and to draw conclusions about overall MCP performance in providing quality, accessible, and timely health care and services to MCMC beneficiaries.

To determine if DHCS conducted compliance reviews with all MCPs within a three-year time period of the review dates for this report, HSAG assessed the dates of each MCP's reviews to determine which reviews were conducted no earlier than three years prior to the start of the review period for this report (July 1, 2014) and no later than the end of the review period for this report (June 30, 2015). HSAG reviewed the most current DHCS compliance reports available as of June 30, 2015. In some instances, the audit took place in the prior review period; however, the report was not available until the current review period. When review of a report reflected full resolution of deficiencies, HSAG included results and follow-up information from compliance reports issued by DHCS outside the review period for this report. Finally, HSAG reviewed opportunities for improvement from the previous review period and assessed whether DHCS followed up with MCPs to ensure that MCPs met requirements.

Compliance monitoring standards fall primarily under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Compliance Results

In accordance with Welfare & Institutions § 19130(b)(3), DHCS conducts the compliance reviews for MCPs rather than contracting with the EQRO to conduct the compliance reviews. DHCS submits audit reports and other compliance-related documentation to HSAG. DHCS uses the Generally Accepted Government Auditing Standards (GAGAS), also known as the Yellow Book, which requires that auditing tools be proprietary. Thus, DHCS could not provide HSAG with information for the 2014–15 review period that would allow HSAG to determine whether DHCS assessed MCPs' compliance with all federal and State requirements.

MCP-specific compliance review results, including HSAG's recommendations, are included in appendices A through Z.

DHCS Follow-up on 2013–14 Monitoring Results

In the 2013–14 MCP-specific evaluation reports, HSAG reported on outstanding compliance review findings. In its assessment of the compliance reports submitted by DHCS to HSAG for the 2014–15 review period, HSAG found that DHCS followed up on all findings outstanding at the

time that HSAG produced the 2013–14 reports. Additionally, MCPs resolved all outstanding findings, resulting in DHCS closing all open CAPs from the reviews.

Monitoring Results for 2014–15

DHCS conducted a compliance review no earlier than three years from the start of the review period for this report (July 1, 2014) and no later than the end of the review period for this report (June 30, 2015) for all but the one specialty MCP referenced below.

- ◆ AIDS Healthcare Foundation—the most recent review was conducted in June 2010. (DHCS indicated to HSAG that it plans to conduct an audit for AHF in the State fiscal year 2016–17.)

The following is a summary of HSAG’s assessment of the compliance review information provided by DHCS to HSAG for production of the 2014–15 MCP-specific evaluation reports and this EQR technical report. The summary includes new information not reported on in previous review periods.

- ◆ DHCS did not issue final reports to MCPs in a timely manner after the on-site visits—DHCS issued final reports several months (and in a few instances more than a year) after the related on-site audits or surveys. Receiving formal documentation of findings from DHCS promptly is important to ensure that MCPs are able to take action to resolve all findings as soon as possible to be fully compliant with federal and State requirements.
- ◆ For the medical performance audits, SPD medical surveys, and focused medical review, DHCS identified findings in most or all of the review areas (e.g., Member Rights). Findings were MCP-specific, with no findings cutting across most or all MCPs.
- ◆ Most MCPs were fully compliant with the State Supported Services contract requirements.
- ◆ In instances where findings were not fully resolved, it was either because the follow-up information was not yet available or because the follow-up occurred well outside the review dates for this report.

Conclusions—Managed Care Health Plan Compliance

As in previous years, while MCPs had challenges meeting all requirements assessed by DHCS, MCPs generally had appropriate resources and written policies and procedures to support their quality improvement programs. Findings cut across all domains of care; and in instances where follow-up information was reviewed, all MCPs resolved the compliance review findings to DHCS’s satisfaction. Since the findings within the assessed areas were MCP-specific, HSAG identified no specific areas for improvement across all MCPs.

Recommendations—Managed Care Health Plan Compliance

Based on the compliance review results, HSAG provides the following recommendation to DHCS regarding the compliance review process:

- ◆ Establish a specific time frame for DHCS to produce and deliver all compliance review reports to ensure that MCPs are able to take action to resolve all findings as soon as possible to be fully compliant with federal and State requirements.

Follow-up on Prior Year's Recommendations

In the *2013–14 Medi-Cal Managed Care Technical Report*, HSAG recommended that DHCS ensure that a comprehensive audit is conducted at least once within a three-year period for all MCPs. As part of the process for producing the *2014–15 Medi-Cal Managed Care Technical Report*, DHCS provided the following information about the actions it took to address this recommendation:

- ◆ California Welfare and Institutions Code § 14456, which became law in January 2015, mandates annual audits for full-service MCPs. Through June 2015, DHCS audited approximately half of the MCPs. Additionally, by June 2015 DHCS had scheduled all contracted, full-service MCPs' comprehensive audits to be conducted before August 2016. Ongoing, a comprehensive audit of MCPs will occur at least every other year.

In the time frame of this report, it is too soon for HSAG to assess whether DHCS's change in policy will result in DHCS conducting a comprehensive audit for all MCPs at least once every three years, HSAG will reassess the status of this recommendation as part of the process for producing the *2015–16 Medi-Cal Managed Care Technical Report*.

Performance Measure Validation

Validating performance measures is one of the three mandatory external quality review activities described at 42 CFR §438.358(b)(2). This requirement allows states, agents (not MCOs or PHIPs), or an EQRO to conduct the mandatory activity. Performance results may be reported to the state by the plan (as required by the state), or the state may calculate the plan's performance on the measures for the preceding 12 months. Performance must be reported by each plan—or calculated by the state—and validated annually. In accordance with 42 CFR §438.240(b), DHCS contractually requires MCPs to have a quality improvement program that calculates and submits performance measure data.

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 MCMC beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set (EAS). DHCS requires that MCPs collect and report EAS rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

CMS requires that states (1) conduct performance measure validation of their contracted health plans to ensure that health plans calculate performance measure rates according to state specifications, and (2) assess the extent to which the health plans' IS provide accurate and complete information.

To comply with the CMS requirements, DHCS contracts with HSAG to conduct validation of the selected EAS 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.¹³ 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 beneficiaries.

Conducting the Review

DHCS's RY 2015 EAS for full-scope MCPs consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS[®]) measures and one measure originally developed by DHCS and the MCPs (with guidance from the EQRO) to be used for the statewide collaborative QIP. Several of

¹³ The CMS EQR Protocols may be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

the 15 required measures include more than one indicator, bringing the total performance measure rates required for MCPs reporting to 30. In this report, “performance measure” or “measure” (rather than indicator) is used to describe the required EAS measures. The performance measures fall under all three domains of care—quality, access, and timeliness. Each full-scope MCP calculated and reported MCP-specific data for the following DHCS-selected measures in the RY 2015 EAS:

- ◆ *All-Cause Readmissions* (DHCS-developed measure for use in the *All-Cause Readmissions* Statewide Collaborative QIP)
- ◆ *Ambulatory Care—Emergency Department (ED) Visits*
- ◆ *Ambulatory Care—Outpatient Visits*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Cervical Cancer Screening*
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years*
- ◆ *Comprehensive Diabetes Care (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—Medical Attention for Nephropathy*
- ◆ *Controlling High Blood Pressure*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total*
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*

- ◆ *Use of Imaging Studies for Low Back Pain*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Each specialty MCP calculated and reported MCP-specific data for two measures approved by DHCS. The measures varied by MCP based on the demographics of each MCP's population and are listed below.

AIDS Healthcare Foundation

AIDS Healthcare Foundation reported rates for the following HEDIS measures:

- ◆ *Colorectal Cancer Screening*
- ◆ *Controlling High Blood Pressure*

Family Mosaic Project

Family Mosaic Project reported rates for the following non-HEDIS measures, which were designed in collaboration with HSAG to measure elements specific to this specialty MCP.

- ◆ *Out-of-Home Placements:* The percentage of Medi-Cal managed care beneficiaries enrolled in Family Mosaic who are discharged to an out-of-home placement during the measurement period.
- ◆ *School Attendance:* The number of capitated Medi-Cal managed care beneficiaries enrolled into Family Mosaic Project with a 2 or 3 in school attendance on the initial Child and Adolescent Needs and Strengths (CANS) outcome/assessment tool and a 2 or 3 in school attendance on the most recent closing CANS during the measurement period.

SCAN Health Plan

SCAN Health Plan reported rates for the following HEDIS measures:

- ◆ *Breast Cancer Screening*
- ◆ *Osteoporosis Management in Women Who Had a Fracture*

Seniors and Persons with Disabilities Performance Measure Stratification

In addition to reporting the EAS in 2015, full-scope MCPs were required to report a separate rate for their SPD population for a selected group of measures. MCPs reported the rates for the SPD population separately via a Microsoft Excel reporting template. The SPD rates were compared to the non-SPD rates to identify statistically significant differences between the two populations.

For RY 2015, DHCS made the following CMS-approved changes to the SPD stratification requirements:

- ◆ DHCS no longer required MCPs to stratify for the SPD population for the:
 - *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* and *LDL-C Screening* indicators because NCQA removed these indicators from the HEDIS measures.
 - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* indicator based on the difference between the stratified populations being small and feedback from MCPs that the stratification results were minimally beneficial for MCPs' quality improvement efforts.
 - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* indicators based on DHCS's research that found the rate for the *Comprehensive Diabetes Care—HbA1c Testing* indicator is highly correlated with HbA1c control/poor control.
- ◆ DHCS calculated the SPD rates using encounter data for the following indicators:
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
 - *Comprehensive Diabetes Care—HbA1c Testing*
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

DHCS required the full-scope MCPs to report SPD and non-SPD rates for the following measures:

- ◆ *All-Cause Readmissions*—originally developed for the Statewide Collaborative QIP
- ◆ *Ambulatory Care—Outpatient Visits*
- ◆ *Ambulatory Care—Emergency Department Visits*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Performance Measure Requirements and Targets

MCMC's quality strategy describes the program's processes to define, collect, and report MCP-specific performance data, as well as overall MCMC performance data, on DHCS-required measures. MCPs must report county/regional rates unless otherwise approved by DHCS.

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. Additionally, DHCS did not establish an MPL or HPL for the *All-Cause Readmissions* measure, which is a non-HEDIS measure used for the *All-Cause Readmissions* collaborative QIP.

DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, a lower rate indicates better performance and a higher 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.

MCPs not meeting the MPLs must submit an improvement plan (IP) or a PDSA cycle to DHCS that outlines actions and interventions the MCP will take to achieve acceptable performance. DHCS uses the established HPLs as a performance goal and recognizes MCPs for outstanding performance.

Objectives

HSAG conducted an NCQA HEDIS Compliance Audit^{TM,14} (or a performance measure validation audit for non-HEDIS measures) to evaluate the accuracy of performance measure results reported by MCPs and to ensure that MCPs followed specifications established by DHCS.

To assess performance related to quality, access, and timeliness of care, HSAG presents the audited rates for each MCP for 2012–15 (as available) and compares the current year's rates to the prior year's rates and the DHCS-established MPLs/HPLs.

Methodology

To assist MCPs in standardized reporting, NCQA develops and makes available technical specifications that provide information on how to collect data for each measure, with general guidelines for sampling and calculating rates. DHCS's EAS requirements for 2015 indicate that MCPs are responsible for adhering to the most current HEDIS specifications.

¹⁴ NCQA HEDIS Compliance AuditTM is a trademark of the National Committee for Quality Assurance (NCQA).

To ensure that MCPs calculate and report performance measures consistent with HEDIS specifications and that the results can be compared to other MCPs' HEDIS results, MCPs must undergo an independent audit. NCQA publishes *HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an IS capabilities assessment and an evaluation of compliance with HEDIS specifications for a plan. DHCS requires that MCPs undergo an annual compliance audit conducted by its contracted EQRO.

The HEDIS process begins well in advance of MCPs reporting their rates. MCPs typically calculated their 2015 HEDIS rates with measurement data from January 1, 2014, to December 31, 2014, with the exception of some measures that deviated slightly from this measurement period. Performance measure calculation and reporting typically involves three phases: off-site, on-site, and post-on-site.¹⁵

Off-site Activity (October through March)

- ◆ MCPs prepare for data collection and the on-site audit.
- ◆ MCPs complete the HEDIS Record of Administration, Data Management, and Processes (Roadmap), a tool used by MCPs to communicate information to the auditor about MCPs' systems for collecting and processing data for HEDIS.
- ◆ The EQRO conducts kick-off calls with MCPs to provide guidance on HEDIS audit processes and to ensure that MCPs are aware of important deadlines.
- ◆ The EQRO reviews MCPs' completed Roadmaps to assess compliance with the audit standards and provides MCPs with an IS standard tracking report that lists outstanding items and areas that require additional clarification.
- ◆ The EQRO reviews MCPs' source code used for calculating the EAS measures to ensure compliance with the technical specifications, unless MCPs use a vendor whose measures are certified by NCQA.
- ◆ MCPs prepare for medical record review validation for EAS measures that require the hybrid method for data collection.
- ◆ The EQRO conducts supplemental data validation for all supplemental data sources that MCPs intend to use for reporting.
- ◆ The EQRO conducts preliminary rate review to assess MCPs' data completeness and accuracy early in the audit process.

¹⁵ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: January 24, 2016.

On-site Activity (January through April)

- ◆ MCPs conduct data capture and data collection.
- ◆ The EQRO conducts on-site audits to assess MCPs' capabilities to collect and integrate data from internal and external sources.
- ◆ The EQRO provides preliminary audit findings to MCPs and DHCS.

Post On-site Activity (May through October)

- ◆ MCPs submit final audited rates to DHCS (June).
- ◆ The EQRO provides final audit reports to MCPs and DHCS (July).
- ◆ The EQRO analyzes data and generates the HEDIS aggregate report in coordination with DHCS.

Data Collection Methodology

NCQA specifies two methods for data capture: the administrative method and the hybrid method.

Administrative Method

The administrative method requires health plans to identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. In addition, health plans derive the numerator(s), or services provided to beneficiaries in the eligible population, from administrative data sources and auditor-approved supplemental data sources. Health plans cannot use medical records to retrieve information. When using the administrative method, the entire eligible population is used as the denominator because NCQA does not allow sampling.

Following are the DHCS-selected EAS measures for which NCQA methodology requires the administrative method to derive rates:

- ◆ *All-Cause Readmissions* (statewide collaborative QIP measure)
- ◆ *Ambulatory Care*
- ◆ *Annual Monitoring for Patients on Persistent Medications*
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Breast Cancer Screening**
- ◆ *Children and Adolescents' Access to Primary Care Practitioners*
- ◆ *Medication Management for People with Asthma*
- ◆ *Osteoporosis Management in Women Who Had a Fracture**
- ◆ *Use of Imaging Studies for Low Back Pain*

*A specialty MCP measure

The administrative method is cost-efficient, but it can produce lower rates due to incomplete data submission (often by capitated providers) as well as data typically not submitted as part of a claims or encounter submission such as Current Procedural Terminology (CPT) II codes, or as a result of global billing practices.

Hybrid Method

The hybrid method requires health plans to identify the eligible population using administrative data and then extract a systematic sample of beneficiaries from the eligible population, which becomes the denominator. Health plans use administrative data to identify services provided to those Medi-Cal beneficiaries. When administrative data do not show evidence that a service was provided, health plans then review medical records for those beneficiaries.

The hybrid method generally produces higher rates but is considerably more labor-intensive. For example, a health plan that has 10,000 beneficiaries who qualify for the *Prenatal and Postpartum Care* measure may use the hybrid method. After randomly selecting 411 eligible beneficiaries, the health plan finds that 161 beneficiaries have evidence of a postpartum visit using administrative data. The health plan then obtains and reviews medical records for the 250 beneficiaries who do not have evidence of a postpartum visit using administrative data. Of those 250 beneficiaries, the health plan finds 54 additional beneficiaries who have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would be $(161 + 54)/411$, or 52 percent.

In contrast, using the administrative method, if the health plan finds that 4,000 of the 10,000 beneficiaries had evidence of a postpartum visit using only administrative data, the final rate for this measure would be $4,000/10,000$, or 40 percent.

Following are the DHCS-selected EAS measures for which NCQA methodology allows hybrid data collection:

- ◆ *Cervical Cancer Screening*
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Colorectal Cancer Screening**
- ◆ *Comprehensive Diabetes Care*
- ◆ *Controlling High Blood Pressure***
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Prenatal and Postpartum Care*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

* A specialty MCP measure

** A full-scope MCP and specialty MCP measure

MCPs that have complete and robust administrative data may choose to report measures using only the administrative method and avoid labor-intensive medical record review; however, currently only two of the MCMC-contracted MCPs report rates in this manner, Kaiser NorCal and Kaiser SoCal. The Kaiser MCPs have IS capabilities, primarily due to their closed-system model and electronic medical records that support administrative-only reporting because medical record review does not generally yield additional data beyond what the MCP had already captured administratively.

Performance Measure Validation Results

HSAG conducted performance measure validation with 26 MCPs. Twenty-five of the MCPs had an NCQA HEDIS Compliance Audit. Family Mosaic Project, a specialty MCP, reported non-HEDIS measures; therefore, it underwent a performance measure validation audit consistent with the CMS protocol for conducting performance measure validation. All audits were conducted by NCQA-certified HEDIS compliance auditors, regardless which audit methodology/protocol was followed.

For the RY 2015, 23 of the 26 audited MCPs used vendors to calculate and produce rates; and all of these vendors achieved full measure certification status by NCQA for the reported HEDIS measures. For Family Mosaic Project and the two MCPs that developed source code internally for measure calculation (Kaiser NorCal and Kaiser SoCal), HSAG reviewed and approved the source code. Since *All-Cause Readmissions* was a DHCS-defined measure, HSAG also reviewed and approved the source code for adherence to DHCS's measure specifications.

Strengths—Performance Measure Validation

HSAG auditors identified the following strengths during the performance measure validation process:

- ◆ All MCPs followed NCQA's specifications in calculating their rates for the DHCS-required measures. MCPs had sufficient transactional systems and processes that captured the required data elements for producing valid rates.
- ◆ Despite notable increases in the number of Medicaid memberships as a result of the Affordable Care Act during the measurement year, most MCPs experienced no significant backlogs in processing membership or enrollment data and claims data that would impact HEDIS reporting.
- ◆ MCPs continued using more standard supplemental data sources to supplement their rates. The majority of MCPs are capturing a large volume of data electronically, which reduces the burden of medical record abstraction.
- ◆ With a few exceptions, HSAG found MCPs fully compliant with the applicable IS standards. For the seven MCPs that did not achieve full compliance with all IS standards during the audit

process, the auditors determined that the issues occurred in these areas: ensuring complete and accurate claims/encounters data from service partners and integrating data for measure calculation. Nonetheless, these deficiencies were resolved before the MCPs reported their rates.

Opportunities for Improvement—Performance Measure Validation

HSAG auditors identified the following challenges during the performance measure validation process.

- ◆ Most challenges and opportunities were MCP-specific, and few challenges were applicable to all or most MCPs. HSAG identified several challenges experienced by MCPs while reporting for HEDIS 2015.
- ◆ Several MCPs sub-contracted with one MCP to provide services for Medi-Cal beneficiaries. In late 2014, this full-service partner suggested a new data format as an alternative to the monthly encounter files submitted to these MCPs for HEDIS reporting. MCPs encountered several challenges in processing the new service data files. Although the issues were eventually resolved for most MCPs, the late introduction of this change by the full-service partner hindered MCPs' abilities to assess data completeness and accuracy and to properly monitor this partner's performance.
- ◆ A few MCPs also encountered some issues in processing claims internally. One MCP changed its claims system during 2014 and found significant claims processing backlogs with its providers. The MCP necessarily reverted to using its original system, and the auditor noted no concerns regarding this change. Nonetheless, due to multiple data challenges, the MCP necessarily requested an extension in submitting its hybrid rates to DHCS.
- ◆ Several MCPs had challenges in providing complete and accurate responses in their Roadmap. A few identified supplemental data sources after the initial Roadmap submission deadline and submitted the corresponding Section 5 portions of the Roadmap late. As MCPs are exploring the use of additional supplemental databases, it is critical to ensure that adequate coordination, oversight, and validation are implemented in a timely manner before these databases are considered for reporting.

Full-scope Managed Care Health Plans Performance Measure Results

Using the validated performance measure rates, HSAG organized, aggregated, and analyzed the data to draw conclusions about full-scope MCP performance in providing accessible, timely, and quality care and services to MCMC beneficiaries.

Table 5.1 provides the MCMC weighted averages for the required EAS measures for RYs 2012 through 2015. Note that data may not be available for all years.

Understanding Table 5.1

The reader should note the following regarding Table 5.1:

- ◆ The MCMC weighted averages compared to the DHCS-established MPLs and HPLs are shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative QIP; therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this

measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.

- All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

Table 5.1—Multi-year Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results for Full-scope Managed Care Health Plans

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	14.43%	14.17%	17.72%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	‡	39.64	43.15	42.06	40.45	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	‡	273.09	283.14	298.16	272.82	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	81.49%	80.77%	84.15%	86.12%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	86.44%	86.91%	87.78%	51.78%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	80.44%	80.54%	83.86%	85.77%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	25.32%	29.96%	27.94%	28.81%	↔
Cervical Cancer Screening	Q,A	—	—	63.69%	59.26%	↓
Childhood Immunization Status—Combination 3	Q,A,T	78.15%	77.25%	75.07%	73.84%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	95.74%	94.42%	95.25%	93.54%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	87.13%	84.89%	86.27%	85.39%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	86.88%	85.89%	86.08%	87.24%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	85.82%	85.62%	82.90%	84.19%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	67.49%	63.20%	60.25%	62.63%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	55.52%	51.32%	50.69%	53.34%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.20%	83.19%	83.13%	85.81%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	50.79%	49.35%	46.64%	49.08%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	81.90%	81.80%	82.65%	84.45%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	38.04%	40.35%	43.73%	39.35%	▲
Controlling High Blood Pressure	Q	—	58.30%	56.34%	61.22%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	62.99%	72.66%	74.44%	73.51%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	58.85%	53.48%	49.08%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	36.52%	32.23%	26.99%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	61.74%	58.61%	56.99%	59.35%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.77%	83.17%	81.33%	81.80%	↔
Use of Imaging Studies for Low Back Pain	Q	81.03%	80.84%	80.35%	79.54%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	68.33%	71.55%	71.17%	77.47%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	72.08%	72.53%	71.37%	73.42%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	56.04%	58.28%	59.53%	63.64%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	76.77%	74.50%	73.29%	72.78%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was originally developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on comparing the 95-percent confidence levels associated with RY 2014 and RY 2015 rates.

* Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

— Indicates the rate is not available.

↓ = Statistically significant decline.

↔ = No statistically significant change.

↑ = Statistically significant improvement.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the minimum performance level [MPL]), and is shaded if the rate is above the 90th percentile (i.e., the high performance level [HPL]) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is bolded if the rate is above the 75th percentile and shaded if the rate is below the 10th percentile, since a lower rate indicates better performance.

Full-scope Managed Care Health Plan Performance Measure Findings

The full-scope MCP performance measure results for reporting year (RY) 2015, which represent calendar year 2014 data, indicate overall improvement across the State. DHCS held 43 MCP reporting units accountable to meet the minimum performance levels (MPLs) in RY 2015 and 44 MCP reporting units accountable in RY 2014 for 22 measures each year. In RY 2015, 81 percent of the reporting unit rates (for which a comparison could be made to the MPLs) were above the

MPLs as compared to RY 2014, when 80 percent of the reporting unit rates were above the MPLs. Further, in RY 2015, 11 percent of the reporting unit rates were above the high performance levels (HPLs). While this is an improvement since the prior year, variability in MCP performance continues.

Top Performance Measures

Full-scope MCPs performed best on the following measures:

- ◆ *Use of Imaging Studies for Low Back Pain*
 - For the fifth consecutive year, the MCMC weighted average for this measure exceeded the MPL.
 - Of the 53 MCP counties/regions with reportable rates in RY 2015, 14 MCP counties/regions (26 percent) had rates above the HPL. The rates for eight MCP counties/regions have been above the HPL for three or more consecutive years.
 - Of the 41 MCP counties/regions for which comparisons can be made, the rate for one MCP county (2 percent) improved significantly from RY 2014 to RY 2015. Additionally, the rates for two other MCP counties improved; and although the improvement was not statistically significant, the change resulted in the rates moving from below the MPL in RY 2014 to above the MPL in RY 2015.
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*
 - For the fifth consecutive year, the MCMC weighted average was higher than the MPL.
 - All 53 MCP reporting units had reportable rates for this measure in RY 2015. The rates for 15 MCP counties/regions (28 percent) were above the HPL, and no MCP county/regional rates were below the MPL. The rates for five MCP counties have been above the HPL for three or more consecutive years.
 - Of the 42 MCP counties/regions for which comparisons can be made, the rates for 29 MCP counties/regions (69 percent) improved significantly from RY 2014 to RY 2015.
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
 - For the fifth consecutive year, the MCMC weighted average for this measure exceeded the MPL.
 - All 53 MCP reporting units had reportable rates for this measure in RY 2015. The rates for 11 MCP counties/regions (21 percent) were above the HPL for this measure. The rates for five MCP counties have been above the HPL for three or more consecutive years.
 - Of the 42 MCP counties/regions for which comparisons can be made, the rates for 18 MCP counties/regions (43 percent) improved significantly from RY 2014 to RY 2015,

resulting in the rates for six MCP counties/regions improving from below the MPL in RY 2014 to above the MPL in RY 2015.

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity: Total*
 - For the fifth consecutive year, the MCMC weighted average for this measure was above the MPL.
 - All 53 MCP reporting units had reportable rates for this measure in RY 2015. The rates for nine MCP counties/regions (17 percent) were above the HPL for this measure. The rates for five MCP counties have been above the HPL for three or more consecutive years.
 - Of the 42 MCP counties/regions for which comparisons can be made, the rates for 16 MCP counties/regions (38 percent) improved significantly from RY 2014 to RY 2015, resulting in the rates for two MCP counties moving from below the MPL in RY 2014 to above the MPL in RY 2015.

In addition to the measures noted above, the rates for multiple MCP counties/regions improved significantly from RY 2014 to RY 2015 for the following measures:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* (15 of 41 MCP counties/regions for which comparisons could be made between RY 2014 and RY 2015 [37 percent])
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* (14 of 41 MCP counties/regions for which comparisons could be made between RY 2014 and RY 2015 [34 percent])
- ◆ *Comprehensive Diabetes Control—HbA1c Testing* (12 of 42 MCP counties/regions for which comparisons could be made between RY 2014 and RY 2015 [29 percent])
- ◆ *Comprehensive Diabetes Control—HbA1c Control (<8.0 Percent)* (11 of 42 MCP counties/regions for which comparisons could be made between RY 2014 and RY 2015 [26 percent])
- ◆ *Comprehensive Diabetes Control—HbA1c Poor Control (>9.0 Percent)* (13 of 42 MCP counties/regions for which comparisons could be made between RY 2014 and RY 2015 [31 percent])
- ◆ *Controlling High Blood Pressure* (19 of 42 MCP counties/regions for which comparisons could be made between RY 2014 and RY 2015 [45 percent])

Opportunities for Improvement

Although many opportunities for improvement exist, HSAG identified several measures for DHCS to consider as priority areas for improvement based on the number of rates below the DHCS-established MPLs. Some of the rates below the MPLs were for counties/regions reporting rates for the first time or for measures for which DHCS does not hold MCPs accountable to meet

the MPLs. However, since DHCS establishes MPLs for the measures, HSAG recommends that DHCS encourage continued improvement on the measures for MCPs with rates below the established MPLs.

HSAG identified the following measures as having the most opportunities for improvement:

- ◆ *All-Cause Readmissions* (Note that although DHCS establishes no MPL or HPL for this measure, based on the number of MCP counties/regions with a significant increase in readmissions, HSAG identified this measure as one on which MCPs should focus improvement efforts.)
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics*
- ◆ *Cervical Cancer Screening*
- ◆ All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- ◆ Both *Medication Management for People with Asthma* measures
- ◆ Both *Prenatal and Postpartum Care* measures
- ◆ *Child Immunization Status—Combination 3*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

Full-scope Managed Care Health Plan High and Low Performers

Three of the 53 MCP counties/regions (6 percent) demonstrated high performance, exceeding the HPLs for 13 or more of the 26 measures for which comparisons were made to benchmarks for analysis:

- ◆ Kaiser SoCal—San Diego County: 21 measures with rates above the HPLs, and no measures with rates below the MPLs.
- ◆ Kaiser NorCal—KP North: 18 measures with rates above the HPLs, and one measure with a rate below the MPL.
- ◆ San Francisco Health Plan—San Francisco County: 13 measures with rates above the HPLs, and two measures with rates below the MPLs.

Twenty-two of the 53 MCP counties/regions (42 percent) showed the greatest opportunity for improvement by having 10 or more measures below the DHCS-established MPLs:

- ◆ Alameda Alliance for Health—Alameda County (13 measures).
- ◆ Anthem Blue Cross Partnership Plan—Alameda County (13 measures), Fresno County (10 measures), Kings County (15 measures), Region 2 (13 measures), Sacramento County (13 measures), and San Benito (13 counties). (Note: RY 2015 was the first year that Anthem Blue

Cross Partnership Plan reported rates for Region 2 and San Benito County. Therefore, DHCS did not require the MCP to submit IPs for rates below the MPLs for the region/county.)

- ◆ California Health & Wellness Plan—Region 1 (12 measures) and Region 2 (12 measures) (Note: RY 2015 was the first year that California Health & Wellness Plan reported rates for Region 1 and Region 2. Therefore, DHCS did not hold the MCP accountable to meet the MPLs for these regions [i.e., the MCP was not required to submit IPs for rates below the MPLs for the regions]).
- ◆ Cal Viva Health—Kings County (11 measures).
- ◆ Care1st Partner Plan—San Diego County (10 measures).
- ◆ Health Net Community Solutions, Inc.—Los Angeles County (10 measures), Sacramento County (11 measures) San Diego County (10 measures), San Joaquin County (10 measures), and Stanislaus county (10 measures).
- ◆ Health Plan of San Joaquin—Stanislaus County (11 measures).
- ◆ Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino counties (14 measures), Sacramento County (13 measures), and Imperial County (13 measures) (Note: RY 2015 was the first year that Molina Healthcare of California Partner Plan, Inc., reported rates for Imperial County. Therefore, DHCS did not hold the MCP accountable to meet the MPLs for this county [i.e., the MCP was not required to submit IPs for rates below the MPLs for the county]).
- ◆ Partnership HealthPlan of California—Northwest (11 measures) and Northeast (13 measures) (Note: RY 2015 was the first year that Partnership HealthPlan of California reported rates for these two regions. Therefore, DHCS did not hold the MCP accountable to meet the MPLs for these regions [i.e., the MCP was not required to submit IPs for rates below the MPLs for the regions]).

Full-scope Managed Care Health Plan Seniors and Persons with Disabilities Result Findings

As in RY 2013 and RY 2014, most MCP counties/regions had SPD rates significantly higher than the non-SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics* measures. The better rates for these measures may be attributed partially to SPD beneficiaries having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

For the third consecutive year, the SPD population had a significantly higher rate of hospital readmissions than the non-SPD population. While a higher rate of hospital readmissions is expected for the SPD population, in the MCP-specific evaluation reports HSAG recommended that MCPs with significantly higher SPD readmissions rates assess the factors leading to the higher readmissions to ensure that the MCPs are meeting the needs of the SPD population.

For most *Children and Adolescents' Access to Primary Care Practitioners* measures wherein a comparison between the SPD and non-SPD rates could be calculated, no statistically significant difference between the SPD and non-SPD rates was identified. For several MCP counties, SPD rates were significantly lower than the non-SPD rates. The lower SPD rates for these measures may be attributed partially to children and adolescents in the SPD population relying on specialist providers as their care sources, based on complicated health care needs, rather than accessing care from primary care providers (PCPs).

As of RY 2015, DHCS received CMS approval to calculate and report a subset of SPD rates using encounter data submitted by MCPs for the following indicators: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, *Comprehensive Diabetes Care—HbA1c Testing*, and *Comprehensive Diabetes Care—Medical Attention for Nephropathy*. The results showed that most MCP counties/regions had SPD rates higher than the non-SPD rates for the three indicators. These findings are consistent with those that MCPs reported and HSAG audited in RY 2013 and RY 2014.

Specialty Managed Care Health Plan Performance Measure Results

The three specialty MCPs had mixed results. A summary of the results follows:

- ◆ AIDS Healthcare Foundation's rate for the *Colorectal Cancer Screening* measure improved significantly from RY 2014 to RY 2015, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015. The MPL for this measure is based on the national commercial 25th percentile since there are no Medicaid benchmarks for this measure.
- ◆ Family Mosaic Project's rates for both measures—*Out-of-Home Placements* and *School Attendance*—remained stable from RY 2014 to RY 2015.
- ◆ SCAN Health Plan's rate for the *Breast Cancer Screening* measure improved significantly from RY 2014 to RY 2015 and remained above the HPL (which is based on the national Medicaid 90th percentile) for the third consecutive year.

HEDIS Improvement Plans

Function of Improvement Plans

MCPs are contractually required to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires that MCPs with rates below these minimum levels submit IPs, which include PDSA cycles, to DHCS. The purpose of an IP is to identify a set of strategies intended to improve the individual MCP's performance for the particular measure that had a rate below the MPL.

Improvement Plan Process

For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next PDSA cycle.

DHCS reviews each IP for design soundness and anticipated intervention effectiveness. To avoid redundancy, if an MCP has an active QIP that addresses a measure with a rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

Throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess whether MCPs were regularly (at least quarterly) assessing progress toward achieving desired IP outcomes. For the 2014–15 MCP-specific evaluation reports, DHCS reviewed IPs for each MCP with rates below the MPLs for RY 2014 (measurement year 2013). DHCS then reviewed the RY 2015 rates (measurement year 2014) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Finally, DHCS assessed whether the MCP would need to continue existing IPs and/or develop new IPs.

For MCPs with existing IPs and for those requiring new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. Additionally, DHCS provided HSAG with PDSA cycle information as applicable.

The IP process is one way DHCS and MCPs engaged in efforts to improve the quality of care for Medi-Cal managed care beneficiaries, including targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Program Quality Strategy (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs used a rapid-cycle approach (including the PDSA cycle process) to strengthen these key quality improvement areas and structured quality improvement resources accordingly. As a result, DHCS may not have required an MCP to submit IPs for all measures with rates below the MPLs. MCPs continue to be contractually required to meet MPLs for all EAS measures.

HEDIS Improvement Plan Results

DHCS provided HSAG with summaries of each IP and PDSA cycle submitted to DHCS by MCPs for rates below the MPLs in the previous reporting year. Each summary included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented or tested to address the barriers, and outcome information. Additionally, the summaries for the PDSA cycles indicated whether the MCP planned to adapt, adopt, or abandon the tested intervention.

In comparing RY 2014 and RY 2015 results, HSAG found that in the previous year (RY 2014), most IPs and PDSA cycles for rates below the MPLs were not successful at bringing the rates to above the MPLs. HSAG assessed the results of the IPs and PDSA cycles implemented by MCPs during the review period for this report (RY 2015) and found that slightly more than half of the IPs and PDSA cycles resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015. While the rates remained below the MPLs for almost half of the measures included in IPs and PDSA cycles, MCPs appear to be making efforts to identify successful strategies to improve performance on all measures to meet or exceed DHCS's minimum performance requirements.

HEDIS Corrective Action Plans

DHCS requires a HEDIS CAP on any MCP demonstrating poor performance on multiple measures over consecutive years. DHCS had one plan under a HEDIS CAP during this reporting period. The MCP continued to implement its CAP to address its poor performance on many measures across all counties. As part of the CAP, the MCP was required to implement QIPs, IPs, and PDSA cycles. The MCP met its annual CAP improvement requirements; however, opportunities for improvement remain.

Conclusions—Performance Measures

DHCS's EAS includes measures that cut across all domains of care (i.e., quality, access, and timeliness), which provides DHCS with the opportunity to assess and monitor the quality, accessibility, and timeliness of care being delivered to MCMC beneficiaries. The DHCS-established MPLs make DHCS's performance expectations clear for MCPs and provide a framework for prioritizing improvement efforts.

DHCS continued to support MCPs in their quality improvement efforts, including:

- ◆ Provided technical assistance in tandem with HSAG on the implementation of rapid-cycle improvement strategies for measures with rates below the DHCS-established MPLs.
- ◆ Assisted MCPs in selecting performance measures for formal QIPs to help structure improvement efforts to increase the likelihood of positive outcomes.
- ◆ Provided more intensive oversight and required more frequent reporting on progress and outcomes for MCPs with multiple years of poor performance on several measures.
- ◆ Offered increased incentive for TPM and GMC model MCPs to perform well by rewarding higher-performing MCPs with increased default membership through DHCS's auto-assignment program.

Recommendations—Performance Measures

Based on the review of the 2015 HEDIS results, HSAG provides the following recommendations to DHCS to support MCPs in their continued efforts to improve performance on measures:

- ◆ Although DHCS issues CAPs to MCPs demonstrating poor performance on multiple measures over consecutive years, HSAG recommends that rather than require MCPs to address poor performance on all measures at once, that DHCS work with MCPs to prioritize areas in need of improvement to increase the likelihood of positive outcomes.
- ◆ Assess whether DHCS should add any measures to the list of priority areas in the Medi-Cal Managed Care Program Quality Strategy moving forward. Following are measures HSAG identified for DHCS's consideration based on declining performance and the number of rates below the DHCS-established MPLs, which are the national Medicaid 25th percentiles.
 - *All-Cause Readmissions*, including focusing on reducing readmissions for the SPD population
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics*
 - *Cervical Cancer Screening*
 - Both *Medication Management for People with Asthma* measures
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

MCP-specific performance measures results, including HSAG's recommendations, are included in appendices A through Z.

Quality Improvement Projects

Validating performance improvement projects (referred to by DHCS as “QIPs”) is one of the three mandatory external quality review activities described at 42 CFR §438.358(b)(1). This requirement allows states, agents (not MCOs or PHIPs), or an EQRO to conduct the mandatory activity.

In accordance with 42 CFR §438.240(d), DHCS contractually requires MCPs to have a quality program that (1) includes ongoing QIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

- ◆ Measuring performance using objective quality indicators
- ◆ Implementing system interventions to achieve quality improvement
- ◆ Evaluating effectiveness of the interventions
- ◆ Planning and initiating activities for increasing and sustaining improvement

DHCS contracted with HSAG to conduct the functions associated with the validation of QIPs.

Conducting the Review

The purpose of a 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 protocol¹⁶ to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and that MCPs meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements resulting from a QIP. In addition to HSAG’s validation of each QIP, DHCS reviews each QIP to identify areas for technical assistance. DHCS uses the QIP information to guide its discussions with MCPs and to monitor MCPs’ progress on quality improvement goals.

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 holding multiple MCMC contracts or with a contract which covers multiple counties/regions must conduct two QIPs for each county/region. Specialty MCPs must conduct a minimum of two QIPs; however, because specialty MCPs serve unique populations

¹⁶ The CMS Protocols may be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: January 22, 2016.

limited in size, DHCS does not require specialty MCPs to participate in the statewide collaborative QIP. Rather, specialty MCPs are required to design and maintain two internal QIPs (IQIPs) with the goal to improve health care quality, access, and/or timeliness for the specialty MCPs' MCMC beneficiaries.

MCPs submit QIP topic proposals to DHCS for review and approval. DHCS reviews each QIP topic to determine its relevance to the MCMC population; whether the topic addresses a key performance gap; and whether the project has the ability to improve beneficiary health, functional status, or satisfaction. Once DHCS approves the QIP topic, the MCP submits the QIP study design to HSAG for validation.

MCPs perform data collection and analysis for baseline and remeasurement periods and report results to DHCS and to HSAG for QIP validation at least annually. Once a QIP is complete, the MCP must submit a new topic proposal to DHCS within 90 days to remain compliant with having two QIPs underway at all times.

Objectives

The purpose of a QIP is to achieve, through ongoing measurements and interventions, statistically significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvement in health care and for interested parties to have confidence in the reported results, the QIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time frame.

HSAG evaluates two aspects of MCPs' QIPs: (1) the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation); and (2) the efficacy of the interventions in achieving and sustaining improvement of MCPs' QIP objectives (QIP results). HSAG's methodology places emphasis on health care outcomes and ensures that statistically significant improvement has been achieved before HSAG assesses for sustained improvement. Placing emphasis on improving QIP outcomes increases the likelihood that beneficiary health, functional status, and/or satisfaction will be positively affected.

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

Methodology

HSAG reviewed and assessed MCP compliance with the following 10 CMS activities:

- ◆ Activity I. Appropriate Study Topic
- ◆ Activity II. Clearly Defined, Answerable Study Question(s)

- ◆ Activity III. Clearly Defined Study Indicator(s)
- ◆ Activity IV. Correctly Identified Study Population
- ◆ Activity V. Valid Sampling Techniques (if sampling was used)
- ◆ Activity VI. Accurate/Complete Data Collection
- ◆ Activity VII. Sufficient Data Analysis and Interpretation
- ◆ Activity VIII. Appropriate Improvement Strategies
- ◆ Activity IX. Real Improvement Achieved
- ◆ Activity X. Sustained Improvement Achieved

Each required protocol activity consists of evaluation elements necessary to complete a valid QIP. HSAG's QIP Review Team scored the evaluation elements within each activity as *Met*, *Partially Met*, or *Not Met*. The scoring methodology also includes a *Not Applicable (NA)* designation for situations in which the evaluation element does not apply to the QIP and a *Not Assessed* scoring designation to be used when the QIP has not progressed to certain activities in the CMS protocol. To ensure a sound and effective review, HSAG designates some elements as critical elements. All critical elements must achieve a *Met* score for the QIP to produce valid and reliable results.

Plan-Do-Study-Act Cycle Requirements

DHCS has historically required that QIPs achieve an overall *Met* validation status, which demonstrates compliance with CMS's protocol for conducting QIPs.¹⁷ Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual QIP submission provide DHCS with a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. The decision was made, in part, because DHCS is transitioning to a new EQRO contract beginning July 1, 2015, and, in part, because of DHCS's focus on rapid-cycle improvement as a way to increase the likelihood of positive outcomes.

DHCS provided a PDSA Cycle Worksheet for MCPs to submit and HSAG, with input from DHCS, developed a review process and feedback form. DHCS instructed MCPs to focus on a small test of change for the PDSA cycle. The PDSA process allows for MCPs to implement rapid-cycle strategies and determine quickly if the interventions are effective or not. Once an MCP determines the interventions' effectiveness, the MCP can adopt, adapt, or abandon the interventions. MCPs required to implement a PDSA cycle could target the entire eligible population in all counties, identify a subset population (in one or more counties), target providers, or focus on a systemic problem.

¹⁷ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 7: Implementation of Performance Improvement Projects: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: January 22, 2016.

Quality Improvement Projects Results

HSAG first presents QIP validation findings related to the overall study design and structure to support a valid and reliable QIP and then presents QIP outcomes achieved during the review period of July 1, 2014, through June 30, 2015. HSAG also includes a summary of PDSA cycles for QIPs that did not achieve a *Met* validation status on the annual submissions. MCP-specific analysis of QIP validation and outcomes, as well as PDSA cycles (where appropriate), can be found in the MCP-specific evaluation reports in appendices A through Z.

Quality Improvement Project Validation Findings

During the review period of July 1, 2014, through June 30, 2015, HSAG validated 47 *ACR* statewide collaborative QIP annual submissions and 75 IQIP annual submissions. While the majority of MCPs with a QIP that did not achieve a *Met* validation status were required to submit a PDSA cycle related to their QIP topic, DHCS made some exceptions based on DHCS and MCP priorities. For example, DHCS required some MCPs to resubmit their IQIPs until they achieved an overall *Met* validation status. As a result, HSAG validated 34 QIP resubmissions.

Table 6.1 summarizes the validation results for all *ACR* statewide collaborative QIP and IQIP annual submissions and resubmissions across CMS protocol activities during the review period.

Table 6.1—Validation Results from July 1, 2014, through June 30, 2015*
(Number = 156 QIP Submissions from 25 MCPs)

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)	94%	6%	0%
	III: Clearly Defined Study Indicator(s)	97%	3%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	97%	2%	1%
	VI: Accurate/Complete Data Collection	90%	5%	5%
Design Total		95%	3%	2%
Implementation	VII: Sufficient Data Analysis and Interpretation	82%	11%	7%
	VIII: Appropriate Improvement Strategies	74%	21%	5%
Implementation Total		80%	14%	6%
Outcomes	IX: Real Improvement Achieved	42%	6%	52%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total**		43%	6%	52%

*The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity across all submissions for each QIP.

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

Design

The Design stage includes QIP validation findings for Activities I through VI. MCPs demonstrated a strong application of the Design stage, meeting 95 percent of the requirements for all applicable evaluation elements within this study stage. MCPs demonstrated an excellent application of Activities I through V by selecting appropriate topics, clearly defining their study questions and indicators, correctly identifying the study populations, and using valid sampling techniques. As in previous years, the activity with the greatest opportunity for improvement was Activity VI, with MCPs meeting 90 percent of the requirements for all applicable evaluation elements for this activity. However, the deficiencies within this activity were related to one MCP not providing a complete data collection plan and not including a description of a defined and systematic process for collecting data.

Implementation

The Implementation stage includes QIP validation findings for Activities VII and VIII. MCPs demonstrated a sufficient application of the Implementation stage, meeting 80 percent of the requirements for all applicable evaluation elements within this study stage.

Activity VII assesses whether the MCP's data analysis techniques comply with industry standards, appropriate statistical tests are used, and accurate/reliable information is obtained. The average percentage of applicable elements in Activity VII with a *Met* score was 82 percent. The main deficiencies within this activity were related to some MCPs not including the following:

- ◆ An interpretation of the findings
- ◆ Factors that threatened the internal or external validity of the findings
- ◆ Factors that affected the ability to compare the baseline measurement period and the Remeasurement period

Activity VIII assesses whether the causal/barrier analysis is adequate to identify barriers to improvement, the MCP has developed appropriate improvement strategies, and the timeline for implementation of interventions is reasonable. For the initial QIP submissions, the average percentage of the applicable elements in Activity VIII with a *Met* score was 74 percent. The lowered score for this activity was due to some MCPs not documenting the annual causal/barrier analysis conducted, not prioritizing the barriers to improvement, and not evaluating the interventions to determine if the improvement strategies were effective.

Outcomes

Activity IX assesses whether statistically significant improvement (i.e., real improvement) over baseline is achieved, reflecting a positive effect on the beneficiaries' care. Forty-five ACR QIPs and 25 IQIPs progressed to the Outcomes stage during this reporting period. However, only six

ACR QIPs and six IQIPs achieved statistically significant improvement over baseline for at least one of the QIP study indicators. The validation results suggest that the interventions that many MCPs are implementing are not resulting in positive outcomes. As mentioned previously, MCPs are not evaluating each intervention or conducting new causal/barrier analyses. Without a method to evaluate the effectiveness of interventions, MCPs are limited in ability to revise, standardize, or discontinue improvement strategies, which ultimately limits success in affecting change in subsequent measurement periods.

Activity X assesses whether sustained improvement was achieved. Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. All three QIPs that progressed to this Activity achieved sustained improvement.

Overall, most QIPs were not successful at achieving the desired improved health outcomes for the QIPs' targeted beneficiaries.

Quality Improvement Project Outcomes Findings

HSAG organized, aggregated, and analyzed QIP outcome data to draw conclusions about MCPs' performance in providing quality, accessible, and timely health care and services to MCMC beneficiaries.

Statewide Collaborative Quality Improvement Projects

The *ACR* QIP falls into the quality and access domains of care. Of the 47 *ACR* QIPs validated during the review period, 45 *ACR* QIPs progressed to the Outcomes stage and therefore could be assessed for statistically significant improvement over baseline. Since Health Net Community Solutions, Inc.—San Joaquin County and Health Plan of San Joaquin—Stanislaus County were newly added to provide MCMC services as of January 1, 2013, their *ACR* QIP did not progress to the point of being assessed for real improvement.

Despite the statewide collaborative effort, only six QIPs achieved statistically significant improvement (represented by a decline in their readmissions rates) from baseline to Remeasurement 1. Following is a summary of the interventions implemented by the six MCPs that achieved statistically significant improvement for their *ACR* QIPs.

- ◆ Anthem Blue Cross Partnership Plan—The MCP implemented the Anthem Case Management Stabilization Program in all nine counties during the Remeasurement 1 time period, and one of the MCP's counties (Kings County) achieved a statistically significant decline in its readmissions rate. The Anthem Case Management Program assigned beneficiaries with risk of 30-day readmissions to either Geocare Case Management or Complex Care Management, based on the level of need. Beneficiaries in Complex Care Management were contacted prior

to or immediately following discharge for case managers to implement the Four Pillars of Care:

- Perform medication reconciliation/self-management education.
 - Identify root cause of admission and conduct education.
 - Identify the treating physician for beneficiary’s post-discharge follow-up care.
 - Develop beneficiary-centric medical documentation.
- ◆ CalOptima—The MCP implemented the Transitions of Care (TOC) program based on Eric Coleman’s Care Transitions Intervention Program. Beneficiaries in the target population were invited to participate in the no-cost program, which included a home visit, follow-up calls, and referrals as needed. Beneficiaries who declined or were not eligible for participation in the TOC program were sent a discharge kit that included a personal health record, medication list, medication pillbox, and resources.
 - ◆ Contra Costa Health Plan—The MCP’s nurses worked on-site at the hospitals with discharge staff to ensure that all required services and follow-up care were arranged before beneficiaries were discharged. The nurses also called beneficiaries post discharge to ensure that all care needs were met. Additionally, the MCP implemented a new initiative to provide a family nurse practitioner to be available to skilled nursing facilities when potential needs to prevent readmissions were identified.
 - ◆ Gold Coast Health Plan—The MCP staff called beneficiaries within 72 hours of discharge to ensure the beneficiaries made and kept their post-discharge follow-up appointments. During the call, the staff asked if the discharge instructions were understood and explained the discharge instructions further, as needed. The beneficiaries were also asked if their prescriptions were filled and taken appropriately. Lastly, the staff offered additional educational materials.
 - ◆ Kaiser SoCal—The MCP staff scheduled follow-up visits within seven days of discharge for beneficiaries at high risk of readmissions. For high-risk beneficiaries residing within the San Diego central quadrant area, the MCP staff scheduled an appointment with a bridge clinic consisting of a hospitalist and a social worker. Additionally, for high-risk beneficiaries who were home-bound, the MCP ordered expedited home health visits within 24 hours after discharge, when needs are highest.
 - ◆ L.A. Care Health Plan—The MCP launched the TOC program by hiring additional staff to make phone calls and evaluate beneficiaries for risk stratification prior to beneficiaries’ discharges. High-risk beneficiaries received additional calls post discharge and were placed in case management after 30 days if they remained at a high risk for readmissions. Beneficiaries at moderate or low risk for readmissions were connected to internal L.A. Care resources and community services. The TOC program also notified the PCPs that the beneficiaries had been in the hospital and assisted the beneficiaries in getting timely appointments or specialty referrals.

Internal Quality Improvement Projects

Of the 75 IQIPs validated during the review period, 22 IQIPs progressed to the Outcomes stage and therefore could be assessed for statistically significant improvement over baseline. Three IQIPs achieved statistically significant improvement in the previous year and therefore could be assessed for sustained improvement. Of the 22 IQIPs that could be assessed for statistically significant improvement over baseline, only three achieved statistically significant improvement over the baseline period for at least one of the QIP study indicators. All three QIPs assessed for sustained improvement maintained or increased the statistically significant improvement achieved over baseline during the current measurement period.

Table 6.2 displays the QIPs assessed for improvement during the review period by MCP, QIP name, domains of care (i.e., quality, access, and timeliness) the QIP addresses, and whether the outcomes demonstrated statistically significant improvement and/or sustained improvement. Please note that in cases where sustained improvement was assessed the statistically significant improvement over baseline was achieved in a previous measurement period.

Table 6.2—Internal Quality Improvement Projects Assessed for Project Outcomes from July 1, 2014, through June 30, 2015

MCP Name	QIP Name	Domain of Care ¹	Statistically Significant Improvement ²	Sustained Improvement ³
Alameda Alliance for Health	<i>Improving Anti-Hypertensive Medication Fills Among Members with Hypertension</i>	Q,A	Yes	Yes
CalViva Health—Fresno County	<i>Retinal Eye Exam</i>	Q,A	No	Not Assessed
CalViva Health—Kings County	<i>Retinal Eye Exam</i>	Q,A	No	Not Assessed
CalViva Health—Madera County	<i>Retinal Eye Exam</i>	Q,A	No	Not Assessed
Care1st Partner Plan	<i>Comprehensive Diabetic Care</i>	Q,A	No	Not Assessed
CenCal Health—San Luis Obispo County	<i>Annual Monitoring for Patients on Persistent Medications</i>	Q	No	Not Assessed
CenCal Health—Santa Barbara County	<i>Annual Monitoring for Patients on Persistent Medications</i>	Q	No	Not Assessed
Central California Alliance for Health—Merced County	<i>Improving Asthma Health Outcomes</i>	Q,A	Yes	Not Assessed
Central California Alliance for Health—Monterey/Santa Cruz counties	<i>Improving Asthma Health Outcomes</i>	Q,A	No	Not Assessed
Community Health Group Partnership Plan	<i>Increasing Postpartum Care Visits within 6 Weeks of Delivery</i>	Q,T	No	Not Assessed
Gold Coast Health Plan	<i>Increase Rate of Annual Diabetic Eye Exam</i>	Q,A	No	Not Assessed
Health Plan of San Joaquin—San Joaquin County	<i>Improving the Percentage of HbA1c Testing</i>	Q,A	No	Not Assessed
Health Plan of San Mateo	<i>Increasing Timeliness of Prenatal Care</i>	Q,A,T	No	Not Assessed

MCP Name	QIP Name	Domain of Care ¹	Statistically Significant Improvement ²	Sustained Improvement ³
Kaiser NorCal	<i>Childhood Immunizations</i>	Q,A,T	No	Not Assessed
Kaiser SoCal	<i>Children’s Access to Primary Care Practitioners</i>	Q,A	Yes	Not Assessed
Kern Family Health Care	<i>Comprehensive Diabetic Quality Improvement Plan</i>	Q,A	No	Not Assessed
L.A. Care Health Plan	<i>Improving HbA1c and Diabetic Retinal Exam Screening Rates</i>	Q,A	No	Not Assessed
Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino counties	<i>Improving Hypertension Control</i>	Q,A	No	Not Assessed
Molina Healthcare of California Partner Plan, Inc.—Sacramento County	<i>Improving Hypertension Control</i>	Q,A	No	Not Assessed
Molina Healthcare of California Partner Plan, Inc.—San Diego County	<i>Improving Hypertension Control</i>	Q,A	No	Not Assessed
Partnership HealthPlan of California—Napa/Solano/Yolo	<i>Improving Access to Primary Care for Children and Adolescents</i>	A	Yes	Yes
Partnership HealthPlan of California—Sonoma County	<i>Improving Access to Primary Care for Children and Adolescents</i>	A	Yes	Yes
Partnership HealthPlan of California—Marin County	<i>Improving Timeliness of Prenatal and Postpartum Care</i>	Q,A,T	No	Not Assessed
Partnership HealthPlan of California—Mendocino County	<i>Childhood Immunization Status—Combo 3</i>	Q,A	No	Not Assessed
San Francisco Health Plan	<i>Improving the Patient Experience</i>	Q,A	Yes	Not Assessed

¹ HSAG’s assignment of QIPs to the domains of care for quality (Q), access (A), and timeliness (T).

² Statistically significant improvement is defined as improvement over the baseline (*p* value < 0.05).

³ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

Yes = (1) Statistically significant improvement over the baseline period was noted for at least one QIP study indicator, or (2) sustained improvement was achieved for at least one study indicator.

No = (1) No indicators demonstrated statistically significant improvement over the baseline period, or (2) sustained improvement was not achieved for any study indicators.

Not assessed = The QIP was not able to be assessed for sustained improvement because (1) the QIP had not yet achieved statistically significant improvement over the baseline period for at least one QIP study indicator, or (2) the current measurement period is the first measurement period wherein statistically significant improvement over the baseline period was achieved.

Following is a summary of the interventions implemented for the IQIPs that achieved positive outcomes for at least one study indicator:

Asthma Health

- ◆ Central California Alliance for Health—At Remeasurement 1, the *Improving Asthma Health Outcomes* QIP achieved statistically significant improvement over baseline for the asthma controller medication compliance rate study indicator in Merced County. The MCP implemented multiple interventions to increase providers' use of the Asthma Action Plan to ensure that appropriate treatments are provided to beneficiaries living with asthma.

Children's and Adolescents' Health

- ◆ Kaiser SoCal—At Remeasurement 2, the *Children's Access to Primary Care Practitioners* QIP achieved statistically significant improvement over baseline for the well-child visit rate study indicator. During the Remeasurement 2 time period, the MCP implemented a monthly rounding intervention wherein the State Programs project manager rounded with clinic staff, reviewed monthly performance, observed processes, and provided verbal instructions with written reference materials. The MCP concluded that the intervention was very successful in standardizing outreach efforts, messaging, consistent documentation, and accountability.
- ◆ Partnership HealthPlan of California—For Napa/Solano/Yolo counties, the *Improving Access to Primary Care for Children and Adolescents* QIP achieved statistically significant improvement over baseline for all four study indicators at Remeasurement 1 and achieved sustained improvement at Remeasurement 2. For Sonoma County, the QIP achieved statistically significant improvement at Remeasurement 1 for three study indicators, all of which achieved sustained improvement at Remeasurement 2. The fourth indicator for Sonoma County achieved statistically significant improvement over baseline at Remeasurement 2. During the Remeasurement 2 time period, the MCP continued to implement the appointment reminder intervention initiated in Remeasurement 1. Based on Remeasurement 1 recommendations, the MCP modified the intervention to prevent duplication of calls to households with more than one child. The MCP standardized this intervention and will monitor ongoing performance to ensure sustainability.

Controlling High Blood Pressure

- ◆ Alameda Alliance for Health—For the *Improving Anti-Hypertensive Medication Fills Among Members with Hypertension* QIP, the MCP reported an incorrect Remeasurement 1 rate for the anti-hypertensive medication fill study indicator in the 2013–14 QIP submission due to applying a past methodology. Once the rate was corrected, the rate for the study indicator achieved statistically significant improvement at Remeasurement 1 and sustained improvement at Remeasurement 2. However, the MCP did not provide an evaluation of individual interventions; so HSAG was unable to determine which improvement strategies were successful at impacting the study indicator.

Patient Experience

- ◆ San Francisco Health Plan—At Remeasurement 1, the *Improving the Patient Experience* QIP achieved statistically significant improvement over baseline for both study indicators, which measured beneficiaries’ satisfaction with their overall health care and personal doctor. The MCP continued the Rapid Dramatic Performance Improvement program, which assisted clinics to track real-time data and ultimately decrease the appointment no-show rate. The MCP also worked with the Institute for Healthcare Communication to lead three all-day training sessions for providers on how to improve communication and patient-centeredness while effectively using an electronic health record during the patient visit.

Plan-Do-Study-Act Cycle Findings

During the review period of July 1, 2014, through June 30, 2015, HSAG reviewed and provided feedback and recommendations on 13 statewide collaborative *ACR* PDSA cycle worksheets and 14 internal PDSA cycle worksheets for QIPs that did not achieve a *Met* validation status during the initial submission.

All-Cause Readmissions Plan-Do-Study-Act Cycle

Each of the following MCPs submitted a PDSA Cycle Worksheet for its *ACR* QIP:

- ◆ Alameda Alliance for Health—Alameda County
- ◆ Anthem Blue Cross Partnership Plan—Fresno County
- ◆ CalViva Health—Fresno, Kings, and Madera counties
- ◆ Care1st Partner Plan—San Diego County
- ◆ CenCal Health—San Luis Obispo and Santa Barbara counties
- ◆ Contra Costa Health Plan—Contra Costa County
- ◆ Gold Coast Health Plan—Ventura County
- ◆ Health Net Community Solutions, Inc.—Tulare County
- ◆ Health Plan of San Mateo—San Mateo County
- ◆ Inland Empire Health Plan—Riverside/San Bernardino counties
- ◆ Kern Family Health Care—Kern County
- ◆ L.A. Care Health Plan—Los Angeles County
- ◆ Santa Clara Family Health Plan—Santa Clara County

As a result of the *ACR* PDSA cycle:

- ◆ Three MCPs met or exceeded their goals.
- ◆ Seven MCPs did not meet their goals; however, of those MCPs, one MCP saw some improvement.
- ◆ Three MCPs were unable to determine if their goals were met.

All but one MCP summarized what was learned as a result of the PDSA cycle. Regarding whether to adopt, adapt, or abandon the changes:

- ◆ Six MCPs indicated plans to adopt the changes.
- ◆ Four MCPs indicated plans to adapt the changes.
- ◆ Two MCPs indicated plans to both adopt and adapt the changes.
- ◆ One MCP indicated plans to abandon the change.

Some MCPs indicated plans to adopt changes without evidence that the test of change was successful. HSAG advised these MCPs to adopt a change only after results of the PDSA cycle demonstrate that the change was successful.

Internal Plan-Do-Study-Act Cycle

Table 6.3 includes MCPs that submitted PDSA Cycle Worksheets for their IQIPs and the counties and name of each internal PDSA cycle.

**Table 6.3—Medi-Cal Managed Care Quarterly Internal PDSA Cycle Submissions
April 1, 2015, through June 30, 2015**

MCP Name and County	Name of Internal PDSA Cycle
Alameda Alliance for Health—Alameda	Anti-Hypertensive Medication Fills Among Members with Hypertension
Anthem Blue Cross Partnership Plan—Rural Expansion Region 1, Rural Expansion Region 2, and San Benito	Childhood Immunizations Combo 3
California Health and Wellness—Imperial	Postpartum
CalOptima—Orange	Improvement of Prenatal Visit Rates for Pregnant Members
Care1st Partner Plan—San Diego	Comprehensive Diabetes Care
CenCal Health—San Luis Obispo	Annual Monitoring for Patients on Persistent Medications
Gold Coast Health Plan—Ventura	Diabetic Eye Exam Member Incentive Project
Health Plan of San Joaquin—San Joaquin and Stanislaus	HbA1c Testing
Health Plan of San Mateo—San Mateo	Increase Timely Prenatal Care in Postpartum Compliance
Inland Empire Health Plan—Riverside/San Bernardino	Diabetes
Kaiser—San Diego County	Well Visits for 3–6-year-old Medi-Cal Members
Kern Family Health Care—Kern	Diabetes Management
Molina Healthcare of California Partner Plan, Inc.—Imperial, Riverside/San Bernardino, Sacramento, and San Diego	Controlling Blood Pressure
Partnership HealthPlan of California—Shasta	Immunizations

As a result of the internal PDSA cycle:

- ◆ Eight MCPs met or exceeded their goals. Note: For one MCP, the goal was met in two of the three counties targeted.
- ◆ Four MCPs did not meet their goals; however, of those MCPs, one MCP saw some improvement.
- ◆ For two MCPs, HSAG was unable to determine if the MCPs met their goals; however, one of the two MCPs saw some improvement.

Regarding whether to adopt, adapt, or abandon the changes:

- ◆ Seven MCPs indicated plans to adopt the changes.
- ◆ Four MCPs indicated plans to adapt the changes.
- ◆ One MCP indicated plans to both adopt and adapt the change.
- ◆ One MCP indicated plans to abandon the change.
- ◆ One MCP is completing additional testing before deciding whether to adopt, adapt, or abandon the change.

Conclusions—Quality Improvement Projects

QIP validation results showed that MCPs demonstrated a strong application of the Design stage, meeting 95 percent of the requirements for all applicable evaluation elements within this study stage. The majority of MCPs established an excellent understanding of activities I through IV, with a few MCPs contributing to the lowered aggregated score for the study stage.

MCPs demonstrated a sufficient application of the Implementation stage, meeting 80 percent of the requirements for all applicable evaluation elements within this study stage. The main deficiencies for Activity VII related to some MCPs not providing interpretations of the findings, factors that threatened the internal or external validity of findings, or factors that affected the ability to compare the baseline measurement period to the Remeasurement period. The lowered aggregated score for Activity VIII was due to some MCPs not documenting the annual causal/barrier analysis conducted, not prioritizing the barriers to improvement, and not evaluating the interventions to determine if improvement strategies were effective.

During the reporting period, 45 *ACR* QIPs and 22 *IQIPs* progressed to the Outcomes stage. However, only six *ACR* QIPs and three *IQIPs* achieved statistically significant improvement over baseline for at least one of the QIP study indicators. Three QIPs progressed to the point of being assessed for sustained improvement, and all three achieved sustained improvement by maintaining or increasing the statistically significant improvement over baseline achieved in the previous measurement period.

While most of the 13 *ACR* PDSA cycles HSAG reviewed did not meet their goals, the majority of the 14 *IQIP* PDSA cycles did achieve their goals. MCPs indicated adopting more than half of the interventions tested through PDSA cycles for both *ACR* and *IQIP* topics. Overall, MCPs provided adequate documentation regarding the PDSA cycles but still have the opportunity to improve the level of detail provided for describing the PDSA cycle activities and reporting the lessons learned.

Consistent with last year's review, the validation results suggest that many interventions MCPs implemented through the QIP process did not result in positive outcomes. Thus, DHCS made a decision to transition to HSAG's rapid-cycle PIP approach starting July 1, 2015. HSAG's redesigned PIP approach places greater emphasis on improving both health care outcomes and processes through the integration of quality improvement science. As a result, all QIPs were closed as of June 30, 2015; and MCPs will no longer submit QIPs to HSAG for validation.

Recommendations—Quality Improvement Projects

Based on review of the QIP validation and PDSA cycle results, HSAG provided MCP-specific recommendations, which are included in appendices A through Z. Since DHCS made a decision to transition the QIPs to the rapid-cycle PIP approach, HSAG has no recommendations to DHCS related to QIPs.

MCP-specific performance measures results, including HSAG's recommendations, are included in Appendices A–Z.

Follow-up on Prior Year's Recommendations

In the *2013–14 Medi-Cal Managed Care Technical Report*, HSAG recommended that DHCS explore with the EQRO a redesigned QIP process that supports MCPs in conducting QIPs using rapid-cycle techniques and a validation process that facilitates greater technical assistance and feedback to MCPs throughout the rapid-cycle QIP process. As part of the process for producing the *2014–15 Medi-Cal Managed Care Technical Report*, DHCS provided the following information on the actions it took to address this recommendation:

- ◆ Under the terms of a new EQR contract (which began July 2015), DHCS requires that the EQRO incorporate rapid-cycle techniques and greater technical assistance to MCPs for QIPs, now referred to as PIPs. Additionally, DHCS continues to incorporate rapid-cycle techniques into other quality improvement work, including PDSA IPs. For HEDIS performance measures wherein DHCS holds MCPs accountable to an MPL, for each area not already being addressed through a PIP, DHCS requires that MCPs complete PDSA IPs for all measures that fall below the MPL.

Conducting the EQRO Review

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions for a managed care program. Therefore, DHCS requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in SFY 2012–13, DHCS contracted with HSAG to conduct an EDV study. During the first contract year, the EDV study focused on an IS review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by MCPs through a review of the medical records. For SFY 2014–15, HSAG assisted DHCS in understanding operational and infrastructure changes implemented by MCPs in support of DHCS's transition to the new PACES.

The results and analyses for the SFY 2013–14 medical record review activities were not available when the 2013–14 EQR technical and MCP-specific evaluation reports were produced. Therefore, HSAG provides a summary of the SFY 2013–14 and SFY 2014–15 EDV studies in this report.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

The *Encounter Data Validation Study Aggregate Report—July 1, 2013–June 30, 2014* includes the detailed methodology, study results, and recommendations; and the individual July 1, 2013–June 30, 2014, MCP-specific EDV study reports include the detailed MCP-specific results and recommendations.¹⁸ Below is a brief summary of the methodology, study results, and recommendations. Summaries of the MCP-specific results and recommendations from the SFY 2013–14 EDV study are found in the MCP-specific evaluation reports in appendices A through Z.

¹⁸ The *Encounter Data Validation Study Aggregate Report—July 1, 2013–June 30, 2014* can be accessed at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx#>. Accessed on: January 18, 2016.

Methodology

Medical and clinical records are considered the “gold standard” for documenting access to and the quality of health care services. For the SFY 2013–14 EDV study, HSAG evaluated MCMC encounter data completeness and accuracy via the review of medical records for physician services rendered in calendar year 2012. The study answered the following question:

- ◆ Are the data elements *Date of Service, Diagnosis Code, Procedure Code, Procedure Code Modifier, Rendering Provider Name, and Billing Provider Name* found on the professional encounters complete and accurate when compared to information contained within the medical records?

HSAG conducted the following steps to answer the study question:

- ◆ Identified the eligible population and generated random samples from the data extracted from the DHCS data warehouse.
- ◆ Procured medical records from providers.
- ◆ Reviewed medical records against the submitted encounter data.
- ◆ Calculated study indicators.

The following MCPs were included in the study:

- ◆ AIDS Healthcare Foundation
- ◆ Alameda Alliance for Health
- ◆ Anthem Blue Cross Partnership Plan
- ◆ CalOptima
- ◆ CalViva Health
- ◆ Care1st Partner Plan
- ◆ CenCal Health
- ◆ Central California Alliance for Health
- ◆ Community Health Group Partnership Plan
- ◆ Contra Costa Health Plan
- ◆ Gold Coast Health Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Health Plan of San Joaquin
- ◆ Health Plan of San Mateo
- ◆ Inland Empire Health Plan
- ◆ Kaiser NorCal
- ◆ Kaiser SoCal

- ◆ Kern Family Health Care
- ◆ L.A. Care Health Plan
- ◆ Molina Healthcare of California Partner Plan, Inc.
- ◆ Partnership HealthPlan of California
- ◆ San Francisco Health Plan
- ◆ Santa Clara Family Health Plan
- ◆ SCAN Health Plan

SFY 2013–14 Encounter Data Validation Study Results

Encounter Data Completeness

HSAG identified the following related to encounter data completeness:

- ◆ DHCS encounters were moderately supported by the documentation in beneficiaries' medical records. Statewide, 26.3 percent of the dates of service, 31.6 percent of diagnosis codes, 43.8 percent of procedure codes, 58.5 percent of procedure code modifiers, 25.0 percent of the rendering provider names, and 35.0 percent of the billing provider names identified in the electronic encounter data were not found in the corresponding medical records.
- ◆ While DHCS encounters had supporting documentation in the medical records at a moderate level, not all services documented in the medical records were submitted to DHCS (encounter data omission). For instance, 9.2 percent of the dates of service, 34.6 percent of diagnosis codes, 22.5 percent of procedure codes, 46.0 percent of procedure code modifiers, 68.1 percent of the rendering provider names, and 8.6 percent of the billing provider names identified in beneficiaries' medical records were not found in DHCS's encounter data.
- ◆ Omissions identified in the medical records (services located in the encounter data but not supported in the medical record) and omissions in the encounter data (services located in the medical record but not in the encounter data) illustrated discrepancies in the completeness of DHCS's encounter data. Data completeness at the MCP level varied considerably.

Encounter Data Accuracy

HSAG identified the following related to encounter data accuracy:

- ◆ Among the data elements that were evaluated for accuracy, 83.6 percent of diagnosis codes, 77.6 percent of procedure codes, 99.5 percent of procedure code modifiers, 63.0 percent of the rendering provider names, and 68.6 percent of the billing provider names identified in the electronic encounter data were supported by medical record documentation.
- ◆ Less than 5 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries' medical records.

SFY 2013–14 Encounter Data Validation Study Recommendations

Based on the study findings, HSAG recommended that DHCS:

- ◆ Review its processes and procedures to ensure that no system issues impact the acceptance of encounter data submitted by MCPs.
- ◆ Work with MCPs to identify the reasons for data incompleteness and/or inaccuracy, and develop strategies for encounter data quality improvement.
- ◆ Consider requiring MCPs to develop encounter-related education programs and subsequent audits for providers.

SFY 2014–15 Encounter Data Validation Study—Assessing MCPs’ Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

In SFY 2014–15, DHCS began transitioning its encounter data system, with the goal that most MCPs would be actively submitting to PACES by early 2015. As a component of encounter data validation, HSAG assisted DHCS in understanding operational and infrastructure changes implemented by MCPs in support of the transition to the new PACES. Specifically, HSAG sought to determine whether the changes applied by MCPs support the creation, processing, and submission of complete, accurate, and timely encounter data to DHCS. HSAG assessed the encounter data systems in place among MCPs operating under the TPM—both LI and CP, GMC model, the COHS model, the Regional model, and select specialty plans. Table 7.1 shows MCPs included in this study as well as each MCP’s PACES transition status as of March 5, 2015.

Table 7.1—MCPs Included in the SFY 2014–15 EDV Study

MCP Name	PACES Transition Status (as of March 5, 2015)
AIDS Healthcare Foundation	Testing*
Alameda Alliance for Health	Testing
Anthem Blue Cross Partnership Plan	Production**
California Health & Wellness Plan	Production
CalOptima	Production
CalViva Health	Testing
Care1st Partner Plan	Testing
CenCal Health	Testing
Central California Alliance for Health	Testing
Community Health Group Partnership Plan	Testing
Contra Costa Health Plan	Testing
Gold Coast Health Plan	Production

MCP Name	PACES Transition Status (as of March 5, 2015)
Health Net Community Solutions, Inc.	Testing
Health Plan of San Joaquin	Testing
Health Plan of San Mateo	Production
Inland Empire Health Plan	Testing
KP Cal, LLC***	Production
Kern Family Health Care	Testing
L.A. Care Health Plan	Testing
Molina Healthcare of California Partner Plan, Inc.	Production
Partnership HealthPlan of California	Testing
San Francisco Health Plan	Production
Santa Clara Family Health Plan	Testing
SCAN Health Plan	Testing

- * “Testing” means that the MCP was in process of completing all testing requirements and was preparing to submit encounter data to DHCS using national standard transactions through PACES.
- ** “Production” means that the MCP had received DHCS approval to submit encounter data to DHCS using national standard transactions through PACES.
- *** KP Cal, LLC, consists of two MCPs: Kaiser NorCal and Kaiser SoCal. These MCPs use the same data system; therefore, they were treated as a single entity for the purposes of this study.

Methodology

HSAG conducted a desk review of MCPs’ IS and encounter data processing and submission. HSAG obtained the HEDIS Roadmap completed by MCPs during their NCQA HEDIS Compliance Audits. The Roadmap is an MCP-specific set of documents that traces the flow of claims submissions from providers to MCPs and details MCP-specific regulations for claims submission. In the Roadmaps, MCPs generally included information on the proportion of facility (institutional) and provider claims submitted electronically, versus on paper, and the proportion of claims submitted to MCPs as encounters.

In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how MCPs prepare data files for submission to the State in light of new transmission standards and expectations. HSAG prepared two variations of the questionnaire based on the status of MCPs’ transitions to submitting encounter data to PACES. HSAG distributed the production version of the questionnaire to the eight MCPs submitting encounter data to PACES as of March 5, 2015, and provided the transition questionnaire to the 16 remaining MCPs. Each questionnaire contained three sections focusing on each of encounter data sources and systems, the MCP’s transition to PACES, and the MCP’s awareness of the DHCS Quality Measures for Encounter Data (QMED). Corresponding items in the production and transition versions of the questionnaire were similarly worded to allow for comparison across all MCPs.

HSAG distributed the supplemental questionnaire to MCPs in March 2015, with follow-up questions based on MCPs' questionnaire responses distributed in April 2015.

Study Limitations

- ◆ Information gathered from MCPs' HEDIS Roadmap submissions was self-reported by MCPs; HSAG did not validate the responses for accuracy. As a result of the timing of the study, finalized (i.e., audited) Roadmap submissions were not available for HSAG's review.
- ◆ Information gleaned from MCPs' supplemental questionnaire responses was self-reported by MCPs; HSAG did not validate the responses for accuracy.

SFY 2014–15 Encounter Data Validation Study Conclusions

Although each MCP has a defined encounter data system/data warehouse and processes for receiving inbound claims/encounters and submitting encounter data to DHCS, Roadmap and questionnaire responses revealed a wide range of third parties responsible for steps in the claims processing pathway. This study provided descriptive information about MCP vendors, and DHCS should review the types of vendor information that MCPs are required to review under their contracts with DHCS. DHCS should consider a special study in the future to compile information on the roles and responsibilities of MCP vendors and on MCPs' oversight of their vendors.

DHCS requires MCPs to implement policies and procedures that define MCPs' internal processes for encounter data submission to DHCS and that help MCPs build a robust, transferable knowledge base about their encounter data systems. Very few MCPs submitted such documentation; however, other MCPs indicated that such policies and procedures are undergoing updates to reflect new processes for PACES and QMED; therefore, follow-up activities with MCPs are needed to ensure that updates are completed. It is unclear from MCP responses whether the lack of supporting documentation provided with the questionnaires reflects an MCP's incomplete processing of the questionnaire or the general unavailability of such documents. Both outcomes highlight a lack of systematic documentation (e.g., policies and procedures, monitoring mechanisms) and likely contribute to inconsistency in the processing and quality of encounter data.

The transition to PACES has addressed some concerns HSAG identified in prior EDV studies regarding areas of inconsistency in the encounter data processes among California's Medi-Cal MCPs. DHCS has addressed the recommendations from the SFY 2012–13 Encounter Data Validation study regarding moving to standardized data formats and requiring MCPs to notify DHCS of system changes. However, MCPs approached the PACES transition process in different ways, and some MCPs had a more difficult transition process based on the data systems and procedures available at the beginning of the transition. One MCP noted that it used the transition to PACES as an opportunity to overhaul its data system, and another noted that its choice to

bridge a legacy system with a new ANSI X12-compliant system has resulted in difficulties passing PACES testing requirements.

SFY 2014–15 Encounter Data Validation Study Recommendations

The following is a brief summary of HSAG’s recommendations to DHCS to strengthen encounter data quality:

- ◆ DHCS should incorporate a re-review of all encounter data policies and procedures as part of ongoing encounter data quality reviews or annual operational reviews. HSAG suggests that DHCS consider conducting reviews on-site at MCPs to observe the degree to which documented policies and procedures are implemented within the organizations and understood by staff.
- ◆ DHCS should monitor encounter data submissions to determine if adjusted encounters are processed in a way that meets DHCS’s expectations. Once this area is fully implemented under PACES, DHCS should consider providing additional technical assistance to MCPs regarding retrospectively adjusted claims/encounters.
- ◆ DHCS should provide technical assistance to MCPs regarding the processing of provider data.
- ◆ DHCS should work with MCPs to better document the expected process for communicating membership changes and to ensure that the most up-to-date and accurate beneficiary files are supplied for use by vendors.
- ◆ For MCPs that indicated using internally developed codes, work with those MCPs to determine whether claims associated with these internal codes are submitted to DHCS. If not, DHCS should determine whether this represents an area of potential misalignment between MCPs’ internal encounter data and the encounter data supplied to DHCS.
- ◆ DHCS should leverage MCPs’ awareness and advanced planning regarding QMED standards to share best practices and reporting techniques among MCPs while communicating with MCPs using methods proven successful during the transition to PACES.

8. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS RELATED TO DOMAINS OF CARE

CMS chose the domains of quality, access, and timeliness as keys to evaluating the performance of Medicaid MCPs. For each domain of care, HSAG provides overall findings, conclusions, and recommendations regarding MCPs' aggregate performance during the review period.

For this report, to assess MCMC's performance related to the quality, access, and timeliness domains of care, HSAG used the results from compliance review standards related to measurement and improvement, the MCMC performance measure weighted average rates, and QIP outcome results for QIPs falling into each domain of care.

MCMC's compliance monitoring review findings during the review period revealed that, similar to prior years, while MCPs had challenges meeting all requirements assessed by DHCS, MCPs generally had appropriate resources and written policies and procedures to support their quality improvement programs. Findings cut across all domains of care; and in instances where DHCS provided follow-up information to HSAG for review, the documentation showed that all MCPs resolved the compliance review findings to DHCS's satisfaction.

All MCPs were able to report valid HEDIS 2015 performance measure rates. Table 8.1 provides notable aggregated weighted performance measure results with the applicable domains of care identified.

Table 8.1—Notable Aggregate Performance Measure Results Including Assigned Domains of Care

Measure ¹	Domain of Care ²	Notable Results for Medi-Cal Managed Care Weighted Average Performance
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	Q, A	<ul style="list-style-type: none"> ◆ Statistically significant decline in performance from RY 2014 to RY 2015.
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	Q	<ul style="list-style-type: none"> ◆ Statistically significant improvement from RY 2014 to RY 2015. ◆ Rate moved from below the MPL in RY 2014 to above the MPL in RY 2015.
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	Q	<ul style="list-style-type: none"> ◆ Statistically significant improvement from RY 2014 to RY 2015.
<i>Cervical Cancer Screening</i>	Q,A	<ul style="list-style-type: none"> ◆ Statistically significant decline in performance from RY 2014 to RY 2015.
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	A	<ul style="list-style-type: none"> ◆ Statistically significant decline in performance from RY 2014 to RY 2015. ◆ Rate remained below the MPL for the third consecutive year.

OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS RELATED TO DOMAINS OF CARE

Measure¹	Domain of Care²	Notable Results for Medi-Cal Managed Care Weighted Average Performance
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	A	<ul style="list-style-type: none"> ◆ Statistically significant decline in performance from RY 2014 to RY 2015. ◆ Rate remained below the MPL for the third consecutive year.
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	A	<ul style="list-style-type: none"> ◆ Statistically significant improvement from RY 2014 to RY 2015. ◆ However, the rate remained below the MPL for the fourth consecutive year.
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	A	<ul style="list-style-type: none"> ◆ Statistically significant improvement from RY 2014 to RY 2015. ◆ However, the rate remained below the MPL for the fourth consecutive year.
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	Q,A	<ul style="list-style-type: none"> ◆ Statistically significant improvement from RY 2014 to RY 2015.
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	Q,A	<ul style="list-style-type: none"> ◆ Statistically significant improvement from RY 2014 to RY 2015.
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	Q	<ul style="list-style-type: none"> ◆ Statistically significant improvement from RY 2014 to RY 2015.
<i>Controlling High Blood Pressure</i>	Q	<ul style="list-style-type: none"> ◆ Statistically significant improvement from RY 2014 to RY 2015.
<i>Medication Management for People with Asthma—Medication Compliance 50% Total</i>	Q	<ul style="list-style-type: none"> ◆ Statistically significant decline in performance from RY 2014 to RY 2015.
<i>Medication Management for People with Asthma—Medication Compliance 75% Total</i>	Q	<ul style="list-style-type: none"> ◆ Statistically significant decline in performance from RY 2014 to RY 2015.
<i>Prenatal and Postpartum Care—Postpartum Care</i>	Q,A,T	<ul style="list-style-type: none"> ◆ Rate moved from below the MPL in RY 2014 to above the MPL in RY 2015; however, the change was not statistically significant.
<i>Use of Imaging Studies for Low Back Pain</i>	Q	<ul style="list-style-type: none"> ◆ Statistically significant decline in performance from RY 2014 to RY 2015.
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	<ul style="list-style-type: none"> ◆ Statistically significant improvement from RY 2014 to RY 2015.
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	<ul style="list-style-type: none"> ◆ Statistically significant improvement from RY 2014 to RY 2015.

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was originally developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

The MCMC performance measure weighted average rate findings and QIP outcome results for each domain of care are categorized below.

Quality

Overall, MCMC's performance related to required quality measures was average, with all MCMC quality-related weighted averages being above the MPLs and below the HPLs. The performance comparison results show that, of the 23 quality measures, the MCMC weighted averages for eight measures achieved significant improvement from RY 2014 to RY 2015. Conversely, the MCMC weighted averages for five of the 23 quality measures were significantly worse in RY 2015 when compared to RY 2014.

The SPD RY 2014 rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures, which fall into the quality domain of care, were significantly better than the non-SPD rates. This result is consistent with RY 2013. The better rates for these measures may be attributed to SPD beneficiaries having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. For the third consecutive year, the SPD rates for the *All-Cause Readmissions* measure, which falls into the quality domain of care, were significantly higher when compared to the non-SPD rates. This is expected based on the greater and often more complicated health care needs of these beneficiaries; however, for MCPs with higher readmission rates for the SPD population, HSAG recommends assessing the factors leading to the higher readmissions rates to ensure that MCPs are meeting the needs of the SPD population.

The following are results for QIPs falling into the quality domain of care.

- ◆ Forty-five of the *ACR* QIPs progressed to the Outcomes stage, and six QIPs achieved statistically significant improvement over baseline at Remeasurement 1.
- ◆ Twenty-three IQIPs progressed to the Outcomes stage.
 - Twenty-two IQIPs were assessed for statistically significant improvement, and only three achieved statistically significant improvement over baseline.
 - The one IQIP assessed for sustained improvement maintained or increased the statistically significant improvement over baseline achieved in the previous measurement period for at least one study indicator.

As has been true in previous years, once a QIP achieves statistically significant improvement, MCPs are often able to maintain or improve upon the positive outcomes. While the QIPs demonstrated some positive outcomes related to the quality of care being delivered to MCMC beneficiaries, MCPs continued to show many opportunities for improvement related to their approaches to ensuring the delivery of quality care to beneficiaries.

Access

As in previous years, no weighted averages exceeded the DHCS-established HPLs for measures falling into the access domain of care. In RY 2015, four access measures (one fewer than in RY 2014) had weighted averages below the MPLs. The performance comparison results show that, of the 14 access measures, the MCMC weighted averages for four measures achieved significant improvement from RY 2014 to RY 2015, while four measures had weighted averages significantly worse in RY 2015 when compared to RY 2014.

The *All-Cause Readmissions* measure falls into the access domain of care. As noted above, for the third consecutive year the SPD population had a significantly higher rate of readmissions than the non-SPD population, which is expected based on the greater and often more complicated health care needs of these beneficiaries. For most of the *Children and Adolescents' Access to Primary Care Practitioners* measures, which fall into the access domain of care, where a comparison between the SPD and non-SPD rates could be calculated there was no statistically significant difference between the SPD and non-SPD rates. For several MCP counties, SPD rates were significantly lower than the non-SPD rates. The lower SPD rates for these measures may be attributed to children and adolescents in the SPD population relying on specialist providers as their care sources, based on complicated health care needs, rather than accessing care from PCPs.

The following are results for QIPs falling into the access domain of care.

- ◆ Forty-five ACR QIPs progressed to the Outcomes stage, and six of those QIPs achieved statistically significant improvement over baseline at Remeasurement 1.
- ◆ Twenty-two IQIPs progressed to the Outcomes stage.
 - Nineteen IQIPs were assessed for statistically significant improvement, and only three achieved statistically significant improvement over baseline.
 - Two IQIPs were assessed for sustained improvement, and both maintained or increased the statistically significant improvement over baseline achieved in the previous measurement period for at least one study indicator.

As indicated above, once a QIP achieves statistically significant improvement, MCPs are often able to maintain or improve upon the positive outcomes. While the QIPs demonstrated some positive outcomes related to the quality of care being delivered to MCMC beneficiaries, MCPs continued to show many opportunities for improvement related to their approaches to ensuring beneficiary access to care.

Timeliness

MCMC's performance related to required timeliness measures was average, with all five MCMC timeliness-related measures' weighted averages being above the MPLs and below the HPLs. All five measures demonstrated neither statistically significant improvement nor statistically significant decline from RY 2014 to RY 2015.

Four IQIPs that progressed to the Outcomes stage fell into the timeliness domain of care. All four IQIPs were assessed for statistically significant improvement, but no IQIPs achieved statistically significant improvement over baseline. MCPs continued to show many opportunities for improvement related to approaches to ensuring timely care for beneficiaries.

Conclusions—All Assessed Areas

Overall, MCMC and its contracted MCPs implemented initiatives that resulted in the provision of quality, accessible, and timely health care services to MCMC beneficiaries.

Taking into account MCMC's compliance monitoring review findings, while MCPs had findings in multiple areas, they were partially compliant with most standards. MCPs generally had appropriate resources and written policies and procedures in place to support quality improvement programs, and all MCPs resolved to DHCS's satisfaction compliance review findings reported on in the previous review period.

Most MCMC weighted averages for RY 2015 remained between the MPLs and HPLs, with four measures having rates below the DHCS-established MPLs. The weighted averages for ten measures improved significantly from RY 2014 to RY 2015, and seven measures had weighted averages significantly worse in RY 2015 when compared to RY 2014.

The SPD population, for the third consecutive year, had a significantly higher rate of hospital readmissions than did the non-SPD population. While a higher rate of hospital readmissions is expected for the SPD population, MCPs with significantly higher SPD readmissions rates have the opportunity to assess the factors leading to the higher readmissions to ensure that they are meeting the needs of the SPD population.

During the review period, HSAG assessed QIPs in all three domains of care for outcomes. As in previous years, results showed that, generally, once a QIP achieves statistically significant improvement MCPs are able to maintain or improve upon the positive outcomes. While the QIPs demonstrated some positive outcomes related to the health care services provided to beneficiaries, the QIP validation results suggest that many interventions MCPs implemented through the QIP process did not result in positive outcomes. Thus, DHCS made a decision to transition to HSAG's

rapid-cycle PIP approach starting July 1, 2015. As a result, all QIPs were closed as of June 30, 2015; and MCPs will no longer submit QIPs to HSAG for validation.

Recommendations—All Assessed Areas

Based on overall assessment of MCMC in the areas of quality and timeliness of and access to care, HSAG included recommendations, as applicable, for each assessed activity in the activity-specific sections of this report. HSAG provided MCP-specific recommendations within the MCP-specific evaluation reports in appendices A through Z. The following summarizes HSAG’s recommendations for DHCS:

- ◆ Establish a specific time frame for DHCS to produce and deliver all compliance review reports to ensure that MCPs are able to take action to resolve all findings as soon as possible to be fully compliant with federal and State requirements.
- ◆ Continue issuing CAPs to MCPs demonstrating poor performance on multiple measures over consecutive years. Rather than require MCPs to address poor performance on all measures at once, work with MCPs to prioritize areas in need of improvement to increase the likelihood of positive outcomes.
- ◆ Assess whether DHCS should add any measures to the list of priority areas in the Medi-Cal Managed Care Program Quality Strategy moving forward. Following are measures HSAG recommends for DHCS’s consideration:
 - *All-Cause Readmissions*, including focusing on reducing readmissions for the SPD population
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics*
 - *Cervical Cancer Screening*
 - Both *Medication Management for People with Asthma* measures
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- ◆ To support accurate and complete encounter data from MCPs, review the *Encounter Data Validation Study Aggregate Report—July 1, 2013–June 30, 2014* and *Encounter Data Validation Study Aggregate Report—July 1, 2014–June 30, 2015*; and identify strategies to address recommendations not already addressed by DHCS to ensure accuracy and completeness of encounter data.

In the next annual review, HSAG will evaluate continued successes of DHCS and MCPs, as well as how DHCS and MCPs progressed with previous recommendations.

DHCS’s documentation of actions taken in response to the 2013–14 external quality review recommendations is included in Table 8.2.

Table 8.2—DHCS’s Self-reported Follow-up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, External Quality Review Technical Report

2013–14 External Quality Review Recommendation	Self-reported Actions Taken by DHCS during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. MCQMD should report outcomes achieved through strategies outlined in the 2014 <i>Medi-Cal Managed Care Program Quality Strategy Report</i>, and indicate whether strategies will be expanded, modified, or eliminated to achieve improvement in key focus areas.</p>	<p>DHCS submitted its <i>2015 Medi-Cal Managed Care Quality Strategy Report Annual Assessment</i> to CMS on November 5, 2015. This report is available online at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx. The report outlines in detail outcomes achieved through strategies from the <i>2014 Medi-Cal Managed Care Program Quality Strategy Report Annual Assessment</i>. In evaluating the performance of MCPs, the report updates progress toward measurable objectives for key indicators, assesses past interventions to improve performance, includes future interventions, describes changes in service delivery and contractual standards, and outlines enhancements in DHCS oversight and monitoring of Medi-Cal Managed Care.</p>
<p>2. Ensure a comprehensive audit is conducted at least once within a three-year period with all MCPs.</p>	<p>DHCS is in compliance with 42 CFR §438.358 for its full-scope health plans as it has conducted a comprehensive review of each of its full-scope plans within the required three-year period. Additionally, California Welfare and Institutions Code § 14456, which became law in January 2015, mandates annual audits for full-scope MCPs. In response to this new State regulation, DHCS audited approximately half of the MCPs by June 2015 and scheduled comprehensive audits for the balance of all full-scope MCPs to be completed before August 2016. DHCS will conduct a comprehensive audit of each full-scope MCP at least every other year and will conduct focused review in off years.</p>
<p>3. MCQMD should explore with the EQRO a redesigned QIP process that supports MCPs in conducting QIPs using rapid-cycle techniques and a validation process that facilitates greater technical assistance to MCPs and feedback throughout the rapid-cycle QIP process.</p>	<p>Under the terms of a new EQR contract (which began July 2015), DHCS requires that the EQRO incorporate rapid-cycle techniques and greater technical assistance to MCPs for QIPs, which are now referred to as PIPs. Additionally, DHCS continues to incorporate rapid-cycle techniques into other quality improvement work, including PDSA IPs. For HEDIS performance measures where DHCS holds MCPs accountable to a MPL, DHCS requires MCPs to complete PDSA IPs for all measures that fall below the MPL, if the area is not already being addressed through a PIP.</p>

MCPs’ documentation of actions taken that address the 2013–14 external quality review recommendations are included in their MCP-specific evaluation reports (see appendices A through Z).

Medi-Cal Managed Care Technical Report

**Appendix A:
Performance Evaluation Report
AIDS Healthcare Foundation
July 1, 2014 – June 30, 2015**

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Appendix A: Performance Evaluation Report – AIDS Healthcare Foundation July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), AIDS Healthcare Foundation (“AHF” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

AHF is a Medi-Cal managed care specialty plan operating in Los Angeles County, providing services primarily to beneficiaries living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Due to AHF’s unique membership, some of the MCP’s contract requirements have been modified from Medi-Cal Managed Care’s (MCMC’s) full-scope MCP contracts. AHF became operational in Los Angeles County to provide MCMC services in April 1995. As of June 30, 2015, AHF had 852 MCMC beneficiaries (referred to as “beneficiaries” in this report).¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: January 9, 2016.

Compliance Reviews

DHCS conducted no audits or surveys for AHF during the review period for this report. HSAG provided information regarding the June 2010 DHCS Member Rights & Program Integrity Unit review in AHF's 2011–12 and 2012–13 MCP-specific reports. HSAG provided in AHF's 2013–14 MCP-specific evaluation report a summary of AHF's follow-up on HSAG's recommendation regarding the MCP ensuring that grievance resolution letters are sent within the required time frame.

AHF will be added to the State Fiscal Year (SFY) 2016–17 annual audit schedule.

Performance Measure Validation—Findings

For reporting year (RY) 2015, AHF was required to report two HEDIS² measures—*Controlling High Blood Pressure* and *Colorectal Cancer Screening*.

The *HEDIS 2015 Compliance Audit Final Report of Findings for AIDS Healthcare Foundation* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance Audit.³ HSAG auditors determined that AHF followed the appropriate specifications to produce valid rates. The auditor identified one area of concern; however, the issue had no impact on measure reporting. Specifically, AHF had no formal process for monitoring data entry; therefore, the auditor recommended that the MCP formally document its data validation process.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. (See Table 3.1 for AHF’s performance measure results for RYs 2012 through 2015.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

**Table 3.1—Multi-Year Performance Measure Results
AHF—Los Angeles County**

Performance Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Controlling High Blood Pressure*</i>	Q,A	68.2%	62.20%	61.07%	61.16%	↔
<i>Colorectal Cancer Screening**</i>	Q,A	64.2%	63.07%	52.04%	73.39%	↑

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 RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011. Rates in RY 2012 were reported to one decimal place. To be consistent with NCQA, rates starting in RY 2013 are reported to two decimal places.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* If the rate is **bolded**, it was below the minimum performance level (MPL) for that year, which is based on the national Medicaid 25th percentile; and if the rate is shaded, it was above the high performance level (HPL) for that year, which is based on the 90th percentile for that year.

** If the rate is **bolded**, it was below the MPL for that year, which is based on the national commercial 25th percentile; and if the rate is shaded, it was above the HPL for that year, which is based on the national commercial 90th percentile. Commercial benchmarks are used because there are no Medicaid benchmarks for this measure.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

Performance Measure Findings

The rate for the *Controlling High Blood Pressure* measure showed no statistically significant change from RY 2014 to RY 2015. The rate improved significantly from RY 2014 to RY 2015 for the *Colorectal Cancer Screening* measure, resulting in the rate moving from below the minimum performance level (MPL) in RY 2014 to above the MPL in RY 2015.

Assessment of Improvement Plans

AHF was required to submit a Plan-Do-Study-Act (PDSA) cycle for the *Colorectal Cancer Screening* measure. At a medical directors meeting, the MCP conducted a presentation of colonoscopy rates stratified by provider and benchmarked against the MPL. AHF determined that the intervention was successful at improving provider compliance with ordering one of the required tests. The MCP planned to adopt the intervention and disseminate the provider profiles at least annually.

AHF’s improvement efforts were successful in bringing the rate for the measure to above the MPL in RY 2015; the MCP will therefore not be required to continue testing PDSA cycles related to the *Colorectal Cancer Screening* measure.

Strengths

AHF followed the appropriate specifications to produce valid performance measure rates. The MCP's improvement efforts were successful at bringing the rate for the *Colorectal Cancer Screening* measure to above the MPL in RY 2015.

Opportunities for Improvement

AHF has the opportunity to formally document the MCP's data validation process based on the HSAG auditor's assessment of the MCP's data entry monitoring process.

Quality Improvement Project Objectives

Specialty MCPs must be engaged in two quality improvement projects (QIPs) at all times; however, because specialty MCPs serve unique populations limited in size, DHCS does not require them to participate in the statewide collaborative QIP. Instead, specialty MCPs are required to design and maintain two internal QIPs with the goal of improving health care quality, access, and/or timeliness for the specialty MCP’s beneficiaries. AHF had two internal QIPs in progress during the review period of July 1, 2014, through June 30, 2015.

Table 4.1 below lists AHF’s QIPs and the QIP conducted; whether the QIP was clinical or nonclinical; and the domains of care (i.e., quality, access, and timeliness) the QIP addressed.

**Table 4.1—Quality Improvement Projects for AHF
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>Increasing CD4 and Viral Load Testing</i>	Clinical	Q, A
<i>Reducing Avoidable Emergency Room Visits</i>	Clinical	Q, A

The *Increasing CD4 and Viral Load Testing* QIPs focused on increasing CD4 and viral load testing for beneficiaries with HIV. The clinical practice guidelines require two tests per year for medically stable patients and three tests per year for medically unstable patients. The number of CD4 T lymphocytes gives a quantitative description of the immune system’s response and susceptibility to opportunistic infections. The viral load demonstrates the effectiveness of anti-retroviral therapy. Both the CD4 and viral load levels are excellent clinical indicators for medical and pharmaceutical management for people living with HIV.

AHF’s *Reducing Avoidable Emergency Room Visits* QIP sought to decrease the percentage of avoidable emergency department visits for beneficiaries. HIV-positive patients have a significantly higher rate of emergency department visits and have a longer duration of stay compared to patients without HIV. AHF hoped to improve the continuity of care between beneficiaries and their primary care providers (PCPs), improve access to PCPs, and encourage preventive care.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
AHF—Los Angeles County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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
Internal QIPs				
<i>Increasing CD4 and Viral Load Testing</i>	Annual Submission	65%	71%	<i>Not Met</i>
	Annual Resubmission 1	94%	86%	<i>Partially Met</i>
	Annual Resubmission 2	100%	100%	<i>Met</i>
<i>Reducing Avoidable Emergency Room Visits</i>	Annual Submission	88%	86%	<i>Not Met</i>
	Annual Resubmission 1	94%	86%	<i>Partially Met</i>
	Annual Resubmission 2	100%	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, 2014, through June 30, 2015, showed that AHF’s annual submissions of both its *Increasing CD4 and Viral Load Testing* and *Reducing Avoidable Emergency Room Visits* QIPs each initially received an overall validation status of *Not Met*. DHCS required the MCP to resubmit the QIPs until they achieved an overall *Met* validation status. Based on HSAG’s validation feedback, AHF resubmitted the QIPs and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a *Met* score for each QIP.

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

Table 4.3—Quality Improvement Project Average Rates*
AHF—Los Angeles County
(Number = 6 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		100%	0%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	83%	0%	17%
	VIII: Appropriate Improvement Strategies	50%	17%	33%
Implementation Total		72%	6%	22%
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		Not Assessed	Not Assessed	Not Assessed

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

HSAG validated Activities I through VIII for both AHF’s *Increasing CD4 and Viral Load Testing* and *Reducing Avoidable Emergency Room Visits* QIP annual submissions.

AHF demonstrated an excellent application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP demonstrated a fair application of the Implementation stage, meeting 72 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. AHF omitted Activities VII and VIII in its initial annual submission of the *Increasing CD4 and Viral Load Testing* QIP, resulting in the QIP receiving a zero score for each activity. AHF subsequently included both Activity VII and VIII in its resubmissions of the *Increasing CD4 and Viral Load Testing* QIP. Additionally, in its initial submissions, AHF did not provide a causal/barrier analysis for either QIP, resulting in lowered scores for Activity VIII. The MCP corrected the deficiencies in the resubmissions, resulting in each QIP achieving an overall *Met* validation status.

Quality Improvement Project Outcomes and Interventions

The *Increasing CD4 and Viral Load Testing* and *Reducing Avoidable Emergency Room Visits* QIPs did not progress to the Outcomes stage during the reporting period; therefore, no outcomes and interventions information is included in this report.

Strengths

AHF demonstrated an excellent application of the Design stage, meeting all applicable evaluation elements within the study stage for both the *Increasing CD4 and Viral Load Testing* and *Reducing Avoidable Emergency Room Visits* QIPs.

Opportunities for Improvement

Although AHF will not be continuing the formal QIPs, the MCP should evaluate the interventions initiated in Remeasurement 1 of the *Increasing CD4 and Viral Load Testing* and *Reducing Avoidable Emergency Room Visits* QIPs and continue improvement efforts in the two focus areas.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

AHF’s SFY 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for AHF. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for AHF

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	30.9%	26.3%	10th–25th	8.8%	9.2%	25th–75th
Diagnosis Code	30.9%	31.6%	25th–75th	62.5%	34.6%	<10th
Procedure Code	66.9%	43.8%	<10th	16.2%	22.5%	75th–90th
Procedure Code Modifier	66.5%	58.5%	25th–75th	NA	46.0%	NA
Rendering Provider Name	NA	25.0%	NA	100.0%	68.1%	0–≤25th
Billing Provider Name	32.4%	35.0%	25th–75th	9.0%	8.6%	25th–75th

Note: HSAG displayed “NA” when the denominator was less than 30.

Overall, the medical record omission rates for AHF ranged from 30.9 percent (*Date of Service* and *Diagnosis Code*) to 66.9 percent (*Procedure Code*). Two of AHF’s five reportable medical record omission rates were slightly better than the respective statewide rates, and the remaining three reportable rates were worse than the statewide rates by as much as 23.1 percentage points (*Procedure Code* element). When compared to other MCPs’ performance, AHF received a percentile ranking of “25th–75th” for three data elements, a percentile ranking of “10th–25th” for one data element, and a percentile ranking of “<10th” for one data element. These findings suggest a moderately low level of completeness among key encounter data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located for the sampled dates of services.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for AHF contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, AHF's rates varied from 8.8 percent (*Date of Service*) to 100 percent (*Rendering Provider Name*). Two of AHF's five reportable encounter data omission rates were better than the respective statewide rates, with the *Procedure Code* encounter data omission rate better than the statewide rate by 6.3 percentage points. However, AHF performed worse than the statewide encounter data omission rates by 27.9 percentage points and 31.9 percentage points for the *Diagnosis Code* and *Rendering Provider Name* data elements, respectively. An opportunity exists for AHF to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in AHF's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to AHF (and/or the data subsequently being submitted to DHCS).
- ◆ AHF did not populate or populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files AHF submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for AHF. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for AHF

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	84.2%	83.6%	25th–75th	NA
Procedure Code	71.0%	77.6%	25th–75th	NA
Procedure Code Modifier	NA	99.5%	NA	—
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	70.8%	68.6%	25th–75th	NA
All-Element Accuracy	0.0%	4.3%	0–≤25th	—

Note: HSAG displayed "NA" when the denominator was less than 30. HSAG displayed "—" when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, AHF's accuracy rates were found to be about average, with two of the three reportable element accuracy rates slightly higher than the respective statewide rates. When comparing the performance among MCPs, all three key data elements with reportable rates received a percentile ranking of "25th–75th".

AHF's all-element accuracy rate was lower than the statewide rate by 4.3 percentage points. No dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries' medical records. The overall accuracy findings indicated the presence of at least one inaccurate data element for all dates of service present in both data sources. While all five key data elements contributed to AHF's relatively low all-element accuracy rate, the *Rendering Provider Name*, *Diagnosis Code*, and *Procedure Code* data elements contributed more than did the other two data elements.

Medical Record Review Recommendations

Based on the study findings for AHF, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, AHF should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. AHF should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ Of the 132 dates of service identified in DHCS's encounter data, no visits had rendering provider names identifiable from DHCS's data system. AHF should work with DHCS to investigate the reasons why no rendering provider names could be identified using DHCS's encounter data and provider data.

- ◆ AHF should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code* and *Procedure Code Modifier* data elements and develop strategies to improve rates.
- ◆ AHF should explore the reasons for the relatively high encounter data omission rates for the *Rendering Provider Name* and *Diagnosis Code* data elements and take actions to improve rates.
- ◆ AHF should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with AHF.
- ◆ AHF should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the

SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.

- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

AHF's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to PACES. Based on review of AHF's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist AHF with improving its encounter data quality. DHCS followed up with AHF regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Although HSAG uses a standardized scoring process to evaluate each full-scope Medi-Cal MCP's performance measure rates and QIP performance in the areas of quality, access, and timeliness domains of care, HSAG does not use this scoring process for specialty MCPs due to the small size of the specialty MCPs' populations. To determine the degree to which specialty MCPs provide quality, accessible, and timely care to beneficiaries, HSAG assesses each specialty MCP's performance related to compliance reviews (as applicable), performance measure rates, QIP validation, QIP outcomes, beneficiary satisfaction surveys (as available), and accuracy and completeness of the MCP's encounter data (as applicable).

Quality

As in previous years, AHF's quality improvement program description included details of the MCP's organizational structure and of monitoring activities designed to ensure that the MCP provides quality care to beneficiaries.

Both of the MCP's required performance measures fall into the quality domain of care. The rate for the *Controlling High Blood Pressure* measure remained above the MPL in RY 2015. The rate improved significantly for the *Colorectal Cancer Screening* measure, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

Both of AHF's QIPs fell into the quality domain of care; however, neither QIP progressed to the Outcomes stage during the reporting period.

Access

AHF's quality and performance improvement work plan included access-related goals, with specified methodologies to evaluate success in meeting the goals. The *2014 Quality and Performance Improvement Evaluation* indicated that the MCP met the Medicaid geo-access standards and emphasizes AHF's commitment to monitoring access to care and addressing beneficiary dissatisfaction when expressed.

Both of the MCP's required performance measures fall into the access domain of care. As indicated above, the rate for the *Controlling High Blood Pressure* measure remained above the MPL in RY 2015 and the rate improved significantly for the *Colorectal Cancer Screening* measure, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

Both of AHF’s QIPs fell into the access domain of care, and, as stated above, neither QIP progressed to the Outcomes stage during the reporting period.

Timeliness

AHF’s quality improvement program documents provide examples of the processes the MCP implements to ensure that timely care is provided to beneficiaries, including resolving grievances as quickly as possible and within required standards. As in previous years, AHF’s quality and performance improvement program description provided information on the MCP’s activities and processes related to beneficiary rights, grievances, continuity and coordination of care, and utilization management, which can all affect the timeliness of care delivered to beneficiaries.

Since no performance measures or QIPs fell into the timeliness domain of care and no new compliance reviews were conducted with AHF, HSAG makes no assessment of the MCP’s 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with AHF’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—AHF’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to AHF	Self-Reported Actions Taken by AHF during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. To improve the HEDIS audit process:</p> <ul style="list-style-type: none"> a. Explore options for using an electronic application process. b. Formally document findings from the MCP’s reconciliation process. c. Update the MCP’s reconciliation procedures. d. Review Roadmap responses prior to submission to ensure that the MCP’s processes are accurately reflected. 	<p>1a. An electronic application process for our members is not feasible since we are a Special Needs Plan (SNP). Verification and confidentiality of diagnosis is required before application can be approved.</p> <p>In terms of HEDIS audit, AHF uses electronic means as much as possible.</p> <p>1b. & 1c. AHF is transitioning its claims systems to a new vendor (RAM), which will take effect in early 2016. Reconciliation processes and their documentation are all being reviewed and revised as needed in 2015.</p>

2013–14 External Quality Review Recommendation Directed to AHF	Self-Reported Actions Taken by AHF during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	1d. Roadmap responses were all reviewed with appropriate staff prior to submission for the HEDIS 2015 report and were accurate as reflected by current HEDIS audit reports. This will continue to be the practice.
2. Assess the factors leading to the statistically significant decline in the rate for the <i>Colorectal Cancer Screening</i> measure, and identify strategies to improve the rate to above the MPL.	After a thorough assessment of the decline in <i>Colorectal Cancer Screening (COL)</i> rates it was determined that the root causes were lack of all data being submitted electronically for 10 years (current year plus a 9-year look back period for colonoscopy) and/or poor abstraction by vendor. With the appropriate submission of HEDIS data for 2015, and 100 percent overread of abstraction, <i>COL</i> rates increased by 21 percent.
3. Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.	With most of the staff being new and AHF hiring a new national quality director, AHF will focus on training and care so that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

Recommendations

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

- ◆ Document the MCP’s data validation process, including a formal process for monitoring data entry.
- ◆ Consider evaluating the interventions initiated in Remeasurement 1 of the *Increasing CD4 and Viral Load Testing* and *Reducing Avoidable Emergency Room Visits* QIPs, and continue improvement efforts in the two focus areas.
- ◆ Review the *2013–14 Encounter Data Validation Study Report*, and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix B:
Performance Evaluation Report
Alameda Alliance for Health
July 1, 2014 – June 30, 2015**

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Appendix B: Performance Evaluation Report – Alameda Alliance for Health July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Alameda Alliance for Health (“AAH” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

AAH is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a “Local Initiative” (LI) MCP in Alameda County under the Two-Plan Model (TPM). Beneficiaries may enroll in AAH, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative CP.

AAH became operational in Alameda County to provide MCMC services effective 1996. As of June 30, 2015, AAH had 239,396 beneficiaries.¹ This represents 80 percent of the beneficiaries enrolled in Alameda County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: October 8, 2015.

Department of Managed Health Care Routine Medical Survey

The Department of Managed Health Care (DMHC) conducted a routine medical survey for AAH on October 16, 2012, through October 19, 2012, covering the review period of July 1, 2011, through July 31, 2012. HSAG summarized the results of the survey in AAH's 2012–13 MCP-specific evaluation report and the status of one outstanding deficiency in AAH's 2013–14 MCP-specific evaluation report. On August 20, 2014, DMHC issued the *Routine Medical Survey Follow-up Report* which stated that all deficiencies had been corrected.

1115 Waiver Seniors and Persons with Disabilities Enrollment Survey

DMHC conducted an 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey (hereafter referred to as “SPD medical survey”) for AAH on October 16, 2012, through October 19, 2012, covering the review period of July 1, 2011, through July 31, 2012. HSAG summarized the results of the survey in AAH's 2012–13 MCP-specific evaluation report and the status of identified potential deficiencies in AAH's 2013–14 MCP-specific evaluation report. On June 25, 2013, DHCS followed up on the deficiencies with a corrective action plan (CAP). In a letter dated October 1, 2014, DHCS stated that it had reviewed AAH's documentation related to potential deficiencies in the areas of Access and Availability and Quality Management and found the MCP to be in compliance. DHCS, therefore, closed the CAP.

Strengths

AAH fully resolved the outstanding potential deficiencies from DMHC's most recent routine medical and SPD medical surveys of the MCP.

Opportunities for Improvement

Since DHCS conducted no new audits or surveys for AAH during the review period and all potential deficiencies from the previous routine medical and SPD medical surveys have been resolved, HSAG has no recommendations for AAH in the area of compliance.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Alameda Alliance for Health* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that AAH followed the appropriate specifications to produce valid rates; however, there were several issues of concern (including data collection) that caused significant impact on measure reporting, resulting in AAH's hybrid rates not being submitted to NCQA. A brief summary of the notable findings and opportunities for improvement is included below.

- ◆ AAH encountered several challenges in ensuring completeness and accuracy of its claims and encounter data used for HEDIS reporting. Although the MCP was able to remedy some of the issues, the diversion of resources to address the claims processing issues resulted in AAH having insufficient resources to conduct adequate oversight of some of its vendors and partners. The auditor recommended that AAH implement ongoing monitoring and oversight of all delegated entities to enable the MCP to proactively identify any process issues or changes with its partners. This will allow the MCP sufficient time to test new data processes and ensure data completeness and accuracy.
- ◆ AAH did not use data received on the Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM 160 form) for HEDIS rates. While the service data provided on the PM 160 form can be found during medical record review, the auditor recommended that the MCP consider using the data from the PM 160 form for future HEDIS rate production to help reduce medical record review costs.
- ◆ As indicated in previous years, the auditor recommended that AAH use industry standard codes to ensure all services on claims are included rather than having to rely on capturing the services through medical record review.
- ◆ Experienced, key staff responsible for managing HEDIS production left AAH at the end of the prior audit season; and because the MCP did not have formally documented HEDIS processes, the new staff assigned to the HEDIS tasks experienced many challenges. Therefore, the auditor recommended that AAH build internal MCP knowledge based on HEDIS policies and procedures and ensure that formal process documentation exists to train new staff members.

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 for AAH's performance measure results for reporting years [RYs] 2012 through 2015.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and

may be directly related to all MCPs with rates that could be compared to the previous year’s rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.

- All four *Children and Adolescents’ Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
AAH—Alameda County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	14.66%	17.42%	16.44%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	42.02	47.24	29.28	35.88	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	315.03	297.17	240.12	275.87	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	87.05%	84.40%	83.78%	83.12%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	86.41%	94.08%	93.43%	49.17%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	84.78%	81.92%	84.34%	81.67%	↓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	31.53%	38.09%	40.90%	34.48%	↓
Cervical Cancer Screening	Q,A	—	—	59.85%	53.53%	↔
Childhood Immunization Status—Combination 3	Q,A,T	78.10%	79.08%	67.40%	75.91%	↑
Children and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months	A	94.63%	92.32%	94.34%	88.24%	↓
Children and Adolescents’ Access to Primary Care Practitioners—25 Months to 6 Years	A	85.48%	83.91%	85.10%	81.44%	↓
Children and Adolescents’ Access to Primary Care Practitioners—7 to 11 Years	A	85.61%	85.06%	87.07%	84.77%	↓
Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years	A	82.03%	84.64%	83.24%	81.65%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	59.85%	59.61%	57.66%	40.39%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	52.55%	48.91%	45.26%	46.23%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	83.21%	83.45%	81.75%	87.10%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	58.88%	51.58%	48.18%	41.85%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	82.97%	82.97%	80.05%	80.05%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	Q	28.47%	37.47%	51.82%	51.09%	↔
<i>Controlling High Blood Pressure</i>	Q	—	53.53%	45.99%	43.07%	↔
<i>Immunizations for Adolescents—Combination 1</i>	Q,A,T	66.67%	76.40%	79.08%	74.45%	↔
<i>Medication Management for People with Asthma—Medication Compliance 50% Total</i>	Q	—	43.88%	41.69%	45.10%	↑
<i>Medication Management for People with Asthma—Medication Compliance 75% Total</i>	Q	—	24.23%	17.80%	27.13%	↑
<i>Prenatal and Postpartum Care—Postpartum Care</i>	Q,A,T	61.07%	57.18%	49.39%	55.47%	↔
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	Q,A,T	88.56%	80.54%	79.56%	66.67%	↓
<i>Use of Imaging Studies for Low Back Pain</i>	Q	84.76%	87.07%	88.58%	87.33%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	55.23%	55.23%	59.61%	42.34%	↓
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	58.64%	64.72%	71.29%	57.42%	↓
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	41.61%	46.23%	61.31%	48.42%	↓
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	77.62%	71.53%	70.80%	71.53%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant decline in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant improvement in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 SPD measure results reported by AAH. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for AAH—Alameda County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	13.50%	19.60%	▼	16.44%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.83%	85.09%	↑	83.12%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	41.77%	54.90%	↔	49.17%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	79.71%	84.74%	↑	81.67%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	88.22%	90.91%	↔	88.24%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	81.35%	84.62%	↑	81.44%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	84.78%	84.47%	↔	84.77%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	81.92%	77.91%	↓	81.65%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

⁴ 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 3.2.

**Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
AAH—Alameda County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
253.99	32.31	422.12	59.71

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
AAH—Alameda County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014– 15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	15.86%	19.54%	19.60%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	69.61	53.35	59.71	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	481.81	387.05	422.12	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.99%	84.69%	85.09%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	94.30%	92.80%	54.90%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.07%	85.18%	84.74%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	85.71%	100.0%	90.91%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	85.99%	86.01%	84.62%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	86.15%	87.57%	84.47%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	80.59%	79.65%	77.91%	↔

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

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
AAH—Alameda County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	10.47%	13.64%	13.50%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	40.42	24.72	32.31	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	240.90	212.26	253.99	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	77.54%	80.91%	81.83%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	41.77%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	73.16%	81.90%	79.71%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	92.41%	94.25%	88.22%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.84%	85.07%	81.35%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.00%	87.03%	84.78%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.99%	83.59%	81.92%	↓

* Member months are a member’s “contribution” to the total yearly membership.
NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rate for the *Use of Imaging Studies for Low Back Pain* measure was above the HPL for the fifth consecutive year.

The rates for the following measures improved significantly from RY 2014 to RY 2015:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Medication Management for People with Asthma— Medication Compliance 75% Total*, resulting in the rate for the measure moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*; however, the rate for the measure remained below the MPL for the third consecutive year

In addition to the rate for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure being below the MPL, the rates for the following measures were below the MPLs in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*—the rate for this measure declined significantly from RY 2014 to RY 2015, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Cervical Cancer Screening*—the rate for this measure declined from RY 2014 to RY 2015, and although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ All four *Children and Adolescents’ Access to Primary Care Practitioners* measures for the fourth consecutive year—In addition to the rates being below the MPLs, the rates declined significantly from RY 2014 to RY 2015
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*—the rate for this measure declined significantly from RY 2014 to RY 2015, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*—the rate for this measure declined from RY 2014 to RY 2015, and although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Controlling High Blood Pressure*
- ◆ *Prenatal and Postpartum Care—Postpartum Care* for the third consecutive year
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*—the rate for this measure declined significantly from RY 2014 and RY 2015, resulting in the rate remaining below the MPL

In addition to the rates for the *Annual Monitoring for Patients on Persistent Medications—Diuretics*, *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*, and *Prenatal and Postpartum Care—Timeliness of Care* measures declining significantly from RY 2014 to RY 2015, the rates for eight additional measures declined significantly from RY 2014 to RY 2015.

Seniors and Persons with Disabilities Findings

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

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—25 Months to 6 Years*

The SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health needs of these beneficiaries. The SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure was significantly worse than the non-SPD rate, which may be attributed to older adolescents relying on specialist providers as their care source, based on complicated health care needs, rather than accessing care from a primary care practitioner.

The SPD rates showed no significant change from RY 2014 to RY 2015, and the non-SPD rates showed significant decline for all four *Children and Adolescents' Access to Primary Care Practitioners* measures.

Assessment of Improvement Plans

The following is a summary of the improvement plans (IPs) AAH was required to submit based on RY 2014 rates:

Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs

AAH identified the following barriers to the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure being above the MPL:

- ◆ Difficulty implementing a new claims processing system which caused a claims backlog and limited access to a complete data set.
- ◆ Budget constraints resulting in:
 - The MCP failing to implement quarterly beneficiary/provider monitoring and provider education.
 - Poor communication between patients and providers due to the providers not sending educational messages to their patients or due to language barriers.
 - Provider and beneficiary incentives not being available.

AAH implemented the following interventions to address the barriers:

- ◆ Provider outreach.
- ◆ Engaged in greater oversight of the MCP's HEDIS vendor.
- ◆ Performed quarterly review of high-volume sites that meet the measure requirements.

DHCS did not require the MCP to submit a Plan-Do-Study-Act (PDSA) cycle for this measure to streamline and prioritize PDSA requirements.

AAH's interventions did not result in the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure improving to above the MPL, and the MCP will be required to continue its IP for this measure.

Controlling High Blood Pressure

AAH identified the following barriers to the rate being above the MPL, which are identical to the barriers identified for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure:

- ◆ Difficulty implementing a new claims processing system which caused a claims backlog and limited access to a complete data set.
- ◆ Budget constraints resulting in:
 - The MCP failing to implement quarterly beneficiary/provider monitoring and provider education.
 - Poor communication between patients and providers due to the providers not sending educational messages to their patients or due to language barriers.
 - Provider and beneficiary incentives not being available.

AAH implemented the following interventions to address the barriers, some of which were implemented as part of the MCP's *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP, which formally ended June 30, 2015:

- ◆ Conducted provider outreach, including sending tip sheets with information about the HEDIS 2015 *Controlling High Blood Pressure* measure changes, encouraging the providers to follow best practices, sending examples of improvement strategies, and conducting quarterly site visits to provide a coordinated effort in sharing current HEDIS practice measures.
- ◆ Identified beneficiaries with uncontrolled hypertension and who were either noncompliant or had never been prescribed anti-hypertensive medications.
- ◆ Conducted beneficiary outreach with interactive voice response (IVR) reminder calls to beneficiaries who did not retrieve their medications and offered them a 90-day supply of maintenance medications (implemented as part of AAH's *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP).
- ◆ Engaged in greater oversight of the MCP's HEDIS vendor (implemented as part of AAH's *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP).

AAH also submitted two PDSA cycles for the *Controlling High Blood Pressure* measure. A summary of each cycle follows:

- ◆ The MCP's objective was to notify the top five providers with the most noncompliant beneficiaries about their beneficiaries' noncompliance. The MCP planned to have the outreach calls conducted by an MCP medical director. No results were provided for this PDSA cycle.
- ◆ The MCP identified the top five prescribers with the most medication fill rates below 40 percent. The objective was to see a 10 percent increase in the percentage of 40 percent or higher fill rates of anti-hypertensive medications at the top five prescribers. After notifying the providers about noncompliant beneficiaries, the MCP conducted IVR reminder calls to beneficiaries. The MCP reported no notable outcomes for the fill rates of beneficiaries assigned to the five providers due to the short measurement period. The MCP indicated that it adopted the IVR call intervention and plans to run another measurement cycle to determine the effectiveness of the medical director calls.

AAH's interventions did not result in the rate for the *Controlling High Blood Pressure* improving to above the MPL, and the MCP will be required to continue its IP for this measure.

Medication Management for People with Asthma

AAH identified the following barriers to the rates for the *Medication Management for People with Asthma—Medication Compliance 50% Total* and *Medication 75% Total* measures being above the MPLs, which are identical to the barriers identified for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Controlling High Blood Pressure* measures:

- ◆ Difficulty implementing a new claims processing system which caused a claims backlog and limited access to a complete data set.
- ◆ Budget constraints resulting in:
 - The MCP failing to implement quarterly beneficiary/provider monitoring and provider education.
 - Poor communication between patients and providers due to the providers not sending educational messages to their patients or due to language barriers.
 - Provider and beneficiary incentives not being available.

AAH implemented several interventions to address the barriers, including:

- ◆ Identified beneficiaries with persistent asthma who were not compliant with their controller medication 50 percent or 75 percent of the time.
- ◆ Conducted IVR calls to beneficiaries who did not retrieve their medications to:
 - Clarify the prescription schedules.
 - Identify triggers.

- Inform the beneficiary of the opportunity to reorder medications by mail after confirming with the pharmacy vendor to identify qualifying pharmacies.
- ◆ Engaged in greater oversight of the MCP's HEDIS vendor.

AAH also submitted two PDSA cycles for the *Medication Management for People with Asthma—Medication Compliance 50% Total* and *Medication 75% Total* measures. A summary of each cycle follows:

- ◆ The MCP identified two sites with 25 or more beneficiaries who were not compliant 50 percent or 75 percent of the time. The MCP tested whether or not conducting follow-up with children ages 5 to 11 years affected them taking their controller medication. No results were provided for this PDSA cycle.
- ◆ AAH produced quarterly reports identifying beneficiaries ages 5 to 64 years who received controller medication and were compliant less than 50 percent of the time. The MCP sent lists of noncompliant beneficiaries and tools to address the noncompliance. AAH also tested the effect of the MCP's Start for Service Program on the frequency of emergency department visits. Due to financial constraints, the MCP was not able to carry out all interventions. Additionally, since the program started later than anticipated, AAH was unable to make a decision regarding whether or not to adopt, adapt, or abandon the interventions. The MCP indicated that it plans to continue all interventions.

The rates for both *Medication Management for People with Asthma* measures improved significantly from RY 2014 to RY 2015, and the rate for the *Medication Compliance 75% Total* measure moved from below the MPL in RY 2014 to above the MPL in RY 2015. The rate for the *Medication Compliance 50% Total* measure remained below the MPL, and the MCP will be required to continue the IP for this measure.

Prenatal and Postpartum Care

AAH identified the following barriers to the rates for the *Prenatal and Postpartum Care—Postpartum Care* and *Timeliness of Prenatal Care* measures being above the MPL:

- ◆ Incomplete beneficiary encounter and supplemental data.
- ◆ Missing data from the MCP's delegated lab vendor.
- ◆ Lack of beneficiary education due to limited financial and human resources, which led to failure in making reminder calls to beneficiaries about prenatal and postpartum visits and the MCP not publishing the beneficiary educational newsletters.
- ◆ HEDIS vendor was delayed in collecting and reporting data prior to the due date.

AAH implemented the following interventions to address the barriers:

- ◆ Implemented a new claims system in January 2014 that allowed data to be sent in Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant format.
- ◆ Created a new data storage warehouse to address missing data issues.
- ◆ Conducted beneficiary education about the importance of prenatal and postpartum care and made IVR calls encouraging beneficiaries to schedule their prenatal and postpartum care visits.
- ◆ Conducted provider outreach.
- ◆ Developed a quarterly claims report to help the MCP monitor the number of beneficiaries receiving a prenatal visit or a postpartum visit between 21 and 56 days after delivery.
- ◆ Continuously analyzed beneficiary data to identify pregnant beneficiaries to encourage prenatal visits with their providers and help with identifying strategies to improve postpartum visit rates.

AAH also submitted one PDSA cycle for the *Prenatal and Postpartum Care* measures. A summary of the cycle follows:

- ◆ The MCP conducted monthly IVR calls to remind beneficiaries of their postpartum visit. The results showed a 66 percent to 80 percent IVR call completion rate and that the IVR call process worked as planned. The MCP planned to continue the calls in 2015. Additionally, the MCP is considering conducting a follow-up beneficiary survey to confirm if the improved postpartum visits rates are attributed to the IVR call program.

The rate for the *Postpartum Care* measure increased by just over 6 percentage points from RY 2014 to RY 2015; however, the improvement was not statistically significant and the rate remained below the MPL. The rate for the *Timeliness of Prenatal Care* measure declined significantly from RY 2014 to RY 2015 and remained below the MPL. AAH will be required to continue the IP for both measures.

Required Improvement Plans for RY 2015

In addition to being required to continue the IPs for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Controlling High Blood Pressure*, *Medication Management for People with Asthma—Medication Compliance 50% Total*, and both *Prenatal and Postpartum Care* measures, AAH will be required to submit IPs/PDSA cycles for the following measures based on RY 2015 rates:

- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Cervical Cancer Screening*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

Strengths

While AAH experienced many challenges during the NCQA HEDIS Compliance Audit process, HSAG auditors determined that AAH followed the appropriate specifications to produce valid rates.

The rate for one measure was above the HPL for the fifth consecutive year, and the rates for four measures improved significantly from RY 2014 to RY 2015, resulting in the rate for one measure moving from below the MPL in RY 2014 to above the MPL in RY 2015.

AAH provided documentation to HSAG of actions the MCP has taken to assess and address the factors resulting in the SPD rates for some measures being significantly worse than the non-SPD rates (See Table 6.1).

Opportunities for Improvement

AAH has the opportunity to address several issues of concern identified during the MCP's NCQA HEDIS Compliance Audit that caused significant impact on measure reporting to ensure a more efficient audit process for RY 2016.

AAH has the opportunity to identify the factors leading to statistically significant decline for 11 measures and the rates for 13 measures being below the MPLs, and to implement strategies that have the potential to result in improved outcomes. AAH also has the opportunity to assess the strategies the MCP implemented to address the higher rate of readmissions for the SPD population to determine if the strategies were successful at reducing readmissions for this population.

Quality Improvement Project Objectives

AAH participated in the statewide collaborative quality improvement project (QIP) and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists AAH'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, and timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for AAH
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension</i>	Clinical	Q, A

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

AAH's *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP measured the percentage of beneficiaries with a diagnosis of hypertension and compared it against national data to determine if there may be underreporting of the condition. To determine rates of medication adherence for beneficiaries diagnosed with hypertension, the MCP measured the percentage of beneficiaries who filled a prescription for their hypertensive medications. Hypertension is a risk factor for heart disease and stroke. Both the identification of high blood pressure and the management of the condition are important to prevent more serious complications.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
AAH—Alameda County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	81%	86%	<i>Partially Met</i>
Internal QIPs				
<i>Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension</i>	Annual Submission	64%	71%	<i>Not 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, 2014, through June 30, 2015, showed that AAH’s annual submission of its *All-Cause Readmissions* QIP received a *Partially Met* validation status. Additionally, the *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP received a *Not Met* validation status. Starting July 1, 2014, DHCS required each MCP with a QIP that did not achieve a *Met* validation status on the annual submission to submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, AAH conducted PDSA cycles for the *All-Cause Readmissions* and *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIPs.

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

Table 4.3—Quality Improvement Project Average Rates*
AAH—Alameda County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		100%	0%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	69%	25%	6%
	VIII: Appropriate Improvement Strategies	50%	0%	50%
Implementation Total**		63%	17%	21%
Outcomes	IX: Real Improvement Achieved**	25%	38%	38%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total**		33%	33%	33%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for AAH’s *All-Cause Readmissions* QIP annual submission and Activities I through X for the MCP’s *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP annual submission.

AAH demonstrated a strong application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. However, the MCP struggled with its application of the Implementation stage for both QIPs, meeting 63 percent of the requirements for all applicable evaluation elements within the study stage. The QIP received a lower score for Activity VII because for the *All-Cause Readmissions* QIP, AAH did not provide a readmissions rate that matched the audited rate reported to DHCS and did not interpret the extent to which the study was successful. Additionally, for the *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP, the MCP misinterpreted the findings of the study, as well as miscalculated the study indicator rate and statistical significance. The MCP did not meet any of the requirements for the applicable evaluation elements for Activity VIII for the *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP.

Both QIPs progressed to the Outcomes stage during the reporting period. However, the *All-Cause Readmissions* QIP did not improve at Remeasurement 1. Instead, the readmissions rate increased significantly from baseline to Remeasurement 1. For the *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP, the rate for one of the two study indicators declined for the second consecutive year. In this year’s annual submission, AAH changed the Remeasurement 1 rate for the second study indicator because the MCP discovered that an incorrect rate was reported in the 2013–14 QIP submission. Once the rate was corrected, the study indicator achieved statistically significant improvement at Remeasurement 1 and sustained the improvement at Remeasurement 2.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for AAH—Alameda County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions			
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]			
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Remeasurement 2 1/1/14–12/31/14	Sustained Improvement [*]
14.7%	17.4%**	‡	‡
QIP #2—Improving Anti-Hypertensive Medication Fills Among Members with Hypertension			
Study Indicator 1: The percentage of members 18–85 years of age continuously enrolled as of December 31 of each measurement year, with a diagnosis of hypertension in the first 6 months of the measurement year who filled at least one anti-hypertensive medication			
Baseline Period 1/1/11–12/31/11	Remeasurement 1 1/1/12–12/31/12	Remeasurement 2 1/1/13–12/31/13	Sustained Improvement [*]
65.6%	64.0%	61.8%	‡
Study Indicator 2: The percentage of members 18–85 years of age continuously enrolled as of December 31 of each measurement year, with a diagnosis of hypertension in the first 6 months of the measurement year and taking at least 1, 2, or 3 anti-hypertensive medications who had a fill rate of at least 40% during the measurement year			
Baseline Period 1/1/11–12/31/11	Remeasurement 1 1/1/12–12/31/12	Remeasurement 2 1/1/13–12/31/13	Sustained Improvement [*]
53.9%	65.6%*	68.6%	Yes

[^]A lower percentage indicates better performance.

[¥] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement from the baseline period (*p* value < 0.05).

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

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

All-Cause Readmissions

AAH's goal for the *All-Cause Readmissions* QIP was to reduce the readmission rate by 5 percent from baseline to Remeasurement 1. Unfortunately, the MCP was unable to meet the project's goal. A review of AAH's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ The Remeasurement 1 readmissions rate in the QIP Summary Form did not match the audited rate reported to DHCS.
- ◆ AAH did not document the extent to which the study was successful in the QIP Summary Form.
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions AAH indicated it planned to implement during the Remeasurement 1 time period:
 - Conduct in-home visits with Medi-Cal beneficiaries discharged from the hospital. The visit includes collecting past medical and family history information, conducting medication review, assessing functional status, and addressing beneficiaries' needs (care coordination referrals, test orders, etc.).
 - Continue to work with providers to obtain timely, accurate, and complete encounter files and claims.

Improving Anti-Hypertensive Medication Fills Among Members with Hypertension

AAH's objective for the *Improving Anti-Hypertensive Medication Fills Among Members with Hypertension* QIP was to achieve a 5 percent improvement for each indicator every year. From baseline to Remeasurement 2, this QIP did not achieve the MCP's objective for either study indicator. The rates for Study Indicator 1 decreased from baseline to Remeasurement 1 and from Remeasurement 1 to Remeasurement 2. For Study Indicator 2, AAH indicated that the Remeasurement 1 rate was incorrectly reported in the 2013–14 QIP submission due to applying a past methodology which undercounted the number of prescriptions filled. Once the rate was corrected, the rate for Study Indicator 2 achieved statistically significant improvement at Remeasurement 1 and sustained the improvement at Remeasurement 2. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ AAH did not provide its causal/barrier analysis for Remeasurement 2.
- ◆ It was not clear which interventions were new, which were continued, and which were abandoned since AAH did not document the month and year each intervention was implemented and the status of each intervention during Remeasurement 2.
- ◆ AAH did not provide an evaluation of individual interventions to determine which interventions were successful at impacting the study indicator rates.

Plan-Do-Study-Act Review

Since neither QIP achieved a *Met* validation status on the annual submission, the MCP was required to conduct a PDSA cycle for each QIP topic.

All-Cause Readmissions

For the *All-Cause Readmissions* PDSA cycle, AAH set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By March 31, 2015, reduce *All-Cause Readmissions* rates as a result of the Transition of Care (TOC) team successfully contacting at least 75 percent of beneficiaries recently discharged from an acute hospital and at risk for readmission. The priority barrier addressed by this objective is a beneficiary's inability to self-manage his or her health care.

The purpose of the *All-Cause Readmissions* PDSA cycle was to test the success of the TOC team's post-discharge outreach calls connecting with beneficiaries, while keeping the existing processes the same.

AAH completed the *All-Cause Readmissions* PDSA cycle and reported an overall post-discharge call success rate of 27 percent. While the MCP did not meet the goal of 75 percent, the MCP determined that the readmissions rate was lower for beneficiaries who received an outreach call compared to those who did not. For beneficiaries who were reached, the readmissions rate was 19.2 percent and for beneficiaries who could not be reached, the readmissions rate was 34.3 percent. Thus, AAH adopted the change and planned to continue to work toward achieving the goal of a 75 percent successful call rate.

Anti-Hypertensive Medication Fills Among Members with Hypertension

For the *Anti-Hypertensive Medication Fills Among Members with Hypertension* PDSA cycle, AAH set the SMART Objective as follows:

By March 31, 2015, the targeted prescribers will increase by 10 percent their anti-hypertensive 40 percent or higher fill rates.

The purpose of the *Anti-Hypertensive Medication Fills Among Members with Hypertension* PDSA cycle was to test whether or not the medical director's call to the top five providers with the most beneficiary medication fill rates below 40 percent increased medication fill rates of 40 percent or higher by 10 percent.

AAH completed the *Anti-Hypertensive Medication Fills Among Members with Hypertension* PDSA cycle and concluded that the change did not produce any notable outcomes in the short measurement period of the PDSA cycle. AAH provided the medication possession ratio (MPR) for eligible beneficiaries with hypertension with one or more prescribers for less than six months. The result for January 2014 to November 2014 was 78.9 percent, and the result for January 2015 to March 2015 was 78.2 percent. Before deciding to adopt or adapt the change, AAH planned to conduct another cycle of calls to the top five prescribers and analyze 90-day MPR results to see if the rates were impacted.

Strengths

AAH demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Anti-Hypertensive Medication Fills Among Members with Hypertension* QIPs. The *Anti-Hypertensive Medication Fills Among Members with Hypertension* QIP achieved statistically significant and sustained improvement for one of the two study indicators.

Opportunities for Improvement

Although the *All-Cause Readmissions* PDSA cycle did not achieve its goal, AAH determined that the readmissions rate was lower for beneficiaries who received an outreach call compared to those who did not. Thus, AAH should follow the documented plans to adopt the change to reach more beneficiaries through outreach calls. Additionally, for the *Anti-Hypertensive Medication Fills Among Members with Hypertension* PDSA cycle, AAH should continue to test the calls and examine medication fill percentages for the top five providers with the most beneficiaries with rates below 40 percent. If the calls are not effective, the MCP should identify potential modifications and test again, or abandon the change and identify a new change that can be tested.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

AAH’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10 th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25 th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75 th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90 th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90 th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10 th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25 th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75 th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90 th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90 th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for AAH. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for AAH

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	18.3%	26.3%	25th–75th	4.4%	9.2%	75th–90th
Diagnosis Code	30.6%	31.6%	25th–75th	26.5%	34.6%	75th–90th
Procedure Code	46.3%	43.8%	10th–25th	15.1%	22.5%	75th–90th
Procedure Code Modifier	72.3%	58.5%	<10th	55.2%	46.0%	10th–25th
Rendering Provider Name	19.5%	25.0%	25th–75th	30.6%	68.1%	75th–90th
Billing Provider Name	28.2%	35.0%	25th–75th	4.8%	8.6%	75th–90th

Overall, the medical record omission rates for AAH ranged from 18.3 percent (*Date of Service*) to 72.3 percent (*Procedure Code Modifier*). Four of AAH’s medical record omission rates were slightly better than the respective statewide rates, and the remaining two rates were worse than the statewide rates by 2.5 and 13.8 percentage points for the *Procedure Code* and *Procedure Code Modifier*, respectively. When compared to other MCPs’ performance, AAH received a percentile ranking of “25th–75th” for four of the six medical record omission rates, “10th–25th” for one rate, and “<10th” for another rate. These findings suggest a somewhat average to low level of completeness among key encounter data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for AAH contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, AAH’s rates varied from 4.4 percent (*Date of Service*) to 55.2 percent (*Procedure Code Modifier*). Five of AAH’s encounter data omission rates were better than the respective statewide rates, and the *Rendering Provider Name* encounter omission rate was better than the statewide rates by 37.5 percentage points. However, AAH performed worse than the statewide

encounter data omission rate by 9.2 percentage points for the *Procedure Code Modifier* data element. An opportunity exists for AAH to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider’s billing office made a coding error.
- ◆ DHCS’s encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in AAH’s encounter data submission process, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider’s performance of the service and submission of the encounter to AAH (and/or the data subsequently being submitted to DHCS).
- ◆ AAH populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files AAH submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for AAH. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for AAH

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	70.2%	83.6%	<10th	Inaccurate Code (71.5%)
Procedure Code	67.7%	77.6%	10th–25th	Lower Level of Services in Medical Records (63.7%); Inaccurate Code (20.8%)
Procedure Code Modifier	NA	99.5%	NA	—
Rendering Provider Name	52.0%	63.0%	10th–25th	Incorrect Names (57.9%)
Billing Provider Name	65.5%	68.6%	25th–75th	Incorrect Names (100%)
All-Element Accuracy	4.0%	4.3%	>25th–<75th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be of less than average accuracy for AAH, with all four reported element accuracy rates

lower than the respective statewide rates and one of those rates (*Billing Provider Name*) approximately equal to the statewide rate. The *Diagnosis Code* data element received a percentile ranking of “<10th,” with the majority of the diagnosis-related errors involving discrepancies in the use of inaccurate codes compared to national coding standards rather than specificity errors. For the *Procedure Code* data element, 63.7 percent of errors were associated with higher-level procedure codes in the DHCS encounter data than were documented in the beneficiaries’ medical records (i.e., the procedure code was considered in error due to a lower level of service documented in the medical record), and 20.8 percent of unmatched procedure codes were associated with the use of inaccurate codes, wherein the reported codes were not supported by national coding standards. All billing provider name errors were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records.

Although AAH’s all-element accuracy rate was slightly lower than the statewide rate, only 4.0 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for 96 percent of the dates of service reviewed in this study. While all five key data elements contributed to AAH’s relatively low all-element accuracy rate, the *Procedure Code Modifier* data element contributed the least.

Medical Record Review Recommendations

Based on the study findings for AAH, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, AAH should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. AAH should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.

- ◆ AAH should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ AAH should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code* and *Procedure Code Modifier* data elements and develop strategies to improve rates.
- ◆ AAH should explore the reasons for the relatively high encounter data omission rates for the *Procedure Code Modifier* data elements and take actions to improve rates.
- ◆ AAH should investigate the reasons for the relatively low element accuracy rates for the *Rendering Provider Name*, *Diagnosis Code*, and *Procedure Code* data elements and take actions to improve rates.
- ◆ AAH should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with AAH.
- ◆ AAH should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted the scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only

contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.

- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

AAH's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to the Post Adjudicated Claims and Encounters System (PACES). Based on review of AAH's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist AAH with improving its encounter data quality. DHCS followed up with AAH regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of AAH's performance in the three domains of care—quality, access, and timeliness.

Quality

HSAG reviewed AAH's Quality Improvement Program Description 2015 document, which included updates to the work plan, organizational chart, and data collection methods, and a description of the newly formed Quality Improvement Subcommittee. The MCP appears to have a quality improvement program structure designed to ensure quality care is provided to its beneficiaries.

The rate for the *Use of Imaging Studies for Low Back Pain* measure, which falls into the quality domain of care, was above the HPL for the fifth consecutive year.

The rates for the following quality measures improved significantly from RY 2014 to RY 2015:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total*, resulting in the rate for the measure moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*; however, the rate for the measure remained below the MPL for the third consecutive year

In addition to the rate for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure being below the MPL, the rates for the following quality measures were below the MPLs in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*—the rate for this measure declined significantly from RY 2014 to RY 2015, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Cervical Cancer Screening*—the rate for this measure declined from RY 2014 to RY 2015, and although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*—the rate for this measure declined significantly from RY 2014 to RY 2015, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*—the rate for this measure declined from RY 2014 to RY 2015, and although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Controlling High Blood Pressure*
- ◆ *Prenatal and Postpartum Care—Postpartum Care* for the third consecutive year
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*—the rate for this measure declined significantly from RY 2014 and RY 2015, resulting in the rate remaining below the MPL

In addition to the rates for the *Annual Monitoring for Patients on Persistent Medications—Diuretics*, *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*, and *Prenatal and Postpartum Care—Timeliness of Care* measures declining significantly from RY 2014 to RY 2015, the rates for the following quality measures declined significantly from RY 2014 to RY 2015:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

For quality measures stratified by the SPD and non-SPD populations, the SPD rates for the *Annual Monitoring for Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures were significantly better than the non-SPD rates. Additionally, the SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of AAH's QIPs fell into the quality domain of care, and both progressed to the Outcomes stage. The *Improving Anti-Hypertensive Diagnosis and Medication Fills Members with Hypertension* QIP achieved statistically significant improvement at Remeasurement 1 and sustained the improvement at Remeasurement 2, suggesting that the implemented interventions were effective at improving the quality of care being provided to beneficiaries with hypertension. Note: In AAH's 2013–14 MCP-specific evaluation report, HSAG indicated that the QIP did not show improvement at Remeasurement 1; however, during the review period for this report, the MCP submitted revised data which showed that significant improvement had been achieved. AAH's documentation for the *Anti-Hypertensive Medication Fills Among Members with Hypertension* PDSA cycle stated that the MCP had insufficient time to assess the effectiveness of the calls to the top five prescribers and planned to conduct another cycle of making the calls to see whether or not the calls make an impact on the medication fill rates for beneficiaries with hypertension.

The *All-Cause Readmissions* QIP did not achieve statistically significant improvement over baseline at Remeasurement 1. The readmissions rate at Remeasurement 1 was significantly higher than the baseline rate, meaning that when compared to the baseline rate, significantly more beneficiaries (ages 21 years and older) were readmitted within 30 days of an inpatient discharge. AAH's *All-Cause Readmissions* PDSA cycle results showed that beneficiaries who received a post-discharge call had a lower readmissions rate and the MCP decided to continue making the calls to reduce readmissions rates.

Overall, AAH showed below-average performance related to the quality domain of care.

Access

AAH's Quality Improvement Program Description 2015 document includes descriptions of mechanisms the MCP implements to ensure beneficiary access to needed health care services.

The rates for the following access measures improved significantly from RY 2014 to RY 2015:

- ◆ *Childhood Immunization Status—Combination 3*

- ◆ *Comprehensive Diabetes Care—HbA1c Testing*

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

- ◆ *Cervical Cancer Screening*— the rate for this measure declined from RY 2014 to RY 2015, and although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ All four *Children and Adolescents' Access to Primary Care Practitioners* measures for the fourth consecutive year—In addition to the rates being below the MPLs, the rates declined significantly from RY 2014 to RY 2015
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*—the rate for this measure declined from RY 2014 to RY 2015, and although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Prenatal and Postpartum Care—Postpartum Care* for the third consecutive year
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*—the rate for this measure declined significantly from RY 2014 and RY 2015, resulting in the rate remaining below the MPL

Five measures stratified for the SPD and non-SPD populations fall into the access domain of care. The *All-Cause Readmissions* measure is one of the measures, and as stated above, the SPD rate was significantly worse than the non-SPD rate, which is to be expected. The SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure was significantly better than the non-SPD rate, and the SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure was significantly worse than the non-SPD rate. The comparatively higher SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure may be attributed to older adolescents relying on specialist providers as their care source, based on complicated health care needs, rather than accessing care from a primary care practitioner.

Both of AAH's QIPs fell into the access domain of care and as stated above, both progressed to the Outcomes stage. Also as stated above, the *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP achieved statistically significant improvement at Remeasurement 1 and sustained that improvement at Remeasurement 2. The improvement suggests that the implemented interventions were effective at improving access to care for beneficiaries with hypertension. Finally, as indicated above, AAH stated that during the PDSA cycle, the MCP had insufficient time to assess the effectiveness of the calls to the top five prescribers and planned to conduct another cycle of making the calls to see whether or not the calls make an impact on the medication fill rates for beneficiaries with hypertension.

As stated above, the *All-Cause Readmissions* QIP did not achieve statistically significant improvement over baseline at Remeasurement 1, and the readmissions rate at Remeasurement 1

was significantly higher than the baseline rate, meaning that when compared to the baseline rate, significantly more beneficiaries (ages 21 years and older) were readmitted within 30 days of an inpatient discharge. Also as indicated above, AAH's *All-Cause Readmissions* PDSA cycle results showed that beneficiaries who received a post-discharge call had a lower readmissions rate and the MCP decided to continue making the calls to reduce readmissions rates.

Overall, AAH showed below-average performance related to the access domain of care.

Timeliness

AAH's Quality Improvement Program Description 2015 provides a brief summary of the MCP's utilization management staff and its responsibilities. AAH's 2014 quality improvement program evaluation document indicates that the MCP delegates the utilization management function and that all delegates achieved 100 percent compliance.

The rate for the *Childhood Immunization Status—Combination 3* measure, which falls into the timeliness domain of care, improved significantly from RY 2014 to RY 2015. The rates for both *Prenatal and Postpartum Care* measures, which also fall into the timeliness domain of care, were below the MPLs, and the *Postpartum Care* measure rate was below the MPL for the third consecutive year. Additionally, the rate for the *Timeliness of Prenatal Care* measure declined significantly from RY 2014 to RY 2015.

Overall, AAH showed average performance related to the timeliness domain of care (based on the standardized scoring for the timeliness domain).

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with AAH's self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP's self-reported actions.

Table 6.1—AAH’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to AAH	Self-Reported Actions Taken by AAH during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Fully resolve the two deficiencies in the area of Access and Availability from the SPD medical survey.</p>	<p>Deficiency 1, as described in the CAP closed letter dated 10/1/2014, was that the plan’s online and printed directory did not include the <i>level of access results</i> for each provider’s address. The plan-proposed action to address this deficiency was accepted and the finding was closed. However, the correction of this deficiency in the online and printed directory was not scheduled to take place until December 2014. DHCS indicated that this correction would be verified in a subsequent audit. The updates to both the online and printed directories occurred and were approved by DHCS. See the attached DHCS emails from April and July 2015. Also attached are sample pages from the provider directory displaying level of access indicators.</p> <p>Deficiency 2, as described in the CAP close letter dated 10/1/2014, pertained to the appointment availability provider survey questions used by the plan. The plan’s corrective action was accepted. However, the plan was instructed to submit its P&P with a target/goal regarding the monitoring of the availability of appointments within its provider network. Attached to this submission is an updated P&P titled: MED-QM-0024 Provider Access and Availability Survey. The Alliance recently joined the ICE [Industry Collaboration Effort] DMHC [Department of Managed Health Care] Access Regulations Appointment Availability Survey Single-Vendor Initiative. The Provider Access and Availability Survey will be completed and results provided to the Alliance and other Medi-Cal health plans participating in this initiative.</p>
<p>2. Ensure that the actions the MCP has taken to address the deficiency identified during the DMHC routine medical survey in the area of Prescription (RX) Drug Coverage meet DMHC’s requirements.</p>	<p>Prior Authorizations (PA) Pharmacists at Alameda Alliance work closely to create member denial letters in an accurate and member - friendly manner. We have developed the denial language matrices that are being updated and edited continuously. See document, AAH Medi-Cal Rationales, which includes the template language matrices coded in the PA system. Latest change to this document was made in May, 2015.</p> <p>We have drug-specific denial reasons for more complex criteria, such as entecavir (treatment for Hepatitis B). See document, <i>Medical Necessary Rationale</i>, which includes drug-specific denial reasons. This was last updated in June 2015.</p> <p>Before sending the letters, PA Pharmacists review each other’s denial language when appropriate denial matrix is not available. The Pharmacy Director reviews more complicated denial cases to ensure the denial reasons are member friendly.</p> <p>Denial letters are audited throughout the year. In May 2015, a sample of 10 denial files were reviewed for the elements:</p> <ol style="list-style-type: none"> 1. Turnaround time (TAT) has been met, and 2. Member denial letter has a complete and member friendly

2013–14 External Quality Review Recommendation Directed to AAH	Self-Reported Actions Taken by AAH during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>denial reason.</p> <p>We have looked at 10 denied cases. All 10 cases met the TAT. Two (2) out of 10 cases had issues with the denial reason. One case had a syntax error and the other case involved using acronyms and medical terminology that the members might not understand. Please see <i>Pharmacy PA Denial Language Review 2015</i> log for details on each case.</p>
<p>3. Since the MCP had 10 measures with rates below the MPLs and nine measures with rates that were significantly worse in 2014 when compared to 2013, work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once. AAH may want to focus efforts on the following measures first since the MCP is required to submit IPs for each of them in 2014:</p> <ul style="list-style-type: none"> a. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs –MPM-ACE/ARB</i> b. <i>Controlling High Blood Pressure - CBP</i> c. <i>Both Medication Management for People with Asthma measures -MMA- 50% & 75%</i> d. <i>Both Prenatal and Postpartum Care measures - PPC-Prenatal & Postpartum</i> 	<p>The Alliance initiated Improvement Plans (IP) for the four (4) 2014 (RY) HEDIS measures below the Minimum Performance Level (MPL) according to DHCS email guidance received 7/1/2014. The IP for PPC- Postpartum visits was continued from the 2013 (RY) HEDIS cycle. On 8/18/2014, the Alliance received DHCS notice of the plan’s IP prioritization and Plan-Do-Study-Act (PDSA) submission timeline for 4 IPs. Listed below are descriptions of each IP and their PDSA submissions, the activities for each, and any results:</p> <p>a. <u>MPM-ACE/ARB</u></p> <p>A PDSA Worksheet for the MPM-ACE/ARB HEDIS measure was submitted 10/1/2014, as scheduled. Activities implemented for this IP included:</p> <ul style="list-style-type: none"> ▪ On 10/6/2014, the Alliance emailed plan providers a Provider Tip Sheet that addressed changes in the HEDIS 2015 MPM measure as well as the purpose for monitoring members on these medications. ▪ In the winter of 2014, a Provider Bulletin was sent to providers outlining the plan’s HEDIS improvement strategies. ▪ The spring 2015 edition of the members “Alliance Alert” newsletter included an article highlighting the importance of taking medications as prescribed, communicating with providers regarding missed doses, side effects, and any questions they might have before starting a new medication. <p>A DHCS-MMCD [Medi-Cal Managed Care Division] evaluation was not received for this PDSA.</p> <p>The IP for the MPM ACE/ARB measure was removed from the Alliance’s IP requirements during a DHCS/HSAG technical assistance call with the plan on November 20, 2014.</p> <p>b. <u>CBP</u></p> <p>A PDSA Worksheet for the CBP measures was submitted on 10/2/2014, as directed. Activities implemented for this IP included:</p> <p>Provider Outreach:</p> <ul style="list-style-type: none"> ▪ On 10/6/14, the Alliance emailed a Provider Tip Sheet that addressed changes in the HEDIS 2015 CBP measure to Alliance Provider; tips for encouraging best practices were also sent. ▪ In winter 2014, a Provider Bulletin was emailed/faxed providers outlining our HEDIS improvement strategies.

2013–14 External Quality Review Recommendation Directed to AAH	Self-Reported Actions Taken by AAH during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>Member outreach:</p> <ul style="list-style-type: none"> ▪ In fall 2014, the Alliance identified members with uncontrolled Hypertension who were either noncompliant in taking their medications or who were never prescribed medications for their diagnosis. ▪ Members who did not retrieve their medications from pharmacy were sent an IVR reminder call. ▪ In 2014, members were offered an option for a 90-day supply for maintenance medications. <p>DHCS-MMCD notified the Alliance in November 2014 that the CBP IP would be combined with the plan’s Quality Improvement Project (QIP) titled “Improving Anti-hypertensive Medication Fills Among Beneficiaries with Hypertension. “ The QIP’s most recent annual submission occurred on 8/27/2014.</p> <p>Intervention activities for the Anti-hypertensive QIP that were continued in 2014 included:</p> <ul style="list-style-type: none"> ▪ Posting information about the Controlling High Blood Pressure measure for HEDIS on the Alliance website and as part of training packets for Provider Services to distribute to providers during provider office visits. ▪ Hypertension clinical practice guidelines were reviewed and approved by the Health Care Quality Committee (HCQC) and posted on the Alliance website for providers. ▪ Provider Services quarterly visits to providers included a HEDIS handout with the Controlling High Blood Pressure measure. ▪ A Health Educator was hired to assist with health education activities. ▪ A Clinical Pharmacist was hired to assist with quality improvement activities. ▪ A Quality Analyst was hired to assist with quality improvement project analysis. ▪ Provided targeted outreach through Case Management and Disease Management; members were also sent reminder letters and tools that empower members to take their medication correctly. <p>A PDSA Worksheet for the now combined Anti-hypertensive QIP and CBP IP was submitted 12/9/2014, as scheduled. A corrected PDSA Worksheet was submitted 12/24/2014. DHCS-MCMC feedback on the 12/24/2014 PDSA Worksheet rated the submission as acceptable.</p> <p>New activities implemented included:</p> <p>By 12/9/2014:</p> <ul style="list-style-type: none"> ▪ Pharmacy Department staff obtained a member anti-hypertensive fill rate report. ▪ Quality Department staff sorted the above report. <p>By 12/31/2014:</p> <ul style="list-style-type: none"> ▪ Quality, Health Education, Communications and Network

2013–14 External Quality Review Recommendation Directed to AAH	Self-Reported Actions Taken by AAH during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>Management staff developed:</p> <ul style="list-style-type: none"> ○ A provider message to accompany the member list, and ○ Talking points for the Medical Director call to top 5 providers with the most member anti-hypertensive medication fill rates below 40%. <ul style="list-style-type: none"> ▪ Network Management staff distributed member anti-hypertensive medication fill rate lists via email to the prescribing provider. <p>By 1/31/2015:</p> <ul style="list-style-type: none"> ▪ Plan Medical Directors called* the above top 5 providers and deliver[ed] “talking point” message. <p>* Medical Director calls to the 5 providers occurred March 3–6, 2015. Provider response to the calls was positive.</p> <p>By 3/31/2014:</p> <p>2,048 Members with a diagnosis of hypertensive and an anti-hypertensive medication prescription were sent an IVR medication reminder call. The IVR call completion rate was 80.6%.</p> <p>A PDSA Worksheet for the now combined Anti-hypertensive QIP and CBP IP was submitted 4/30/2015, as scheduled. No new activities were implemented.</p> <p>c. MMA</p> <p>An HSAG Improvement Plan for the MMA measures was submitted on 11/2/2014, as directed. Intervention activities reported in this PDSA included:</p> <ul style="list-style-type: none"> ▪ On 10/6/14, the Alliance emailed network providers a Provider Tip Sheet that addressed changes in the HEDIS 2015 MMA measure as well as tips for encouraging best practices. ▪ The Provider Services quarterly site visits were modified to include sharing current HEDIS practice measures, including MMA strategies. ▪ In winter of 2014, a Provider Bulletin was emailed/faxed [to] providers outlining our HEDIS improvement strategies. ▪ In October 2014, a Provider Tip Sheet was emailed to plan providers outlining HEDIS measures below MPL with guidelines/tips. ▪ The Quality Department staff collaborates with the Analytics Department to identify member Asthma and MMA utilization trends. ▪ In the fall of 2014, members with persistent asthma who were not compliant with their controller medication 25% of the time and 75% of the time were identified: <ul style="list-style-type: none"> ○ Members who did not retrieve their medications from pharmacy were reminded through an IVR call.

2013–14 External Quality Review Recommendation Directed to AAH	Self-Reported Actions Taken by AAH during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<ul style="list-style-type: none"> ○ Health education materials were posted on the plan website, and distributed to members upon request, to educate members on the importance of reporting side effects, clearing up any confusion with the prescriptions schedule and identifying triggers. ○ Members were informed in member mailed materials and on the plan’s website of the opportunity to reorder medications by mail. <p>A PDSA Worksheet for the MMA IP with an activity update was submitted 12/24/2014, as scheduled. Additional activities implemented for this project included:</p> <ul style="list-style-type: none"> ▪ The Alliance’s QI and Pharmacy staff arranged for controller medication Q3-2014 reports from the Pharmacy Benefit Management vendor database. ▪ Care Management/Disease Management (CM/DM) staff received weekly reports from Alameda County Asthma Start Program identifying Alameda Alliance Medi-Cal children referred to the Asthma Start Program: <ul style="list-style-type: none"> ○ CM/DM staff calls and mails literature to members informing them of Asthma Start outreach resources, encouraging their participation. ○ Members who agree are enrolled in the plan’s asthma disease management program. ○ Plan health navigators make follow-up calls to members not contacted and encourage them to rejoin the asthma Start Program. ▪ The inter-agency weekly referral process between the county Asthma Start Program and the Alliance CM/DM program was enhanced in spring 2015: <ul style="list-style-type: none"> ○ The Alliance now sends member health information to Asthma Start contacts to include inpatient and ED visit history and medication history/compliance. ▪ The Alliance’s QI and Pharmacy staff matched controller medication compliance reports with names of children enrolled in the Asthma Start Program who were contacted/not contacted for Q3-2014 and at the end of Q1-2015; this information was forwarded to CM/DM staff. ▪ In April 2015, an IVR call was placed to AAH children with a diagnosis of asthma who were prescribed a controller medication but whose pharmacy records indicated noncompliance. A 63% call completion rate was achieved. ▪ Alliance Health Education staff attended the Alameda Asthma Coalition “World Asthma Day” in spring 2015 and met with Alliance members who attended the event. ▪ The June 2015 Provider Bulletin issue included an article titled “Asthma and Diagnosing.”

2013–14 External Quality Review Recommendation Directed to AAH	Self-Reported Actions Taken by AAH during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<ul style="list-style-type: none"> ▪ The Alliance continues to reimburse the American Lung Association for members who participate in a school-based asthma program called “Oakland Kicks Asthma.” <p>d. PPC IP</p> <p>A single PDSA Worksheet for the two (2) PPC measures was submitted on 9/2/2014, as directed. Intervention activities reported in this PDSA included:</p> <ul style="list-style-type: none"> ▪ Starting 7/22/2014, IVR calls encouraging a postpartum visit are made monthly to Medi-Cal members who delivered a baby in the prior month. ▪ Starting with the fall 2014 edition, and annually thereafter, the Alliance <i>Member Alert</i> will include an article informing Medi-Cal members about the importance of a postpartum visit between 21–56 days after delivering a baby. ▪ Starting with the fall 2014 edition, and annually thereafter, the Alliance <i>Provider Bulletin</i> will include an article informing providers that deliver babies to do a follow-up postpartum visit within the appropriate time frame. ▪ A quarterly claim report was developed to monitor the number of Medi-Cal members who receive a postpartum visit between 21–56 days after delivery. ▪ Starting with the fall 2014 edition, and annually thereafter, the Alliance <i>Member Alert</i> will include an article informing Medi-Cal members about the importance of making and keeping prenatal visits with their provider. ▪ Prenatal education materials are mailed weekly from the Health Education unit to Medi-Cal members whose claims indicate a service for a recently diagnosed pregnancy. This has been and is an ongoing activity. <p>The DHCS-MMCD evaluation of the above PDSA submission was received by the plan on September 24, 2014. A “not met” score was issued because no quantitative data was [were] collected or submitted. All other evaluation elements were rated as “met.”</p> <p>PDSA Worksheets for the PPC IP were submitted December 9, 2014 (1 week extension was approved) and March 13, 2015. A DHCS-MMCD evaluation was not received for either PDSA submission. The activities listed above were continued. Data results from the monthly postpartum IVR calls were reported. Completion rates for July 2014 through April 2015 monthly calls ranged from 55–85% for an average of 68%. Results of a claim analysis for the completed postpartum reminder IVR calls from November 2015 through May 2015 were varied. Postpartum visit dates of service from December 2014 and April 2015 were within the recommended 3–8 weeks after delivery for an average of 28% of members receiving a completed postpartum reminder IVR call.</p>

<p>2013–14 External Quality Review Recommendation Directed to AAH</p>	<p>Self-Reported Actions Taken by AAH during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation</p>
<p>4. Assess the factors leading to the SPD rates for the <i>All-Cause Readmissions</i> and <i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i> measures being significantly worse than the non-SPD rates to ensure that the MCP is meeting the needs of the SPD population.</p>	<p><u>SPD rates for the All-Cause Readmissions</u></p> <p>The plan experienced a higher All-Cause Readmission Rate in the SPD population compared to the non-SPD population. Multiple factors contribute to the higher rate in the SPD population, including:</p> <ul style="list-style-type: none"> ▪ Higher count of medical comorbidities in the SPD population compared to non-SPD members, as indicated by the higher risk scores. ▪ Medical comorbidities, when present, are more complex. ▪ Higher incidence of behavioral and psycho-social issues in the SPD population, thereby limiting the ability of the member to provide self-care post hospital discharge. ▪ Members with a previous hospital admission, as identified through the Health Risk Assessment (HRA), did not receive a care plan. ▪ Absence of a comprehensive case management program targeted to the unique needs of the SPD population; the case management program in place at the time was not specific to membership types. ▪ Absence of a Transition of Care (TOC) program to facilitate hospital discharge planning and post-discharge case management. ▪ Absence of a Concurrent Review (CCR) process to evaluate admissions against criteria and only approve admissions when medically necessary. The denials of inappropriate inpatient admissions serves to encourage hospitals to appropriately evaluate patients in an outpatient observation setting before admitting to the inpatient setting. <p>Both SPD and non-SPD members were affected by the absence of a TOC and CCR process. However, SPD members experienced a greater negative impact due to their more complex medical conditions, thus contributing to the higher all-cause readmission rate.</p> <p>The plan recognizes the need for more management of SPD members to reduce the readmission rates for these members. The plan implemented multiple strategies to better identify SPD members recently hospitalized for case management, review the admissions at the time it occurs, and provide post-discharge case management.</p> <p>HRA Process:</p> <ul style="list-style-type: none"> ▪ Members receive a care plan from a case manager when HRA responses indicate a recent hospitalization or multiple emergency room admissions. ▪ Following the care plan, members are assessed for eligibility and enrollment into other case and disease management programs. <p>CCR Process:</p> <ul style="list-style-type: none"> ▪ Inpatient Utilization Management (UM) Nurses review hospital admissions and additional bed days for medical necessity using MCG (a nationally recognized set of clinical guidelines). ▪ UM nurses collaborate with the plan’s Medical Director(s) to

2013–14 External Quality Review Recommendation Directed to AAH	Self-Reported Actions Taken by AAH during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>determine medical necessity and when deemed to be not medically necessary, the plan issues denials to hospitals for the same day.</p> <ul style="list-style-type: none"> ▪ Medical Director(s) are available for peer-to-peer discussions on difficult cases and collaborate on the best treatment plan for the member. <p>Transition of Care Process:</p> <ul style="list-style-type: none"> ▪ An Alliance UM Nurse manages the placement process for members currently in the hospital that need a lower level of care upon discharge (i.e., skilled nursing facility, long-term acute, sub-acute). ▪ The UM Nurse coordinates the discharge process with the hospital case managers to ensure safe discharge. <p>Members with complex medical conditions are also identified for case management for 30 days post discharge. Case Managers establish contact with members within 72 hours post discharge and follow up at the 7, 15, 21, and 28 days post-discharge. Through the series of interactions, Case Managers address member’s needs and concerns related to access to care, pharmaceuticals, and overall health conditions. At the end of the 28 day mark, members are assessed for eligibility for other case management programs.</p> <p><u>SPD Rates for Children and Adolescents’ Access to Primary Care Practitioners (CAP)</u></p> <p>The majority of SPD members in the 12–19-year-old group are in the SPD disabled aid code. Additionally, these members may also be CCS eligible. The lower CAP measure rate for these SPD members may be due to their use of a specialist as a primary care provider (PCP). Claim and encounter data from a Specialist acting as a PCP would not be included when HEDIS sample member data for the CAP measure is [are] calculated. As a result, the SPD CAP rate would appear worse than the non-SPD rate. Additionally, non-SPD members in this age group are more likely to participate in school and community athletic activities that may require an annual physical.</p>
<p>5. Refer to the QIP Completion Instructions and previous QIP validation tools prior to submitting QIPs to ensure data completeness.</p>	<p>The Alliance’s Quality Department staff will review the QIP requirements, completion instructions, and previous QIP validation tools prior to submitting future QIPs to ensure data completeness and accuracy.</p>
<p>6. Since AAH’s <i>Improving Anti-Hypertensive Medication Fills Among Members with Hypertension</i> QIP has not been successful at improving the indicators’ rates, conduct a new causal/barrier analysis and assess if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.</p>	<p>See attached document named “Recommendation 6__MCP Response- Anti-hypertensive QIP.pdf” for the response to this recommendation.</p>

Recommendations

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

- ◆ Address several issues of concern identified during the MCP's NCQA HEDIS Compliance Audit that caused significant impact on measure reporting to ensure a more efficient audit process for RY 2016. Specifically, the MCP should:
 - Implement ongoing monitoring and oversight of all delegated entities to enable the MCP to proactively identify any process issues or changes with its partners. This will allow the MCP sufficient time to test new data processes and ensure data completeness and accuracy.
 - Consider using the data from the Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM 160 form) for future HEDIS rate production to help reduce medical record review costs.
 - Use industry standard codes to ensure all services on claims are included rather than having to rely on capturing the services through medical record review. Note: the auditor has made this recommendation in previous years.
 - Build internal MCP knowledge based on HEDIS policies and procedures and ensure that formal process documentation exists to train new staff members.
- ◆ Identify the factors leading to statistically significant decline for 11 measures and the rates for 13 measures being below the MPLs and implement strategies that have the potential to result in improved outcomes.
- ◆ Assess the strategies the MCP implemented to address the higher rate of readmissions for the SPD population to determine if the strategies were successful at reducing readmissions for this population.
- ◆ Although AAH will not be continuing the formal QIPs or PDSA cycles, the MCP should:
 - ◆ Follow the documented plans to reach more beneficiaries through post-discharge outreach calls to reduce *All-Cause Readmissions*.
 - ◆ Continue to test outreach calls and examine medication fill percentages for the top five providers with the most beneficiaries with rates below 40 percent through additional *Anti-Hypertensive Medication Fills Among Members with Hypertension* PDSA cycles. If the calls are not effective, the MCP should identify potential modifications and test again, or abandon the change and identify a new change that can be tested.
- ◆ Review the 2013–14 Encounter Data Validation Study Report and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix C:
Performance Evaluation Report
Anthem Blue Cross Partnership Plan
July 1, 2014 – June 30, 2015**

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Appendix C: Performance Evaluation Report

Anthem Blue Cross Partnership Plan

July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Anthem Blue Cross Partnership Plan (“Anthem” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

Anthem, formerly Blue Cross of California prior to April 1, 2008, operated in 28 counties during the July 1, 2014, through June 30, 2015, review period for this report. Anthem, a full-scope MCP, delivers care to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) under the Two-Plan Model (TPM) in eight counties, the Regional model in 18 counties, the Geographic Managed Care (GMC) model in one county, and the San Benito model in one county.

Anthem became operational in Sacramento County to provide MCMC services effective in 1994, with expansion into additional counties occurring in subsequent years—Alameda, Contra Costa, Fresno, San Francisco, and Santa Clara counties in 1996 and Tulare County in 2005. Anthem expanded into Kings and Madera counties in March 2011 and continued providing services in Fresno County under a new contract covering Fresno, Kings, and Madera counties. As part of the expansion authority under Section 1115 of the Social Security Act, MCMC expanded into several rural eastern counties of California in 2013. Under the expansion, Anthem contracted with DHCS to provide MCMC services in Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo,

Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba, and San Benito counties beginning November 1, 2013.

Anthem's Two-Plan Model

Anthem delivers services to its beneficiaries as a “Local Initiative” (LI) MCP and “commercial plan” (CP) MCP under the TPM. Table 1.1 shows the counties in which Anthem provided services to beneficiaries under the TPM and denotes which MCP is the CP and which is the LI for each county.

Table 1.1—Anthem Counties Under the Two-Plan Model

County	Commercial Plan	Local Initiative Plan
Alameda	Anthem	Alameda Alliance for Health
Contra Costa	Anthem	Contra Costa Health Plan
Fresno	Anthem	CalViva Health
Kings	Anthem	CalViva Health
Madera	Anthem	CalViva Health
San Francisco	Anthem	San Francisco Health Plan
Santa Clara	Anthem	Santa Clara Family Health Plan
Tulare	Health Net Community Solutions, Inc.	Anthem

Anthem's GMC Model

The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within a specified geographic area (county). Anthem operates in Sacramento County under the GMC model. For Sacramento County, beneficiaries may select from the following MCPs in addition to Anthem:

- ◆ Health Net Community Solutions, Inc.
- ◆ Kaiser NorCal
- ◆ Molina Healthcare of California Partner Plan, Inc.

Anthem's Regional Model

Anthem delivers services to its beneficiaries under the Regional model in Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba counties. The other MCPs operating under the Regional model are California Health & Wellness Plan and Kaiser NorCal. California Health & Wellness Plan operates in all 18 counties; and Kaiser NorCal operates in Amador, El Dorado, and Placer counties. Beneficiaries may enroll in Anthem or in the alternative CP in the respective counties.

Table 1.2 shows the number of beneficiaries for Anthem for each county, the percent of the beneficiaries enrolled in the county, and the MCP's total number of beneficiaries as of June 30, 2015.¹

Table 1.2—Anthem Enrollment as of June 30, 2015

County	Anthem Enrollment as of June 30, 2015	Percent of Anthem Beneficiaries Enrolled in the County
Alameda	59,912	20%
Alpine	148	55%
Amador	4,865	81%
Butte	28,674	46%
Calaveras	3,005	33%
Colusa	4,055	65%
Contra Costa	26,872	14%
El Dorado	8,962	33%
Fresno	100,588	28%
Glenn	3,938	45%
Inyo	1,870	49%
Kings	18,196	43%
Madera	18,893	36%
Mariposa	2,538	70%
Mono	1,539	63%
Nevada	10,965	62%
Placer	29,142	67%
Plumas	2,137	52%
Sacramento	154,390	39%
San Benito	7,169	100%
San Francisco	22,126	15%
Santa Clara	65,052	22%
Sierra	335	59%
Sutter	19,074	63%
Tehama	9,293	48%
Tulare	86,201	47%
Tuolumne	4,574	42%
Yuba	13,877	61%
Total	708,390	

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: December 9, 2015.

2. **MANAGED CARE HEALTH PLAN COMPLIANCE** *for Anthem Blue Cross Partnership Plan*

1115 Waiver Seniors and Persons with Disabilities Enrollment Survey

The most recent Department of Managed Health Care (DMHC) 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey (hereafter referred to as “SPD medical survey”) for Anthem was conducted November 12, 2013, through November 15, 2013, covering the review period of September 1, 2012, through August 31, 2013. DMHC reviewed the following areas during the on-site survey:

- ◆ Utilization Management
- ◆ Continuity of Care
- ◆ Availability and Accessibility
- ◆ Member Rights
- ◆ Quality Management

In a report issued by DMHC to DHCS dated September 3, 2014, DMHC indicated that it identified potential deficiencies in all areas reviewed except Continuity of Care, with the greatest number of potential deficiencies (five) being in the area of Member Rights.

In a letter to Anthem dated September 16, 2014, DHCS indicated that the MCP was required to provide a corrective action plan (CAP) and respond to deficiencies documented in the DMHC SPD medical survey report. In a letter dated October 30, 2015, DHCS indicated that on November 4, 2014, Anthem provided DHCS with a response to its CAP, which addressed findings contained in the SPD medical survey report. DHCS indicated that one deficiency in the area of Quality Management was provisionally closed and that all other deficiencies were closed. The letter indicated that the communication would serve as DHCS’s final response to Anthem’s CAP.

Note: Although the October 30, 2015, letter falls outside the July 1, 2014, through June 30, 2015, review dates for this MCP-specific evaluation report, HSAG included the information since it indicates DHCS’s final response to the MCP’s CAP related to the November 2013 SPD medical survey.

Medical Audit

The most recent medical audit for Anthem was conducted November 12, 2013, through November 22, 2013, covering the review period of September 1, 2012, through August 31, 2013. DHCS reviewed the following areas during the on-site survey:

- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Availability and Accessibility
- ◆ Member's Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

A report issued by DHCS September 4, 2014, indicated that DHCS identified findings and provided recommendations for all review areas. In a letter dated August 5, 2015, DHCS stated that on October 16, 2014, Anthem provided DHCS with a response to its CAP originally issued on September 16, 2014, regarding remaining open items. The letter stated that, upon further review, DHCS provisionally closed five deficiencies, instructing Anthem to provide DHCS with evidence of operationalization and supporting documentation of the various identified items.

Note: Although the August 5, 2015, letter falls outside the July 1, 2014, through June 30, 2015, review dates for this MCP-specific evaluation report, HSAG included the information since it indicates that DHCS has provisionally closed all open deficiencies.

Strengths

Anthem provided a response to DHCS regarding the CAP issued in relation to the November 2013 medical audit, and the response resulted in DHCS provisionally closing all open deficiencies. Additionally, Anthem responded to all identified deficiencies from the November 2013 SPD medical survey, resulting in DHCS issuing a final response to the MCP's CAP.

Opportunities for Improvement

Anthem has the opportunity to ensure that the MCP provides DHCS with the required documentation regarding the MCP's process for assigning clinical severity level, a deficiency identified during the November 2013 DMHC SPD medical survey and provisionally closed by DHCS. Additionally, Anthem has the opportunity to ensure that the MCP provides evidence to DHCS regarding the operationalization and supporting documentation of the provisionally closed deficiencies from the November 2013 medical audit.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Anthem Blue Cross Partnership Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that Anthem followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the notable findings and opportunities for improvement is included below.

- ◆ Although for HEDIS 2015 Anthem began reporting rates for three new regions made up of 19 counties, the auditor identified no major issues with Anthem's enrollment and claims/encounter data processes.
- ◆ Due to Anthem's large number of supplemental data sources used for reporting, the auditor recommended that the MCP develop a process to ensure that a separate Roadmap supplemental data section and supporting documentation for each data source are included in its January Roadmap submission to allow the auditor sufficient time to review the information.
- ◆ To ensure Anthem's ability to use the online provider portal as a non-standard supplemental data source, the auditor recommended that the MCP work with its website vendor to develop a process to validate the data fields.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 through Table 3.12 for Anthem's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1 through Table 3.12

The reader should note the following regarding Table 3.1 through Table 3.12:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

- DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.

- All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
Anthem—Alameda County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	14.67%	18.16%	23.31%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	55.63	68.25	67.55	61.74	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	215.86	154.77	212.17	191.03	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	79.35%	77.02%	81.73%	84.87%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	72.88%	73.14%	80.81%	82.88%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	39.13%	42.36%	33.83%	32.65%	↔
Cervical Cancer Screening	Q,A	—	—	49.18%	56.88%	↑
Childhood Immunization Status—Combination 3	Q,A,T	70.56%	71.29%	71.30%	71.00%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	93.51%	84.39%	85.16%	87.06%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	82.89%	67.77%	77.82%	82.88%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	84.12%	79.12%	78.58%	84.49%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	79.44%	77.65%	75.18%	80.02%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	47.45%	35.92%	38.41%	45.58%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	35.28%	34.22%	35.10%	39.53%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	73.48%	63.83%	75.94%	83.02%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	32.36%	30.58%	26.05%	40.93%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	68.86%	71.36%	73.95%	77.67%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	60.58%	63.35%	67.55%	50.23%	▲
Controlling High Blood Pressure	Q	—	30.66%	34.15%	42.42%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	64.96%	73.16%	73.04%	68.52%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	42.61%	44.30%	45.36%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	20.87%	21.94%	23.87%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	50.61%	36.74%	50.23%	50.46%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	72.99%	75.18%	73.95%	77.08%	↔
Use of Imaging Studies for Low Back Pain	Q	91.46%	90.20%	88.04%	84.68%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	44.04%	62.29%	46.17%	58.33%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	62.04%	61.07%	47.33%	61.81%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	31.14%	37.47%	40.84%	49.77%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.71%	57.32%	65.51%	72.41%	↑

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.2—Multi-Year Performance Measure Results*
Anthem—Contra Costa County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	18.62%	17.30%	16.77%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	52.20	61.62	62.60	59.90	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	213.84	202.66	234.67	201.00	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	76.67%	77.90%	80.33%	80.22%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	67.86%	71.53%	75.90%	81.74%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	NA	54.29%	42.42%	NA	Not Comparable
Cervical Cancer Screening	Q,A	—	—	53.94%	48.38%	↔
Childhood Immunization Status—Combination 3	Q,A,T	68.37%	76.16%	75.46%	68.29%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	93.04%	96.93%	95.12%	93.77%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	82.73%	85.01%	86.44%	85.36%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	80.01%	85.18%	88.29%	88.50%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	80.28%	82.76%	84.96%	87.31%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	46.72%	50.99%	46.13%	52.30%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	36.50%	38.61%	37.64%	45.94%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	67.15%	69.31%	75.28%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	29.20%	39.60%	36.16%	46.64%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	64.96%	67.33%	78.60%	79.15%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	65.69%	52.97%	56.83%	42.40%	▲
Controlling High Blood Pressure	Q	—	46.15%	43.88%	49.71%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	65.02%	68.35%	65.30%	70.87%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	40.34%	40.74%	51.38%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	18.18%	21.60%	28.73%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	48.15%	44.64%	44.26%	43.70%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	76.30%	79.46%	72.95%	72.27%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	92.59%	81.48%	S	S	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	42.58%	57.66%	50.00%	55.32%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	53.77%	52.31%	55.09%	55.79%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	25.55%	36.74%	47.92%	46.99%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	67.45%	63.93%	75.83%	66.87%	↓

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.3—Multi-Year Performance Measure Results*
Anthem—Fresno County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	13.83%	14.38%	21.30%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	43.10	48.83	50.04	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	247.54	236.16	232.63	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	80.77%	82.80%	83.15%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	81.48%	82.63%	84.60%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	29.65%	33.76%	34.20%	↔
Cervical Cancer Screening	Q,A	—	—	50.93%	52.79%	↔
Childhood Immunization Status—Combination 3	Q,A,T	—	70.80%	67.36%	67.82%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	94.35%	93.76%	92.76%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	82.85%	83.38%	86.16%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	80.34%	83.51%	85.49%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	76.54%	79.14%	83.00%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	58.74%	52.44%	54.17%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	38.35%	44.89%	39.58%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	77.18%	79.33%	83.10%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	41.99%	36.22%	42.13%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	77.43%	80.22%	81.02%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	50.24%	50.00%	51.39%	↔
Controlling High Blood Pressure	Q	—	50.85%	53.32%	50.47%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	70.80%	68.22%	73.38%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	35.29%	33.16%	35.20%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	14.10%	15.57%	17.98%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	54.74%	52.90%	56.74%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	79.56%	74.94%	76.98%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	—	84.06%	82.85%	80.13%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	58.88%	54.29%	71.76%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	63.02%	59.86%	59.26%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	46.23%	49.65%	46.30%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	67.88%	79.63%	76.62%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Performance Measure Results*
Anthem—Kings County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	16.58%	8.43%	15.63%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	68.85	68.06	64.22	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	368.80	320.37	280.75	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	85.71%	81.64%	81.16%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	84.56%	77.36%	78.92%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	28.57%	32.69%	31.82%	↔
Cervical Cancer Screening	Q,A	—	—	56.05%	49.76%	↔
Childhood Immunization Status—Combination 3	Q,A,T	—	66.77%	68.51%	66.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	95.06%	94.74%	94.85%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	86.53%	83.25%	86.59%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	NA	84.78%	83.98%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	NA	84.64%	85.98%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	58.44%	54.39%	56.39%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	38.31%	40.35%	37.05%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	75.00%	72.51%	74.43%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	38.64%	25.73%	34.75%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	73.38%	77.19%	81.97%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	55.19%	64.91%	57.05%	▲
Controlling High Blood Pressure	Q	—	43.55%	43.30%	49.65%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	56.12%	69.66%	74.03%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	NA	40.22%	38.30%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	NA	16.30%	20.21%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	54.37%	45.70%	45.41%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	86.11%	80.08%	76.53%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	—	76.03%	84.30%	76.92%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	46.47%	40.74%	68.06%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	44.04%	43.29%	56.25%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	31.39%	38.66%	36.34%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	57.66%	65.05%	70.60%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—Multi-Year Performance Measure Results*
Anthem—Madera County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	10.87%	8.63%	21.98%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	59.71	58.44	56.13	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	313.66	293.80	288.72	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	76.60%	84.36%	82.02%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	78.26%	78.64%	83.33%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	6.25%	20.00%	6.35%	↓
Cervical Cancer Screening	Q,A	—	—	60.19%	61.31%	↔
Childhood Immunization Status—Combination 3	Q,A,T	—	76.40%	63.78%	69.38%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	97.83%	98.47%	95.07%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	88.53%	90.94%	92.14%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	NA	90.80%	90.49%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	NA	88.72%	90.07%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	66.81%	61.09%	62.68%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	55.02%	54.91%	54.35%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	84.72%	84.36%	84.06%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	51.97%	43.27%	42.39%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	79.04%	80.73%	84.78%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	36.24%	47.64%	51.81%	↔
Controlling High Blood Pressure	Q	—	53.36%	53.36%	50.71%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	67.29%	72.62%	74.82%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	NA	29.66%	44.44%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	NA	16.95%	25.40%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	51.57%	59.89%	57.37%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	76.10%	77.47%	79.47%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	—	70.10%	83.54%	81.91%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	77.62%	56.94%	85.38%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	70.07%	61.81%	82.83%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	48.66%	52.55%	69.84%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	80.29%	86.81%	85.19%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table 3.6—Multi-Year Performance Measure Results*
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	11.04%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	46.39	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	292.88	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	84.36%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	86.83%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	20.00%	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	39.86%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	67.04%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	96.82%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	87.27%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	92.54%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	95.74%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	63.74%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	41.76%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	86.54%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	39.84%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	76.10%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	50.55%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	50.93%	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	50.00%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	64.12%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	82.87%	Not Comparable
Use of Imaging Studies for Low Back Pain	Q	—	—	—	73.46%	Not Comparable

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	—	64.12%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	—	46.99%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	—	31.71%	Not Comparable
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	—	64.35%	Not Comparable

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table 3.7—Multi-Year Performance Measure Results*
Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	8.39%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	54.21	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	212.47	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	77.42%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	80.41%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	22.50%	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	48.24%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	50.82%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	93.56%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	82.95%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	92.77%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	93.40%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	63.41%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	36.28%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	83.60%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	39.43%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	73.19%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	50.79%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	44.65%	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	51.30%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	59.63%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	85.15%	Not Comparable

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	—	—	—	74.30%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	—	62.27%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	—	45.14%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	—	35.42%	Not Comparable
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	—	58.93%	Not Comparable

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.8—Multi-Year Performance Measure Results*
Anthem—Sacramento County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	12.63%	11.83%	16.76%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	41.30	53.18	53.51	54.99	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	210.80	210.46	216.69	198.90	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	61.68%	65.15%	80.33%	85.37%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	86.11%	87.80%	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	61.75%	67.21%	80.50%	85.13%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	24.14%	31.29%	27.54%	32.92%	↔
Cervical Cancer Screening	Q,A	—	—	50.70%	56.51%	↔
Childhood Immunization Status—Combination 3	Q,A,T	57.42%	62.77%	58.80%	66.20%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	94.51%	93.16%	94.03%	92.27%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	81.91%	80.19%	81.58%	81.66%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	81.22%	81.14%	80.92%	83.49%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	80.23%	80.56%	78.14%	80.93%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	56.20%	57.04%	50.11%	49.88%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	32.36%	28.16%	37.75%	40.60%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	76.16%	75.24%	75.28%	76.80%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	49.15%	46.12%	40.18%	46.17%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	71.53%	71.60%	79.47%	81.67%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	42.58%	47.09%	47.68%	43.85%	↔
Controlling High Blood Pressure	Q	—	47.45%	48.11%	43.43%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	51.58%	61.80%	62.62%	66.44%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	44.31%	49.21%	42.25%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	21.54%	30.61%	23.61%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	54.26%	47.92%	49.88%	56.25%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	76.89%	78.73%	72.39%	79.86%	↑

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	84.94%	84.34%	83.20%	81.54%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	63.02%	65.45%	61.11%	68.06%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	71.29%	69.34%	63.43%	62.96%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	39.42%	44.53%	47.45%	49.54%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	64.33%	67.37%	70.83%	67.21%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.9—Multi-Year Performance Measure Results*
Anthem—San Benito County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	NA	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	50.76	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	234.71	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	NA	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	NA	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	43.06%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	58.33%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	93.08%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	78.21%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	62.86%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	34.29%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	77.14%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	S	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	54.29%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	62.86%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	NA	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	76.92%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	48.15%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	77.78%	Not Comparable
Use of Imaging Studies for Low Back Pain	Q	—	—	—	NA	Not Comparable

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	—	71.76%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	—	50.46%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	—	23.84%	Not Comparable
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	—	65.74%	Not Comparable

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table 3.10—Multi-Year Performance Measure Results*
Anthem—San Francisco County

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	14.19%	16.67%	24.15%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	38.76	52.12	58.29	56.78	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	250.78	275.35	293.45	253.37	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	80.10%	82.57%	84.48%	80.91%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	79.10%	81.99%	84.19%	83.95%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	50.53%	53.25%	53.49%	47.06%	↔
Cervical Cancer Screening	Q,A	—	—	54.80%	64.32%	↑
Childhood Immunization Status—Combination 3	Q,A,T	72.41%	74.68%	74.70%	75.76%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	95.41%	96.11%	96.63%	90.76%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	90.78%	86.94%	89.05%	84.62%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	91.67%	90.85%	89.23%	91.20%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	89.56%	89.58%	88.40%	87.60%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	62.33%	61.80%	56.44%	60.42%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	51.63%	45.26%	49.78%	48.61%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	83.72%	86.13%	82.00%	83.56%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	53.49%	52.55%	44.44%	46.30%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	80.00%	85.89%	82.67%	84.95%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	33.95%	36.01%	47.56%	46.30%	↔
Controlling High Blood Pressure	Q	—	51.82%	48.45%	51.16%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	69.42%	68.02%	76.52%	78.02%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	38.20%	42.61%	56.95%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	17.98%	25.22%	34.44%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	64.02%	64.85%	56.55%	52.59%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	85.71%	88.48%	77.38%	71.85%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	80.39%	86.73%	89.11%	84.38%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	73.24%	60.06%	78.47%	76.16%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	79.32%	72.99%	75.00%	69.91%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	71.78%	65.52%	68.06%	61.57%	↓
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	80.00%	79.26%	80.55%	71.46%	↓

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.11—Multi-Year Performance Measure Results*
Anthem—Santa Clara County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	13.74%	13.75%	17.19%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	37.89	41.51	47.16	45.39	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	232.42	254.81	257.20	209.85	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	84.95%	86.63%	87.64%	86.17%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	84.21%	86.61%	85.77%	85.87%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	20.00%	27.20%	28.24%	29.49%	↔
Cervical Cancer Screening	Q,A	—	—	62.56%	65.35%	↔
Childhood Immunization Status—Combination 3	Q,A,T	66.91%	74.94%	67.82%	69.21%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	95.63%	95.81%	95.43%	94.04%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	86.67%	87.39%	87.49%	86.01%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	87.63%	88.05%	89.72%	88.86%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	86.34%	87.62%	85.64%	86.24%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	65.69%	58.50%	44.15%	54.29%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	64.48%	49.76%	45.25%	52.44%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	85.89%	79.85%	83.00%	84.69%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	61.31%	53.88%	45.03%	56.61%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	79.56%	80.10%	80.13%	83.99%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	29.44%	39.08%	43.27%	33.41%	▲
Controlling High Blood Pressure	Q	—	46.72%	40.93%	49.77%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	60.10%	68.86%	72.45%	75.50%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	43.37%	43.67%	53.50%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	28.11%	24.90%	38.27%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	60.64%	56.20%	60.65%	56.84%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	79.52%	76.71%	80.09%	80.97%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	82.43%	83.67%	80.35%	80.72%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	53.28%	55.23%	48.15%	68.75%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	70.56%	65.94%	46.99%	64.58%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	38.44%	50.36%	34.49%	52.78%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	76.72%	76.72%	74.45%	77.08%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.12—Multi-Year Performance Measure Results*
Anthem—Tulare County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	11.70%	10.59%	16.58%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	25.62	42.20	42.71	43.20	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	194.99	293.82	325.32	317.42	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	70.48%	78.55%	85.06%	83.04%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	69.03%	81.57%	84.53%	82.83%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	20.19%	19.52%	23.42%	17.08%	↓
Cervical Cancer Screening	Q,A	—	—	63.43%	60.79%	↔
Childhood Immunization Status—Combination 3	Q,A,T	64.96%	71.78%	72.22%	66.67%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	92.51%	92.47%	97.75%	97.24%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	71.01%	82.72%	90.35%	91.20%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	81.80%	79.60%	88.21%	91.28%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	82.21%	82.20%	87.52%	90.62%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	68.13%	68.45%	54.97%	64.58%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	33.09%	35.68%	47.02%	46.30%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	77.13%	78.40%	83.00%	82.87%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	45.26%	48.54%	42.60%	42.13%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	77.62%	81.55%	81.46%	78.24%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	45.74%	43.69%	46.36%	48.38%	↔
Controlling High Blood Pressure	Q	—	53.28%	52.99%	49.07%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	57.91%	70.97%	78.70%	78.22%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	38.07%	43.12%	44.21%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	18.88%	21.05%	23.98%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	53.13%	55.96%	58.24%	59.26%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.07%	76.16%	82.37%	81.25%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	80.85%	81.07%	85.90%	82.18%	↓
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	83.94%	81.51%	65.28%	79.81%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	68.13%	64.23%	57.18%	68.21%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	50.36%	47.93%	47.92%	49.19%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	71.95%	64.91%	71.93%	72.45%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.13 through Table 3.36 present a summary of the RY 2015 SPD measure results reported by Anthem. Table 3.13 through Table 3.24 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.25 through Table 3.36 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.13—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Alameda County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	13.26%	25.07%	▼	23.31%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.44%	84.97%	↔	84.87%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	74.66%	84.52%	↑	82.88%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	87.00%	NA	Not Comparable	87.06%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	82.86%	83.43%	↔	82.88%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	84.81%	80.49%	↔	84.49%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	80.28%	77.83%	↔	80.02%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

⁴ 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 3.13 through Table 3.24.

Table 3.14—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Contra Costa County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	13.75%	17.74%	↔	16.77%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	79.17%	80.60%	↔	80.22%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	76.47%	83.95%	↔	81.74%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	93.82%	NA	Not Comparable	93.77%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	85.36%	85.29%	↔	85.36%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	88.73%	85.92%	↔	88.50%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	87.49%	86.15%	↔	87.31%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.15—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Fresno County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.90%	26.58%	▼	21.30%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.12%	85.24%	↑	83.15%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.36%	87.22%	↑	84.60%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	92.83%	NA	Not Comparable	92.76%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.11%	88.03%	↔	86.16%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	85.47%	85.97%	↔	85.49%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	82.88%	84.57%	↔	83.00%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.16—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Kings County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	S	17.11%	↔	15.63%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.84%	79.75%	↔	81.16%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	73.97%	82.14%	↔	78.92%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	94.74%	NA	Not Comparable	94.85%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.28%	96.30%	↑	86.59%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	83.64%	88.89%	↔	83.98%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	86.26%	83.33%	↔	85.98%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 3.17—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Madera County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	17.35%	25.37%	↔	21.98%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	75.24%	87.80%	↑	82.02%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	79.55%	85.53%	↔	83.33%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	95.06%	NA	Not Comparable	95.07%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	92.04%	97.44%	↔	92.14%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	90.19%	96.67%	↔	90.49%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	90.21%	88.17%	↔	90.07%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.18—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	11.04%	NA	Not Comparable	11.04%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.36%	NA	Not Comparable	84.36%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.83%	NA	Not Comparable	86.83%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.82%	NA	Not Comparable	96.82%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	87.27%	NA	Not Comparable	87.27%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	92.54%	NA	Not Comparable	92.54%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	95.74%	NA	Not Comparable	95.74%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.19—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	8.39%	NA	Not Comparable	8.39%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	77.42%	NA	Not Comparable	77.42%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.41%	NA	Not Comparable	80.41%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	93.56%	NA	Not Comparable	93.56%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	82.95%	NA	Not Comparable	82.95%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	92.77%	NA	Not Comparable	92.77%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	93.40%	NA	Not Comparable	93.40%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.20—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Sacramento County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	7.09%	20.29%	▼	16.76%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	79.35%	87.82%	↑	85.37%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	77.75%	87.67%	↑	85.13%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	92.23%	NA	Not Comparable	92.27%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	81.71%	80.35%	↔	81.66%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	83.42%	84.38%	↔	83.49%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	80.99%	80.38%	↔	80.93%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.21—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—San Benito County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	NA	NA	Not Comparable	NA
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	93.08%	NA	Not Comparable	93.08%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	78.23%	NA	Not Comparable	78.21%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	NA	NA	Not Comparable	NA
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	NA	NA	Not Comparable	NA

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.22—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—San Francisco County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	S	25.49%	▼	24.15%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	77.98%	81.41%	↔	80.91%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	89.13%	83.44%	↔	83.95%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	90.64%	NA	Not Comparable	90.76%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	85.13%	68.42%	↓	84.62%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	91.52%	85.42%	↔	91.20%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	88.26%	81.30%	↓	87.60%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 3.23—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Santa Clara County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	11.06%	19.38%	▼	17.19%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.56%	85.50%	↔	86.17%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.01%	85.44%	↔	85.87%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	94.31%	NA	Not Comparable	94.04%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.22%	74.68%	↓	86.01%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	89.02%	84.87%	↔	88.86%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	86.46%	80.27%	↓	86.24%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.24—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Tulare County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.45%	21.19%	▼	16.58%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.37%	85.03%	↑	83.04%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	79.21%	86.70%	↑	82.83%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	97.22%	NA	Not Comparable	97.24%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	91.15%	93.26%	↔	91.20%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	91.36%	89.50%	↔	91.28%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	90.64%	90.29%	↔	90.62%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

**Table 3.25—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem—Alameda County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
168.72	49.70	279.57	109.49

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

**Table 3.26—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem—Contra Costa County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
191.29	53.97	263.60	98.09

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

**Table 3.27—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem—Fresno County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
214.46	46.64	380.66	77.75

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

**Table 3.28—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem—Kings County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
255.64	58.16	499.29	117.00

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

**Table 3.29—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem—Madera County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
267.13	53.49	536.73	86.42

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

**Table 3.30—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
292.88	46.39	0.00	0.00

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

**Table 3.31—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa,
Mono, Nevada, Placer, Tuolumne, and Yuba Counties)**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
212.47	54.21	0.00	0.00

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

**Table 3.32—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem—Sacramento County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
174.75	49.78	340.85	85.62

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

**Table 3.33—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem—San Benito County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
234.43	50.77	308.82	49.02

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

**Table 3.34—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem—San Francisco County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
207.43	37.25	336.25	92.01

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

**Table 3.35—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem—Santa Clara County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
190.87	41.49	311.19	66.24

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

**Table 3.36—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem—Tulare County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
296.37	39.08	571.12	92.92

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

Table 3.37 through Table 3.48 present the three-year trending information for the SPD population, and Table 3.49 through Table 3.60 present the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.37—RY 2015 (MY 2014) HEDIS SPD Trend Table
Anthem—Alameda County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	15.98%	19.74%	25.07%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	114.02	115.98	109.49	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	189.35	294.17	279.57	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	79.85%	83.77%	84.97%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	75.70%	82.80%	84.52%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	63.92%	78.70%	83.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	84.46%	79.11%	80.49%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	77.30%	70.43%	77.83%	↑

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.38—RY 2015 (MY 2014) HEDIS SPD Trend Table
Anthem—Contra Costa County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	23.00%	19.78%	17.74%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	93.77	97.01	98.09	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	201.70	284.86	263.60	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.49%	81.38%	80.60%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.72%	78.77%	83.95%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.33%	89.36%	85.29%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	77.78%	87.61%	85.92%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	82.10%	83.50%	86.15%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.39—RY 2015 (MY 2014) HEDIS SPD Trend Table
Anthem—Fresno County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	16.79%	16.18%	26.58%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	69.24	74.31	77.75	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	401.81	367.46	380.66	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.19%	83.57%	85.24%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.44%	85.08%	87.22%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	80.80%	84.85%	88.03%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	81.52%	84.70%	85.97%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	75.98%	79.00%	84.57%	↑

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.40—RY 2015 (MY 2014) HEDIS SPD Trend Table
Anthem—Kings County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	19.82%	S	17.11%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	140.74	119.47	117.00	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	662.36	563.40	499.29	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.55%	82.43%	79.75%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.28%	83.70%	82.14%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	80.00%	80.00%	96.30%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	95.92%	88.89%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	84.93%	83.33%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.41—RY 2015 (MY 2014) HEDIS SPD Trend Table
Anthem—Madera County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	17.31%	S	25.37%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	95.08	98.73	86.42	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	542.71	509.81	536.73	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	78.72%	86.18%	87.80%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.04%	84.62%	85.53%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.48%	93.62%	97.44%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	97.44%	96.67%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	92.86%	88.17%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.42—RY 2015 (MY 2014) HEDIS SPD Trend Table
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	—	—	NA	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	0.00	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	0.00	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	—	—	NA	Not Comparable

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.43—RY 2015 (MY 2014) HEDIS SPD Trend Table
Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	—	—	NA	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	0.00	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	0.00	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	—	—	NA	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.44—RY 2015 (MY 2014) HEDIS SPD Trend Table
Anthem—Sacramento County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	15.52%	13.26%	20.29%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	85.17	82.77	85.62	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	331.70	356.44	340.85	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	67.13%	82.21%	87.82%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	85.29%	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	70.32%	83.72%	87.67%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	88.37%	92.31%	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	77.94%	78.10%	80.35%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	83.54%	83.31%	84.38%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	81.66%	79.13%	80.38%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.45—RY 2015 (MY 2014) HEDIS SPD Trend Table
Anthem—San Benito County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	NA	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	49.02	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	308.82	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	NA	Not Comparable

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.46—RY 2015 (MY 2014) HEDIS SPD Trend Table
Anthem—San Francisco County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	15.35%	17.38%	25.49%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	89.99	95.72	92.01	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	349.50	373.20	336.25	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.49%	84.77%	81.41%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.14%	84.60%	83.44%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	NA	70.97%	68.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	94.12%	77.50%	85.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.78%	88.35%	81.30%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.47—RY 2015 (MY 2014) HEDIS SPD Trend Table
Anthem—Santa Clara County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	14.47%	16.33%	19.38%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	62.01	74.19	66.24	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	364.03	374.95	311.19	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.02%	89.63%	85.50%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.38%	88.49%	85.44%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	87.16%	81.45%	74.68%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	88.81%	86.89%	84.87%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	87.01%	83.11%	80.27%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.48—RY 2015 (MY 2014) HEDIS SPD Trend Table
Anthem—Tulare County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	15.70%	12.83%	21.19%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	85.58	83.89	92.92	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	494.61	561.54	571.12	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.10%	85.94%	85.03%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.27%	87.12%	86.70%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.87%	89.09%	93.26%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	81.43%	86.57%	89.50%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	83.68%	86.76%	90.29%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.49—RY 2015 (MY 2014) Non-SPD Trend Table
Anthem—Alameda County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.84%	10.91%	13.26%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	55.23	53.18	49.70	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	144.94	187.84	168.72	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	66.07%	71.79%	84.44%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	62.94%	70.77%	74.66%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	84.31%	85.30%	87.00%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	67.90%	77.79%	82.86%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	78.76%	78.54%	84.81%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	77.69%	75.79%	80.28%	↑

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.50—RY 2015 (MY 2014) Non-SPD Trend Table
Anthem—Contra Costa County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	8.89%	S	13.75%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	56.21	56.15	53.97	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	202.82	225.26	191.29	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	72.41%	76.47%	79.17%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	58.00%	67.35%	76.47%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.88%	95.23%	93.82%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	84.85%	86.31%	85.36%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	85.69%	88.35%	88.73%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	82.84%	85.16%	87.49%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.51—RY 2015 (MY 2014) Non-SPD Trend Table
Anthem—Fresno County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	10.55%	10.68%	9.90%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	40.31	45.59	46.64	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	231.05	219.48	214.46	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	79.15%	81.76%	80.12%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.81%	78.59%	80.36%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	94.28%	93.86%	92.83%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	82.89%	83.33%	86.11%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	80.30%	83.46%	85.47%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	76.57%	79.14%	82.88%	↑

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.52—RY 2015 (MY 2014) Non-SPD Trend Table
Anthem—Kings County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	11.84%	S	S	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	61.10	61.93	58.16	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	337.12	291.39	255.64	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.82%	80.56%	82.84%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.13%	68.66%	73.97%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.01%	94.71%	94.74%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	86.69%	83.36%	86.28%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	84.26%	83.64%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	84.62%	86.26%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.53—RY 2015 (MY 2014) Non-SPD Trend Table
Anthem—Madera County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	2.50%	S	17.35%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	56.55	54.40	53.49	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	293.16	272.13	267.13	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	74.47%	81.82%	75.24%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	65.79%	68.42%	79.55%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.05%	98.45%	95.06%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.48%	90.87%	92.04%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	90.58%	90.19%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	88.52%	90.21%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.54—RY 2015 (MY 2014) Non-SPD Trend Table
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	11.04%	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	46.39	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	292.88	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	84.36%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	86.83%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	96.82%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	87.27%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	92.54%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	95.74%	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.55—RY 2015 (MY 2014) Non-SPD Trend Table
Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo,
Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	—	—	8.39%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	54.21	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	212.47	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	77.42%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	80.41%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	—	—	93.56%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	—	—	82.95%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	—	—	92.77%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	—	—	93.40%	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.56—RY 2015 (MY 2014) Non-SPD Trend Table
Anthem—Sacramento County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	7.85%	8.70%	7.09%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	47.88	48.19	49.78	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	190.39	191.26	174.75	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	60.90%	75.38%	79.35%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	59.22%	70.27%	77.75%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	93.23%	94.06%	92.23%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	80.26%	81.70%	81.71%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	81.02%	80.76%	83.42%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	80.47%	78.05%	80.99%	↑

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.57—RY 2015 (MY 2014) Non-SPD Trend Table
Anthem—San Benito County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	NA	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	50.77	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	234.43	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	93.08%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	78.23%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	NA	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.58—RY 2015 (MY 2014) Non-SPD Trend Table
Anthem—San Francisco County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	6.56%	S	S	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	32.91	35.87	37.25	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	237.72	245.67	207.43	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	77.78%	82.42%	77.98%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.13%	80.39%	89.13%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.08%	96.95%	90.64%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.28%	89.53%	85.13%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.74%	89.73%	91.52%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	89.69%	88.40%	88.26%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.59—RY 2015 (MY 2014) Non-SPD Trend Table
Anthem—Santa Clara County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	12.43%	6.88%	11.06%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	37.66	41.56	41.49	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	234.32	232.83	190.87	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.37%	83.51%	87.56%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.21%	79.27%	87.01%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.07%	95.97%	94.31%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	87.40%	87.66%	86.22%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	88.02%	89.89%	89.02%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	87.64%	85.77%	86.46%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.60—RY 2015 (MY 2014) Non-SPD Trend Table
Anthem—Tulare County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.83%	8.22%	9.45%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	38.85	39.20	39.08	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	278.32	305.19	296.37	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	75.69%	84.20%	81.37%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	77.22%	81.50%	79.21%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	92.49%	97.77%	97.22%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	82.70%	90.38%	91.15%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	79.53%	88.28%	91.36%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	82.13%	87.56%	90.64%	↑

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

NA = A Not Applicable audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the All-Cause Readmissions measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant decline in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant improvement in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

RY 2015 was the first year that Anthem reported rates for Region 1, Region 2, and San Benito County; therefore, the MCP was not held accountable to meet the MPLs for these reporting units in RY 2015 (i.e., the MCP was not required to submit an improvement plan [IP] for measures with rates below the MPLs). While Anthem was not held accountable in RY 2015 to meet the MPLs in Region 1, Region 2, and San Benito County, HSAG includes the performance measure results from the reporting units in the analyses that follow. Anthem should address areas of poor performance and implement lessons learned from areas where performance goals were met because the MCP will be held accountable to meet the MPLs in RY 2016. Since the MCP did not report rates for the Region 1, Region 2, and San Benito County in RY 2014, no information regarding these areas is included in analyses that include comparisons between RY 2014 and RY 2015.

Measures Reflecting Anthem's Improved Performance

Across all reporting units, Anthem had 298 rates for which an assessment of performance relative to the HPLs was made. Nine of these rates (3 percent) were above the HPLs in RY 2015:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Francisco County (fifth consecutive year)
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in Region 1
- ◆ *Use of Imaging Studies for Low Back Pain* in Alameda (fifth consecutive year), Contra Costa, and San Francisco (third consecutive year) counties
- ◆ All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents* measures in Madera County
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Madera County

Across all reporting units, 56 (23 percent) of 242 rates for which a comparison could be made between RY 2014 and RY 2015 were significantly better in RY 2015 when compared to RY 2014. The numbers of measures with rates that improved significantly by reporting unit follow:

- ◆ Alameda County—13 measures
- ◆ Santa Clara County—10 measures
- ◆ Sacramento County—7 measures
- ◆ Tulare County—6 measures
- ◆ Contra Costa County—5 measures
- ◆ Kings County—5 measures
- ◆ Fresno County—4 measures
- ◆ Madera County—4 measures
- ◆ San Francisco County—2 measures

The significant improvement for 21 rates (9 percent) resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015. Seventeen additional rates (7 percent) improved from RY 2014 to RY 2015. Although the improvement was not significant, the change resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015. The numbers of measures with rates that moved from below the MPLs in RY 2014 to above the MPLs in RY 2015 by reporting unit follow:

- ◆ Alameda County—seven measures
- ◆ Contra Costa County—seven measures

- ◆ Santa Clara County—six measures
- ◆ Kings County—five measures
- ◆ Fresno County—four measures
- ◆ Madera County—three measures
- ◆ Sacramento County—three measures
- ◆ San Francisco County—three measures
- ◆ Tulare County—no measures

Measures Reflecting Anthem's Declining Performance

Across all reporting units, 112 (38 percent) of 298 rates for which an assessment of performance relative to the MPLs was made were below the MPLs, with 48 (43 percent) of the 112 rates being below the MPLs for three or more consecutive years. The numbers of measures with rates below the MPLs by reporting unit follow:

- ◆ Kings County—15 measures, with 6 having rates below the MPLs for at least three consecutive years
- ◆ Alameda County—13 measures, with all 13 having rates below the MPLs for at least three consecutive years
- ◆ Region 2—13 measures (first year reporting rates)
- ◆ Sacramento County—13 measures, with 10 having rates below the MPLs for at least three consecutive years
- ◆ San Benito County—13 measures (first year reporting rates)
- ◆ Region 1—8 measures (first year reporting rates)
- ◆ San Francisco County—6 measures, with 1 having a rate below the MPL for at least three consecutive years
- ◆ Fresno County—10 measures, with 8 having rates below the MPLs for at least three consecutive years
- ◆ Contra Costa County—9 measures, with 6 having rates below the MPLs for at least three consecutive years
- ◆ Madera County—5 measures, with 2 having rates below the MPLs for at least three consecutive years
- ◆ Tulare County—5 measures, with 2 having rates below the MPLs for at least three consecutive years
- ◆ Santa Clara County—2 measures

While the rates below the MPLs cut across all External Accountability Set measures, measures with at least half of the MCP's reporting units having rates below the MPLs include:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* (10 reporting units)
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* (nine reporting units)
- ◆ *Cervical Cancer Screening* (six reporting units)
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* (10 reporting units)
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* (seven reporting units)
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* (eight reporting units)
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total* (six reporting units)
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* (six reporting units)

Additionally, while DHCS establishes no MPL for the *All-Cause Readmissions* measure, HSAG noted that the rates declined significantly from RY 2014 to RY 2015 for this measure for seven of the nine reporting units with reported rates for both years.

Across all reporting units, 21 (9 percent) of 242 rates for which a comparison could be made between RY 2014 and RY 2015 were significantly worse in RY 2015 when compared to RY 2015. The numbers of measures with rates significantly worse in RY 2015 when compared to RY 2015 by reporting unit follow:

- ◆ San Francisco County—five measures
- ◆ Sacramento County—four measures
- ◆ Madera County—three measures
- ◆ Tulare County—three measures
- ◆ Contra Costa County—two measures
- ◆ Alameda County—one measure
- ◆ Fresno County—one measure
- ◆ Kings County—one measure
- ◆ Santa Clara County—one measure

The significant change for eight of the 21 rates (38 percent) resulted in them moving from above the MPLs in RY 2014 to below the MPLs in RY 2015. Eight additional rates declined from RY 2014 to RY 2015. Although the decline was not statistically significant, the change resulted in the rates moving from above the MPLs in RY 2014 to below the MPLs in RY 2015.

Seniors and Persons with Disabilities Findings

Across all reporting units, few statistically significant differences existed between the SPD and non-SPD rates. Notable differences include:

- ◆ The SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate for six of the nine reporting units able to report an SPD rate for the measure. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.
- ◆ The SPD rates were significantly worse than the non-SPD rates in San Francisco and Santa Clara counties for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* and *12 to 19 Years* measures; however, the higher SPD rates may be partially attributed to children and adolescents in the SPD population in the specified age groups in these counties relying on specialty providers as their health care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Across all measures stratified for the SPD and non-SPD populations, most measures showed no significant change in SPD and non-SPD rates from RY 2014 to RY 2015. One noteworthy variation was that the SPD rates were significantly worse in RY 2015 when compared to RY 2014 for the *All-Cause Readmissions* measure for six of the nine reporting units with reported SPD rates in both years. Conversely, no statistically significant variation existed for the non-SPD rates between RY 2014 and RY 2015 for the *All-Cause Readmissions* measure.

Assessment of Improvement Plans

Anthem's CAP, revised in November 2013 (for a minimum of three years, through 2016), had additional components (two QIPs) added in September 2014. Please see the Quality Improvement Projects section of this report for a summary of QIPs conducted during the review period.

Anthem is now required to achieve set milestones for each year of the CAP for all county indicators within the nine counties included in the CAP. During the review period for this report, Anthem continued to conduct quarterly Plan-Do-Study-Act (PDSA) cycles on all CAP QIPs and IPs and to produce extensive quarterly CAP progress reports. DHCS and the EQRO provided Anthem with feedback on CAP activities each quarter through a technical assistance conference call. Anthem's quality improvement director met monthly with the DHCS nurse consultant assigned to the MCP to provide updates on all CAP areas. As required, Anthem met with DHCS leadership quarterly to provide CAP updates and updates on overall progress.

During the review period for this report, Anthem's interventions and PDSA cycles focused on many activities at the data, provider, and beneficiary level to improve performance on the MCP's CAP IPs on *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Annual Monitoring*

for Patients on Persistent Medications measures. For RY 2015, the rates for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure were above the MPLs for all counties required to conduct IPs. While Anthem made some progress on performance related to the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures, the rates remained below the MPLs in all counties included in the CAP, except Santa Clara County.

Strengths

Anthem followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern. Although for RY 2015 Anthem began reporting rates for three new regions made up of 19 counties, the auditor identified no major issues with Anthem's enrollment and claims/encounter data processes.

Although Anthem continued to show many opportunities for improvement, across all reporting units, nine rates were above the HPLs and 56 rates were significantly better in RY 2015 when compared to RY 2014. Additionally, across all reporting units 38 rates moved from below the MPLs in RY 2014 to above the MPLs in RY 2015.

Opportunities for Improvement

To ensure an efficient HEDIS audit process, the MCP should develop a process to ensure that a separate Roadmap supplemental data section with supporting documentation is included in the MCP's January Roadmap submission. Additionally, to ensure Anthem's ability to use the online provider portal as a non-standard supplemental data source for HEDIS measure reporting, the MCP should work with its website vendor to develop a process to validate the data fields.

Anthem should continue to work with DHCS and the EQRO quarterly, at minimum, to identify priority areas for improvement. Anthem should determine which strategies have been successful at improving performance so that the MCP can duplicate the strategies across all reporting units, as appropriate.

Additionally, for the *All-Cause Readmissions* measure, since the SPD rates were significantly worse than the non-SPD rates, and the SPD rates were significantly worse in RY 2015 when compared to RY 2014, while the non-SPD rate remained stable, Anthem's poor performance in the total rates for the measure can be attributed to the SPD population's readmissions. Therefore, Anthem has the opportunity to assess the factors leading to the significant increase in readmissions for the SPD population to ensure that the MCP is meeting the needs of this population.

Quality Improvement Project Objectives

As part of Anthem’s CAP, the MCP is required to conduct QIPs and PDSA cycles. Anthem participated in the statewide collaborative QIP and had five internal QIPs in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists Anthem’s QIPs and indicates the counties in which the QIP was conducted; whether the QIP was clinical or nonclinical; and the domains of care (i.e., quality, access, and timeliness) the QIP addressed.

**Table 4.1—Quality Improvement Projects for Anthem
July 1, 2014, through June 30, 2015**

QIP	Counties	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, Tulare	Clinical	Q, A
<i>Childhood Immunization Status</i>	Sacramento	Clinical	Q, A, T
<i>Controlling High Blood Pressure</i>	Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, Tulare	Clinical	Q
<i>Improving Diabetes Management</i>	Alameda, Contra Costa, Fresno, Kings, Sacramento, San Francisco, Tulare	Clinical	Q, A
<i>Improving Timeliness of Prenatal and Postpartum Care</i>	Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, Tulare	Clinical	Q, A, T
<i>Medication Management for People with Asthma</i>	Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, Tulare	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 ages 21 years and older.

Readmissions have been associated with lack of proper discharge planning and poor care transition.

Reducing readmissions may demonstrate improved follow-up and care management of beneficiaries, leading to improved health outcomes.

Anthem's *Childhood Immunization Status* QIP targeted beneficiaries who will turn 2 years of age during the measurement year. The administration of immunizations has dramatically decreased the occurrence of many diseases including diphtheria, tetanus, pertussis, and small pox. However, due to either misconceptions about immunizations' side effects or lack of access, the number of children who have not received immunizations has increased. By understanding why children are not receiving life-saving vaccines, Anthem hoped to increase the percentage of children who receive the recommended immunizations.

The *Controlling High Blood Pressure* QIP focused on improving adequate blood pressure control among beneficiaries ages 18 to 85 with hypertension diagnosis. Hypertension is a major risk factor for stroke and heart disease; and by controlling blood pressure, beneficiaries with hypertension may reduce their risk for more severe health issues.

The *Improving Diabetes Management* QIP focused on improving blood pressure control; HbA1c control (<8.0 percent), poor control (>9.0 percent), and testing; nephropathy; and retinal eye exams. Ongoing management of beneficiaries with diabetes is critical to preventing complications and ensuring their optimal health.

The *Improving Timeliness of Prenatal and Postpartum Care* QIP focused on improving the care women receive during and post pregnancy. Maintaining regular prenatal care visits throughout a pregnancy may help in the identification and treatment of any problems that may arise. Providing postpartum care is essential to positive health outcomes.

The *Medication Management for People with Asthma* QIP targeted beneficiaries living with persistent asthma and focused on improving their compliance with controller medication treatment. Asthma is a treatable chronic condition that may be managed in an outpatient setting. By using controller medication as prescribed, beneficiaries can better control their asthma and, ultimately, may reduce hospital admissions, emergency room visits, and unscheduled visits to the doctor.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
Anthem—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, and Tulare Counties
July 1, 2014, through June 30, 2015**

Name of Project/Study	Counties	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>	Alameda, Fresno, San Francisco, and Santa Clara received the same score.	Annual Submission	69%	100%	<i>Partially Met</i>
	Contra Costa, Madera, Sacramento, and Tulare received the same score.	Annual Submission	73%	100%	<i>Partially Met</i>
	Kings	Annual Submission	81%	100%	<i>Met</i>
Internal QIPs					
<i>Childhood Immunization Status</i>	Sacramento	Annual Submission	88%	90%	<i>Partially Met</i>
		Annual Resubmission 1	100%	100%	<i>Met</i>
<i>Controlling High Blood Pressure</i>	All counties—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, and Tulare—received the same score.	Study Design Submission	67%	57%	<i>Not Met</i>
		Study Design Resubmission 1	94%	100%	<i>Met</i>
<i>Improving Diabetes Management</i>	Alameda, Fresno, and Sacramento received the same score.	Annual Submission	84%	90%	<i>Partially Met</i>
		Annual Resubmission 1	100%	100%	<i>Met</i>
	Contra Costa	Annual Submission	74%	78%	<i>Partially Met</i>
		Annual Resubmission 1	100%	100%	<i>Met</i>
	Kings	Annual Submission	79%	89%	<i>Partially Met</i>
		Annual Resubmission 1	100%	100%	<i>Met</i>
	San Francisco	Annual Submission	88%	90%	<i>Partially Met</i>
		Annual Resubmission 1	100%	100%	<i>Met</i>

Name of Project/Study	Counties	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
	Tulare	Annual Submission	76%	80%	<i>Partially Met</i>
		Annual Resubmission 1	100%	100%	<i>Met</i>
<i>Improving Timeliness of Prenatal and Postpartum Care</i>	Alameda and Fresno received the same score.	Annual Submission	88%	80%	<i>Partially Met</i>
		Annual Resubmission 1	100%	100%	<i>Met</i>
	Contra Costa, Kings, and Madera received the same score.	Annual Submission	89%	89%	<i>Partially Met</i>
		Annual Resubmission 1	100%	100%	<i>Met</i>
	Sacramento, Santa Clara, and Tulare received the same score.	Annual Submission	92%	90%	<i>Partially Met</i>
		Annual Resubmission 1	100%	100%	<i>Met</i>
<i>Medication Management for People with Asthma</i>	All counties—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, and Tulare—received the same score.	Study Design Submission	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*.

Statewide Collaborative Quality Improvement Project

Validation results during the review period of July 1, 2014, through June 30, 2015, showed that Anthem’s annual submission of its *All-Cause Readmissions* QIP achieved an overall *Met* validation status for Kings County while receiving a *Partially Met* validation status for Alameda, Contra Costa, Fresno, Madera, Sacramento, San Francisco, Santa Clara, and Tulare counties. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual

submission submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, CalViva conducted a PDSA cycle for the *All-Cause Readmissions* QIP.

Internal Quality Improvement Projects

Although MCPs with QIPs that did not achieve a *Met* validation status on the first submission were required to submit a PDSA cycle rather than resubmit the QIP, due to Anthem being on a CAP, DHCS required the MCP to resubmit its internal QIPs until each QIP achieved an overall *Met* validation status. The following is a summary of each internal QIP's validation results:

- ◆ The *Childhood Immunization Status* QIP annual submission for Sacramento County received an overall validation status of *Partially Met*. Based on HSAG's validation feedback, Anthem resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a *Met* score.
- ◆ The *Controlling High Blood Pressure* QIP study design submission received an overall validation status of *Not Met* for Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, and Tulare counties. Anthem resubmitted the QIP for each county and achieved an overall *Met* validation status, with 94 percent of noncritical and 100 percent of critical evaluation elements receiving a *Met* score.
- ◆ The *Improving Diabetes Management* QIP annual submission received an overall validation status of *Partially Met* for Alameda, Contra Costa, Fresno, Kings, Sacramento, San Francisco, and Tulare counties. Anthem resubmitted the QIP for each county and achieved an overall *Met* validation status, with 100 percent of evaluation elements (critical and noncritical) receiving a *met* score.
- ◆ The *Improving Timeliness of Prenatal and Postpartum Care* QIP annual submission received an overall validation status of *Partially Met* for Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, and Tulare counties. Anthem resubmitted the QIP for each county and achieved an overall *Met* validation status, with 100 percent of evaluation elements (critical and noncritical) receiving a *Met* score.
- ◆ The *Medication Management for People with Asthma* QIP study design submission achieved an overall *Met* validation status for Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, and Tulare counties, with 90 percent of the evaluation elements and 100 percent of the critical elements receiving a *Met* score.

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

Table 4.3—Quality Improvement Project Average Rates*
Anthem—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento,
San Francisco, Santa Clara, and Tulare Counties
(Number = 68 QIP Submissions, 6 QIP Topics)
July 1, 2014, through June 30, 2015

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)	87%	13%	0%
	III: Clearly Defined Study Indicator(s)	93%	7%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	99%	1%	0%
	VI: Accurate/Complete Data Collection	81%	9%	10%
Design Total		91%	5%	4%
Implementation	VII: Sufficient Data Analysis and Interpretation**	78%	15%	8%
	VIII: Appropriate Improvement Strategies	75%	25%	0%
Implementation Total		77%	18%	5%
Outcomes	IX: Real Improvement Achieved	44%	0%	56%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		44%	0%	56%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through XI for Anthem’s *All-Cause Readmissions* QIP annual submission; Activities I through VIII for the MCP’s *Childhood Immunization Status*, *Improving Diabetes Management*, and *Improving Timeliness of Prenatal and Postpartum Care* QIPs annual submissions; and Activities I through VI for the *Controlling High Blood Pressure* and *Medication Management for People with Asthma* QIPs’ study design submissions.

Anthem demonstrated a strong application of the Design stage, meeting 91 percent of the requirements for all applicable evaluation elements within the study stage for all six QIPs. For the *Controlling Blood Pressure* study design submission, Anthem did not adequately define the target population or the study indicators, resulting in lowered scores for Activities II and III. For the *Improving Timeliness of Prenatal and Postpartum Care* QIP, the MCP reported the incorrect sample size for Study Indicator 2, resulting in a lowered score for Activity V. Additionally for the *Controlling High Blood Pressure* QIP, the MCP did not document the complete data collection process and tool; qualifications of the medical record abstraction staff; or estimated degree of data completeness, resulting in a lowered score for Activity VI. Anthem also did not provide qualifications of the medical record abstraction staff for the *Improving Diabetes Management* QIP or the data collection

process for the *Medication Management for People with Asthma* QIP, both of which contributed to the lowered score for Activity VI.

The *All-Cause Readmissions*, *Childhood Immunization Status*, *Improving Diabetes Management*, and *Improving Timeliness of Prenatal and Postpartum Care* QIPs progressed to the Implementation stage during the reporting period. Anthem demonstrated an adequate application of the Implementation stage for these QIPs, meeting 77 percent of the requirements for all applicable evaluation elements within the study stage. The *All-Cause Readmissions* and *Improving Diabetes Management* QIPs had multiple documentation issues, resulting in lower scores for Activities VII and VIII. Anthem did not document the numerator and denominator for Study Indicator 2 for the *Improving Timeliness of Prenatal and Postpartum Care* QIP, resulting in a lowered score for Activity VII. For the *Childhood Immunization Status* QIP, Anthem did not prioritize the causal/barrier analysis or document the implementation date of the interventions, resulting in a lowered score for Activity VIII.

Only the *All-Cause Readmissions* QIP progressed to the Outcomes stage during the reporting period. However, Anthem received a low score for Activity IX because the *All-Cause Readmission* QIP only achieved statistically significant improvement over baseline in Kings County. Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

The *Controlling High Blood Pressure* and *Medication Management for People with Asthma* QIPs did not progress to the Implementation or Outcomes stages during the reporting period; therefore, no intervention or outcome information is included in this report.

In addition, although the *Childhood Immunization Status*, *Improving Diabetes Management*, and *Improving Timeliness of Prenatal and Postpartum Care* QIPs progressed to the Implementation stage during the reporting period, DHCS required Anthem to move towards conducting PDSA cycles for QIP topics as part of Anthem's CAP. Therefore, no intervention information is included in this report. DHCS monitors the progress of all PDSA cycles through quarterly contacts (at minimum) with Anthem as part of the MCP's CAP.

All-Cause Readmissions QIP

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

**Table 4.4—Quality Improvement Project Outcomes for Anthem—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, and Tulare Counties
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions Rates			
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]			
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement[‡]
Alameda	14.7%	18.2%**	‡
Contra Costa	18.6%	17.3%	‡
Fresno	13.8%	14.4%	‡
Kings	16.6%	8.4%*	‡
Madera	10.9%	8.6%	‡
Sacramento	12.6%	11.8%	‡
San Francisco	14.2%	16.7%	‡
Santa Clara	13.7%	13.8%	‡
Tulare	11.7%	10.6%	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement from the baseline period (p value < 0.05).

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

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

Anthem’s goal for the *All-Cause Readmissions* QIP was to achieve statistically significant decline in readmissions rates from baseline to Remeasurement 1 in each county. The MCP met the project’s goal in Kings County. However, although the readmissions rate declined in Contra Costa, Madera, Sacramento, and Tulare counties, the change was not statistically significant. Also of note, the readmissions rate increased significantly in Alameda County. A review of the MCP’s QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ Anthem identified and prioritized the following barriers during Remeasurement 1:
 - Beneficiaries are discharged without sufficient education regarding medication.
 - Beneficiaries lack information related to their medical condition.
 - Homebound beneficiaries do not receive the continuum of care to prevent readmission.
 - Beneficiaries do not receive adequate care management from hospital to home post-discharge.
- ◆ Although the interventions were not successful at improving the QIP outcomes, Anthem implemented the Anthem Case Management Stabilization Program in all nine counties during Remeasurement 1. The following is a brief description of the MCP’s stabilization program:

- The MCP reviews the daily census to identify and assign beneficiaries to either Geocare Case Management or Complex Care Management, based on the level of need.
- Beneficiaries in Complex Care Management are contacted prior to or immediately after hospital discharge.
- Case managers implement the Four Pillars of Care:
 - Perform medication reconciliation/self-management education.
 - Identify root cause of admission and conduct education.
 - Identify the treating physician for beneficiary's post-discharge follow-up care.
 - Develop beneficiary-centric medical documentation.
- Monthly reports are generated to reflect the number of beneficiaries engaged in the program, and quarterly reports reflect the readmission rates for periodic monitoring of outcomes.

Plan-Do-Study-Act Review

All-Cause Readmissions

The *All-Cause Readmissions* QIP did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for the QIP topic.

For the *All-Cause Readmissions* PDSA cycle, Anthem set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By March 31, 2015, demonstrate a 25 percent increase (from 50 percent to 75 percent) in the beneficiary enrollment rate in the Anthem Case Management Stabilization Program for beneficiaries discharged from Community Regional Medical Center in Fresno County with a diagnosis of heart failure. Increase in enrollment will be accomplished by the case manager contacting the beneficiary prior to discharge and providing information and education.

The purpose of the *All-Cause Readmissions* PDSA cycle was to measure the beneficiary enrollment rate for the Anthem Case Management Stabilization Program for beneficiaries discharged from Community Regional Medical Center with a diagnosis of heart failure during first quarter of 2015 in order to address the potential barrier of inadequate care management of beneficiaries from hospital to home post-discharge and to measure the increase in enrollment from fourth quarter of 2014 to first quarter of 2015.

Anthem completed the *All-Cause Readmissions* PDSA cycle and reported that eight beneficiaries fit the criteria for the PDSA cycle. Of those, five beneficiaries (63 percent) successfully enrolled in

the program and two beneficiaries (40 percent) had readmissions. The two readmitted beneficiaries were re-enrolled into the program after the readmissions and demonstrated no further readmissions. Anthem planned to adapt the intervention to focus on a larger target population (beneficiaries with admissions related to HEDIS indicator diagnoses of asthma, diabetes, and hypertension).

Childhood Immunizations Combination 3

For the three new reporting units, rather than DHCS requiring Anthem to submit QIPs, DHCS required that the MCP submit a PDSA cycle. Anthem chose *Childhood Immunizations Combination 3* for the PDSA cycle topic and set the SMART Objective as follows:

By March 31, 2015, increase the number of providers using the immunization registries by 5 percent in each of the three regions (Region 1, Region 2, and San Benito) through preparation of educational materials and provider visits.

The purpose of the *Childhood Immunizations Combination 3* PDSA cycle was to test if a targeted intervention would increase by 5 percent the number of providers participating in the immunization registries in each of Region 1, Region 2, and San Benito.

Anthem completed the *Childhood Immunizations Combination 3* PDSA cycle without meeting the goal; however, the MCP reported an increase in the use of the California Immunization Registry (CAIR) at provider sites in two expansion regions (Region 1 and Region 2). No change occurred in San Benito County (one identified provider continued to use the registry). Anthem planned to adopt the change and set the goal of improving by 5 percent by June 30, 2015.

Strengths

Anthem was one of six MCPs that achieved statistically significant improvement over baseline for the statewide collaborative *All-Cause Readmissions* QIP, with the rate improving significantly for Kings County. In addition, the *All-Cause Readmissions* PDSA cycle results indicated that the MCP's test of change was successful at increasing the enrollment rate for the Anthem Case Management Stabilization Program. Lastly, the *Medication Management for People with Asthma* QIP achieved a *Met* validation status on the first study design submission.

Opportunities for Improvement

Since DHCS closely monitors Anthem's QIPs and PDSA cycles as part of the MCP's CAP, the MCP should continue to work closely with DHCS on QIPs and PDSA cycles to achieve performance improvement across all reporting units.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

Anthem’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for Anthem. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for Anthem

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	55.0%	26.3%	<10th	14.4%	9.2%	10th–25th
Diagnosis Code	55.7%	31.6%	<10th	44.4%	34.6%	10th–25th
Procedure Code	63.4%	43.8%	<10th	20.2%	22.5%	25th–75th
Procedure Code Modifier	70.2%	58.5%	10th–25th	40.0%	46.0%	25th–75th
Rendering Provider Name	79.0%	25.0%	<10th	97.7%	68.1%	>25th–<75th
Billing Provider Name	62.1%	35.0%	<10th	14.7%	8.6%	10th–25th

Overall, the medical record omission rates for Anthem ranged from 55.0 percent (*Date of Service*) to 79.0 percent (*Rendering Provider Name*). All six of Anthem’s medical record omission rates were worse than the respective statewide rates by at least 11.7 percentage points (*Procedure Code Modifier*) and as much as 54.0 percentage points (*Rendering Provider Name*). When compared to other MCPs’ performance, Anthem received a percentile ranking of “<10th” for five of the six medical record omission rates, with a percentile ranking of “10th–25th” for *Procedure Code Modifier*. These findings suggest poor levels of completeness among all key encounter data elements when compared to beneficiaries’ medical records. There were some variations among the nine counties for Anthem, with Madera County generally performing best and Tulare County worst for all data elements except *Procedure Code Modifier* and *Rendering Provider Name*.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located, which was the primary reason for the medical record omissions for Anthem.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.

- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for Anthem contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, Anthem's rates varied from 14.4 percent (*Date of Service*) to 97.7 percent (*Rendering Provider Name*). Two of Anthem's encounter data omission rates were better than the respective statewide rates—*Procedure Code* by 2.3 percentage points and *Procedure Code Modifier* by 6.0 percentage points. However, for four data elements, Anthem performed worse than the statewide encounter data omission rates; for one of these four data elements (*Rendering Provider Name*), Anthem's rate was 29.6 percentage points worse than the statewide rate. Anthem has an opportunity to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information. At the county level, there were some variations. However, the difference between the highest and lowest encounter data omission rates among nine counties was less than 22 percentage points for each of the six key data elements.

The most common reasons for encounter data omissions were:

- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in Anthem's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes rather than the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to Anthem (and/or the data subsequently being submitted to DHCS).
- ◆ Anthem populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files Anthem submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for Anthem. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for Anthem

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	81.4%	83.6%	10th–25th	Inaccurate Code (90.0%)
Procedure Code	82.9%	77.6%	25th–75th	Inaccurate Code (55.2%); Higher Level of Services in Medical Records (23.1%)
Procedure Code Modifier	99.5%	99.5%	25th–75th	—
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	69.1%	68.6%	25th–75th	Incorrect Names (98.9%)
All-Element Accuracy	0.1%	4.3%	>25th–<75th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to have somewhat better than average accuracy for Anthem, with three of the four element accuracy rates higher than the respective statewide rates. When comparing performance among the MCPs, three of the four key data elements received a percentile ranking of “25th–75th” and one element received a percentile ranking of “10th–25th” (*Diagnosis Code*). The *Diagnosis Code* data element showed that the majority of diagnosis-related errors (90.0 percent) involved discrepancies in the use of inaccurate codes compared to national coding standards rather than specificity errors. For the *Procedure Code* data element, 55.2 percent of the unmatched procedure codes were associated with the use of inaccurate codes, where the reported codes were not supported by national coding standards; and 23.1 percent of the errors were associated with lower-level procedure codes in the DHCS encounter data than were documented in the medical records (i.e., the procedure code was considered an error due to a higher level service documented in the medical record). Nearly all *Billing Provider Name* errors were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records. At the county level, there were some variations for the element accuracy rates. For example, the *Billing Provider Name* accuracy rates ranged from 50.7 percent (Santa Clara County) to 86.4 percent (Sacramento County).

Anthem’s all-element accuracy rate was worse than the statewide rate by 4.2 percentage points. Only 0.1 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and

Billing Provider Name) when compared to beneficiaries' medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 99 percent of the dates of service reviewed in this study. While all five key data elements contributed to Anthem's relatively low all-element accuracy rate, the *Rendering Provider Name* data element contributed most to the inaccuracy.

Medical Record Review Recommendations

Based on the study findings for Anthem, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, Anthem should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
 - Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. Anthem should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ Of the 1,151 dates of service identified in the DHCS encounter data, only 42 visits contained rendering provider names identifiable from the DHCS data system. Anthem should work with DHCS to investigate the reasons why so few rendering provider names could be identified using DHCS encounter and provider data.
- ◆ Anthem should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ Anthem should investigate the reasons for the relatively high medical record omission rates for all six key data elements and develop strategies to improve rates.
- ◆ Anthem should explore the reasons for the relatively high encounter data omission rate for the *Diagnosis Code* data element and take actions to improve rates.
- ◆ Anthem should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These

activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with Anthem.

- ◆ Anthem should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP’s Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

Anthem’s SFY 2014–15 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the EDV study, which assessed the MCP’s operational and infrastructure changes in support of DHCS’s transition to PACES. Based on review of Anthem’s Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist Anthem with improving its encounter data quality. DHCS followed up with Anthem regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of Anthem's performance in the three domains of care—quality, access, and timeliness.

Quality

HSAG reviewed Anthem's *2015 Medicaid Quality Management Program Description*, which provided details on the MCP's organizational structure to support the delivery of quality care to beneficiaries. The MCP's processes support continuous quality improvement and monitoring of the health care services provided to beneficiaries.

For RY 2015, 23 measures fell into the quality domain of care. The following are notable findings across all reporting units for measures falling into the quality domain of care.

- ◆ Eight (3 percent) of 252 rates for which an assessment of performance relative to the MPLs and HPLs could be made were above the HPLs in RY 2015:
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Francisco County (fifth consecutive year)
 - *Use of Imaging Studies for Low Back Pain* in Alameda (fifth consecutive year), Contra Costa, and San Francisco (third consecutive year) counties
 - All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures in Madera County
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Madera County
- ◆ Forty-three (21 percent) of 206 rates for which comparisons could be made between RY 2014 and RY 2015 improved significantly from RY 2014 to RY 2015. Additionally, the rates for 33 (41 percent) of 80 measures with rates below the MPLs in RY 2014 improved to above the MPLs in RY 2015.
- ◆ Eighty-seven (35 percent) of 252 rates for which an assessment of performance relative to the MPLs and HPLs could be made were below the MPLs, with 36 (41 percent) of the 87 rates being below the MPLs for at least three consecutive years.
- ◆ Sixteen (8 percent) of 206 rates for which comparisons could be made between RY 2014 and RY 2015 were significantly worse in RY 2015 when compared to RY 2014.
- ◆ Eleven (9 percent) of 118 rates that were above the MPLs in RY 2014 moved to below the MPLs in RY 2015.
- ◆ For quality measures stratified by the SPD and non-SPD populations, the SPD rates were significantly better than the non-SPD rates for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Fresno, Madera, Sacramento, and Tulare counties
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Alameda, Fresno, Sacramento, and Tulare counties
- ◆ The SPD rates for the *All-Cause Readmissions* measure were significantly worse than the non-SPD rates for six of the nine reporting units able to report an SPD rate for the measure. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

All six of Anthem's QIPs fell into the quality domain of care. Only the *All-Cause Readmissions* QIP progressed to the Outcomes stage. The QIP achieved statistically significant improvement at

Remeasurement 1 (RY 2014) in Kings County only; however, the readmissions rate was significantly worse in RY 2015 when compared to RY 2014 in this county. Anthem also conducted a PDSA cycle for the *All-Cause Readmissions* topic to test whether or not beneficiaries being contacted by a case manager prior to their discharge from a targeted hospital would result in an increase in the enrollment rate for the Anthem Case Management Stabilization Program. The intervention resulted in an increase in the enrollment rate, and the MCP planned to adapt the intervention to focus on a larger target population.

Anthem's PDSA cycle for its expansion counties was for the *Childhood Immunizations Combination 3* topic, which fell under the quality domain of care. The intervention resulted in an increase in the number of providers participating in the immunization registries at provider sites in Region 1 and Region 2; however, San Benito County experienced no change in the number of providers using the registry. The MCP planned to adopt the change.

Overall, Anthem showed below-average performance related to the quality domain of care.

Access

HSAG's review of Anthem's *2015 Medicaid Quality Management Program Description* found that the MCP has processes in place to monitor and evaluate beneficiary access to care. Anthem's *2014 Medicaid Quality Management Program Evaluation* report included information on the MCP's progress toward achieving access-related goals. Anthem reported some success at achieving access-related goals; however, identified access to care as an area with opportunities for improvement in 2015.

For RY 2015, 14 measures fell into the access domain of care. The following are notable findings across all reporting units for measures falling into the access domain of care.

- ◆ Two (1 percent) of 154 rates for which an assessment of performance relative to MPLs and HPLs could be made were above the HPLs:
 - *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in Region 1
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Madera County
- ◆ Twenty-one (17 percent) of 126 rates for which comparisons could be made between RY 2014 and RY 2015 improved significantly from RY 2014 to RY 2015. Additionally, the rate for 18 (35 percent) of 51 measures with rates below the MPLs in RY 2014 improved to above the MPLs in RY 2015.
- ◆ Sixty-three (41 percent) of 154 rates for which an assessment of performance relative to MPLs and HPLs could be made were below the MPLs, with 25 (40 percent) of the 63 rates being below the MPLs for at least three consecutive years.
- ◆ Fifteen (12 percent) of 126 rates for which comparisons could be made between RY 2014 and RY 2015 were significantly worse in RY 2015 when compared to RY 2014.

- ◆ Eight (12 percent) of 66 rates that were above the MPL in RY 2014 moved to below the MPLs in RY 2015.
- ◆ Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The *All-Cause Readmissions* measure is one of those measures and, as stated above, the rates were significantly worse than the non-SPD rates for six of the nine reporting units able to report an SPD rate for the measure. Additionally, the SPD rates were significantly worse than the non-SPD rates in San Francisco and Santa Clara counties for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* and *12 to 19 Years* measures. As previously noted, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Also, the higher SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population in the specified age groups relying on specialty providers as their health care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Four of Anthem's six QIPs fell into the access domain of care. As noted above, only the *All-Cause Readmissions* QIP progressed to the Outcomes stage. While the QIP achieved statistically significant improvement at Remeasurement 1 (RY 2014) in Kings County, the readmissions rate was significantly worse in RY 2015 when compared to RY 2014 in this county. Also as previously noted, the MCP's PDSA cycle for the *All-Cause Readmissions* topic was successful at increasing the enrollment rate in the Anthem Case Management Stabilization Program, and the MCP planned to adapt the intervention to focus on a larger target population.

Anthem's PDSA cycle for its expansion counties for the *Childhood Immunizations Combination 3* topic fell under the access domain of care. As noted above, Anthem planned to adopt the change since the intervention resulted in an increase in the number of providers participating in the immunization registries at provider sites in Region 1 and Region 2.

Overall, Anthem showed below-average performance related to the access domain of care.

Timeliness

As in previous years, Anthem's *2015 Medicaid Quality Management Program Description* included information about the MCP's organizational structure related to grievances, continuity and coordination of care, and utilization management, along with descriptions of the MCP's monitoring activities for timeliness-related processes.

For RY 2015, five measures fell into the timeliness domain of care. The following are notable findings across all reporting units for measures falling into the timeliness domain of care.

- ◆ One (2 percent) of 60 rates for which an assessment of performance relative to MPLs and HPLs could be made was above the HPL—the rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in Madera County.
- ◆ Three (7 percent) of 45 rates for which comparisons could be made between RY 2014 and RY 2015 improved significantly from RY 2014 to RY 2015:
 - *Childhood Immunization Status—Combination 3* in Sacramento County
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Sacramento County, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Alameda County, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ Four (9 percent) of 45 rates for which comparisons could be made from RY 2014 and RY 2015 improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015:
 - *Childhood Immunization Status—Combination 3* in Madera County
 - *Prenatal and Postpartum Care—Postpartum Care* in Fresno and Sacramento counties
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Madera County
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Kings County
- ◆ Twenty (33 percent) of 60 rates for which an assessment of performance relative to MPLs and HPLs could be made were below the MPLs.
- ◆ The rates for two (4 percent) of 45 rates for which comparisons could be made between RY 2014 and RY 2015 declined significantly from RY 2014 to RY 2015:
 - *Childhood Immunization Status—Combination 3* in Contra Costa County
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Contra Costa and San Francisco counties
- ◆ Two (40 percent) of five timeliness measure rates in Kings County declined from RY 2014 to RY 2015. Although the decline was not statistically significant, the change resulted in the rates moving from above the MPLs in RY 2014 to below the MPLs in RY 2015:
 - *Childhood Immunization Status—Combination 3*
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Two of Anthem’s QIPs fell into the timeliness domain of care. Neither QIP progressed to the Outcomes stage; therefore, HSAG cannot assess the QIPs’ impact on the timeliness of care delivered to beneficiaries.

Anthem’s PDSA cycle for its expansion counties for the *Childhood Immunizations Combination 3* topic fell under the timeliness domain of care. As noted above, Anthem planned to adopt the change since the intervention resulted in an increase in the number of providers participating in the immunization registries at provider sites in Region 1 and Region 2.

Overall, Anthem showed below-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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with Anthem’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—Anthem’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to Anthem	Self-Reported Actions Taken by Anthem during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Continue to work closely with DHCS on implementation and monitoring of the CAP, including conducting at least a quarterly assessment of progress and making changes when indicated.</p>	<p>Anthem met with DHCS regarding the CAP in May 2014, August 2014, November 2014, December 2014, March 2015, and June 2015. The quality management staff meets with Maureen Farrell from DHCS monthly to give updates on IPs and QIPs for the CAP. Anthem implemented the new PDSA format for quarterly reporting and progress reports for DHCS at each meeting. Anthem has also participated in the DHCS newly formed collaborative for diabetes, prenatal and postpartum, and controlling high blood pressure workgroups.</p>
<p>2. Engage in the following efforts to improve performance on required performance measures:</p> <ul style="list-style-type: none"> a. In instances where rates have improved, assess the factors contributing to the improvement and duplicate the improvement strategies, as appropriate, across counties. b. For measures with rates that continue to decline and for measures with rates below the MPLs, reassess the barriers to the MCP improving performance, prioritize the barriers, and identify rapid-cycle improvement strategies to target the prioritized barriers. 	<p>a. Regional teams were formed to identify specific trends per county with the goal to implement best practices for provider education, member education, and data improvements. Each regional executive director, along with quality management, data team, provider relations, and health education staff met to identify solutions to share statewide or at the county-specific level based on HEDIS measures. For example a lab analysis was completed statewide to determine which medical groups had arrangements with lab vendors and how successful the data exchanged were between organizations. We improved in several measures based on this effort at identifying the issues and solutions with the groups and vendors across the state. Field representatives and intervention specialists identified other best practices. Plans were considered for continuance of these best practices or implementation in counties that did not perform as well.</p>

2013–14 External Quality Review Recommendation Directed to Anthem	Self-Reported Actions Taken by Anthem during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>c. Continue quarterly evaluation of the MCP’s improvement efforts so that effective strategies can be expanded and ineffective strategies can be modified or eliminated.</p> <p>d. Continue to work with DHCS and the EQRO to identify priority areas for improvement and strategies that have the best chance at resulting in positive outcomes.</p>	<p>b. Anthem reviews the measures monthly (and more frequently for subsets of data) using the PDSA process. Barriers are identified per measure, county, medical group, and provider through the newly formed Deep Dive meetings held in each region and through the weekly HEDIS strategy meetings. Interventions were identified and implemented in each Anthem county to improve performance.</p> <p>c. Anthem reports on the quality improvement projects quarterly to DHCS and HSAG.</p> <p>These quarterly reports have been modified in format and now include a PDSA-format template provided by DHCS and HSAG. The report format includes a project update aimed at improving performance, an identified SMART objective, analysis, and actions taken. Anthem provides other updates at the leadership meeting with DHCS and includes the following in presentations:</p> <ul style="list-style-type: none"> • Interim HEDIS results • Quarterly goals • Quarterly interventions to reach the set goals (Plan-Do-Study-Act cycle) if previous quarter’s goals were met • Goals/interventions planned in the following quarter <p>In addition, Anthem meets monthly with Maureen Farrell from DHCS to review the improvement plans. Monthly HEDIS rates, goals, and interventions are presented as are planned goals and interventions for the next month.</p>
<p>3. Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.</p>	<p>Anthem Blue Cross continues to work on identifying effective ways to approach improvement efforts. A complete causal/barrier analysis, which included using data, was conducted for all counties with measures under the MPL according to region. The barrier analysis revealed:</p> <ul style="list-style-type: none"> • Progress made with incomplete lab results data, with opportunities further defined at the provider group level. • Progress made in some counties with the eye exam rate, but data opportunities from vision providers are still missing (EyePac and VSP data files for prior year where we may use the historical data) • Continued issues with providers in some counties and some provider groups not using the Immunization Registry routinely. • Lack of timely and accurate encounter data from some provider medical groups. <p>Anthem Blue Cross continues to develop improvement strategies designed to make the greatest impact based on the causal/barrier analysis. Strategies include:</p> <ul style="list-style-type: none"> • Developing work teams with the provider medical groups to ensure that all lab results are collected. • Developing clinic days in coordination with the vision providers.

2013–14 External Quality Review Recommendation Directed to Anthem	Self-Reported Actions Taken by Anthem during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<ul style="list-style-type: none"> • Providing support to providers to increase participation with the Immunization Registry to help improve administrative data. • Working with the State to improve Immunization Registry processes and strategies. • Forming encounter data workgroups to perform root cause analysis and recommend fixes. <p>Anthem Blue Cross ensures the ongoing evaluation of improvement strategies by periodic monitoring of activity statistics quarterly and annually. Progress is evaluated based on the HEDIS results.</p>

Recommendations

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

- ◆ Ensure that the MCP provides DHCS with the required documentation regarding the MCP’s process for assigning clinical severity level, which was a deficiency identified during the November 2013 DMHC SPD medical survey and provisionally closed by DHCS.
- ◆ Ensure that the MCP provides evidence to DHCS regarding the operationalization and supporting documentation of the provisionally closed deficiencies from the November 2013 medical audit.
- ◆ To ensure an efficient HEDIS audit process, develop a process to ensure that a separate Roadmap supplemental data section with supporting documentation is included in the MCP’s January Roadmap submission.
- ◆ To ensure Anthem’s ability to use the online provider portal as a non-standard supplemental data source for HEDIS measure reporting, work with the MCP’s website vendor to develop a process to validate the data fields.
- ◆ Continue to work with DHCS and the EQRO quarterly, at minimum, to identify MCP-specific priority areas for improvement. Based on DHCS priorities and measures with multiple reporting units demonstrating poor performance, HSAG recommends that the MCP ensure implementation of improvement efforts related to the following measures:
 - *All-Cause Readmissions*, including assessing the factors leading to the significant increase in hospital readmissions for the SPD population to ensure that the MCP is meeting the needs of this population.
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*.
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics*.

- *Cervical Cancer Screening.*
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.*
 - *Medication Management for People with Asthma—Medication Compliance 50% Total.*
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care.*
- ◆ Determine which strategies have been successful at improving performance, and duplicate the strategies across all reporting units as appropriate.
 - ◆ Continue to work closely with DHCS on CAP QIPs and PDSA cycles to achieve performance improvement across all reporting units.
 - ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix D:
Performance Evaluation Report
California Health & Wellness Plan
July 1, 2014 – June 30, 2015**

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Appendix D: Performance Evaluation Report

California Health & Wellness Plan

July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), California Health & Wellness Plan (“CHW” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

CHW is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) under the Regional and Imperial Models. In all counties, beneficiaries may enroll in CHW or in the alternative commercial plan (CP).

CHW became operational to provide MCMC services effective November 1, 2013. Table 1.1 shows the counties in which CHW provides MCMC services, the alternative CPs for each county, the number and percentage of beneficiaries enrolled in CHW for each county, and the MCP’s total number of beneficiaries as of June 30, 2015.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: January 7, 2016.

Table 1.1—CHW Enrollment as of June 30, 2015

County	Alternative Commercial Plan	Enrollment as of June 30, 2015	CHW's Percentage of Beneficiaries Enrolled in the County
Alpine	Anthem Blue Cross Partnership Plan (Anthem)	121	45%
Amador	Anthem Kaiser NorCal	1,117	19%
Butte	Anthem	33,061	54%
Calaveras	Anthem	5,987	67%
Colusa	Anthem	2,197	35%
El Dorado	Anthem Kaiser NorCal	17,331	63%
Glenn	Anthem	4,917	56%
Imperial	Molina Healthcare of California Partner Plan, Inc.	53,010	76%
Inyo	Anthem	1,928	51%
Mariposa	Anthem	1,099	30%
Mono	Anthem	918	37%
Nevada	Anthem	6,696	38%
Placer	Anthem Kaiser NorCal	10,508	24%
Plumas	Anthem	2,016	49%
Sierra	Anthem	237	41%
Sutter	Anthem	11,024	37%
Tehama	Anthem	10,111	52%
Tuolumne	Anthem	6,203	58%
Yuba	Anthem	8,974	39%
Total		177,455	

2. **MANAGED CARE HEALTH PLAN COMPLIANCE** *for California Health & Wellness Plan*

Compliance Reviews

DHCS conducted no reviews for CHW during the review period for this report; however, at the time of the production of this report, DHCS informed HSAG that the Department of Managed Health Care (DMHC) conducted a medical survey for CHW August 10, 2015, through August 14, 2015, for the review period of June 1, 2014, through May 1, 2015. HSAG will include the results of the survey in CHW's 2015–16 MCP-specific evaluation report.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for California Health & Wellness Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that CHW followed the appropriate specifications to produce valid rates, and no issues of concern were identified.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 through Table 3.3 for CHW's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1 through Table 3.3

The reader should note the following regarding Table 3.1 through Table 3.3:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.

- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
CHW—Imperial County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	S	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	61.92	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	299.04	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	93.60%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	93.93%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	39.22%	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	55.10%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	61.90%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	98.15%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	89.84%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	72.61%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	56.79%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	90.20%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	32.29%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	80.62%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	56.35%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	68.87%	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	72.01%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	55.37%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	72.55%	Not Comparable
Use of Imaging Studies for Low Back Pain	Q	—	—	—	59.27%	Not Comparable

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	—	73.32%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	—	56.01%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	—	46.63%	Not Comparable
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	—	71.39%	Not Comparable

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table 3.2—Multi-Year Performance Measure Results*
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	13.56%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	47.61	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	331.93	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	81.59%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	81.33%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	16.15%	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	44.53%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	63.94%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	94.23%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	88.33%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	70.60%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	39.20%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	84.63%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	40.31%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	76.17%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	44.99%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	54.20%	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	53.97%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	63.50%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	76.40%	Not Comparable
Use of Imaging Studies for Low Back Pain	Q	—	—	—	77.96%	Not Comparable

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	—	50.72%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	—	39.90%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	—	29.33%	Not Comparable
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	—	59.62%	Not Comparable

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table 3.3—Multi-Year Performance Measure Results*
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	17.65%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	59.57	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	257.36	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	81.43%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	82.69%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	18.60%	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	40.88%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	52.08%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	91.36%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	80.61%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	61.20%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	38.14%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	87.80%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	40.13%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	83.37%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	48.12%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	51.88%	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	48.60%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	53.28%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	72.99%	Not Comparable

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	—	—	—	78.98%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	—	57.21%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	—	53.13%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	—	42.31%	Not Comparable
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	—	59.13%	Not Comparable

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.4 through Table 3.9 present a summary of the RY 2015 Seniors and Persons with Disabilities (SPD) measure results reported by CHW. Table 3.4 through Table 3.6 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.7 through Table 3.9 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.4—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CHW—Imperial County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	S	NA	Not Comparable	S
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	93.25%	97.40%	↔	93.60%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	93.32%	100.0%	↔	93.93%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	98.25%	NA	Not Comparable	98.15%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	89.77%	97.78%	↔	89.84%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	NA	NA	Not Comparable	NA
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	NA	NA	Not Comparable	NA

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

⁴ 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 through Table 3.6.

Table 3.5—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	12.38%	NA	Not Comparable	13.56%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.51%	82.81%	↔	81.59%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.84%	87.50%	↔	81.33%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	94.20%	NA	Not Comparable	94.23%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	88.29%	93.10%	↔	88.33%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	NA	NA	Not Comparable	NA
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	NA	NA	Not Comparable	NA

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.6—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	S	NA	Not Comparable	17.65%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.31%	83.33%	↔	81.43%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	82.15%	88.89%	↔	82.69%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	91.35%	NA	Not Comparable	91.36%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	80.58%	NA	Not Comparable	80.61%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	NA	NA	Not Comparable	NA
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	NA	NA	Not Comparable	NA

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

**Table 3.7—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
CHW—Imperial County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
294.65	61.43	585.22	94.32

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

**Table 3.8—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
325.44	46.76	608.59	83.85

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

**Table 3.9—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer,
Tuolumne, and Yuba Counties)**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
253.23	59.01	454.03	86.17

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

Table 3.10 through Table 3.12 present the three-year trending information for the SPD population, and Table 3.13 through Table 3.15 present the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.10—RY 2015 (MY 2014) HEDIS SPD Trend Table
CHW—Imperial County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	NA	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	94.32	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	585.22	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	97.40%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	100.0%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	97.78%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	NA	Not Comparable

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.11—RY 2015 (MY 2014) HEDIS SPD Trend Table
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	NA	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	83.85	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	608.59	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	82.81%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	87.50%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	93.10%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	NA	Not Comparable

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.12—RY 2015 (MY 2014) HEDIS SPD Trend Table
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer,
Tuolumne, and Yuba Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	—	—	NA	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	86.17	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	454.03	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	83.33%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	88.89%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	—	—	NA	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.13—RY 2015 (MY 2014) Non-SPD Trend Table
CHW—Imperial County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	S	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	61.43	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	294.65	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	93.25%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	93.32%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	98.25%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	89.77%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	NA	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.14—RY 2015 (MY 2014) Non-SPD Trend Table
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	12.38%	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	46.76	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	325.44	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	81.51%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	80.84%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	94.20%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	88.29%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	NA	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table 3.15—RY 2015 (MY 2014) Non-SPD Trend Table
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	—	—	S	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	59.01	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	253.23	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	81.31%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	82.15%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	—	—	91.35%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	—	—	80.58%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	—	—	NA	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

Since RY 2015 was the first year that CHW reported performance measure rates, no comparison to prior years' performance can be made. Each reporting unit had 22 measures with reportable rates and for which MPLs and HPLs were established.

The rates were above the HPLs in Imperial County for the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

The rates were below the MPLs in all reporting units for the following measures:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Imperial County was the highest performing county, with three rates above the HPLs and six rates below the MPLs. Regions 1 and 2 each had no rates above the HPLs and 12 measures below the MPLs.

Seniors and Persons with Disabilities Findings

In most instances, the SPD and non-SPD rates were given a *Not Applicable (NA)* audit finding because the MCP's denominators were too small (i.e., <30). Therefore, HSAG was unable to conduct comparative analysis on the SPD rates compared to the non-SPD rates for most measures. In instances where HSAG could conduct comparative analysis, no significant differences existed between the two populations.

Improvement Plans

Since RY 2015 was the first year CHW was required to report performance measure rates, DHCS did not require the MCP to submit improvement plans (IPs) for measures with rates below the MPLs.

Strengths

CHW followed the appropriate specifications to produce valid rates, and the HSAG auditor identified no issues of concern. The MCP had three measures with rates above the HPLs.

Opportunities for Improvement

CHW has the opportunity to identify the factors leading to 30 rates being below the MPLs and to implement improvement strategies that have the likelihood of bringing the rates to above the MPLs in RY 2016. The MCP should work with DHCS to prioritize areas for improvement rather than trying to work on all measures at once.

Quality Improvement Project Objectives

Since DHCS decided to restructure the QIP process with the new EQRO contact starting July 1, 2015, DHCS did not require CHW to conduct any QIPs during the review period of July 1, 2014–June 30, 2015. Instead, DHCS required CHW to submit one Plan-Do-Study-Act (PDSA) cycle on a priority topic.

Plan-Do-Study-Act Review

CHW submitted a PDSA cycle on the topic of *Postpartum Care Outreach*. The MCP set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By May 1, 2015, CHW will call, between one and 21 postpartum days, 100 percent of beneficiaries who receive prenatal care at Clinicas de Salud del Pueblo in Imperial County and deliver between January 15, 2015, and April 15, 2015.

The purpose of the *Postpartum Care Outreach* PDSA cycle was to test if increasing the number of calls made to beneficiaries to provide postpartum care education and scheduling assistance would increase the number of postpartum visit appointments scheduled.

CHW carried out the *Postpartum Care Outreach* PDSA cycle as planned. The MCP reported reaching 55 of the 88 women (62.5 percent) who delivered during the measurement period. However, 44 women already had a postpartum visit appointment scheduled at the time of the call. Of these, five appointments were scheduled too early, prior to 21 days postpartum. All 16 women who needed a postpartum visit appointment declined scheduling assistance from the outreach caller. CHW concluded that incorrect telephone numbers, women wanting to make their own appointments, and language barriers attributed to the low outreach and appointment scheduling rates. The MCP also learned that Clinicas de Salud del Pueblo initiated its own intervention at the same time as the *Postpartum Care Outreach* PDSA cycle; therefore, the effectiveness of the beneficiary outreach throughout the PDSA cycle was inconclusive. The MCP indicated that it will adapt and test the postpartum care outreach intervention in additional settings.

Strengths

CHW was able to conduct the *Postpartum Care Outreach* PDSA cycle as planned and documented thoroughly the factors that impacted the results of the intervention.

Opportunities for Improvement

CHW should follow the plans to adapt the beneficiary outreach intervention documented in the *Postpartum Care Outreach* PDSA Worksheet and test the change through additional PDSA cycles.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

As the SFY 2013–14 encounter data validation (EDV) study was on services provided in 2012, CHW was not included in the study.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP’s Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

CHW’s SFY 2014–15 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the EDV study, which assessed the MCP’s operational and infrastructure changes in support of DHCS’s transition to the Post Adjudicated Claims and Encounters System (PACES). Based on review of CHW’s Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist CHW with improving its encounter data quality. DHCS followed up with CHW regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of CHW's performance in the three domains of care—quality, access, and timeliness.

Quality

As in the previous year, CHW's *Quality Assessment and Performance Improvement Program Description* included a summary of the MCP's processes designed to monitor and ensure the quality of care delivered to beneficiaries. Additionally, CHW's *Annual Quality Assessment and Performance Improvement Program Evaluation* indicated that the MCP added resources to the Quality Assessment and Performance Improvement Program as part of the MCP's commitment to quality.

Each reporting unit had 20 quality measures with reportable rates and for which MPLs and HPLs were established. The rates were above the HPLs in Imperial County for the following quality measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

Across all reporting units, 27 rates for quality measures were below the MPLs. Imperial County, Region 1, and Region 2 had six, 11, and 10 quality measures with rates below the MPLs, respectively.

Overall, CHW showed below-average performance related to the quality domain of care based on performance measure rates only. DHCS did not require CHW to submit QIPs during the review period; therefore, there were no QIP data to include in HSAG's assessment of the MCP's performance related to the quality domain of care.

Access

CHW's *Annual Quality Assessment and Performance Improvement Program Evaluation* included a summary of the MCP's evaluation of access standards. While CHW exceeded many access-related goals, the MCP identified a number of opportunities for improvement. These are reflected in CHW's quality improvement work plan.

Each reporting unit had 11 access measures with reportable rates and for which MPLs and HPLs were established. Nineteen rates were below the MPLs for measures falling in the access domain of care. Imperial County, Region 1, and Region 2 had three, seven, and nine access measures with rates below the MPLs, respectively.

Overall, CHW showed below-average performance related to the access domain of care based on performance measure rates only. DHCS did not require CHW to submit QIPs during the review period; therefore, there were no QIP data to include in HSAG's assessment of the MCP's performance related to the access domain of care.

Timeliness

As in the previous year, CHW's *Quality Assessment and Performance Improvement Program Description* provided information on the MCP's organizational structure related to continuity and coordination of care, grievances and appeals, and utilization management—all of which can affect the timeliness of care delivered to beneficiaries. Additionally, CHW's quality improvement work plan included objectives to monitor and evaluate the MCP's utilization management program.

Five of the required performance measures fall into the timeliness domain of care. All reporting units had reportable rates for the measures. The rates were below the MPLs for the following measures:

- ◆ *Childhood Immunization Status—Combination 3* in Imperial County and Regions 1 and 2
- ◆ *Immunizations for Adolescents—Combination 1* in Regions 1 and 2
- ◆ *Prenatal and Postpartum Care—Postpartum Care* in Imperial County and Region 2
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Imperial County and Regions 1 and 2
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Regions 1 and 2

The rates were below the MPLs for all five timeliness measures in Region 2 compared to three and four measures in Imperial County and Region 1, respectively.

Overall, CHW showed below-average performance related to the timeliness domain of care based on performance measure rates only. DHCS did not require CHW to submit QIPs during the review period; therefore, there were no QIP data to include in HSAG’s assessment of the MCP’s 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with CHW’s self-reported actions taken through June 30, 2015, that address the recommendations.. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—CHW’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to CHW	Self-Reported Actions Taken by CHW during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Work with DHCS and the EQRO to ensure that the MCP understands DHCS’s 2015 performance measure reporting requirements.</p>	<p>10/30/14: CHW received the HEDIS Record of Administration, Data Management, and Processes (Roadmap) packet initiating the HEDIS 2015 audit activities.</p> <p>1/21/15: Kick-off call conducted with HSAG and CHW.</p> <p>1/29/15: CHW submitted completed Roadmap to HSAG.</p> <p>2/16/15: CHW received preliminary Information System Tracking Grid/Roadmap findings from HSAG.</p> <p>2/26/15: CHW submitted source code for all measures not covered under NCQA Measure Certification to HSAG.</p>

2013–14 External Quality Review Recommendation Directed to CHW	Self-Reported Actions Taken by CHW during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>3/2/15: HSAG conducted on-site visit with CHW.</p> <p>3/16/15: CHW received preliminary audit findings report with interim IS Tracking Grid from HSAG.</p> <p>3/31/15: HSAG finalized approval of all supplemental data and notified CHW of results.</p> <p>4/29/15: Preliminary rate review and feedback completed.</p> <p>5/1/15: HSAG selected measures for medical record review validation (MRRV) and informed CHW of the selection.</p> <p>5/15/15: CHW completed the medical record abstraction process for all hybrid measures and submitted to HSAG final numerator-compliant counts for all hybrid measures and numerator-compliant lists and exclusions for the selected MRRV measures.</p> <p>5/18/15: HSAG selected for review 16 records and exclusions for each selected MRRV measure and informed CHW of the selections.</p> <p>5/29/15: CHW submitted final, signed HEDIS Roadmap Attestation to HSAG.</p> <p>5/26/15: CHW submitted selected charts to HSAG for MRRV.</p> <p>6/1/15: CHW sent final rates to HSAG.</p> <p>6/2/15: HSAG sent MRRV results to CHW.</p> <p>6/9/15: HSAG approved final rates. Auditor lock applied to Interactive Data Submission System (IDSS) submissions; CHW submitted auditor-locked submissions with attestations to NCQA.</p>
<p>2. Work with DHCS and the EQRO in preparation of the MCP’s QIP submission due to DHCS in January 2015.</p>	<p>11/25/14: CHW received letter from DHCS regarding QIPs process.</p> <p>12/1/14–1/29/15: CHW work groups met to identify a priority barrier and SMART objective for the PDSA cycle. QIP topic selected for Imperial County: Postpartum.</p> <p>1/30/15: CHW submitted to HSAG and DHCS the “Plan” part of the PDSA Cycle Worksheet.</p> <p>2/2/15: CHW received QIP PDSA Cycle Feedback from HSAG; no changes were required.</p> <p>2/3/15–4/15/15: CHW carried out the test as planned.</p> <p>5/29/15: CHW submitted the final completed PDSA worksheet to HSAG and DHCS.</p> <p>6/1/15: CHW received QIP PDSA Cycle Feedback from HSAG. HSAG recommended that CHW complete expanded outreach but work to alleviate barriers it identified prior to expanding the change.</p> <p>6/15/15 (ongoing): CHW addressing identified barriers prior to expanding outreach.</p>

Recommendations

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

- ◆ Identify the factors leading to 30 rates being below the MPLs and implement improvement strategies that have the likelihood of bringing the rates to above the MPLs in RY 2016.
 - Work with DHCS to prioritize areas for improvement rather than trying to work on all measures at once.
- ◆ Test the adapted beneficiary outreach intervention identified in the *Postpartum Care Outreach* PDSA Worksheet through additional PDSA cycles.

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

Medi-Cal Managed Care Technical Report

**Appendix E:
Performance Evaluation Report
CalOptima
July 1, 2014 – June 30, 2015**

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Appendix E: Performance Evaluation Report – CalOptima

July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), CalOptima (“CalOptima” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

CalOptima is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a County Organized Health System (COHS).

CalOptima became operational to provide services in Orange County in October 1995. As of June 30, 2015, CalOptima had 747,653 beneficiaries in Orange County.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: October 27, 2015.

Focused Medical Review

The most recent focused medical review for CalOptima was conducted February 10, 2014, through February 14, 2014, covering the review period of July 1, 2013, through December 31, 2013. DHCS assessed the following areas:

- ◆ Utilization Management
- ◆ Prior Authorization Procedures
- ◆ Referral Tracking System
- ◆ Delegation of Utilization Management
- ◆ Pharmaceutical Services
- ◆ Grievances and Appeals
- ◆ Fraud and Abuse Program

DHCS issued a report on April 15, 2014, which summarized the findings from the February 2014 focused medical review. DHCS identified findings in all assessed areas and provided detailed recommendations for each area. In a letter dated June 1, 2015, DHCS stated that on April 1, 2015, CalOptima provided DHCS with the MCP's final response to the corrective action plan (CAP) originally issued on May 28, 2014. The letter stated that DHCS had reviewed all remaining open items and found CalOptima to be in compliance. Therefore, DHCS closed the CAP.

1115 Waiver Seniors and Persons with Disabilities Enrollment Survey

The Department of Managed Health Care (DMHC) conducted an 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey (hereafter referred to as "SPD medical survey") for CalOptima September 29, 2014, through October 3, 2014, covering the review period January 1, 2014, through July 31, 2014. DMHC assessed the following areas related to CalOptima's delivery of care to the SPD population:

- ◆ Utilization Management
- ◆ Continuity of Care
- ◆ Availability and Accessibility
- ◆ Member Rights
- ◆ Quality Management

DMHC issued a report to DHCS July 29, 2015. In the report, DMHC indicated that it identified findings in the areas of Utilization Management, Availability and Accessibility, Member Rights, and Quality Management. In a letter dated November 6, 2015, DHCS stated that on November 4, 2015, CalOptima provided DHCS with the MCP's final response to the CAP originally issued on September 17, 2015. The letter stated that DHCS had reviewed all remaining open items and found CalOptima to be in compliance. DHCS therefore closed the CAP.

Note that while DHCS issued the referenced report and letter outside the review dates for this MCP-specific evaluation report, HSAG included the information because it was in reference to an SPD medical survey that occurred within the review dates for this report and because the MCP resolved all findings related to the survey.

Medical and State Supported Services Audit

DHCS conducted a medical and State Supported Services audit for CalOptima September 29, 2014, through October 10, 2014, covering the review period of July 1, 2013, through June 30, 2014. DHCS assessed the following areas:

- ◆ Compliance with State Supported Services contract and regulations
- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Member's Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

Reports were issued by DHCS January 5, 2015, for each audit type. DHCS found CalOptima to be in compliance with the State Supported Services contractual requirements; however, DHCS identified findings in all areas reviewed under the medical audit. In a letter dated February 11, 2015, DHCS stated that on February 6, 2015, CalOptima provided DHCS with the MCP's final response to the CAP originally issued on December 29, 2014. The letter stated that DHCS had reviewed all remaining open items and found CalOptima to be in compliance. DHCS stated that it closed the CAP; however, one item was provisionally closed. The provisional item was in the area of Utilization Management, and DHCS indicated that the MCP should submit meeting minutes from its Quality Improvement and Delegation Oversight Committee meeting to provide evidence that delegated-level open and unused prior authorizations are being reported to the responsible committees.

Strengths

Although CAPs were issued for CalOptima's most recent focused medical review, medical audit, and SPD medical survey, the MCP sufficiently responded to all recommendations and DHCS closed the CAPs.

Opportunities for Improvement

While the CAP was closed by DHCS for CalOptima's most recent medical audit, the MCP has the opportunity to ensure that it provides the requested Quality Improvement and Delegation Oversight Committee meeting minutes to DHCS as evidence that delegated-level open and unused prior authorizations are being reported to the responsible committees.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for CalOptima* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance Audit.³ HSAG auditors determined that CalOptima followed the appropriate specifications to produce valid rates, and no issues of concern were identified. The auditor noted that although CalOptima experienced a large number of enrollments in 2014 due mostly to the implementation of the Affordable Care Act, the MCP processed enrollment applications timely and reported no backlogs.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. (See Table 3.1 for CalOptima’s performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP’s performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA’s national percentiles. MPLs and HPLs align with NCQA’s national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS’s *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
CalOptima—Orange County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	16.69%	15.22%	17.60%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	36.79	36.08	34.90	35.17	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	351.89	330.09	271.66	256.82	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	90.25%	90.75%	90.55%	90.07%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	90.38%	93.54%	89.69%	52.78%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	89.29%	90.65%	89.62%	89.44%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	20.73%	21.81%	20.65%	22.00%	↔
Cervical Cancer Screening	Q,A	—	—	71.63%	62.78%	↓
Childhood Immunization Status—Combination 3	Q,A,T	81.30%	84.25%	79.40%	78.94%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	97.67%	97.34%	97.42%	94.16%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	92.55%	91.12%	91.43%	89.52%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	92.05%	91.64%	92.30%	92.68%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	90.37%	90.41%	89.07%	89.96%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	73.76%	73.95%	69.30%	74.07%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	69.25%	66.05%	67.91%	63.89%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	86.45%	82.33%	85.12%	89.81%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	58.71%	56.98%	59.07%	61.57%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	85.38%	83.02%	85.81%	82.64%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	30.97%	37.21%	32.33%	27.78%	↔
Controlling High Blood Pressure	Q	—	64.64%	67.25%	69.29%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	69.21%	80.86%	84.15%	77.18%	↓
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	48.71%	50.10%	52.55%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	25.60%	28.33%	28.62%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	69.38%	63.66%	58.96%	64.15%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	84.82%	78.42%	85.07%	84.20%	↔
Use of Imaging Studies for Low Back Pain	Q	79.00%	78.34%	75.25%	76.66%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	76.92%	81.39%	75.68%	79.35%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	81.43%	82.78%	84.19%	83.29%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	71.62%	75.56%	72.64%	76.10%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	82.54%	86.69%	83.94%	85.71%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 SPD measure results reported by CalOptima. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CalOptima—Orange County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	14.49%	19.97%	▼	17.60%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.91%	91.07%	↑	90.07%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	46.90%	55.00%	↔	52.78%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.62%	91.12%	↑	89.44%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	94.33%	75.19%	↓	94.16%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	89.59%	87.18%	↓	89.52%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	92.88%	88.65%	↓	92.68%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	90.27%	83.86%	↓	89.96%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

⁴ 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 3.2.

**Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
CalOptima—Orange County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
227.07	33.33	536.97	52.48

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
CalOptima—Orange County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014– 15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	18.82%	16.83%	19.97%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	46.80	51.03	52.48	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	559.23	573.24	536.97	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.78%	91.90%	91.07%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	93.77%	90.06%	55.00%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.88%	91.16%	91.12%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	85.60%	85.27%	75.19%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.36%	85.47%	87.18%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	85.40%	85.84%	88.65%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	81.99%	80.71%	83.86%	↑

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

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
CalOptima—Orange County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	11.35%	10.83%	14.49%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	34.15	32.50	33.33	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	288.81	226.81	227.07	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.58%	86.11%	88.91%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	91.18%	NA	46.90%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.39%	83.73%	87.62%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.45%	97.54%	94.33%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.29%	91.62%	89.59%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	92.03%	92.64%	92.88%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	90.99%	89.52%	90.27%	↑

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

NA = A Not Applicable audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the All-Cause Readmissions measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant decline in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant improvement in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rates for the following measures were above the HPLs in RY 2015:

- ◆ Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)
- ◆ Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)
- ◆ Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total (fifth consecutive year)
- ◆ Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total (fifth consecutive year)
- ◆ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (third consecutive year)

The rates for the following measures improved significantly from RY 2014 to RY 2015:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*

The rates for the following measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Cervical Cancer Screening*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Immunizations for Adolescents—Combination 1*

Seniors and Persons with Disabilities Findings

The SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures were significantly better than the non-SPD rates. The SPD rates for the *All-Cause Readmissions* and all four *Children and Adolescents' Access to Primary Care Practitioners* measures were significantly worse than the non-SPD rates. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners* may be attributed to children and adolescents in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Across all measures stratified for the SPD and non-SPD populations, there was no notable variation in the SPD and non-SPD rates from RY 2014 to RY 2015 not already reflected in the analysis above, except the following:

- ◆ The non-SPD rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure improved significantly from RY 2014 to RY 2015.
- ◆ The SPD rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure declined significantly from RY 2014 to RY 2015.

Assessment of Improvement Plans

Based on RY 2014 performance measure rates, CalOptima was not required to submit any improvement plans (IPs) and will be required to submit no IPs based on RY 2015 rates.

Strengths

CalOptima followed the appropriate specifications to produce valid performance measure rates, and the auditor identified no issues of concern. The auditor noted that although CalOptima experienced a large number of enrollments in 2014—due mostly to the implementation of the Affordable Care Act—the MCP processed enrollment applications timely and reported no backlogs.

CalOptima had five measures with rates above the HPLs in RY 2015, and the rates for three measures improved significantly from RY 2014 to RY 2015. The MCP provided documentation of the actions that the MCP has taken to assess the factors leading to some SPD rates being significantly worse than the non-SPD rates (See Table 6.1).

Opportunities for Improvement

CalOptima has the opportunity to assess the factors leading to the significant decline in the MCP's performance for five measures and in the rate for one measure being below the MPL, and to implement strategies to improve performance.

Quality Improvement Project Objectives

CalOptima participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists CalOptima’s QIPs and indicates whether the QIP was clinical or nonclinical and the domains of care (i.e., quality, access, and timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for CalOptima
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Improvement of Prenatal Visit Rates for Pregnant Members</i>	Clinical	Q, A, T

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

CalOptima’s *Improvement of Prenatal Visit Rates for Pregnant Members* QIP focused on improving the care women receive during pregnancy. Maintaining regular prenatal care visits throughout a pregnancy may help to identify and treat any problems that arise, as well as improve the chances of healthy babies being delivered.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
CalOptima—Orange County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	85%	100%	<i>Met</i>
Internal QIPs				
<i>Improvement of Prenatal Visit Rates for Pregnant Members</i>	Annual Submission	80%	80%	<i>Partially 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, 2014, through June 30, 2015, showed that CalOptima’s annual submission of its *All-Cause Readmissions* QIP achieved a *Met* validation status, with 100 percent of the critical evaluation elements receiving a *Met* score. The *Improvement of Prenatal Visit Rates for Pregnant Members* QIP annual submission received an overall validation status of *Partially Met*. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission, submit a Plan-Do-Study-Act (PDSA) cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, CalOptima conducted a PDSA cycle for the *Improvement of Prenatal Visit Rates for Pregnant Members* QIP.

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

Table 4.3—Quality Improvement Project Average Rates*
CalOptima—Orange County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

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)	50%	33%	17%
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		89%	7%	4%
Implementation	VII: Sufficient Data Analysis and Interpretation	69%	8%	23%
	VIII: Appropriate Improvement Strategies	67%	33%	0%
Implementation Total		68%	16%	16%
Outcomes	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		100%	0%	0%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

HSAG validated Activities I through IX for CalOptima’s *All-Cause Readmissions* annual submission and Activities I through VIII for the MCP’s *Improvement of Prenatal Visit Rates for Pregnant Members* QIP annual submission.

CalOptima demonstrated an adequate application of the Design stage, meeting 89 percent of the requirements for all applicable evaluation elements within the study stage. The MCP met 100 percent of the requirements for all applicable evaluation elements within the Design stage for the *All-Cause Readmissions* QIP. For the *Improvement of Prenatal Visit Rates for Pregnant Members* QIP, CalOptima did not accurately document the population size, sample size, or margin of error, resulting in a lowered score for Activity V.

The MCP demonstrated a modest application of the Implementation stage for these QIPs, meeting 68 percent of the requirements for all applicable evaluation elements within the study stage. For the *All-Cause Readmissions* QIP, CalOptima did not indicate if any factors threatened the internal or external validity of the findings, miscalculated the *p* values comparing the baseline and Remeasurement 1 rates, and omitted the factors that affected the ability to compare the baseline with Remeasurement 1 rates, resulting in lower scores for Activity VII. In addition, for the *Improvement of Prenatal Visit Rates for Pregnant Members* QIP, CalOptima did not document the factors

that threatened the internal or external validity of findings and did not prioritize the barriers identified, resulting in lower scores for Activities VII and VIII.

Only the *All-Cause Readmissions* QIP progressed to the Outcomes stage during the reporting period. CalOptima's *All-Cause Readmissions* QIP achieved statistically significant improvement over baseline at Remeasurement 1, resulting in the QIP meeting 100 percent of the requirements for all applicable evaluation elements for Activity IX. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

Improvement of Prenatal Visit Rates for Pregnant Members QIP

The *Improvement of Prenatal Visit Rates for Pregnant Members* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the interventions that CalOptima indicated it planned to implement during the Remeasurement 1 time period of the *Improvement of Prenatal Visit Rates for Pregnant Members* QIP:

- ◆ Develop a preconception health education information sheet to share with beneficiaries and the community.
- ◆ Develop a pregnancy resource booklet specific to Orange County to distribute to pregnant beneficiaries and community collaboratives.
- ◆ Develop a step-by-step guide for beneficiaries on how to access health plan services.
- ◆ Partner with *Text4Baby* to provide co-messaging to pregnant beneficiaries and collect beneficiary data to develop future interventions.
- ◆ Update the current Prenatal Notification Report form and expand the method of delivery.
- ◆ Inform providers, health networks, and provider representative staff of the importance of prenatal notification reports submission.
- ◆ Implement a pilot project to test the electronic submission of the prenatal notification reports via electronic health records systems.

All-Cause Readmissions QIP

The *All-Cause Readmissions* QIP progressed to the Outcomes stage during the review period. Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e.,

the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

**Table 4.4—Quality Improvement Project Outcomes for CalOptima—Orange County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions		
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
16.7%	15.2%*	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement from the baseline period (*p* value < 0.05).

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

The *All-Cause Readmissions* QIP met the goal to achieve statistically significant decline in readmission rates from baseline to Remeasurement 1. A review of the MCP’s QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ CalOptima implemented the Transitions of Care (TOC) program based on Eric Coleman’s Care Transitions Intervention Program. Beneficiaries in the target population were invited to participate in the no-cost program, which includes a home visit, follow-up calls, and possible referrals. Beneficiaries who declined or were not eligible for participation in the TOC program were sent a discharge kit that included a personal health record, medication list, medication pillbox, and resources.
- ◆ Evaluation of the TOC program revealed that beneficiaries who participated in the program had:
 - A lower rate of 30-day readmissions.
 - More confidence in using and understanding their personal health record and obtaining a follow-up visit with a physician.
 - A higher rate of attending their follow-up visit with primary care physician or specialist.

Plan-Do-Study-Act Review

The *Improvement of Prenatal Visit Rates for Pregnant Members* QIP did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for the QIP topic.

For the *Improvement of Prenatal Visit Rates for Pregnant Members* PDSA cycle, CalOptima set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By March 2015, increase CalOptima's prenatal notification reports rates by 5 percent by continuing to collaborate internally and educating case management and network operations departments.

The purpose of the *Improvement of Prenatal Visit Rates for Pregnant Members* PDSA cycle was to test whether a targeted intervention would increase the number of prenatal notification report submissions from quarter 4, 2014 to quarter 1, 2015.

CalOptima's data revealed that the rate of prenatal notification reports received increased from CY 2013 to CY 2014. The quarterly results for the numbers of prenatal notification reports received also increased from quarter 4, 2014 to quarter 1, 2015. CalOptima obtained positive feedback from case management staff and provider offices regarding the prenatal notification reports. The MCP indicated that it is adopting the change and considering follow-up reminders to providers regarding the prenatal notification reports.

Strengths

The *All-Cause Readmissions* QIP achieved a *Met* validation status the first submission, and CalOptima was one of six MCPs that achieved statistically significant improvement over baseline for the statewide collaborative *All-Cause Readmissions* QIP. In addition, the *Improvement of Prenatal Visit Rates for Pregnant Members* PDSA cycle results indicated that CalOptima's test of change was successful at increasing the number of prenatal notification report submissions from quarter 4, 2014 to quarter 1, 2015.

Opportunities for Improvement

Although CalOptima will not be continuing the formal QIPs, the MCP should continue to reassess the barriers to improvement and implement the TOC program since the rate for the *All-Cause Readmissions* measure was significantly worse in RY 2015 when compared to RY 2014. In addition, since the *Improvement of Prenatal Visit Rates for Pregnant Members* PDSA cycle achieved positive outcomes, CalOptima should continue to collaborate internally and educate case management and network operations departments about the prenatal notification reports. Lastly, the MCP should consider conducting another PDSA cycle to test whether the follow-up reminders to providers regarding the prenatal notification reports will impact the prenatal notification report submission rates.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

CalOptima’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for CalOptima. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for CalOptima

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	19.2%	26.3%	25th–75th	9.0%	9.2%	25th–75th
Diagnosis Code	23.1%	31.6%	75th–90th	37.8%	34.6%	25th–75th
Procedure Code	42.1%	43.8%	25th–75th	27.5%	22.5%	25th–75th
Procedure Code Modifier	NA	58.5%	NA	NA	46.0%	NA
Rendering Provider Name	23.0%	25.0%	25th–75th	47.1%	68.1%	>25th–<75th
Billing Provider Name	31.3%	35.0%	25th–75th	10.3%	8.6%	25th–75th

Note: HSAG displayed “NA” when the denominator was less than 30.

Overall, the medical record omission rates for CalOptima ranged from 19.2 percent (*Date of Service*) to 42.1 percent (*Procedure Code*). All five of CalOptima’s reportable medical record omission rates were better than the respective statewide rates, with the *Diagnosis Code* data element 8.5 percent better than the statewide medical omission rate. When compared to other MCPs’ performance, CalOptima received a percentile ranking of “25th–75th” for four medical record omission rates and “75th–90th” for the *Diagnosis Code* element. These findings suggest a moderate level of completeness among key encounter data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for CalOptima contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, CalOptima's rates varied from 9 percent (*Date of Service*) to 47.1 percent (*Rendering Provider Name*). Two of CalOptima's reported encounter data omission rates were better than the respective statewide rates with the *Rendering Provider Name* encounter omission rate being better than the statewide rate by 21 percentage points. However, CalOptima performed worse than the statewide encounter data omission rate by 5 percentage points for the *Procedure Code* data element. An opportunity exists for CalOptima to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data received from the MCPs).
- ◆ A deficiency occurred in CalOptima's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to CalOptima (and/or the data subsequently being submitted to DHCS).
- ◆ CalOptima populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files CalOptima submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for CalOptima. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for CalOptima

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	86.4%	83.6%	25th–75th	NA
Procedure Code	81.6%	77.6%	25th–75th	Inaccurate Code (48.6%); Lower Level of Services in Medical Records (46.3%)

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Procedure Code Modifier	NA	99.5%	NA	—
Rendering Provider Name	48.6%	63.0%	<10th	Incorrect Names (80.3%)
Billing Provider Name	83.6%	68.6%	75th–90th	NA
All-Element Accuracy	5.8%	4.3%	>25th–<75th	—

Note: HSAG displayed “NA” when the denominator was less than 30.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be generally accurate for CalOptima—with three reported element accuracy rates higher than the respective statewide rates and one rate (*Rendering Provider Name*) lower by 14.4 percentage points. When comparing the performance among the assessed MCPs, two of the five key data elements received a percentile ranking of “25th–75th”, one element received a percentile ranking of “75th–90th”, and one element received a percentile ranking of “<10th”. For the *Procedure Code* data element, 46.3 percent of the errors involved providers submitting a higher-level service code than that supported in the beneficiary’s medical record, and 48.6 percent of the identified errors were associated with the use of inaccurate codes not supported by national coding standards. The majority of rendering provider name errors were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records.

Although CalOptima’s all-element accuracy rate was better than the statewide rate, only 5.8 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 94 percent of the dates of service reviewed in this study. While all five key data elements contributed to CalOptima’s relatively low all-element accuracy rate, the *Rendering Provider Name* data element contributed most to the inaccuracy.

Medical Record Review Recommendations

Based on the study findings for CalOptima, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, CalOptima should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data submitted to DHCS.

- Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. CalOptima should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ CalOptima should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ CalOptima should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code* and *Billing Provider Name* data elements and develop strategies to improve rates.
- ◆ CalOptima should explore the reasons for the relatively high encounter data omission rates for the *Rendering Provider Name* and *Diagnosis Code* data elements and take actions to improve rates.
- ◆ CalOptima should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with CalOptima.
- ◆ CalOptima should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical

record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.

- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

CalOptima's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to PACES. Based on review of CalOptima's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist CalOptima with improving its encounter data quality. DHCS followed up with CalOptima regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of CalOptima's performance in the three domains of care—quality, access, and timeliness.

Quality

HSAG reviewed CalOptima's quality improvement information and, as in previous years, found detailed information on the MCP's quality program structure as well as goals and objectives designed to ensure that quality care is provided to beneficiaries.

The rates for the following quality measures were above the HPLs:

- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total* (fifth consecutive year)
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total* (fifth consecutive year)
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (third consecutive year)

The rate for the *Comprehensive Diabetes Care—HbA1c Testing* measure, which falls into the quality domain of care, improved significantly from RY 2014 to RY 2015.

The rates for the following quality measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Cervical Cancer Screening*
- ◆ *Immunizations for Adolescents—Combination 1*

For quality measures stratified by the SPD and non-SPD populations, the SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures were significantly better than the non-SPD rates. Additionally, the SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rates; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of CalOptima’s QIPs fell into the quality domain of care. Only the *All-Cause Readmissions* QIP progressed to the Outcomes stage. While the QIP demonstrated statistically significant improvement from baseline (RY 2013) to Remeasurement 1 (RY 2014), the RY 2015 rate for the *All-Cause Readmissions* measure was significantly worse when compared to RY 2014—suggesting that CalOptima needs to reassess the effectiveness of the MCP’s interventions designed to reduce readmissions.

CalOptima was required to submit a PDSA cycle for its *Improvement of Prenatal Visit Rates for Pregnant Members* QIP topic, and the MCP’s intervention was successful at increasing the number of prenatal notification reports submitted by providers. Based on the success of the intervention, CalOptima planned to adopt the intervention.

Overall, CalOptima showed above-average performance related to the quality domain of care.

Access

HSAG reviewed CalOptima's quality improvement information and, as in the previous year, the MCP included goals in its quality improvement work plan related to beneficiary access to care. CalOptima's 2014 *Quality Improvement Program Evaluation* document provided eight key findings from the MCP's annual accessibility study and documented barriers and interventions related to each finding. CalOptima also provided a summary of the MCP's Access and Availability Team's activities, which included updates to access and availability policies, provider monitoring, and developing beneficiary education materials regarding the MCP's access and availability standards.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which falls into the access domain of care, was above the HPL for the third consecutive year.

The rates for the following access measures improved significantly from RY 2014 to RY 2015:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*

The rates for the following access measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Cervical Cancer Screening*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Immunizations for Adolescents—Combination 1*

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The *All-Cause Readmissions* measure is one of those measures and, as stated, its SPD rate was significantly worse than the non-SPD rate—which is to be expected. Additionally, all four *Children and Adolescents' Access to Primary Care Practitioners* measures' SPD rates were significantly worse than the non-SPD rates. The significantly lower SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Both of CalOptima's QIPs fell into the access domain of care. As noted above, only the *All-Cause Readmissions* QIP progressed to the Outcomes stage and, while the QIP demonstrated statistically

significant improvement from baseline (RY 2013) to Remeasurement 1 (RY 2014), the RY 2015 rate for the *All-Cause Readmissions* measure was significantly worse when compared to RY 2014.

Also as noted, CalOptima was required to submit a PDSA cycle for its *Improvement of Prenatal Visit Rates for Pregnant Members* QIP topic; and the MCP planned to adopt the tested intervention, which was successful at increasing the number of prenatal notification reports submitted by providers.

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

Timeliness

HSAG reviewed CalOptima's quality improvement program description and, as in previous years, found information on activities related to beneficiary rights, grievances, continuity and coordination of care, and utilization—which all may affect the timeliness of care delivered to beneficiaries.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which falls into the timeliness domain of care, was above the HPL for the third consecutive year.

The rate for the *Immunizations for Adolescents—Combination 1* measure, which falls into the timeliness domain of care, declined significantly from RY 2014 to RY 2015.

CalOptima's *Improvement of Prenatal Visit Rates for Pregnant Members* QIP fell into the timeliness domain of care and, as noted above, the MCP was required to submit a PDSA cycle for its *Improvement of Prenatal Visit Rates for Pregnant Members* QIP topic. Also as noted, the MCP planned to adopt the tested intervention, which was successful at increasing the number of prenatal notification reports submitted by providers.

Overall, CalOptima 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with CalOptima's self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP's self-reported actions.

Table 6.1—CalOptima’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. While the rates for the <i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i> and <i>Use of Imaging Studies for Low Back Pain</i> measures remained above the MPLs, CalOptima has the opportunity both to assess the factors leading to the rates for these measures declining significantly from 2013 to 2014 and to implement strategies to prevent further decline.</p>	<p><u><i>Children and Adolescents’ Access to Primary Care Practitioners—12-19 Years:</i></u></p> <p>In December 2014, CalOptima sent out a Teen and Young Adult Newsletter to all CalOptima Medi-Cal members 12 through 18 years of age. The Teen and Young Adult Newsletter included topics such as well care visits, preventive screenings, healthy eating, and exercise.</p> <p>CalOptima is hosting a Tdap Vaccination and Health and Wellness Fair for 11 and 12 year olds. At this fair, the target population will be provided counseling and health education materials on a variety of topics that include preventive screenings and vaccinations.</p> <p><u><i>Use of Imaging Studies for Low Back Pain:</i></u></p> <p>CalOptima has developed a provider education campaign to address this measure. A provider letter along with a fact sheet were developed to educate providers on when and how to appropriately recommend imaging study for members with lower back pain.</p>
<p>2. Assess the factors leading to the SPD rates for the following measures being significantly worse than the non-SPD rates to ensure that the needs of the SPD population are being met:</p> <ul style="list-style-type: none"> a. <i>All-Cause Readmissions</i> b. All four <i>Children and Adolescents’ Access to Primary Care Practitioners</i> measures c. <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> 	<p>CalOptima has reviewed the SPD rates and non-SPD rates for the DHCS identified measures.</p> <p><u><i>All-Cause Readmissions:</i></u> SPD members tend to have more co-morbidities and chronic conditions that typically lead to the use of emergency rooms (ERs) rather than seeing a primary care physician (PCP). They tend to be less compliant with treatment due to complications associated with their health conditions, and that leads to a higher rate of readmissions. In addition, social issues play a large factor in member compliance since SPD members face barriers, such as transportation issues, that hinder them from going to the doctors.</p> <p><u><i>Children and Adolescents’ Access to Primary Care Practitioners measures:</i></u></p> <p>SPD members may not see their PCP because they feel they have already received the services they need from their specialist. SPD members also tend to have a lot of office visits with their specialist and may want to avoid another visit with their PCP. SPD members tend to have more co-morbidities and chronic conditions that typically lead to the use of ERs rather than seeing a PCP. In addition, social issues play a large factor in member compliance since SPD members face barriers, such as transportation issues, that may hinder them from going to the doctors.</p> <p>In researching the SPD members not compliant with the measure, we found that 18 percent of the sample had not seen a PCP but had seen</p>

2013–14 External Quality Review Recommendation Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>a specialist in the time frame. In addition, a number of members were seen either in the ER or inpatient.</p> <p><u>Comprehensive Diabetes Care–Blood Pressure Control :</u> SPD members tend to be less compliant with treatment due to complications associated with their health conditions. SPD members with high risk conditions may not place blood pressure control as a health priority.</p>
<p>3. Ensure that all required documentation is included in the QIP Summary Form. The MCP should reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to submission.</p>	<p>Upon receipt of the QIP validation tool and results, CalOptima has reviewed the QIP Summary Form and the comments in the validation tool from HSAG to identify the areas of deficiency. In addition, CalOptima reviewed the QIP Completion Instructions submitted by DHCS.</p>

Recommendations

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

- ◆ Ensure provision of the requested Quality Improvement and Delegation Oversight Committee meeting minutes to DHCS as evidence that delegated-level open and unused prior authorizations are being reported to the responsible committees.
- ◆ Assess the factors leading to declining or poor performance for the following measures to prevent further decline in performance or to improve performance:
 - *All-Cause Readmissions*
 - *Cervical Cancer Screening*
 - *Children and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months*
 - *Children and Adolescents’ Access to Primary Care Practitioners—25 Months to 6 Years*
 - *Immunizations for Adolescents—Combination 1*
- ◆ Although CalOptima will not be continuing the formal QIPs, the MCP should:
 - Continue to collaborate internally and educate case management and network operations departments about the prenatal notification reports.

- Consider conducting another PDSA cycle to test whether follow-up reminders to providers regarding the prenatal notification reports will impact the prenatal notification report submission rates.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix F:
Performance Evaluation Report
CalViva Health
July 1, 2014 – June 30, 2015**

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Appendix F: Performance Evaluation Report – CalViva Health

July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), CalViva Health (“CalViva” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

CalViva is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries in Fresno, Kings, and Madera counties may enroll in CalViva, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan.

CalViva became operational in Fresno, Kings, and Madera counties to provide MCMC services effective March 2011. As of June 30, 2015, CalViva had 258,240 beneficiaries in Fresno County, 24,502 beneficiaries in Kings County, and 33,103 beneficiaries in Madera County—for a total of 315,845 beneficiaries.¹ This represents 72 percent of the beneficiaries enrolled in Fresno County, 57 percent in Kings County, and 64 percent in Madera County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: August 11, 2015.

Medical and State Supported Services Audits

The most recent medical and State Supported Services audits for CalViva were conducted by DHCS February 3, 2015, through February 13, 2015, covering the review period of November 1, 2013, through October 31, 2014. DHCS reviewed the following areas:

- ◆ Compliance with State Supported Services contract and regulations
- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Member's Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

Reports were issued by DHCS July 3, 2015, for each audit type. DHCS found CalViva to be compliant with the State Supported Services contractual requirements and with requirements in the areas of Utilization Management, Quality Management, and Administrative and Organizational Capacity. DHCS identified two of the three findings in the area of Access and Availability of Care as ongoing.

In a letter dated January 5, 2016, DHCS stated that it had issued CalViva a closeout letter on November 18, 2015, which indicated that one deficiency was provisionally closed, requiring additional follow-up. The letter also indicated that on November 30, 2015, CalViva provided DHCS with additional information, bringing the provisionally closed item into full compliance and resulting in DHCS closing all deficiencies from the medical audit.

Note that while DHCS issued the referenced reports and letter outside the review dates for this MCP-specific evaluation report, HSAG included the information because it was in reference to audits that occurred within the review dates for this report and because the MCP had resolved all findings related to the medical audit.

Strengths

DHCS found CalViva to be fully compliant with State Supported Services contractual requirements and with requirements in the areas of Utilization Management, Quality Management, and Administrative and Organizational Capacity during the February 2015 medical and State Supported Services audits. Additionally, CalViva fully resolved all findings from the medical audit

in the areas of Case Management and Coordination of Care, Access and Availability of Care, and Member's Rights.

Opportunities for Improvement

CalViva fully resolved all findings from the February 2015 medical audit; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for CalViva Health* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance Audit.³ HSAG auditors determined that CalViva followed the appropriate specifications to produce valid rates, and no issues of concern were identified. Although CalViva experienced a significant increase in membership during the reporting year (29 percent), the MCP identified no backlogs or delays in processing beneficiary data. The auditor reviewed documentation and queries provided by CalViva, which confirmed that data integrity and processing were not impacted by the increase in membership.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. (See Table 3.1 through Table 3.3 for CalViva’s performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1 through Table 3.3

The reader should note the following regarding Table 3.1 through Table 3.3:

- ◆ The MCP’s performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA’s national percentiles. MPLs and HPLs align with NCQA’s national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS’s *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or

² Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).

- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
CalViva—Fresno County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	10.64%	13.10%	17.43%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	45.57	50.13	31.76	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	448.77	469.48	298.94	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	82.27%	84.64%	84.88%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	86.60%	80.77%	47.37%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	83.02%	84.96%	84.82%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	38.41%	38.66%	40.38%	↔
Cervical Cancer Screening	Q,A	—	—	64.34%	64.74%	↔
Childhood Immunization Status—Combination 3	Q,A,T	—	76.89%	71.80%	66.96%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	97.82%	96.60%	95.19%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	91.50%	91.08%	89.70%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	91.74%	91.42%	91.47%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	90.68%	87.51%	88.04%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	48.66%	54.26%	60.58%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	48.91%	48.42%	53.77%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	82.97%	79.81%	84.67%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	43.80%	38.20%	47.69%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	75.67%	76.89%	82.00%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	47.45%	54.74%	43.31%	▲
Controlling High Blood Pressure	Q	—	58.88%	53.12%	61.46%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	—	76.89%	72.46%	74.03%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	70.53%	44.11%	38.30%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	43.01%	24.31%	17.59%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	63.75%	61.20%	60.46%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	90.02%	88.02%	86.22%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	—	82.11%	79.90%	77.90%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	69.10%	64.96%	73.66%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	71.29%	74.94%	74.63%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	44.53%	52.55%	57.80%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	81.51%	82.69%	76.80%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate. Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.2—Multi-Year Performance Measure Results*
CalViva—Kings County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	10.31%	7.92%	13.94%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	60.31	62.09	40.29	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	452.56	430.69	289.58	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	80.23%	87.21%	80.17%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	78.03%	84.25%	82.83%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	32.14%	17.24%	27.37%	↔
Cervical Cancer Screening	Q,A	—	—	57.18%	51.12%	↔
Childhood Immunization Status—Combination 3	Q,A,T	—	69.83%	70.06%	57.76%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.98%	94.68%	89.62%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	89.73%	83.58%	83.53%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	NA	87.06%	86.25%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	NA	84.62%	85.55%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	50.36%	45.50%	57.18%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	42.82%	48.42%	49.15%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	80.54%	78.59%	79.08%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	41.85%	39.66%	44.28%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	78.35%	78.10%	82.24%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	50.85%	52.07%	46.72%	↔
Controlling High Blood Pressure	Q	—	55.23%	41.03%	56.69%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	—	73.59%	73.20%	75.00%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	NA	48.59%	56.63%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	NA	30.51%	29.59%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	57.46%	52.84%	52.82%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	89.93%	82.67%	83.38%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	—	75.50%	80.23%	75.11%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	48.42%	37.47%	76.40%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	53.28%	45.99%	63.26%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	41.36%	36.98%	45.26%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	67.40%	59.29%	64.82%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.3—Multi-Year Performance Measure Results*
CalViva—Madera County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	10.81%	13.40%	15.51%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	50.89	52.05	30.91	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	444.01	482.26	327.12	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	80.80%	83.06%	86.14%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	81.88%	85.94%	82.97%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	25.61%	16.67%	20.65%	↔
Cervical Cancer Screening	Q,A	—	—	64.44%	58.68%	↔
Childhood Immunization Status—Combination 3	Q,A,T	—	71.29%	66.96%	69.54%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	98.53%	98.08%	95.37%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	91.75%	93.49%	92.02%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	NA	92.88%	92.71%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	NA	90.68%	90.48%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	59.37%	64.96%	67.40%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	55.72%	60.34%	63.02%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	85.89%	88.32%	88.32%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	46.47%	43.07%	50.12%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	81.27%	82.00%	83.45%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	43.31%	49.39%	38.44%	▲
Controlling High Blood Pressure	Q	—	56.69%	52.10%	62.93%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	—	65.66%	69.68%	74.86%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	NA	42.78%	41.01%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	NA	24.23%	21.63%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	65.90%	50.27%	66.67%	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	93.35%	80.05%	87.10%	↑

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	—	77.17%	70.68%	74.24%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	62.29%	59.28%	90.95%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	73.72%	68.81%	87.44%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	64.72%	60.82%	80.40%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	84.43%	87.34%	83.16%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.4 through Table 3.9 present a summary of the RY 2015 Seniors and Persons with Disabilities (SPD) measure results reported by CalViva. Table 3.4 through Table 3.6 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.7 through Table 3.9 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.4—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CalViva—Fresno County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	11.20%	20.99%	▼	17.43%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.74%	86.47%	↑	84.88%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	51.11%	Not Comparable	47.37%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.37%	87.20%	↑	84.82%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	95.28%	80.95%	↓	95.19%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	89.69%	89.91%	↔	89.70%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	91.36%	93.95%	↑	91.47%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	87.98%	89.10%	↔	88.04%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

⁴ 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 through Table 3.6.

Table 3.5—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CalViva—Kings County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.13%	18.91%	▼	13.94%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	77.15%	85.09%	↑	80.17%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.54%	90.30%	↑	82.83%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	89.65%	NA	Not Comparable	89.62%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	83.59%	81.82%	↔	83.53%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	86.01%	91.11%	↔	86.25%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	85.35%	88.24%	↔	85.55%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.6—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CalViva—Madera County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.80%	20.61%	▼	15.51%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.62%	88.84%	↔	86.14%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.77%	85.00%	↔	82.97%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.30%	NA	Not Comparable	95.37%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.95%	94.64%	↔	92.02%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	92.69%	93.33%	↔	92.71%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	90.64%	87.07%	↔	90.48%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.7—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures CalViva—Fresno County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
294.85	30.78	336.48	40.72

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

Table 3.8—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures CalViva—Kings County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
278.19	38.54	399.51	57.15

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

Table 3.9—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures CalViva—Madera County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
320.60	30.13	406.08	40.34

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

Table 3.10 through Table 3.12 present the three-year trending information for the SPD population, and Table 3.13 through Table 3.15 present the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.10—RY 2015 (MY 2014) HEDIS SPD Trend Table
CalViva—Fresno County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	12.30%	15.39%	20.99%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	66.02	70.05	40.72	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	551.16	555.25	336.48	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.76%	85.27%	86.47%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	89.61%	82.26%	51.11%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.44%	86.97%	87.20%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	91.46%	100.0%	80.95%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	90.62%	91.65%	89.91%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	93.76%	93.33%	93.95%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	90.79%	88.51%	89.10%	↔

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.11—RY 2015 (MY 2014) HEDIS SPD Trend Table
CalViva—Kings County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	12.69%	8.57%	18.91%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	115.90	113.80	57.15	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	737.46	651.69	399.51	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.71%	91.32%	85.09%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.11%	92.14%	90.30%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.47%	87.65%	81.82%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	90.00%	91.11%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	85.71%	88.24%	↔

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.12—RY 2015 (MY 2014) HEDIS SPD Trend Table
CalViva—Madera County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	14.04%	16.36%	20.61%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	72.47	78.44	40.34	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	648.89	665.45	406.08	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.11%	85.77%	88.84%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.55%	89.71%	85.00%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.79%	97.17%	94.64%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	94.29%	93.33%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	88.42%	87.07%	↔

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.13—RY 2015 (MY 2014) Non-SPD Trend Table
CalViva—Fresno County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	7.69%	7.78%	11.20%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	42.99	47.62	30.78	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	435.84	458.67	294.85	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.26%	83.64%	82.74%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	79.47%	81.23%	81.37%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	97.90%	96.57%	95.28%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	91.52%	91.06%	89.69%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	91.65%	91.33%	91.36%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	90.67%	87.45%	87.98%	↔

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.14—RY 2015 (MY 2014) Non-SPD Trend Table
CalViva—Kings County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	5.00%	S	9.13%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	53.80	55.66	38.54	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	419.16	403.24	278.19	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	74.65%	81.71%	77.15%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	71.18%	74.56%	78.54%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.94%	94.85%	89.65%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.73%	83.44%	83.59%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	86.92%	86.01%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	84.55%	85.35%	↔

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.15—RY 2015 (MY 2014) Non-SPD Trend Table
CalViva—Madera County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.41%	S	9.80%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	48.98	49.54	30.13	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	425.90	464.83	320.60	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	76.08%	80.41%	84.62%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	75.86%	81.42%	81.77%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.67%	98.06%	95.30%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.77%	93.38%	91.95%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	92.84%	92.69%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	90.76%	90.64%	↔

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

Across all counties, the rates for five measures were above the HPLs. The rates for the following measures were above the HPLs for the third consecutive year:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Fresno County
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Madera County

Across all counties, the rates for 17 measures were significantly better in RY 2015 when compared to RY 2014, and the significant improvement for the following measures resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) in Kings County*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent) in Fresno County*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent) in Fresno County*
- ◆ *Controlling High Blood Pressure in Kings County*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total in Kings County*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total in Kings County*
- ◆ *Prenatal and Postpartum Care—Postpartum Care in Madera County*

The rates for the following measures improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs in Madera County*
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis in Kings and Madera counties*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent) in Kings County*
- ◆ *Use of Imaging Studies for Low Back Pain in Madera County*

Across all counties, the rates for 20 measures were below the MPLs. The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure in Kings County was below the MPL for the third consecutive year. The rates for 11 measures were significantly worse in RY 2015 when compared to RY 2014, and the significant change for the following measures resulted in the rates moving from above the MPL in RY 2014 to below the MPL in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs in Kings County*
- ◆ *Childhood Immunization Status—Combination 3 in Kings County*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months in Fresno and Madera counties*
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total in Fresno County*

The rates for the following measures declined from RY 2014 to RY 2015; and although the decline was not statistically significant, the change resulted in the rates moving from above the MPL in RY 2014 to below the MPL in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs in Fresno County*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics in Fresno, Kings, and Madera counties*
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total in Madera County*

Madera County performed the best, with four measures with rates above the HPLs and four measures with rates below the MPLs. Kings County was the lowest performing county, with no measures with rates above the HPLs and 11 measures with rates below the MPLs. Fresno County had one measure with a rate above the HPL and five measures with rates below the MPLs.

Seniors and Persons with Disabilities Findings

Across all counties, most measures had no statistically significant difference between the SPD and non-SPD rates. The SPD rates were significantly better than the non-SPD rates for the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Fresno and Kings counties
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Fresno and Kings counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* in Fresno County

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

- ◆ *All-Cause Readmissions* in Fresno, Kings, and Madera counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in Fresno County

Please note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health needs of these beneficiaries.

Across all counties, most SPD and non-SPD rates showed no statistically significant change from RY 2014 to RY 2015.

Assessment of Improvement Plans

CalViva worked with DHCS to prioritize the schedule for the MCP to develop improvement plans (IPs) for measures with rates below the MPLs in RY 2014. The following is a summary of the IPs and Plan-Do-Study-Act (PDSA) cycles the MCP conducted:

Comprehensive Diabetes Care Measures for Fresno and Kings Counties

The IP included the following measures:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

CalViva identified several barriers to the rates exceeding the MPLs, including:

- ◆ Poor communication with specific high-volume provider groups resulting in medical record data collection issues. Additionally, the provider groups were transitioning to using electronic medical records, which delayed medical records location and extraction efforts.
- ◆ Providers appearing to be unaware of the clinical guidelines or being unresponsive in treating higher than optimal HbA1c levels and blood pressure rates in accordance with clinical recommendations.
- ◆ Through a race/ethnicity analysis, the MCP determined that race/ethnicity was a factor for some beneficiaries in Fresno County and identified barriers including beneficiaries' lack of understanding about how to best monitor their diabetes and fear of test results for those who had not been taking care of themselves.

CalViva implemented the following interventions to address the barriers:

- ◆ Initiated corrective action plans (CAPs) for the two high-volume clinics to address the data collection issues. The MCP's HEDIS team monitors the CAPs, and the team works with a central contact person from each clinic to address identified issues.
- ◆ Expanded the MCP's existing quarter Diabetes Retinal Exam (DRE) provider profile to include notification of beneficiaries with diabetes who are noncompliant with HbA1c testing or have poorly controlled HbA1c levels.
- ◆ Developed an incentive program to encourage beneficiaries to seek care with their physician to complete the necessary diabetes screenings.

CalViva also submitted three PDSA cycles for the *Comprehensive Diabetes Care* measures. A summary of each cycle follows:

- ◆ The MCP tested whether or not distributing (to at least two targeted clinics quarterly) provider profiles listing beneficiaries needing their annual HbA1c test would lead to a statistically significant increase in HbA1c testing over baseline results by the end of one year. Initial chart review results showed HbA1c testing rates for both clinics to be above the MPL. Additionally, the MCP measured the percentage of beneficiaries with poorly controlled HbA1c levels; and the rates were better than the MPL for both clinics. The MCP plans to keep the process in place and expand it to two additional clinics in Fresno County.
- ◆ The MCP expanded the first PDSA cycle by adding two clinics in Fresno County. Results for the two initial sites showed an increase in HbA1c testing rates and will be used as baseline rates for future reporting. The MCP plans to continue the process and to add hand-delivery of the profiles to ensure that the data reach the appropriate clinic staff.
- ◆ The MCP tested whether or not hand-delivering (to at least four clinics quarterly) provider profiles listing beneficiaries needing their annual HbA1c test would lead to a statistically

significant increase in HbA1c testing over baseline result by the end of one year. Results showed an increase in HbA1c testing across all four clinics. The MCP plans to continue hand-delivering the profiles and monitoring the clinics quarterly.

The MCP's improvement efforts resulted in the following rates improving from RY 2014 to RY 2015 and exceeding the MPL in RY 2015:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Kings County
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in Fresno and Kings counties
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Fresno County

The rate for the *Comprehensive Diabetes Care—HbA1c Testing* measure in Kings County remained below the MPL in RY 2015, and the MCP will be required to continue its IP for this measure in Kings County.

Prenatal and Postpartum Care—Postpartum Care for Kings and Madera Counties

CalViva identified several barriers to the rates being above the MPLs, including:

- ◆ Challenges obtaining claims, encounter, and other medical records data from providers resulting from:
 - Providers being reluctant to provide medical records and data.
 - Providers transitioning from paper medical records to electronic medical records.
 - A substantial proportion of medical charts requiring multiple complex follow-up steps to ascertain the postpartum visit date.
- ◆ Beneficiaries being seen for their postpartum care visit outside the required time frame.
- ◆ Beneficiaries not understanding the importance of timely postpartum care.
- ◆ Disparities in postpartum care. The MCP conducted analyses and found that, in Madera County, Latina mothers had statistically significantly lower postpartum care rates compared to White mothers.

CalViva implemented the following interventions to address the barriers:

- ◆ Initiated a CAP with the vendor responsible for obtaining medical records data to improve the accuracy and completeness of the data.
- ◆ Faxed weekly notifications to providers regarding beneficiaries who recently delivered a baby reminding them of the time frame for being seen for postpartum care visits. The fax requests a response from the provider with the date and time of the beneficiary's scheduled postpartum care visit.

- ◆ Sent letters to beneficiaries who recently delivered a baby, emphasizing and explaining the importance of scheduling their postpartum care visit within three to six weeks after delivery. Additionally, the letter included, as incentive for beneficiaries who attended their postpartum care visit, an invitation to participate in a monthly raffle and instruction to send the completed raffle submission form to the MCP.
- ◆ Initiated a provider incentive program for high-volume providers with historically low postpartum care visit rates. The incentive program targeted front office staff, a departure from the provider incentive programs usually implemented by MCPs.
- ◆ Made interactive voice response calls to beneficiaries and, when the call was answered, connected the beneficiary to a member services representative who encouraged the beneficiary to schedule her postpartum care visit and offered appointment scheduling and transportation assistance.

CalViva also submitted three PDSA cycles for the *Postpartum Care* measures. For all three cycles, the MCP tested whether or not notifying providers by fax of their patients' live births would increase provider compliance with scheduling postpartum care visits for beneficiaries within the required time frame. Based on the first PDSA cycle results, the MCP planned to continue the fax notification program in the next quarter with some modifications to improve results. In the second quarter, the MCP found that the results were not as good as in the previous PDSA cycle. The MCP attributed the poorer results to seasonal factors and planned to continue the program. For the final PDSA cycle, the results showed a 9 percentage point improvement from the previous quarter. Based on the results, CalViva decided to adopt the fax notification program and monitor results for sustained improvement for an additional quarter.

CalViva's improvement efforts resulted in the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure for Madera County improving significantly from RY 2014 to RY 2015, moving the rate to above the MPL. The rate for Kings County, however, remained below the MPL; and the MCP will be required to continue its IP for this measure in Kings County.

Kings County

The IP included the following measures:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Controlling High Blood Pressure*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

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

- ◆ Challenges obtaining data from the MCP's data vendors.
- ◆ Poor communication with specific high-volume provider groups, resulting in medical record data collection issues. Additionally, one provider group was transitioning to using electronic medical records, which delayed medical records location and extraction efforts. This same provider group also encountered challenges related to the integration of several smaller, independently run clinics experiencing difficulty adapting to the larger provider system.
- ◆ Providers not submitting the *Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM-160)*.

CalViva implemented the following interventions to address the barriers:

- ◆ Initiated a CAP with the HEDIS vendor to improve the accuracy and completeness of medical records data.
- ◆ Initiated a CAP for the high-volume provider in Kings County to address the challenges identified during RY 2014. The MCP's HEDIS team monitored the CAP, and the team worked with a central contact person from the clinic to address identified issues.
- ◆ Worked with the MCP's already-established PM-160 task force and the MCP's provider relations staff to conduct outreach to high-volume providers to encourage them to submit encounter data in addition to the PM-160 forms.

CalViva also submitted two PDSA cycles for the King's County measures:

- ◆ For the first PDSA cycle, the MCP tested whether or not educating and training the highest volume provider in Kings County on how to complete and submit the PM-160 forms would result in a higher PM-160 submission rate. The MCP learned about various barriers as a result of the test, including inaccurate membership counts, lack of a standardized process for completing PM-160 forms, and changes in provider assignment leading to inaccurate membership counts.
- ◆ For the second PDSA cycle, the MCP tested whether or not standardizing the PM-160 completion process and educating the highest volume provider in Kings County on including the clinic National Provider Identifier on the form would result in a higher PM-160 submission rate. The results showed that the provider had not fully standardized the process for completing and submitting the PM-160 forms. As a result, CalViva plans to adapt the change for the next PDSA cycle to include the following modifications:
 - Require that all provider staff who document using PM-160 forms be trained on the correct procedures for completing the form.
 - Inform the provider of the correct health plan codes by county, and reinforce that all staff who document using PM-160 forms must be trained.

- Continue to work with the providers to ensure that standardized procedure is communicated across all provider sites within the organization.

CalViva's improvement efforts resulted in the rates for all measures except *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* improving from below the MPLs in RY 2014 to above the MPLs in RY 2015. CalViva will be required to continue its IP for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in Kings County.

Medication Management for People with Asthma—Medication Compliance 50% Total for Fresno and Madera Counties

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

- ◆ Providers being unaware of their beneficiaries' nonadherence to medication management regimens.
- ◆ Beneficiaries ages 5 through 18 having significantly lower compliance than the older subpopulations.
- ◆ Disproportionately lower compliance for Hispanic and Spanish-speaking beneficiaries.

CalViva implemented the following interventions to address the barriers:

- ◆ Created a provider profile to send to providers to inform them of beneficiaries with a low rate of asthma controller medication dispensation. Additionally, the providers were informed of the MPL and HPL benchmarks, recommended clinical guidelines, and best practices for engaging beneficiaries with disproportionately low compliance. Finally, the MCP contacted high-volume providers by phone and in person to review the information contained in the provider profile.
- ◆ Created a letter to send to adult beneficiaries and guardians of beneficiaries under the age of 18 years to inform of the option to join the MCP's disease management program.
- ◆ Created an "Asthma Action Plan" to send to targeted adult beneficiaries and guardians of beneficiaries under the age of 18 years and beneficiaries enrolled in the MCP's disease management program. The cover letter to the action plan described the purpose of the action plan and encouraged beneficiaries to contact their providers to complete the plan and discuss any concerns about their asthma. Spanish and Hmong versions of the materials were also created.
- ◆ Developed a social media asthma education program to engage, inform, and educate teens about asthma and the need to adhere to medication and treatment regimens. The first phase included enhancing information on the MCP's T2X website designed for beneficiaries ages 13 to 18 years. The second phase of the program included the development of an asthma health text messaging campaign with pre- and post-tests and which provided educational information, videos, poll questions, and opportunities for teens to share what they had learned.

CalViva also submitted two PDSA cycles for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure:

- ◆ The MCP tested whether or not informing and educating the targeted providers in Fresno and Madera counties about their beneficiaries' low rate of asthma medication dispensation would result in a higher compliance rate for beneficiaries who remain on an asthma controller medication for at least 50 percent of their treatment period. The MCP determined that modifications needed to be made and planned to conduct the modified outreach to the providers in the following quarter.
- ◆ The MCP tested whether or not engaging and educating targeted beneficiaries in Fresno and Madera Counties about how to better control their asthma would result in a higher compliance rate for beneficiaries who remain on an asthma controller medication for at least 50 percent of their treatment period. The MCP mailed educational materials to all beneficiaries with asthma; however, for future mailings, the MCP is considering taking a targeted approach and mailing to subgroups with disproportionately low compliance rates rather than sending the information to all beneficiaries with asthma.

CalViva's improvement efforts were not successful at improving the rates for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure to above the MPLs in RY 2015. Therefore, the MCP will be required to continue the IP for this measure for Fresno and Madera counties.

Strengths

CalViva followed the appropriate specifications to produce valid rates, and no issues of concern were identified. Although CalViva experienced a significant increase in membership during the reporting year (29 percent), the MCP identified no backlogs or delays in processing beneficiary data.

Across all counties, the rates for five measures were above the HPLs. Across all counties, the rates for 17 measures were significantly better in RY 2015 when compared to RY 2014, and the rates for 12 measures improved from below the MPLs in RY 2014 to above the MPLs in RY 2015.

CalViva provided documentation of actions the MCP has taken to improve rates on measures, including specific efforts related to addressing performance being lower in Kings County when compared to Fresno and Madera counties (See Table 6.1). The MCP also provided detailed information on efforts to ensure that the MCP is meeting the needs of the SPD population, including implementation of a transitional care management program designed to reduce readmissions.

Opportunities for Improvement

CalViva has the opportunity to assess the effectiveness of improvement strategies related to each performance measure with a rate below the MPL to determine whether strategies should be expanded, modified, or eliminated. Additionally, the MCP should continue to address data issues identified in Kings County to improve performance in this county.

Quality Improvement Project Objectives

CalViva participated in the statewide collaborative quality improvement project (QIP) and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 lists CalViva’s QIPs and indicates the county in which the QIP was conducted; whether the QIP was clinical or nonclinical; and the domains of care (i.e., quality, access, and timeliness) the QIP addressed.

**Table 4.1—Quality Improvement Projects for CalViva
July 1, 2014, through June 30, 2015**

QIP	Counties	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Fresno, Kings, Madera	Clinical	Q, A
<i>Retinal Eye Exams</i>	Fresno, Kings, Madera	Clinical	Q, A

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

The *Retinal Eye Exams* QIP targeted the MCP’s diabetic beneficiaries and focused on increasing retinal eye exams. Ongoing management of beneficiaries with diabetes is critical to preventing complications and ensuring optimal health for these beneficiaries.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
CalViva—Fresno, King, and Madera Counties
July 1, 2014, through June 30, 2015**

Name of Project/Study	Counties	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>	Fresno and Madera received the same score.	Annual Submission	81%	86%	<i>Partially Met</i>
	Kings	Annual Submission	85%	86%	<i>Partially Met</i>
Internal QIPs					
<i>Retinal Eye Exams</i>	Fresno	Annual Submission	89%	100%	<i>Met</i>
	Kings and Madera received the same score.	Annual Submission	91%	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, 2014, through June 30, 2015, showed that CalViva’s annual submission of its *All-Cause Readmissions* QIP received a *Partially Met* validation status in all three counties. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, CalViva conducted a PDSA cycle for the *All-Cause Readmissions* QIP. The *Retinal Eye Exams* QIP annual submission achieved an overall validation status of *Met* in all three counties, with 100 percent of the critical evaluation elements receiving a *Met* score.

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

Table 4.3—Quality Improvement Project Average Rates*
CalViva—Fresno, Kings, and Madera Counties
(Number = 6 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

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	100%	0%	0%
Design Total		100%	0%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	88%	12%	0%
	VIII: Appropriate Improvement Strategies**	88%	13%	0%
Implementation Total		88%	12%	0%
Outcomes	IX: Real Improvement Achieved**	38%	0%	63%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total**		38%	0%	63%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for both CalViva’s *All-Cause Readmissions* and *Retinal Eye Exams* QIP annual submissions.

CalViva demonstrated a strong application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP demonstrated an adequate application of the Implementation stage, meeting 88 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *All-Cause Readmissions* QIP, CalViva reported incorrect Remeasurement 1 rates for all three counties inconsistent with the audited rates reported to DHCS, resulting in lower scores for Activity VII. For the *Retinal Eye Exams* QIP, the MCP did not document evaluations for all interventions conducted. In addition, the MCP did not provide supporting data for documented evaluations of interventions. The incomplete documentation and failure to provide supporting data led to a lowered score for Activity VIII. CalViva received a low score for Activity IX because neither QIP achieved statistically significant improvement over baseline. Activity X was not assessed since sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

Table 4.4—Quality Improvement Project Outcomes for CalViva—Fresno, Kings, and Madera Counties July 1, 2014, through June 30, 2015

QIP #1—All-Cause Readmissions Rates			
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for beneficiaries 21 years of age and older [^]			
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
Fresno	10.6%	13.1%*	‡
Kings	10.3%	7.9%	‡
Madera	10.8%	13.4%	‡
QIP #2—Retinal Eye Exam			
Study Indicator: The percentage of diabetic beneficiaries receiving a retinal eye exam during the measurement year			
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
Fresno	48.9%	48.4%	‡
Kings	42.8%	48.4%	‡
Madera	55.7%	60.3%	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

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

All-Cause Readmissions QIP

CalViva’s goal for the *All-Cause Readmissions* QIP was to achieve statistically significant decline in readmissions rates from baseline to Remeasurement 1 in each county. Unfortunately, for all three counties, the MCP did not meet the project’s goal. Although the readmissions rate declined in Kings County, the change was not statistically significant. CalViva’s readmissions rates in Fresno and Madera counties increased at Remeasurement 1, with the rate for Fresno County increasing significantly when compared to the baseline rate. A review of the MCP’s QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ The Remeasurement 1 readmissions rates in the QIP Summary Forms did not match the audited rates reported to DHCS.
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions CalViva indicated it planned to implement during the Remeasurement 1 time period:
 - Continue and adapt a transitional care model program using the Coleman Care Transitions Intervention as the underlying foundation.
 - Continue and adapt on-site case manager interventions at high-volume hospitals.
 - Continue and adapt the ambulatory case management program to focus on transitions of care and continuity of care.
 - Provide beneficiary education about the most common chronic conditions and symptoms that may be an indication that conditions are worsening.
 - Make interactive voice response (IVR) calls to beneficiaries hospitalized for any condition to encourage them to call their providers and/or the Nurse Advice Line for any questions about their care and to set up follow-up appointments with their primary care providers.

Retinal Eye Exam QIP

CalViva's goal for the *Retinal Eye Exam* QIP was to achieve a statistically significant increase in eye exam rates from baseline to Remeasurement 1 in each county. Unfortunately, for all three counties, the MCP did not meet the project's goal. Although the eye exam rates increased in Kings and Madera counties, the improvement was not statistically significant. CalViva's eye exam rate in Fresno County declined at Remeasurement 1 compared to the baseline. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ CalViva did not document evaluation plans for all interventions described in the QIP Summary Forms. In addition, the MCP did not provide supporting data for some of the documented evaluations.
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions CalViva indicated it planned to implement during the Remeasurement 1 time period:
 - Visit three high-volume, low-compliant clinics (one clinic per county) to:
 - Conduct a presentation outlining the project goals, barriers identified to date, clinic-specific rates, documentation requirements, recommendations for improvement, and plans for remeasurement.
 - Compare the quarterly provider profile of noncompliant cases with a claims report to evaluate improvements in both clinical procedures and billing procedures, and share this information with the clinics.

- Audit 10 percent of eligible beneficiaries per clinic quarterly to concurrently evaluate the complete process, including exam results in the clinic record and compliance with overall improvement strategy implementation.
- Distribute an educational flyer to communicate the importance of an annual retinal eye exam and the process for obtaining the exam.
- Include an article on retinal eye exams for beneficiaries with diabetes in the MCP's spring 2014 newsletter.

Plan-Do-Study-Act Review

The *All-Cause Readmissions* QIP did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for the QIP topic.

For the *All-Cause Readmissions* PDSA cycle, CalViva set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By March 1, 2015, there will be at least a 15 percent increase from the baseline rate of 34 percent (July 1, 2014, to July 31, 2014) for CalViva transitional care management (TCM) program beneficiaries who attend a physician appointment within seven days of discharge from an inpatient admission at Community Regional Medical Center. TCM program beneficiaries are assisted by the nurse with scheduling/validating their appointment and addressing any barriers that may prevent appointment attendance.

The purpose of the *All-Cause Readmissions* PDSA cycle was to test whether or not TCM nurse interventions improve the rate of physician visits by CalViva beneficiaries within seven days of discharge.

CalViva completed the *All-Cause Readmissions* PDSA cycle as planned. The results indicated improvement for beneficiaries who attended a physician appointment within seven days of discharge. The MCP reported a rate of 51 percent for Quarter 1, 2015—a 17 percentage point increase from the baseline rate of 34 percent. CalViva documented plans to adopt the change tested, and the nurse will intervene when barriers (including lack of transportation, medical offices resistance to scheduling, and lack of understanding of the importance of and how to request a follow-up appointment) are identified.

Strengths

CalViva demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Retinal Eye Exam* QIPs. The *Retinal Eye Exam* QIP achieved a *Met* validation status the first submission.

The *All-Cause Readmissions* PDSA cycle results indicated that CalViva's test of change was successful at increasing the number of beneficiaries who attended a physician appointment within seven days of discharge.

Opportunities for Improvement

The *All-Cause Readmissions* PDSA cycle demonstrated gradual improvement in beneficiaries' post-discharge appointment attendance; therefore, CalViva should follow the documented plans to adopt the change in additional settings. Additionally, CalViva should continue to address barriers and monitor the readmissions rates going forward. Finally, CalViva should explore issues identified through the *All-Cause Readmissions* PDSA cycle to ensure that providers are involved in the post-discharge treatment plan process.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

CalViva’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for CalViva. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for CalViva

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	25.8%	26.3%	25th–75th	5.2%	9.2%	75th–90th
Diagnosis Code	30.0%	31.6%	25th–75th	26.0%	34.6%	75th–90th
Procedure Code	42.0%	43.8%	25th–75th	10.7%	22.5%	≥90th
Procedure Code Modifier	68.6%	58.5%	25th–75th	44.5%	46.0%	25th–75th
Rendering Provider Name	31.1%	25.0%	25th–75th	88.4%	68.1%	>25th–<75th
Billing Provider Name	32.3%	35.0%	25th–75th	4.4%	8.6%	75th–90th

Overall, the medical record omission rates for CalViva ranged from 25.8 percent (*Date of Service*) to 68.6 percent (*Procedure Code Modifier*). Four of CalViva’s medical record omission rates were slightly better than the respective statewide rates, and the remaining two rates were worse than the statewide rates (the *Procedure Code Modifier* rate by 10.1 percentage points and the *Rendering Provider Name* rate by 6.1 percentage points). When compared to other MCPs’ performance, CalViva received a percentile ranking of “25th–75th” for all six medical record omission rates. These findings suggest a moderate level of completeness among key encounter data elements when compared to beneficiaries’ medical records. HSAG noted some variations among the three counties for CalViva. The medical record omissions for Kings County were generally higher than the other counties except for the *Procedure Code Modifier* data element.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for CalViva contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, CalViva's rates varied from 4.4 percent (*Billing Provider Name*) to 88.4 percent (*Rendering Provider Name*). Five of CalViva's encounter data omission rates were better than the respective statewide rates, with the *Procedure Code* encounter omission rate being better than the statewide rate by 11.8 percentage points (i.e., received a percentile ranking of "≥90th"). However, CalViva performed worse than the statewide encounter data omission rate by 20.3 percentage points for the *Rendering Provider Name* data element. An opportunity exists for CalViva to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information. At the county level, HSAG noted some variations.

The most common reasons for encounter data omissions were:

- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in CalViva's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to CalViva and/or DHCS.
- ◆ CalViva populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files CalViva submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for CalViva. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for CalViva

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	83.7%	83.6%	25th–75th	Inaccurate Code (95.2%)
Procedure Code	92.8%	77.6%	≥90th	Lower Level of Services in Medical Records (41.6%); Inaccurate Code (40.4%)
Procedure Code Modifier	100.0%	99.5%	≥75th	—
Rendering Provider Name	97.4%	63.0%	≥90th	NA
Billing Provider Name	84.6%	68.6%	75th–90th	Incorrect Names (92.4%)
All-Element Accuracy	6.6%	4.3%	>25th–<75th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be quite accurate for CalViva, with all element accuracy rates higher than the respective statewide rates. When compared to the other MCPs, four of the five key data elements ranked in the 75th percentile or above. The *Diagnosis Code* data element received a percentile ranking of “25th–75th”, with the majority of diagnosis-related errors involving discrepancies in the use of inaccurate codes compared to national coding standards rather than specificity errors. For the *Procedure Code* data element, 41.6 percent of the errors were associated with higher-level procedure codes in the DHCS encounter data than were documented in the medical records (i.e., the procedure code was considered an error if a lower level of service was documented in the medical record); 40.4 percent of the unmatched procedure codes were associated with the use of inaccurate codes, where the reported codes were not supported by national coding standards. The majority of the billing provider name errors were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records.

Despite the relatively high element accuracy rates for CalViva, only 6.6 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 93 percent of the dates of service reviewed in this study. While all five key data elements contributed to CalViva’s relatively low all-element accuracy rate, the *Rendering Provider Name* data element contributed the most to the inaccuracy.

Medical Record Review Recommendations

Based on the study findings for CalViva, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, CalViva should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounter System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. CalViva should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ CalViva should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ CalViva should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code* and *Procedure Code Modifier* data elements and develop strategies to improve rates.
- ◆ CalViva should explore the reasons for the relatively high encounter data omission rates for the *Procedure Code Modifier* and *Rendering Provider Name* data elements and take actions to improve rates.
- ◆ CalViva should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with CalViva.
- ◆ CalViva should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP’s Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

CalViva’s SFY 2014–15 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the EDV study, which assessed the MCP’s operational and infrastructure changes in support of DHCS’s transition to the Post Adjudicated Claims and Encounters System (PACES). Based on review of CalViva’s Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist CalViva with improving its encounter data quality. DHCS followed up with CalViva regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of CalViva's performance in the three domains of care—quality, access, and timeliness.

Quality

HSAG reviewed CalViva's quality improvement program description and found detailed documentation of processes the MCP uses to ensure that quality care is provided to its beneficiaries. HSAG also reviewed the MCP's 2015 quality improvement work plan, which includes initiatives designed to improve the quality of care provided to beneficiaries.

The rates for the following quality measures were above the HPLs in RY 2015:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Fresno County for the third consecutive year
- ◆ All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures in Madera County
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Madera County for the third consecutive year

Across all counties, the rates for 17 quality measures were significantly better in RY 2015 when compared to RY 2014, and the rates for 12 quality measures moved from not meeting the MPLs in RY 2014 to exceeding the MPLs in RY 2015.

The rates for the following quality measures were below the MPLs in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Fresno and Kings counties
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Fresno, Kings, and Madera counties
- ◆ *Cervical Cancer Screening* in Kings County
- ◆ *Childhood Immunization Status—Combination 3* in Kings County
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* in Kings County
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total* in Fresno and Madera counties
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total* in Fresno and Madera counties
- ◆ *Prenatal and Postpartum Care—Postpartum Care* in Kings County for the third consecutive year
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Kings County

Across all counties, the rates for six quality measures were significantly worse in RY 2015 when compared to RY 2014, and the rates for eight quality measures moved from above the MPLs in RY 2014 to below the MPLs in RY 2015.

For quality measures stratified by the SPD and non-SPD populations, the SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures in Fresno and Kings counties were significantly better than the non-SPD rates. Additionally, the SPD rates for the *All-Cause Readmissions* measure in Fresno, Kings, and Madera counties were significantly worse than the non-SPD rates; however, the higher rate of hospital readmissions for

the SPD population is expected based on the greater and often more complicated health needs of these beneficiaries.

Both of CalViva's QIPs fell into the quality domain of care. Neither QIP demonstrated statistically significant improvement from baseline to Remeasurement 1. The MCP's *All-Cause Readmissions* PDSA cycle, however, was successful at increasing the number of beneficiaries who attended a physician appointment within seven days of discharge.

Overall, CalViva showed below-average performance related to the quality domain of care.

Access

CalViva's quality improvement program description includes processes designed to ensure beneficiaries access to needed health care services. The MCP's 2015 quality improvement work plan continued three initiatives, from the previous year, that focus on improving access to care. The MCP's 2014 evaluation of the work plan activities indicates that the MCP is on target with most access-related initiatives and is meeting or making progress toward meeting established goals.

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure falls into the access domain of care. The rate for this measure in Madera County was above the HPL for the third consecutive year.

Both *Prenatal and Postpartum Care* measures fall into the access domain of care. The rates for both measures improved significantly from RY 2014 to RY 2015 in Madera County, and the improvement resulted in the rate for the *Postpartum Care* measure moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rates for the following access measures were below the MPLs in RY 2015:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in Fresno, Kings, and Madera counties
- ◆ *Cervical Cancer Screening* in Kings County
- ◆ *Childhood Immunization Status—Combination 3* in Kings County
- ◆ All four *Children and Adolescents' Access to Primary Care Practitioners* measures in Kings County
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in Madera County
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* in Kings County
- ◆ *Prenatal and Postpartum Care—Postpartum Care* in Kings County for the third consecutive year
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Kings County

Across all counties, the rates for eight access measures were significantly worse in RY 2015 when compared to RY 2014; and the rates for three access measures moved from above the MPLs in RY 2014 to below the MPLs in RY 2015.

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The *All-Cause Readmissions* measure is one of the measures and, as stated above, the SPD rates were significantly worse than the non-SPD rates in all three of CalViva's counties, which is to be expected. Other differences between the SPD and non-SPD rates for access measures were:

- ◆ The SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measure in Fresno County was significantly worse than the non-SPD rate.
- ◆ The SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure in Fresno County was significantly better than the non-SPD rate.

Both of CalViva's QIPs fell into the access domain of care. As stated above, neither QIP demonstrated statistically significant improvement from baseline to Remeasurement 1. Also as noted above, the MCP's *All-Cause Readmissions* PDSA cycle was successful at increasing the number of beneficiaries who attended a physician appointment within seven days of discharge.

Overall, CalViva showed below-average performance related to the access domain of care.

Timeliness

CalViva's quality improvement program description includes processes to assess and monitor timeliness of care related to the areas of beneficiary rights and protections, grievances, continuity and coordination of care, and utilization management.

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure falls into the timeliness domain of care. The rate for this measure in Madera County was above the HPL for the third consecutive year. The rates for both *Prenatal and Postpartum Care* measures in Madera County improved significantly from RY 2014 to RY 2015, and the improvement resulted in the rate for the *Postpartum Care* measure moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rate for the *Childhood Immunization Status—Combination 3* measure declined significantly from RY 2014 to RY 2015 in Kings County, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015. Two other timeliness measures also had rates below the MPLs in RY 2015:

- ◆ *Prenatal and Postpartum Care—Postpartum Care* in Kings County for the third consecutive year
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Kings County

Overall, CalViva 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with CalViva’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—CalViva’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Since across all counties CalViva Health had 23 measures with rates below the MPLs and 14 measures with rates that were significantly worse in RY 2014 when compared to RY 2013, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.</p>	<p>CalViva Health (the “Plan”) responded to HSAG’s recommendation to work with DHCS to identify priority areas for improvement and focus efforts on the priority areas by conducting an assessment of all measures below the MPLs by county and by measure type. This assessment allowed the Plan to group similar issues and develop a prioritized schedule for Improvement Plan (IP) development and quarterly monitoring and reporting, which was then recommended to the DHCS staff and leadership for discussion and approval.</p> <ul style="list-style-type: none"> On July 25, 2014, CalViva Health’s Chief Medical Officer (CMO), Chief Compliance Officer, and Director of Medical Management met with the DHCS Medical Policy Section Chief and the assigned DHCS Nurse Consultant for an initial discussion of CalViva Health’s priorities for measures, QIP options, and the September 2, 2014, submission. The outcome of the meeting was that DHCS and CalViva Health would collaborate to develop a prioritized reporting schedule for IPs and quarterly reporting. Performance measures would be grouped by topic and county and submissions staggered over the next several months to allow time for meaningful improvement strategy identification, implementation, and evaluation. On July 31, 2014, CalViva Health’s CMO and Director of Medical Management met with the DHCS Nurse Consultant to draft an initial, prioritized list. It was agreed that an IP for <i>Diabetes</i> and an IP for <i>Postpartum Visits</i> would be submitted by September 2, 2014. These would be followed by a Kings County effort focused on data issues and an <i>Asthma</i> IP. Following the initial Improvement Plan development, quarterly monitoring and reporting on these projects would follow the Plan-Do-Study-Act (PDSA) methodology for rapid-cycle improvement. <p>During the months of August and September further discussions resulted in the development and approval of the following final <u>CalViva Health Submission Schedule</u>:</p> <p>September 2, 2014—IP#1 (Diabetes Bundle) and IP#2 (Postpartum Visit) November 3, 2014—IP#3 (Kings County Bundle)</p>

2013–14 External Quality Review Recommendation Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>December 15, 2014—IP#4 (Asthma Medication Compliance)</p> <p>January 5, 2015—PDSA (Diabetes Bundle) and PDSA (Postpartum Visits)</p> <p>February 2, 2015—PDSA (Kings County Bundle)</p> <p>March 2, 2015—PDSA (Asthma Medication Compliance)</p> <p>April 2, 2015—PDSA (Diabetes Bundle) and PDSA (Postpartum Visits)</p> <p>May 4, 2015—PDSA (Kings County Bundle)</p> <p>June 2, 2015—PDSA (Asthma Medication Compliance)</p> <p>July 2, 2015—PDSA (Diabetes Bundle) and PDSA (Postpartum Visit)</p> <p>All submission deadlines have been met according to the schedule, with improvement noted in several areas.</p>
<p>2. Identify the factors contributing to Kings County performing worse than Fresno and Madera counties and then duplicate strategies being used in Fresno and Madera counties, as appropriate, to improve performance measure rates in Kings County.</p>	<p>The key factors that contributed to poor performance in Kings County when compared to Fresno and Madera counties seemed to be associated with numerous challenges in obtaining valid and complete data for many of the HEDIS performance measures. An extensive causal/barrier analysis of Kings County performance was conducted and resulted in the identification of the following:</p> <ul style="list-style-type: none"> • Multiple issues associated with collection of medical claims, encounters, and medical records data by the contracted HEDIS vendor. Analysis of both administrative and hybrid measure data collection and retrieval procedures and abstraction processes revealed opportunities for improved communication, project management, and problem resolution. As a result, a set of comprehensive improvement strategies was developed for each barrier throughout the data collection process in order to standardize practices related to medical record abstraction, improve workflow, and increase accuracy of medical record review. • Data collection barriers with one specific high-volume provider in Kings County. For RY 2014, one participating provider entity was identified to manage 58 percent of CalViva Health’s membership in Kings County. An assessment of the data revealed that this one provider entity lowered (and in several cases significantly lowered) the HEDIS rates for measures not meeting the minimum performance level. Discussions with the provider revealed that the organization was undergoing numerous changes during the HEDIS data collection time period, including transitioning from physical paper charts to electronic medical records and the integration of several smaller independently run clinics into the larger provider system. These changes contributed to barriers in data collection. As a result, working with the provider entity, a number of improvement strategies were identified to address barriers throughout the data collection process in order to improve the workflow and accuracy of medical record review. • Low PM-160 submissions among provider groups in Kings County. PM-160 Information Only (INF) form must be submitted for every

2013–14 External Quality Review Recommendation Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>pediatric exam delivered to a CalViva Health beneficiary to report preventive health services rendered. PM-160 forms are used to collect HEDIS rates for specific pediatric measures. An analysis of PM-160 form submission rates revealed that Kings County providers submitted fewer forms per beneficiary than Fresno or Madera counties. As a result, a PM-160 task force was created by CalViva Health leadership in order to address barriers to form submission. This multidisciplinary team meets quarterly to analyze data and to identify and address barriers to form submission.</p>
<p>3. For measures with SPD rates that are significantly worse than the non-SPD rates, assess the factors leading to the SPD rates being significantly worse to ensure that the MCP is meeting the needs of the SPD population.</p>	<p>CalViva Health calculates and monitors SPD rates for several performance measures each year including but not limited to: <i>All-Cause Readmissions, Ambulatory Care, Children and Adolescents’ Access to Primary Care Practitioners, and Monitoring of Persistent Medications</i>. For the vast majority of these measures, the SPD population performs better than the non-SPD population, indicating that the Plan is addressing the needs of the SPD population.</p> <p>One measure that demonstrates a higher (worse) rate for the SPD population is <i>All-Cause Readmissions</i> for all three counties. CalViva Health participated in the Statewide Collaborative QIP during this reporting period in an effort to reduce hospital readmissions for all beneficiaries and, in particular, for the SPD population. It is not unexpected that the SPD population demonstrates a higher readmission rate than non-SPDs due to the multiple comorbidities and disease progression associated with this chronically ill population.</p> <p>A transitional care management (TCM) program focused on the SPD population was initiated in late 2013 and continues in an effort to reduce readmissions by focusing TCM staff on key factors that are known to impact this issue:</p> <ul style="list-style-type: none"> • Medication reconciliation • Primary care provider (PCP) office visit within one week of discharge • Knowledge of red flags to indicate condition is worsening • Patient Centered Health Record—a tool to document key health information <p>This program attained full implementation in Fresno County in 2014 with rapid cycle improvement efforts focused on ensuring the beneficiary completes a PCP office visit within one week of discharge from the hospital. This is an ongoing program.</p>
<p>4. Reference the QIP Completion Instructions to ensure that all required documentation for each activity has been addressed prior to submission.</p>	<p>During this reporting period, CalViva Health has submitted reports on two QIPs:</p> <ol style="list-style-type: none"> 1. <i>Comprehensive Diabetes Care</i>—Diabetic Retinal Eye Exam and the Plan met all HSAG validation requirements. 2. <i>All-Cause Readmissions Collaborative</i> and the Plan met all HSAG validation requirements. <p>The QIP Completion Instructions were followed for all submissions.</p>

Recommendations

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

- ◆ Assess the effectiveness of improvement strategies related to each performance measure with a rate below the MPL to determine whether strategies should be expanded, modified, or eliminated.
- ◆ Continue to address data issues identified in Kings County to improve performance in this county.
- ◆ As a follow-up to the *All-Cause Readmissions* PDSA cycle that the MCP tested:
 - Follow the documented plans to adopt the successful change in additional settings since the test of change resulted in an increase in the number of beneficiaries who attended a physician appointment within seven days of discharge from the hospital.
 - Continue to address barriers and monitor readmissions rates.
 - Explore issues identified through the PDSA cycle to ensure that providers are involved in the post-discharge treatment plan process.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix G:
Performance Evaluation Report
Care1st Partner Plan
July 1, 2014 – June 30, 2015**

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Appendix G: Performance Evaluation Report – Care1st Partner Plan July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Care1st Partner Plan (“Care1st” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

Care1st is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) under a Geographic Managed Care (GMC) model in San Diego County. The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within a specified geographic area (county).

For San Diego County, beneficiaries may select from the following MCPs in addition to Care1st:

- ◆ Community Health Group Partnership Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Kaiser SoCal
- ◆ Molina Healthcare of California Partner Plan, Inc.

Care1st became operational in San Diego County to provide MCMC services in February 2006. As of June 30, 2015, Care1st had 69,308 beneficiaries.¹ This represents 11 percent of the beneficiaries enrolled in this county.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: October 8, 2015.

Medical and State Supported Services Audit

DHCS conducted a medical and State Supported Services audit for Care1st December 3, 2013, through December 13, 2013, covering the period of October 1, 2012, through September 30, 2013. DHCS assessed the following areas:

- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Member’s Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

DHCS issued two reports on July 31, 2014—one summarizing the State Supported Services findings and one summarizing the medical audit findings. DHCS indicated that Care1st was in compliance with the State Supported Services contractual requirements; however, DHCS identified findings in all areas it assessed during the medical audit portion of the December on-site visit.

In a letter dated October 30, 2014, DHCS stated that on October 13, 2014, Care1st provided DHCS with a response to the corrective action plan (CAP) originally issued on August 27, 2014. The letter stated that DHCS reviewed all open items and found all to be in compliance. Therefore, DHCS closed the CAP.

1115 Waiver Seniors and Persons with Disabilities Enrollment Survey

The most recent Department of Managed Health Care (DMHC) 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey (hereafter referred to as “SPD medical survey”) for Care1st was December 3, 2013, through December 6, 2013, covering the period of October 1, 2012, through September 30, 2013. HSAG included a summary of the survey results in Care1st’s 2013–14 MCP-specific evaluation report. DMHC identified potential deficiencies in the areas of Utilization Management, Availability and Accessibility of Services, Member Rights, and Quality Management. A CAP was issued on July 10, 2014. In a letter dated September 22, 2014, DHCS stated that on September 18, 2014, Care1st provided DHCS with a response to its CAP. The letter stated that DHCS reviewed all open items and found all to be in compliance. Therefore, DHCS closed the CAP.

Strengths

Care1st fully resolved all deficiencies identified in the MCP's most recent medical and State Supported Services audit and SPD medical survey.

Opportunities for Improvement

Since Care1st resolved all deficiencies identified in the MCP's most recent medical and State Supported Services audit and SPD medical survey, HSAG has no recommendations related to compliance reviews.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Care1st Partner Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that Care1st followed the appropriate specifications to produce valid rates, and no issues of concern were identified.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 for Care1st's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.

- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
Care1st—San Diego County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	15.64%	15.57%	16.89%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	48.06	50.84	51.00	53.48	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	239.46	291.33	279.31	366.29	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	89.19%	81.79%	83.72%	85.47%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	NA	NA	62.50%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	86.76%	80.19%	83.96%	87.37%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	15.38%	20.83%	27.41%	25.20%	↔
Cervical Cancer Screening	Q,A	—	—	43.31%	49.64%	↔
Childhood Immunization Status—Combination 3	Q,A,T	73.24%	72.75%	65.45%	69.34%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	90.56%	93.54%	89.27%	85.60%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	78.47%	82.76%	80.91%	77.82%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	81.48%	82.67%	80.88%	80.73%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	77.75%	81.15%	78.71%	76.16%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	73.90%	58.39%	46.72%	48.66%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	47.39%	40.39%	37.71%	53.53%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	88.76%	84.91%	81.27%	87.59%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	49.00%	51.82%	42.58%	48.42%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	88.35%	85.40%	82.24%	84.18%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	36.95%	42.09%	51.82%	39.42%	▲
Controlling High Blood Pressure	Q	—	51.71%	42.82%	59.37%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	62.13%	70.26%	67.88%	55.72%	↓
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	40.59%	54.55%	42.07%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	24.75%	37.01%	24.83%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	67.06%	59.18%	60.58%	64.96%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	85.00%	81.12%	81.02%	79.08%	↔
Use of Imaging Studies for Low Back Pain	Q	82.72%	70.00%	72.11%	76.85%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	65.94%	74.45%	54.99%	75.67%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	68.37%	72.26%	62.29%	75.67%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	46.72%	51.58%	37.96%	64.96%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	73.44%	67.07%	67.34%	66.18%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 SPD measure results reported by Care1st. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Care1st—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	13.92%	19.22%	▼	16.89%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.75%	85.97%	↔	85.47%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	62.50%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.75%	87.10%	↔	87.37%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	86.15%	NA	Not Comparable	85.60%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	78.31%	59.63%	↓	77.82%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	81.66%	64.66%	↓	80.73%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	77.52%	58.79%	↓	76.16%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

▲▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

⁴ 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 3.2.

Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures Care1st—San Diego County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
345.87	49.57	478.22	74.91

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table Care1st—San Diego County

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	17.35%	16.90%	19.22%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	73.34	68.85	74.91	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	415.00	399.63	478.22	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.13%	85.13%	85.97%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.24%	85.98%	87.10%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	70.83%	69.03%	59.63%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	82.50%	62.64%	64.66%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	78.13%	70.67%	58.79%	↓

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
Care1st—San Diego County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.65%	8.64%	13.92%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	43.32	44.72	49.57	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	249.97	237.00	345.87	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.85%	76.14%	84.75%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	75.23%	72.65%	87.75%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	93.78%	89.78%	86.15%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.10%	81.31%	78.31%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	82.68%	81.93%	81.66%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	81.22%	79.34%	77.52%	↔

* Member months are a member's "contribution" to the total yearly membership.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rates for the following measures were significantly better in RY 2015 when compared to RY 2014:

- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Controlling High Blood Pressure*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015

- ◆ All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

The rates for the following measures improved from RY 2014 to RY 2015, and although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates for the following measures were below the MPLs in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* (third consecutive year)
- ◆ *Cervical Cancer Screening*
- ◆ All four *Children and Adolescents' Access to Primary Care Practitioners* measures (fourth consecutive year), and the rates for the *12 to 24 Months*, *25 Months to 6 Years*, and *12 to 19 Years* measures declined significantly from RY 2014 to RY 2015
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Immunizations for Adolescents—Combination 1*, and the rate declined significantly from RY 2014 to RY 2015
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*, and the rate declined significantly from RY 2014 to RY 2015

In addition to the rates above that declined significantly from RY 2014 to RY 2015, the rate for the *Medication Management for People with Asthma—Medication Compliance 75% Total* measure declined significantly from RY 2014 to RY 2015.

Seniors and Persons with Disabilities Findings

The SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate. The SPD rates for three of the *Children and Adolescents' Access to Primary Care Practitioners* measures—*25 Months to 6 Years*, *7 to 11 Years*, and *12 to 19 Years*—were significantly worse than the non-SPD rates. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population relying on specialty providers as their care source, based on complicated health care needs, rather than accessing care from a primary care provider (PCP).

Overall, the SPD rates showed no significant change from RY 2014 to RY 2015, with the SPD rate for only one measure being significantly worse in RY 2015 when compared to RY 2014 (*Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*). When comparing the non-SPD rates in RY 2014 and RY 2015, two measures had non-SPD rates that were significantly better in RY 2015 when compared to RY 2014, and three measures had non-SPD rates that were significantly worse in RY 2015 when compared to RY 2014.

Assessment of Improvement Plans

Care1st was required to submit improvement plans (IPs) for the following measures with rates below the MPLs in RY 2014:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* (continued from the previous year)
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Comprehensive Diabetes Control—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Controlling High Blood Pressure*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Care1st had a *Comprehensive Diabetic Care* QIP in place during the review period; therefore, DHCS did not require the MCP to submit an IP for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure (which had a rate below the MPL in RY 2014). Instead, the MCP worked to improve the rate for the measure through the QIP. Information regarding the QIP is included in Section 4 of this report. Note that the rate for the measure improved significantly from RY 2014 to RY 2015, moving the rate to above the MPL in RY 2015.

The following is a summary of the IPs and Plan-Do-Study-Act (PDSA) cycles the MCP conducted to improve rates on the measures with rates below the MPLs in RY 2014:

Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs

The IP for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure was continued from the previous year. Care1st identified the following new barriers to the rate being above the MPL:

- ◆ The MCP experienced significant staff turnover in its quality improvement department in 2014, which severely disrupted planned improvement activities and documentation. Care1st noted that DHCS provided technical assistance to the MCP regarding testing a PDSA cycle; however, the Plan portion of the cycle was unclear and contained multiple interventions. Additionally, staff

attrition during the test of change may have contributed to the MCP having difficulty implementing and reporting on the PDSA cycle.

- ◆ The MCP received incomplete lab data.
- ◆ There was a lack of provider education on the importance of the measure and the specific clinical guidelines.

Care1st also indicated that while the MCP was able to establish direct submission of lab data from large lab providers in a standardized format, other providers that contract with the MCP's delegated groups do not submit the data directly to Care1st.

The MCP implemented several new interventions to address the barriers, including:

- ◆ Provided a list of noncompliant beneficiaries to providers and asked the providers to request the lab tests for the beneficiaries or submit a copy of the test results if available.
- ◆ Built a supplemental database of all records received via the provider outreach project.
- ◆ Initiated a conversation with a contracted provider regarding the provider making improvements to its annual supplemental data files, and requested a lab file.
- ◆ Provided educational webinars to the primary care network through the pay-for-performance program and added the *Annual Monitoring for Patients on Persistent Medications* measure to the measurement set.

Care1st continued to offer provider incentives and added information regarding this measure to the MCP's monthly gap listings through the MCP's provider Web portal. The MCP reported that it eliminated its beneficiary outreach activities.

Care1st submitted one PDSA cycle for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure. The MCP initiated a provider outreach project and sent gaps in care lists to PCPs requesting them to either order the required labs for noncompliant beneficiaries or submit the requested lab results. The MCP created a supplemental database to track the progress of the project. The MCP identified two barriers after analyzing the lab and encounter data:

- ◆ Incomplete lab data (e.g., faxed lab reports did not include a date of service).
- ◆ Provider knowledge deficit related to the measure's clinical guidelines.

Care1st indicated that it will adapt the change by building a supplemental database to access beneficiary data and if effective, the MCP will expand the interventions to family practice sites.

The MCP's improvement efforts were not successful at improving the rate to above the MPL in RY 2015, and Care1st will therefore be required to continue the IP for this measure.

Childhood Immunization Status—Combination 3

Care1st identified the following barriers to the rate for the *Childhood Immunization Status—Combination 3* measure being above the MPL:

- ◆ Incomplete encounter data submission. A 10 percent data gap from federally qualified health centers (FQHCs) was identified.
- ◆ Providers not being aware of which beneficiaries are in need of necessary immunizations.
- ◆ Lack of reminder and appointment scheduling calls to beneficiaries.
- ◆ Beneficiaries not taking the initiative to schedule appointments in a timely manner.
- ◆ Low participation by providers in the immunizations registry.

Care1st implemented the following interventions to address the barriers:

- ◆ Conducted provider and beneficiary outreach:
 - Notified both the beneficiary and physician of gaps in care.
 - Created a dedicated outreach team to make beneficiary and provider calls and hired temporary staff to address any additional call volume.
 - Provided direct access to appointment scheduling systems for some of the largest FQHCs.
 - Made up to three reminder calls for all beneficiaries with gaps in care.
 - Updated the gaps in care reports every month to ensure noncompliant beneficiaries were accurately identified.
- ◆ Collected HEDIS data through the MCP's provider portal to include FQHCs and not just individual providers.
- ◆ Collected supplemental data in Industry Collaboration Effort (ICE) format.
- ◆ Entered data into the MCP's internal supplemental database for all dates of service in 2014.
- ◆ Enhanced the provider portal to include FQHCs and offered incentives to providers that submitted additional data via the portal.

Care1st's improvement efforts resulted in the rate for the measure improving by more than 3 percentage points; and although the improvement was not statistically significant, the change moved the rate to above the MPL in RY 2015.

Controlling High Blood Pressure

Care1st submitted a combined IP to address the rates for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *Controlling High Blood Pressure* measures being below the MPLs in RY 2014. The MCP identified the following barriers to the rates being above the MPLs:

- ◆ Provider staff members not taking a second blood pressure reading if the first reading is elevated.
- ◆ Beneficiaries being noncompliant due to:
 - Lacking awareness that managing their diet and exercising can help control their hypertension.
 - Not having access to adequate educational classes.
 - Skipping their medication and follow-up appointments.
 - Having language barriers.

Care1st implemented the following interventions to address the barriers:

- ◆ Conducted provider and beneficiary outreach:
 - Notified both the beneficiaries and physicians of gaps in care.
 - Created a dedicated outreach team to make beneficiary and provider calls and hired temporary staff to address any additional call volume.
 - Provided direct access to appointment scheduling systems for some of the largest FQHCs.
 - Made up to three reminder calls for all beneficiaries with gaps in care.
 - Updated the gaps in care reports every month to ensure noncompliant beneficiaries were accurately identified.
- ◆ Educated providers and office staff on the importance of repeating blood pressure readings when the first reading is elevated. Modes of education included a nurse educator providing one-on-one education and faxing written materials at least twice each year.

Care1st submitted two PDSA cycles for the measures. A summary of each cycle follows:

- ◆ The MCP submitted an objective only, which was to increase by 10 percent the number of beneficiaries with diabetes in need of an annual primary care visit for blood pressure control at four large-volume FQHCs by scheduling visits for the beneficiaries.
- ◆ The MCP submitted a plan to decrease by 10 percent the number of beneficiaries with a blood pressure reading greater than 140/90 mm Hg. The MCP plans to identify beneficiaries with diabetes with blood pressure greater than 140/90 mm Hg at four FQHCs. The MCP plans to conduct at least monthly monitoring of the blood pressure rates, and to conduct provider and beneficiary education to achieve the objective. The PDSA cycle had not yet reached the Do, Study, or Act phases.

Care1st's improvement efforts were successful at improving the rate for the *Controlling High Blood Pressure* measure to above the MPL in RY 2015. The improvement in the rate from RY 2014 to RY 2015 was statistically significant. While the rate for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure improved by almost 2 percentage points, the improvement was

not statistically significant and was not enough to move the rate to above the MPL in RY 2015. The MCP will be required to continue the IP for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Care1st identified the following barriers to the rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure being above the MPL:

- ◆ Incomplete encounter data submissions. A 10 percent data gap from FQHCs was identified.
- ◆ Providers not being aware of beneficiaries in need of a well-child visit.
- ◆ Lack of reminder and appointment scheduling calls to beneficiaries.

The MCP implemented several interventions to address the barriers, including:

- ◆ Conducted provider and beneficiary outreach, including:
 - Notified the beneficiary and PCP of gaps in care four to five months before the end of the year to improve compliance.
 - Created a dedicated outreach team to make beneficiary and provider calls.
 - Provided access to appointment systems for some of the largest FQHCs.
 - Hired temporary staff to handle additional call volume—staff made up to three reminder calls for all beneficiaries with gaps in care.
- ◆ Continued to offer incentives to providers who submitted supplemental data via the provider portal.
- ◆ Allowed FQHCs and clinics the option of submitting data in the ICE format directly to the MCP.

Although the rate for the measure declined by slightly more than 1 percentage point, the decline was not statistically significant. Since the MPL was lower for RY 2015 than for RY 2014, the rate for the measure moved to above the MPL in RY 2015.

Required Improvement Plans for RY 2015

In addition to being required to continue IPs for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measures, Care1st will be required to submit IPs for the following measures:

- ◆ *Cervical Cancer Screening*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*

Strengths

HSAG auditors determined that Care1st followed the appropriate specifications to produce valid rates, and no issues of concern were identified.

The rates for eight measures were significantly better in RY 2015 when compared to RY 2014. The MCP's improvement efforts resulted in the rates for four measures moving from below the MPLs in RY 2014 to above the MPLs in RY 2015.

Care1st provided documentation of actions the MCP has taken to improve rates on measures. Additionally, Care1st indicated that with the MCP's revamped outreach process, SPD beneficiaries are identified and an effort is made to understand their specific needs. The MCP will arrange for home visits, when appropriate, to ensure the SPD beneficiaries' needs are thoroughly assessed. (See Table 6.1)

Opportunities for Improvement

Care1st has the opportunity to identify the factors leading to continued poor performance on some measures and implement strategies to improve the measures' rates. Regarding measures for which Care1st has already been implementing improvement strategies, including strategies targeting the SPD population, the MCP has the opportunity to assess the effectiveness of the strategies to determine whether they should be expanded, modified, or eliminated.

Quality Improvement Project Objectives

Care1st participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists Care1st’s QIPs, whether the QIP is clinical or nonclinical, and the domains of care (i.e., quality, access, and timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for Care1st
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Comprehensive Diabetes Care</i>	Clinical	Q, A

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

The *Comprehensive Diabetes Care* QIP targeted beneficiaries with diabetes and focused on increasing low-density lipoprotein (LDL) screening, nephropathy monitoring, retinal eye exams, and HbA1c screening, and on decreasing the percentage of beneficiaries with an HbA1c test result greater than 9 percent (indicating poor control). Ongoing management of beneficiaries with diabetes is critical to preventing complications and ensuring optimal health.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
Care1st—San Diego County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	81%	86%	<i>Partially Met</i>
Internal QIPs				
<i>Comprehensive Diabetes Care</i>	Annual Submission	71%	80%	<i>Not 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, 2014, through June 30, 2015, showed that Care1st’s annual submission of its *All-Cause Readmissions* QIP received a *Partially Met* validation status. The MCP’s *Comprehensive Diabetes Care* QIP received an overall validation status of *Not Met*. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, Care1st conducted a PDSA cycle for both the *All-Cause Readmissions* and *Comprehensive Diabetes Care* QIPs.

Table 4.3 summarizes the aggregated validation results for Care1st’s QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
Care1st—San Diego County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

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)**	67%	17%	17%
	VI: Accurate/Complete Data Collection	90%	0%	10%
Design Total		89%	4%	7%
Implementation	VII: Sufficient Data Analysis and Interpretation**	71%	18%	12%
	VIII: Appropriate Improvement Strategies**	75%	13%	13%
Implementation Total		72%	16%	12%
Outcomes	IX: Real Improvement Achieved**	38%	0%	63%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total**		38%	0%	63%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for both *All-Cause Readmissions* and *Comprehensive Diabetes Care* QIP annual submissions.

Care1st demonstrated an adequate application of the Design stage, meeting 89 percent of the requirements for all applicable evaluation elements within the study stage. The MCP documented an incorrect population size and did not provide the manual data collection tool in the *Comprehensive Diabetes Care* QIP submission, resulting in lower scores for Activities V and VI.

The MCP demonstrated a sufficient application of the Implementation stage, meeting 72 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *All-Cause Readmissions* QIP, Care1st reported an incorrect interpretation of results, resulting in a lower score for Activity VII. For the *Comprehensive Diabetes Care* QIP, the MCP did not document the factors that threatened the internal or external validity of findings or factors that affected the ability to compare the baseline measurement with Remeasurement 3, which also contributed to a lower score for Activity VII. In addition, Care1st did not document an evaluation plan or evaluation results of the interventions implemented, resulting in a lower score for Activity VIII.

Both QIPs progressed to the Outcomes stage during the reporting period. While the study indicator for the *All-Cause Readmissions* QIP improved over baseline, the improvement was not statistically significant. The *Comprehensive Diabetes Care* QIP also did not achieve statistically significant improvement over baseline for any of its five study indicators at Remeasurement 3. As a result, Care1st only met 38 percent of the requirements for all applicable evaluation elements within Activity IX. Activity X was not assessed since sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for Care1st—San Diego County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions				
Study Indicator 1: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]				
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13			Sustained Improvement [*]
15.6%	15.6%			‡
QIP #2—Comprehensive Diabetes Care				
Study Indicator 1: The percentage of diabetic members 18–75 years of age who received at least one HbA1c screening test				
Baseline Period 1/1/10–12/31/10	Remeasurement 1 1/1/11–12/31/11	Remeasurement 2 1/1/12–12/31/12	Remeasurement 3 1/1/13–12/31/13	Sustained Improvement [*]
83.6%	88.8%	84.9%	81.3%	‡
Study Indicator 2: The percentage of diabetic members 18–75 years of age with an HbA1c result of >9 (poor control) or no HbA1c screening test [^]				
Baseline Period 1/1/10–12/31/10	Remeasurement 1 1/1/11–12/31/11	Remeasurement 2 1/1/12–12/31/12	Remeasurement 3 1/1/13–12/31/13	Sustained Improvement [*]
30.9%	37.0%	42.1%	51.8%*	‡
Study Indicator 3: The percentage of diabetic members 18–75 years of age who received an LDL screening test				
Baseline Period 1/1/10–12/31/10	Remeasurement 1 1/1/11–12/31/11	Remeasurement 2 1/1/12–12/31/12	Remeasurement 3 1/1/13–12/31/13	Sustained Improvement [*]
80.6%	81.5%	78.6%	73.0%	‡

QIP #2—Comprehensive Diabetes Care				
Study Indicator 4: The percentage of diabetic members 18–75 years of age who received a retinal eye exam				
Baseline Period 1/1/10–12/31/10	Remeasurement 1 1/1/11–12/31/11	Remeasurement 2 1/1/12–12/31/12	Remeasurement 3 1/1/13–12/31/13	Sustained Improvement*
41.8%	47.4%	40.4%	37.7%	‡
Study Indicator 5: The percentage of diabetic members 18–75 years of age who received a nephropathy screening test				
Baseline Period 1/1/10–12/31/10	Remeasurement 1 1/1/11–12/31/11	Remeasurement 2 1/1/12–12/31/12	Remeasurement 3 1/1/13–12/31/13	Sustained Improvement*
87.3%	88.4%	85.4%	82.2%	‡

^A lower percentage indicates better performance.

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

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

All-Cause Readmissions QIP

Care1st’s goal for the *All-Cause Readmissions* QIP was to reduce readmissions rates by 10 percent from baseline to Remeasurement 1. Unfortunately, the MCP did not meet the project’s goal as the readmission rate did not change at Remeasurement 1. A review of the MCP’s QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ The readmissions rate for the SPD population decreased from 17.35 percent (baseline) to 16.90 percent (Remeasurement 1).
- ◆ Although the interventions were not successful at improving the total population readmissions rate, the following is a brief description of the interventions Care1st indicated it planned to implement during the Remeasurement 1 time period. However, it is not clear from the MCP’s documentation which interventions Care1st actually implemented.
 - Discharge Planning:
 - Selected hospitals have an on-site hospitalist and in-house case management.
 - Case management and discharge planning began when the beneficiary was admitted to any of the selected hospitals.
 - A case manager was assigned, social services goals were set, and a plan was developed to assess triggers for readmission.
 - Ensured that all beneficiaries being discharged have a follow-up appointment with their PCP or specialist scheduled within seven days of discharge.
 - Ensured that a full medication reconciliation is completed with the PCP within seven days of discharge.

- Assuring Beneficiaries Follow Up with PCP:
 - Case manager or coordinator placed a reminder call to the beneficiary the day prior to the scheduled PCP or specialist follow-up appointment.
 - Follow-up call was made to the beneficiary after the PCP or specialist visit to confirm the beneficiary was seen and, if the beneficiary was not seen, the appointment was rescheduled.
 - Free transportation was arranged for beneficiaries as needed.

Comprehensive Diabetes Care QIP

For the *Comprehensive Diabetes Care QIP*, Care1st used the same goal for both Remeasurement 2 and Remeasurement 3. The MCP set the QIP's goal to achieve the NCQA Medicaid percentile that was the next percentile category higher than the reported rate for each measure. For example, if the measure's rate was currently at the NCQA Medicaid 50th percentile, the goal would be the 75th percentile. Unfortunately, Care1st did not meet the QIP's goal, and the QIP still had not achieved statistically significant improvement over baseline for any of the five study indicators at Remeasurement 3. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ As in previous years, Care1st did not provide complete and/or accurate information throughout the QIP Summary Form. Specific examples included the MCP not documenting the factors that threatened the internal or external validity of findings or factors that affected the ability to compare the baseline measurement with Remeasurement 3. Additionally, the MCP did not document an evaluation plan or evaluation results of the interventions implemented.
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions Care1st indicated it planned to implement during the Remeasurement 3 time period. However, it is not clear from the MCP's documentation which interventions Care1st actually implemented.
 - Identified beneficiaries with uncontrolled diabetes or who were still in need of diabetes preventive services by using the following interventions:
 - Mailed educational materials semiannually to the beneficiaries.
 - Developed a proactive outreach program that focused on placing follow-up calls; sending medication adherence postcards; using case managers, pharmacists, or clinical educators to remind beneficiaries of the importance of taking insulin and educating them on medication adherence; and identifying beneficiaries in need of transportation services.
 - Assigned a dedicated project manager to focus on QIPs.

- Developed a methodology to identify the top 10 high-volume, low-performing providers. Once these providers were identified, implemented high-touch interventions including the following:
 - Conducted face-to-face visits.
 - Provided educational materials and seminars on-site at provider offices or via webinar that focused on treatment protocols, management of short- and long-term complications, ways to develop the care plan, and efficient use of clinic staff.
 - Reviewed medical records for accuracy.
 - Expedited specialty care referrals for endocrinology, ophthalmology, podiatry, nephrology, and neurology.
 - Made direct beneficiary referrals to an endocrinologist.
 - Provided templates of care plans to the providers.
- Worked with labs and vision service providers to obtain more real-time data.
- Relunched the MCP's provider incentive program.

Plan-Do-Study-Act Review

Both the *All-Cause Readmissions* and *Comprehensive Diabetes Care* QIPs did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for each QIP topic.

All-Cause Readmissions

For the *All-Cause Readmissions* PDSA cycle, Care1st set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

Care1st will improve the appointment scheduling rate for patients being discharged from the hospital by 5 percent by March 31, 2015.

The purpose of the *All-Cause Readmissions* PDSA cycle was to test if beneficiaries are more likely to schedule and keep their appointments if the MCP has access to appointment systems.

Care1st was unable to complete the *All-Cause Readmissions* PDSA cycle due to key staff changes. The MCP indicated that two staff members (quality improvement coordinator and registered nurse) worked at the designated FQHC facility. The quality improvement coordinator and registered nurse made follow-up calls to beneficiaries to facilitate medication reconciliation and scheduled follow-up appointments for patients with their PCPs. However, there was no direct tracking of completion of these activities. Care1st plans to modify the intervention and focus on improving the appointment scheduling rates for patients discharged from the hospital by 5 percent by October 31, 2015.

Improving Retinal Eye Exam Rates in Patients with Diabetes

For the *Comprehensive Diabetes Care* QIP topic, Care1st narrowed the focus to *Improving Retinal Eye Exam Rates in Patients with Diabetes* for the PDSA cycle. The MCP set the SMART Objective as follows:

Care1st will decrease the number of providers that have no specialty type in the March Vision Services provider file by 10 percent by March 31, 2015. This activity will improve the quality of the provider data file for March Vision Services and result in an increase in encounter data and an improvement in [retinal eye exam] administrative rates by 3 percent by March 31, 2015.

The purpose of the *Improving Retinal Eye Exam Rates in Patients with Diabetes* PDSA cycle was to test if targeted data collection will decrease the number of providers that do not have a National Provider Identifier (NPI) or specialty type in the March Vision Care provider file. This will ensure that the encounters received can be correctly used to calculate the HEDIS rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure.

Care1st completed the *Improving Retinal Eye Exam Rates in Patients with Diabetes* PDSA cycle as planned. Initially, there were a total of 542 vision specialist providers; of those, 399 (74 percent) were missing NPIs and specialty types. The MCP implemented a manual process to correct the issue. In measuring the effectiveness of the change, there was improvement. From January 2015 to March 2015, no providers were identified with missing NPIs and specialty types. Care1st will adopt the change and coordinate with the data administrator to ensure provider files are complete with accurate NPI information prior to being uploaded.

Strengths

Care1st demonstrated excellent results for the *Improving Retinal Eye Exam Rates in Patients with Diabetes* PDSA cycle by eliminating missing and incorrect NPI information in the provider files.

Opportunities for Improvement

Care1st should evaluate how the change tested through the *Improving Retinal Eye Exam Rates in Patients with Diabetes* PDSA cycle impacted the retinal eye exam rate and whether there was improvement as a result of the change. In addition, the MCP should continue to adopt the change tested and proactively correct the issue of having incomplete NPI and specialty type information in additional provider files.

Since Care1st was unable to complete the *All-Cause Readmissions* QIP as planned due to staff changes, the MCP should continue with its modified plans to test the *All-Cause Readmissions* intervention to improve the appointment scheduling rates for patients discharged from the hospital.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

Care1st’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for Care1st. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for Care1st

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	23.0%	26.3%	25th–75th	7.4%	9.2%	25th–75th
Diagnosis Code	29.2%	31.6%	25th–75th	38.7%	34.6%	25th–75th
Procedure Code	33.9%	43.8%	25th–75th	14.6%	22.5%	75th–90th
Procedure Code Modifier	19.2%	58.5%	≥90th	29.8%	46.0%	25th–75th
Rendering Provider Name	20.1%	25.0%	25th–75th	35.0%	68.1%	75th–90th
Billing Provider Name	24.6%	35.0%	75th–90th	7.6%	8.6%	25th–75th

Overall, the medical record omission rates for Care1st ranged from 19.2 percent (*Procedure Code Modifier*) to 33.9 percent (*Procedure Code*). All six of Care1st’s medical record omission rates were better than the respective statewide rates. When compared to other MCPs’ performance, Care1st received a percentile ranking of “25th–75th” for four medical record omission rates and rankings of “75th–90th” and “≥90th” for the remaining two elements (*Billing Provider Name* and *Procedure Code Modifier*, respectively). These findings suggest a moderate level of completeness among key encounter data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for Care1st contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, Care1st’s rates varied from 7.4 percent (*Date of Service*) to 38.7 percent (*Diagnosis Code*). Five of Care1st’s encounter data omission rates were better than the respective statewide rates with the *Rendering Provider Name* encounter omission rate being better than the

statewide rates by 33.1 percentage points (“75th–90th”). However, Care1st performed worse than the statewide encounter data omission rate by 4.1 percentage points for the *Diagnosis Code* data element. An opportunity exists for Care1st to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider’s billing office made a coding error.
- ◆ DHCS’s encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields or DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in Care1st’s encounter data submission process, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider’s performance of the service and submission of the encounter to Care1st (and/or the data subsequently being submitted to DHCS).
- ◆ Care1st populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files Care1st submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for Care1st. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for Care1st

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	92.0%	83.6%	≥90th	NA
Procedure Code	95.4%	77.6%	≥90th	NA
Procedure Code Modifier	100.0%	99.5%	≥90th	—
Rendering Provider Name	66.7%	63.0%	25th–75th	NA
Billing Provider Name	71.1%	68.6%	25th–75th	NA
All-Element Accuracy	18.9%	4.3%	≥90th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be quite accurate for Care1st with all element accuracy rates higher than the respective

statewide rates. When comparing performance among the assessed MCPs, three of the five key data elements ranked in the 90th percentile or above. The *Rendering Provider Name* and *Billing Provider Name* data elements each received a percentile ranking of “25th–75th.”

Although Care1st’s all-element accuracy rate was better than the statewide rate, only 18.9 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 81 percent of the dates of service reviewed in this study. While the inaccuracy from each of the five key data elements contributed to Care1st’s all-element accuracy rate, the *Procedure Code Modifier* data element contributed the least to the all-element inaccuracies.

Medical Record Review Recommendations

Based on the study findings for Care1st, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, Care1st should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. Care1st should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ Care1st should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ Care1st should investigate the reasons for the relatively high medical record omission rate for the *Procedure Code* data element and develop strategies to improve the rate.
- ◆ Care1st should explore the reasons for the relatively high encounter data omission rate for the *Diagnosis Code* data element and take actions to improve the rate.

- ◆ Care1st should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with Care1st.
- ◆ Care1st should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP’s Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

Care1st’s SFY 2014–15 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the EDV study, which assessed the MCP’s operational and infrastructure changes in support of DHCS’s transition to PACES. Based on review of Care1st’s Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist Care1st with improving its encounter data quality. DHCS followed up with Care1st regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of Care1st's performance in the three domains of care—quality, access, and timeliness.

Quality

HSAG reviewed Care1st's available quality improvement program documents and found descriptions of various processes the MCP implements to ensure quality care is delivered to Medi-Cal beneficiaries. Additionally, Care1st included information on ways the MCP modified its organizational structure in response to high staff turnover and to ensure efficient quality improvement program processes.

The rates for the following quality measures were significantly better in RY 2015 when compared to RY 2014:

- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Controlling High Blood Pressure*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

The rates for the following quality measures improved from RY 2014 to RY 2015, and although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates for the following quality measures were below the MPLs in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* (third consecutive year)
- ◆ *Cervical Cancer Screening*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Immunizations for Adolescents—Combination 1*, and the rate declined significantly from RY 2014 to RY 2015
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*, and the rate declined significantly from RY 2014 to RY 2015

In addition to the rates above that declined significantly from RY 2014 to RY 2015, the rate for the *Medication Management for People with Asthma—Medication Compliance 75% Total* measure, which falls into the quality domain of care, declined significantly from RY 2014 to RY 2015.

For quality measures stratified by the SPD and non-SPD populations, the SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of Care1st's QIPs fell into the quality domain of care, and both progressed to the Outcomes stage during the reporting period. While the study indicator for the *All-Cause Readmissions* QIP improved over baseline, the improvement was not statistically significant. The *Comprehensive Diabetes Care* QIP also did not achieve statistically significant improvement over baseline for any of its five study indicators.

Care1st planned to implement an *All-Cause Readmissions* PDSA cycle; however, the MCP was unable to complete the cycle due to key staff changes. Care1st indicated that it plans to modify the planned intervention and focus on improving the appointment scheduling rates for patients discharged from the hospital by 5 percent by October 31, 2015.

Care1st implemented an *Improving Retinal Eye Exam Rates in Patients with Diabetes* PDSA cycle to test if targeted data collection would decrease the number of providers that do not have an NPI or specialty type in the March Vision Care provider file. This will ensure that the encounters received can be correctly used to calculate the HEDIS rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure. The test of change was successful in improving data completeness, and the MCP indicated it will adopt the change.

Overall, Care1st showed below-average performance related to the quality domain of care.

Access

HSAG reviewed Care1st's quality improvement work plan and found access-related goals. The MCP's annual evaluation document identified various barriers to access and outlined interventions the MCP implemented and planned to implement to address the barriers.

The rates for the following access measures were significantly better in RY 2015 when compared to RY 2014:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*

The rates for the following access measures improved from RY 2014 to RY 2015, and although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates for the following access measures were below the MPLs in RY 2015:

- ◆ *Cervical Cancer Screening*

- ◆ All four *Children and Adolescents' Access to Primary Care Practitioners* measures (fourth consecutive year), and the rates for the *12 to 24 Months*, *25 Months to 6 Years*, and *12 to 19 Years* measures declined significantly from RY 2014 to RY 2015
- ◆ *Immunizations for Adolescents—Combination 1*, and the rate declined significantly from RY 2014 to RY 2015

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The *All-Cause Readmissions* measure is one of the measures and as stated above, the SPD rate was significantly worse than the non-SPD rate, which is to be expected. The SPD rates for three of the *Children and Adolescents' Access to Primary Care Practitioners* measures—*25 Months to 6 Years*, *7 to 11 Years*, and *12 to 19 Years*—were significantly worse than the non-SPD rates. The significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population relying on specialty providers as their care source, based on complicated health care needs, rather than accessing care from a PCP.

Both of Care1st's QIPs fell into the access domain of care. As stated above, both progressed to the Outcomes stage during the reporting period, and both achieved no statistically significant improvement for any of the study indicators.

As stated above, Care1st planned to implement an *All-Cause Readmissions* PDSA cycle; however, the MCP was unable to complete the cycle due to key staff changes. Also as indicated above, Care1st's *Improving Retinal Eye Exam Rates in Patients with Diabetes* PDSA cycle was successful in improving data completeness, and the MCP indicated it will adopt the change.

Overall, Care1st showed below-average performance related to the access domain of care.

Timeliness

Care1st's quality improvement program description includes processes related to utilization management, grievances, and continuity and coordination of care—all of which may support the delivery of timely care to beneficiaries.

The rates for the following timeliness measures improved from RY 2014 to RY 2015, and although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rate for the *Immunizations for Adolescents—Combination 1* measure, which falls into the timeliness domain of care, was below the MPLs in RY 2015, and the rate declined significantly from RY 2014 to RY 2015.

Overall, Care1st 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with Care1st’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions. Additionally, the MCP referenced various attachments in its responses to the recommendations. HSAG reviewed the documents submitted by the MCP as attachments and included the information, as appropriate, in the applicable sections of this report.

Table 6.1—Care1st’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to Care1st	Self-Reported Actions Taken by Care1st during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Ensure that all potential deficiencies identified during the December 2013 SPD medical survey in the areas of Utilization Management and Member Rights are fully resolved.</p>	<p>The Utilization Management process and procedure has been revised to assure appropriate documentation of medical necessity is documented and communicated. The member appeals letter has been revised, and we have included here as attachment H as evidence of correction.</p>
<p>2. Since the MCP had 11 measures with rates below the MPLs and 10 measures with rates that were significantly worse in 2014 when compared to 2013, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once. Care1st may want to focus efforts on the following measures first:</p> <ul style="list-style-type: none"> a. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs (MPM)</i> b. <i>Childhood Immunization Status—Combination 3 (CIS)</i> c. <i>Comprehensive Diabetes Care—Blood</i> 	<p>Care1st Health Plan has investigated the rate decreases and has found both data and service gaps. Care1st has initiated a very proactive process for tracking, outreach, and improvement in these measures.</p> <p>The QI department has initiated a monthly HEDIS measure data gap report and now provides these listings to outreach staff. In addition, we supply these gap listings to each PCP and contracted Independent Practice Association (IPA)/Medical Group. We have initiated routine quality meetings with the IPA/Medical Groups, creating a collaborative approach to outreach.</p> <p>At the beginning of each year, going forward, we will run our HEDIS measures and send out educational mailings to our members who will be due for services. The focus at the beginning of the year will be those with disease-related measures such as diabetes, hypertension, and asthma, to assure complete assessments are being done.</p> <p>In the middle of the year we will start collecting medical records on those members with a gap on these measures. Those identified with a gap will have records evaluated to close any data-related gaps and if a gap still remains will be sent to our Outreach Department for a</p>

2013–14 External Quality Review Recommendation Directed to Care1st	Self-Reported Actions Taken by Care1st during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p><i>Pressure Control (<140/90 mm Hg) (CDC_BP)</i></p> <p>d. <i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC_Eye)</i></p> <p>e. <i>Controlling High Blood Pressure (CBP)</i></p> <p>f. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)</i></p>	<p>member contact call and scheduling.</p> <p>Care1st Quality Department has initiated these interventions with a goal to improve all measures that failed to meet benchmarks.</p> <p>On this update, we will address the six measures individually with an IP document labeled as attachments A, B, C, D, E, and F.</p> <p>a) MPM—We have had the improvement over the two years we expected with the interventions and now for these two cohorts we have met and exceeded the MPL for this measure. See Attachment A.</p> <p>b) CIS—We have seen a first-year decline but added additional outreach to intervention and the following year have improved significantly and reached and exceeded the MPL for this measure also. See Attachment B.</p> <p>c) CDC_BP—We had added this to our interventions but have not seen the expected improvement. We have revised our improvement plan to add more proactive outreach, which includes getting members in for assessment and care at the beginning of the year with a goal for follow-up. We have detailed new goals for this measure. See Attachment C.</p> <p>d) CDC_Eye—We have seen significant improvement in this measure this past year, which is because of the proactive outreach in scheduling members for the service. We have a contracted eye care vendor that makes scheduling easy because no authorization is needed. Although the first year did not show improvement the following year was significant and we have reached and exceeded the MPL. See Attachment D.</p> <p>e) CBP—We have seen similar declines in the first year followed by a significant improvement in the next year. Although there have been measure changes that could have helped to improve the rate, we have seen a significant improvement over last year and have met and exceeded the MPL for this measure. See Attachment E.</p> <p>f) W34—This measure has remained with the same rate for the past three years. The rate is slightly above the MPL but has not improved in two years. This measure had proactive mailings being sent but did not have the proactive outreach contact calls due to the larger size of the population. This year we will add this to the proactive outreach contact calls to see if we can improve this rate further this 2015 measurement year. See Attachment F.</p>
<p>3. Assess the factors leading to the SPD rates for five measures being significantly worse than the non-SPD rates to ensure that the MCP is meeting the needs of the SPD population.</p>	<p>Seniors and Persons with Disabilities require an extra effort to assure those with special needs are getting the services they need in a timely manner. With our revamped outreach process, SPD members are identified and outreached specifically to understand the needs better. If the member needs a home visit, our outreach department will identify this need and provide a clinician to visit the home and assess the member needs.</p>

2013–14 External Quality Review Recommendation Directed to Care1st	Self-Reported Actions Taken by Care1st during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
4. Refer to the QIP Completion Instructions and previous QIP Validation Tools prior to submitting QIPs to ensure completeness of the data.	Care1st has hired new staff in Quality Improvement to address resource issues and assure a strong QIP process. Adding additional staff will allow us to assure complete comprehensive processes and tools have been developed to assure the QIP process is well documented in assuring improvement from the interventions.
5. For the <i>Comprehensive Diabetic Care</i> QIP, discontinue or modify existing interventions or identify new interventions to better address the recently identified priority barriers, including the large influx of SPD members with diabetes.	Care1st Health Plan has seen a decline in 2013 of the rates for all CDC measures. The QIP interventions were not fully implemented during this time with staffing changes. The QIP was reevaluated and major revisions were made to the QIP to align the goals with the interventions and assure close monitoring will be done. We have attached a revised QIP description, interventions, and results for 2014 to this response and will continue the QIP for another measurement year to track and assure improving rates. See Attachment G.

Recommendations

Based on the overall assessment of Care1st in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following to the MCP:

- ◆ Identify the factors leading to continued poor performance on some measures and implement strategies to improve the measures’ rates. For measures for which Care1st has already been implementing improvement strategies, the MCP has the opportunity to assess the effectiveness of the strategies to determine whether they should be expanded, modified, or eliminated. Specific measures in need of improvement include:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
 - *Cervical Cancer Screening*
 - *All four Children and Adolescents’ Access to Primary Care Practitioners*—Although DHCS does not hold MCPs accountable to meet the MPLs for these measures due to the small range of variation between the MPL and HPL threshold for each measure, the MCP should assess the factors contributing to the decline in the measures’ rates to ensure beneficiaries in the applicable age groups are receiving needed health care services.
 - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
 - *Immunizations for Adolescents—Combination 1*
 - *Medication Management for People with Asthma—Medication Compliance 50% Total*
- ◆ Continue to assess the factors leading to SPD rates being significantly worse than the non-SPD rates for the *All-Cause Readmissions* and three of the *Children and Adolescents’ Access to Primary Care Practitioners* measures. Additionally, continue to assess the effectiveness of previously implemented interventions and design new interventions, as applicable, to ensure that the MCP is meeting the needs of its SPD population.

- ◆ Continue to test adapted plans documented in the *All-Cause Readmissions* PDSA Cycle Worksheet to improve the appointment scheduling rates for patients discharged from the hospital.
- ◆ Regarding the *Improving Retinal Eye Exam Rates in Patients with Diabetes* PDSA cycle:
 - Evaluate how the change tested in the PDSA cycle impacted the overall results of the retinal eye exam rate.
 - Continue to adopt the change tested through the PDSA cycle to improve the quality of data in additional provider files.
- ◆ Review the 2013–14 *Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

In the next annual review, HSAG will evaluate Care1st's progress with these recommendations along with its continued successes.

Medi-Cal Managed Care Technical Report

**Appendix H:
Performance Evaluation Report
CenCal Health
July 1, 2014 – June 30, 2015**

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Appendix H: Performance Evaluation Report – CenCal Health

July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), CenCal Health (“CenCal” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

CenCal is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a County Organized Health System (COHS).

CenCal became operational to provide MCMC services in Santa Barbara County in September 1983 and San Luis Obispo in March 2008. As of June 30, 2015, CenCal had 111,137 beneficiaries in Santa Barbara County and 52,979 beneficiaries in San Luis Obispo County—for a total of 164,116 beneficiaries.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: December 16, 2015.

1115 Waiver Seniors and Persons with Disabilities Enrollment Survey

The California Department of Managed Health Care (DMHC) conducted an 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey (hereafter referred to as “SPD medical survey”) for CenCal October 14, 2014, through October 17, 2014, covering the review period of January 1, 2014, through July 31, 2014. DHCS assessed the following areas related to CenCal’s delivery of care to the SPD population:

- ◆ Utilization Management
- ◆ Continuity of Care
- ◆ Availability and Accessibility of Services
- ◆ Member Rights
- ◆ Quality Management

DMHC issued a report to DHCS June 5, 2015. In the report, DMHC indicated that it had identified two potential deficiencies in the area of Utilization Management and one potential deficiency in the area of Availability and Accessibility of Services.

A letter from DHCS dated November 6, 2015, indicated that CenCal provided DHCS with its most recent response to its corrective action plan (CAP), originally issued on October 5, 2015. The letter stated that all potential deficiencies from the SPD medical survey were closed and, therefore, that DHCS had closed the CAP. Note that while DHCS issued the referenced letter outside the review dates for this MCP-specific evaluation report, HSAG included the information because it was in reference to a survey that occurred within the review dates for this report and because the MCP resolved all findings related to the survey.

Medical and State Supported Services Audit

DHCS conducted two audits in tandem—a medical audit and a State Supported Services audit—of CenCal October 14, 2014, through October 24, 2014, covering the review period of August 1, 2013, through July 31, 2014.

DHCS assessed the following areas:

- ◆ Compliance with State Supported Services contract and regulations
- ◆ Utilization Management

- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Members' Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

DHCS issued two reports on April 2, 2015—one for the medical audit and one for the State Supported Services audit. In the State Supported Services audit report, DHCS indicated that CenCal was in compliance with the contractual requirements for sensitive services and DHCS made no recommendations. In the medical audit report, DHCS identified findings and made recommendations for all areas reviewed under the scope of the medical audit.

A letter from DHCS dated December 28, 2015, indicated that CenCal provided DHCS with its most recent response to its CAP, originally issued June 29, 2015. The letter indicated that DHCS had reviewed and closed all deficiencies from the medical audit. Note that while DHCS issued the referenced letter outside the review dates for this MCP-specific evaluation report, HSAG included the information because it was in reference to an audit that occurred within the review dates for this report and because the MCP resolved all findings related to the audit.

Strengths

During CenCal's October 2014 SPD medical survey, DMHC identified no potential deficiencies in the areas of Continuity of Care, Member Rights, and Quality Management. Additionally, DHCS identified no findings during CenCal's October State Supported Services audit. Finally, CenCal resolved all potential deficiencies from the October 2014 SPD medical survey and findings from the October 2014 medical audit.

Opportunities for Improvement

Since CenCal has no outstanding deficiencies from DMHC's most recent SPD medical survey and DHCS's most recent medical and State Supported Services audit, HSAG has no recommendations for CenCal related to compliance reviews.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for CenCal Health* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance Audit.³ HSAG auditors determined that CenCal followed the appropriate specifications to produce valid rates, and no issues of concern were identified.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. (See Table 3.1 and Table 3.2 for CenCal’s performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1 and Table 3.2

The reader should note the following regarding Table 3.1 and Table 3.2:

- ◆ The MCP’s performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA’s national percentiles. MPLs and HPLs align with NCQA’s national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS’s *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).

² Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit™ is a trademark of NCQA.

- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
CenCal—San Luis Obispo County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	13.49%	12.28%	12.36%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	65.82	63.56	58.78	57.39	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	343.58	346.43	334.76	341.47	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	82.95%	81.02%	80.16%	83.99%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	82.35%	84.20%	84.92%	85.09%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	33.33%	14.46%	17.24%	28.85%	↑
Cervical Cancer Screening	Q,A	—	—	62.77%	61.34%	↔
Childhood Immunization Status—Combination 3	Q,A,T	76.39%	78.03%	77.43%	79.73%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	96.17%	95.31%	96.78%	93.11%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	87.31%	86.21%	89.60%	84.30%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	88.32%	87.64%	90.47%	89.84%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	86.08%	86.69%	86.83%	88.33%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	67.64%	70.56%	65.94%	68.33%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	61.56%	58.39%	59.12%	65.59%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	81.02%	82.00%	84.18%	84.29%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	59.37%	61.31%	58.15%	54.61%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	84.67%	82.73%	85.40%	83.29%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	32.60%	31.14%	30.90%	34.66%	↔
Controlling High Blood Pressure	Q	—	63.02%	54.43%	59.90%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	60.10%	71.65%	65.79%	68.88%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	42.34%	45.28%	41.04%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	26.28%	26.77%	21.27%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	70.11%	71.04%	70.47%	67.82%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	82.76%	87.43%	87.13%	88.79%	↔
Use of Imaging Studies for Low Back Pain	Q	77.86%	75.69%	80.89%	86.51%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	62.29%	64.23%	77.13%	84.67%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	59.61%	61.31%	60.10%	63.75%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	47.69%	50.36%	51.82%	56.45%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	69.79%	67.97%	72.95%	66.87%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.2—Multi-Year Performance Measure Results*
CenCal—Santa Barbara County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	11.13%	13.15%	13.80%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	48.37	52.16	51.43	51.03	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	346.64	335.52	301.90	302.48	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	86.89%	84.72%	85.79%	86.43%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	86.11%	84.85%	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	87.25%	85.46%	86.74%	87.26%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	29.55%	19.13%	22.62%	28.93%	↔
Cervical Cancer Screening	Q,A	—	—	74.45%	70.40%	↔
Childhood Immunization Status—Combination 3	Q,A,T	85.20%	85.84%	83.56%	81.25%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	97.31%	97.84%	98.49%	96.79%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	90.42%	91.16%	93.58%	91.58%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	89.69%	90.88%	92.88%	93.73%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	87.69%	89.29%	90.59%	90.59%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	69.10%	74.21%	72.02%	70.60%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	71.29%	70.56%	68.61%	71.36%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	92.21%	83.94%	86.37%	90.95%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	69.34%	59.61%	59.37%	61.06%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	87.35%	82.48%	84.91%	85.18%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	22.63%	33.58%	31.87%	29.15%	↔
Controlling High Blood Pressure	Q	—	60.58%	60.25%	62.03%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	70.07%	78.74%	80.90%	74.44%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	47.38%	50.28%	45.26%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	27.67%	26.70%	23.43%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	76.35%	73.44%	76.83%	74.10%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	80.74%	81.64%	85.98%	84.92%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	80.46%	80.57%	81.72%	83.26%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	66.42%	70.56%	74.21%	83.62%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	67.88%	72.75%	72.99%	77.92%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	44.77%	51.34%	57.66%	67.49%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	76.01%	79.34%	80.65%	74.07%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.3 through Table 3.6 present a summary of the RY 2015 SPD measure results reported by CenCal. Table 3.3 and Table 3.4 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.5 and Table 3.6 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.3—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CenCal—San Luis Obispo County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	12.06%	12.70%	↔	12.36%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.10%	84.97%	↔	83.99%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.36%	85.96%	↔	85.09%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	93.18%	NA	Not Comparable	93.11%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	84.43%	78.76%	↔	84.30%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	90.17%	83.87%	↓	89.84%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	89.19%	77.16%	↓	88.33%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

⁴ HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD Compared to Non-SPD” column in Table 3.3 and Table 3.4.

Table 3.4—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CenCal—Santa Barbara County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.81%	17.34%	▼	13.80%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.97%	88.66%	↑	86.43%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.57%	90.32%	↑	87.26%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.80%	NA	Not Comparable	96.79%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.56%	92.95%	↔	91.58%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	93.82%	91.17%	↔	93.73%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	90.60%	90.43%	↔	90.59%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the All-Cause Readmissions measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly higher SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly lower SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A Not Applicable audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.5—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures CenCal—San Luis Obispo County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
313.29	53.41	646.84	100.46

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

**Table 3.6—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
CenCal—Santa Barbara County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
280.68	47.04	595.81	104.75

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

Table 3.7 and Table 3.8 present the three-year trending information for the SPD population, and Table 3.9 and Table 3.10 present the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.7—RY 2015 (MY 2014) HEDIS SPD Trend Table
CenCal—San Luis Obispo County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	16.54%	14.96%	12.70%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	100.09	95.46	100.46	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	599.51	598.85	646.84	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.88%	83.97%	84.97%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.25%	90.28%	85.96%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	73.87%	76.07%	78.76%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	83.22%	83.22%	83.87%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	76.61%	79.72%	77.16%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.8—RY 2015 (MY 2014) HEDIS SPD Trend Table
CenCal—Santa Barbara County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	13.88%	16.41%	17.34%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	101.65	102.10	104.75	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	566.20	596.56	595.81	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.86%	89.25%	88.66%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	87.10%	83.33%	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.10%	89.19%	90.32%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.40%	90.99%	92.95%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	87.97%	90.32%	91.17%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	89.83%	89.52%	90.43%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.9—RY 2015 (MY 2014) Non-SPD Trend Table
CenCal—San Luis Obispo County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	6.70%	6.71%	12.06%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	57.42	53.41	53.41	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	303.89	296.02	313.29	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	74.84%	71.79%	83.10%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.57%	72.97%	84.36%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	95.37%	96.86%	93.18%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.59%	90.04%	84.43%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	87.92%	90.91%	90.17%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	87.58%	87.41%	89.19%	↑

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.10—RY 2015 (MY 2014) Non-SPD Trend Table
CenCal—Santa Barbara County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	5.54%	7.29%	9.81%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	46.35	46.42	47.04	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	308.44	272.79	280.68	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.90%	79.54%	83.97%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.97%	81.53%	83.57%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.87%	98.48%	96.80%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.26%	93.63%	91.56%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	91.01%	92.99%	93.82%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	89.25%	90.65%	90.60%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A Not Applicable audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the All-Cause Readmissions measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant decline in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant improvement in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rates exceeded the HPLs for the following measures in Santa Barbara County:

- ◆ Childhood Immunization Status—Combination 3 (fifth consecutive year)
- ◆ Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (fifth consecutive year)
- ◆ Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent) (fifth consecutive year)
- ◆ Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)
- ◆ Prenatal and Postpartum Care—Postpartum Care
- ◆ Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*

The rates exceeded the HPLs for the following measures in San Luis Obispo County:

- ◆ *Use of Imaging Studies for Low Back Pain*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*

The rates improved significantly from RY 2014 to RY 2015 for the following measures:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Luis Obispo County, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* in Santa Barbara County
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* in Santa Barbara County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total* in San Luis Obispo and Santa Barbara counties
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total* in Santa Barbara County

The rates declined significantly from RY 2014 to RY 2015 for the following measures:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in San Luis Obispo and Santa Barbara counties, resulting in the rate for San Luis Obispo County moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* in San Luis Obispo and Santa Barbara counties, resulting in the rate for San Luis Obispo County moving from above the MPL in RY 2014 to below the MPL in RY 2015

The rates for the following measures declined from RY 2014 to RY 2015, and although the decline was not statistically significant, the change resulted in the rates moving from above the MPLs in RY 2014 to below the MPLs in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in San Luis Obispo County
- ◆ *Both Medication Management for People with Asthma—Medication Compliance* measures in San Luis Obispo and Santa Barbara counties

In addition to the rates below the MPLs listed above, the rate was below the MPL for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure in San Luis Obispo County for the fourth consecutive year.

As in previous years, Santa Barbara County performed better than San Luis Obispo County, with seven measures having rates above the HPLs and two measures having rates below the MPLs—compared to San Luis Obispo having two measures with rates above the HPLs and six measures with rates below the MPLs.

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures in Santa Barbara County.

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

- ◆ *All-Cause Readmissions* in Santa Barbara County
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* and *12 to 19 Years* in San Luis Obispo County

Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners* measures in San Luis Obispo County may be attributed to children and adolescents in the SPD population in the specified age groups relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Across all measures stratified for the SPD and non-SPD populations, no variations occurred in the SPD rates for either of the MCP's counties from RY 2014 to RY 2015. The following variations were noted for the non-SPD rates:

- ◆ The non-SPD rate was significantly better in RY 2015 when compared to the RY 2014 non-SPD rate for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in San Luis Obispo County
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in San Luis Obispo County
 - *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* in Santa Barbara County
 - *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in San Luis Obispo County
- ◆ The non-SPD rate was significantly worse in RY 2015 when compared to the RY 2014 non-SPD rate for the following measures:

- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in San Luis Obispo and Santa Barbara counties
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* in San Luis Obispo and Santa Barbara counties

Assessment of Improvement Plans

CenCal was required to submit one Plan-Do-Study-Act (PDSA) cycle based on RY 2014 rates. A summary of the PDSA cycle follows. Note that the MCP had an *Annual Monitoring for Patients on Persistent Medications* QIP in place during the reporting period, so no separate improvement plan (IP) or PDSA cycle was required for the *Annual Monitoring for Patients on Persistent Medications—ACE or ARBs* measure in San Luis Obispo County. A summary of the MCP's improvement efforts related to this measure is included in the Quality Improvement Projects section of this report.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

The MCP was required to conduct a PDSA cycle for San Luis Obispo County based on the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure being below the MPL in RY 2014. CenCal tested whether or not conducting visits with high-volume providers to educate them on the appropriate use of antibiotics for adults with acute bronchitis would decrease the inappropriate prescribing of antibiotics for beneficiaries with bronchitis. The MCP found that the intervention was successful and planned to adopt the intervention.

The rate for the measure improved significantly from RY 2014 to RY 2015, resulting in the rate moving to above the MPL in RY 2015. The MCP will not be required to continue this PDSA cycle.

Required Improvement Plans for RY 2015

CenCal will be required to submit IPs or PDSA cycles for the following measures based on RY 2015 performance measure rates:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in San Luis Obispo County
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in San Luis Obispo County
- ◆ Both *Medication Management for People with Asthma—Medication Compliance* measures in San Luis Obispo and Santa Barbara counties

Although the rates were below the MPLs in San Luis Obispo County for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* and *25 Months to 6 Years* measures, DHCS requires no IPs or PDSA cycles for these measures due to the small range of variation between the MPL and HPL threshold for each measure.

Strengths

CenCal followed the appropriate specifications to produce valid performance measure rates, and the auditor identified no issues of concern.

Across both counties, the rates exceeded the HPLs for nine measures, with the rates for three measures in Santa Barbara County exceeding the HPLs for five consecutive years. Additionally, the rates improved significantly from RY 2014 to RY 2015 for six measures, and the improvement for one of the measures resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

Opportunities for Improvement

CenCal has the opportunity to assess the factors leading to eight rates being below the MPLs and four rates declining significantly from RY 2014 to RY 2015 and to implement strategies to improve the MCP's performance on the measures. The MCP also has the opportunity to assess the factors leading to the significantly higher rate of hospital readmissions for the SPD population in Santa Barbara County to ensure that the MCP is meeting the needs of this population.

Quality Improvement Project Objectives

CenCal participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

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

**Table 4.1—Quality Improvement Projects for CenCal
July 1, 2014, through June 30, 2015**

QIP	Counties	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	San Luis Obispo and Santa Barbara	Clinical	Q, A
<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 ages 21 years and older. Readmissions have been associated with lack of proper discharge planning and poor care transition. Reducing readmissions may demonstrate improved follow-up and care management of beneficiaries, leading to improved health outcomes.

CenCal’s *Annual Monitoring for Patients on Persistent Medications* QIP focused on monitoring 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 strived to ensure better compliance with and effectiveness of the medications and to monitor potential side effects.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (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, 2014, through June 30, 2015**

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>	San Luis Obispo	Annual Submission	69%	86%	<i>Partially Met</i>
	Santa Barbara	Annual Submission	65%	86%	<i>Partially Met</i>
Internal QIPs					
<i>Annual Monitoring for Patients on Persistent Medications</i>	Both counties received the same score.	Annual Submission	62%	86%	<i>Partially 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, 2014, through June 30, 2015, showed that CenCal’s annual submission of its *All-Cause Readmissions* and *Annual Monitoring for Patients on Persistent Medications* QIPs each received a *Partially Met* validation status in both counties. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, CenCal conducted PDSA cycles for both the *All-Cause Readmissions* and *Annual Monitoring for Patients on Persistent Medications* QIPs.

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, 2 QIP Topics)
July 1, 2014, through June 30, 2015

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)	N/A	N/A	N/A
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		100%	0%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation**	63%	13%	25%
	VIII: Appropriate Improvement Strategies**	13%	75%	13%
Implementation Total		46%	33%	21%
Outcomes	IX: Real Improvement Achieved	31%	13%	56%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		31%	13%	56%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

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

CenCal demonstrated a strong application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP struggled with its application of the Implementation stage, meeting 46 percent of the requirements for all applicable evaluation elements within the study stage. The *All-Cause Readmissions* and *Annual Monitoring for Patients on Persistent Medications* QIPs had multiple implementation issues, resulting in lowered scores for Activities VII and VIII.

Both QIPs progressed to the Outcomes stage during the reporting period. However, the MCP received a low score for Activity IX because neither QIP achieved statistically significant improvement over baseline at Remeasurement 1. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for CenCal—
San Luis Obispo and Santa Barbara Counties
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions			
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]			
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
San Luis Obispo	13.5%	12.3%	‡
Santa Barbara	11.1%	13.2%	‡
QIP #2—Annual Monitoring for Patients on Persistent Medications			
Study Indicator 1: The percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year			
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
San Luis Obispo	81.0%	80.2%	‡
Santa Barbara	84.7%	85.8%	‡
Study Indicator 2: The percentage of members 18 years of age and older who received at least 180 treatment days of Digoxin during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year			
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
San Luis Obispo	59.1%*	81.0%*	‡
Santa Barbara	86.1%	84.9%	‡
Study Indicator 3: The percentage of members 18 years of age and older who received at least 180 treatment days of Diuretics during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year			
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
San Luis Obispo	84.2%	84.9%	‡
Santa Barbara	85.5%	86.7%	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

* The rate was reported for purposes of the QIP only. The measure received a *Not Applicable* audit finding because the MCP's denominator was too small to report to NCOA (less than 30).

All-Cause Readmissions QIP

CenCal's goal for the *All-Cause Readmissions* QIP was to achieve a 10 percent reduction in readmissions rates from baseline to Remeasurement 1 in each county. Unfortunately, for both counties, the MCP did not meet the project's goal. Although the readmissions rate declined in San Luis Obispo County, the change did not meet the 10 percent reduction and was not statistically significant. CenCal's readmissions rate in Santa Barbara County increased at Remeasurement 1. A review of the MCP's QIP Summary Forms and QIP Validation Tools revealed the following:

- ◆ CenCal did not document a complete causal/barrier analysis for the Remeasurement 1 time period.
- ◆ Although the interventions were not successful at improving QIP outcomes, following is a brief description of the interventions CenCal indicated it implemented during the Remeasurement 1 time period:
 - Developed a hospital census process to identify and track beneficiaries discharged from in-area hospitals.
 - Established high/low-risk criteria to perform targeted interventions based on the needs of the beneficiaries.
 - Developed a primary care provider (PCP) incentive payment process to reimburse providers for the extra time needed to accommodate access to timely (within 72 hours) appointments for discharged beneficiaries.
 - Developed intradepartmental collaboration to facilitate PCP appointment scheduling for beneficiaries requiring assistance, letter notification for beneficiaries unable to be reached by telephone, provider services promotion, training of PCPs, and claims reports and payments.
 - Established a readmissions agreement with a large federally qualified health center (FQHC) PCP clinic system to perform outreach to its beneficiaries and provided an incentive to the clinic for reducing its readmissions rates.
 - Developed a fax/email process to notify PCPs within 24 hours of their beneficiaries being discharged from hospitals so that the PCPs could perform outreach and increase beneficiary access to timely appointments. Provided discharge summaries to PCPs as part of this process.

Annual Monitoring for Patients on Persistent Medications QIP

CenCal's goal for the *Annual Monitoring for Patients on Persistent Medications* QIP was to achieve 10 percent increase in the rates from baseline to Remeasurement 1 for each study indicator in each county, with the exception of Study Indicator 2 in San Luis Obispo County. The goal for Study Indicator 2 in San Luis Obispo County was to meet the DHCS-established MPL for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure. Unfortunately, for both counties, the MCP did not meet the project's goal. Although some study indicator rates increased from

baseline to Remeasurement 1, the change was not statistically significant. A review of the MCP's QIP Summary Forms and QIP Validation Tools revealed the following:

- ◆ CenCal's multi-departmental workgroup identified and prioritized the following barriers during the Remeasurement 1 time period:
 - Providers do not believe monitoring is important and do not track beneficiaries on persistent medications.
 - Beneficiaries do not comply with monitoring tests.
 - Providers and beneficiaries are unaware of the clinical practice guidelines for monitoring patients on persistent medications.
- ◆ Although the interventions were not successful at improving QIP outcomes, following is a brief description of the interventions CenCal indicated it implemented during the Remeasurement 1 time period:
 - Provided annual performance profiles to the providers based on HEDIS results. The MCP performed on-site visits for high-volume, low-performing providers and called or mailed a summary to low-volume, high-performing clinics.
 - Published a provider bulletin article regarding the importance of monitoring patients on persistent medications.
 - Mailed the providers a list of eligible beneficiaries who did not receive the required tests.

Plan-Do-Study-Act Review

Neither the *All-Cause Readmissions* nor the *Annual Monitoring for Patients on Persistent Medications* QIP achieved a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for each QIP topic.

All-Cause Readmissions

For the *All-Cause Readmissions* PDSA cycle, CenCal set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

For dates of service, January 1, 2015, through March 31, 2015, CenCal Health Quality Improvement staff will increase the percentage of post-discharge visits from 37 percent to 45 percent and sustain hospital readmission rates at 8 percent for one large multi-site FQHC clinic system. CenCal Health will perform monthly quality meetings and focus this clinic's case-management efforts on those beneficiaries with a primary diagnosis of congestive heart failure (CHF), liver failure, chronic obstructive pulmonary disease, or diabetes (the highest rates of readmissions) and those with a potentially preventable admission diagnosis.

The purpose of the *All-Cause Readmissions* PDSA cycle was to test if focused provider education and interventions would increase post-discharge visits and improve the effectiveness of these visits to decrease readmissions rates for beneficiaries assigned to these sites.

CenCal completed the *All-Cause Readmissions* PDSA cycle, but reported that the FQHC's post discharge visit rate decreased from 37.33 percent to 16.17 percent. The MCP determined that the FQHC may not have been committed to the process because there was no contract that rewarded the FQHC for reducing readmissions. (The FQHC's readmissions reduction program contract ended during the *All-Cause Readmissions* PDSA cycle time frame.) Instead of using the readmissions reduction program, the MCP's case management staff met with the FQHC nursing directors and case managers to prioritize and focus on high-risk beneficiaries with diabetes, asthma, chronic obstructive pulmonary disease (COPD), and CHF. CenCal also stopped sending data reports to the FQHC and encouraged it to obtain the information directly from hospitals; however, it was unclear if the FQHC did that. The overall readmissions rate was not measured at the time the MCP reported PDSA cycle results due to the MCP allowing sufficient time to receive claims data.

CenCal indicated that the MCP plans to continue to monitor the readmissions rates and encourage providers to perform post-discharge follow-up visits using Transitions of Care worksheets. The MCP also documented plans to initiate an intensified chronic care management program for beneficiaries with the highest risk of readmissions. CenCal indicated it hired a health program nurse and planned to launch the Heart SMART program by July 1, 2015. Lastly, CenCal's administration is evaluating the expansion of incentive payments to allow providers to bill without a code modifier because this process has proven to be difficult.

Annual Monitoring for Patients on Persistent Medications

For the *Annual Monitoring for Patients on Persistent Medications* PDSA cycle, Cen Cal set the SMART Objective as follows:

By March 31, 2015, increase the number of beneficiaries assigned to one large multi-site FQHC who are on ACE inhibitors/ARBs (as per HEDIS specifications for the *Annual Monitoring for Patients on Persistent Medications* sub-measure) who complete the appropriate monitoring test to surpass the 25th percentile of 84.6 [percent] by enlisting the FQHC's call center to reach out to beneficiaries and schedule appointments.

The purpose of the *Annual Monitoring for Patients on Persistent Medications* PDSA cycle was to test if beneficiary outreach performed by the PCP will increase compliance with treatment guidelines for ACE inhibitors/ARBs.

CenCal completed the *Annual Monitoring for Patients on Persistent Medications* PDSA cycle and reported difficulty ascertaining which service completions were directly attributable to the

outreach calls. Of the 121 eligible beneficiaries identified as noncompliant, 25 percent obtained the service during the study period; however, over one third obtained the service prior to the outreach call. CenCal concluded that while the outreach call intervention may have led to the completion of services, it was difficult to isolate the impact of the intervention and interventions already in place. The MCP indicated plans to repeat a call campaign targeting noncompliant beneficiaries.

Strengths

CenCal demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Annual Monitoring for Patients on Persistent Medications* QIPs.

Opportunities for Improvement

Although CenCal will not be continuing the formal QIPs, the MCP should continue to monitor the planned improvement efforts as documented in the *All-Cause Readmissions* PDSA Cycle Worksheet. In addition, the MCP should consider testing the outreach call to improve the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* through additional PDSA cycles.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

CenCal’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for CenCal. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for CenCal

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	24.4%	26.3%	25th–75th	12.2%	9.2%	10th–25th
Diagnosis Code	30.2%	31.6%	25th–75th	40.0%	34.6%	10th–25th
Procedure Code	28.5%	43.8%	75th–90th	32.0%	22.5%	10th–25th
Procedure Code Modifier	52.4%	58.5%	25th–75th	26.8%	46.0%	75th–90th
Rendering Provider Name	NA	25.0%	NA	99.2%	68.1%	>25th–<75th
Billing Provider Name	30.4%	35.0%	25th–75th	12.3%	8.6%	10th–25th

Note: HSAG displayed “NA” when the denominator was less than 30.

Overall, the medical record omission rates for CenCal ranged from 24.4 percent (*Date of Service*) to 52.4 percent (*Procedure Code Modifier*). All five of CenCal’s reported medical record omission rates were better than the respective statewide rates, with the rate for the *Procedure Code* data element 15.3 percentage points better. When compared to the other MCPs’ performance, CenCal’s medical record omission rates were generally similar to the statewide rates, with the exception of a percentile ranking of “75th–90th” received for the *Procedure Code* omission rate. These findings suggest a moderate level of completeness among key encounter data elements when compared to beneficiaries’ medical records. There are some variations between the two counties for CenCal, and medical record omission rates were generally higher for San Luis Obispo County.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., Date of Service).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for CenCal contained additional services which should not have been included for comparison with the medical records.

- ◆ Billing provider names are generally not part of the information included in medical records.
- ◆ For encounter data omissions, CenCal's rates varied from 12.2 percent (Date of Service) to 99.2 percent (Rendering Provider Name). Five of CenCal's encounter data omission rates were worse than the respective statewide rates, with the Rendering Provider Name encounter omission rate being worse than the statewide rate by 31.1 percentage points. However, CenCal performed better than the statewide encounter data omission rate by 19.2 percentage points for the Procedure Code Modifier data element. An opportunity exists for CenCal to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information. At the county level, there were some variations, and encounter data omission rates were generally higher for Santa Barbara County.
- ◆ The most common reasons for encounter data omissions were:
 - ◆ The provider's billing office made a coding error.
 - ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
 - ◆ A deficiency occurred in CenCal's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
 - ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
 - ◆ A lag occurred between the provider's performance of the service and submission of the encounter to CenCal (and/or the data subsequently being submitted to DHCS).
 - ◆ CenCal populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files CenCal submitted to DHCS were not complete or accurate

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for CenCal. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for CenCal

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	84.5%	83.6%	25th–75th	Inaccurate Code (98.7%)
Procedure Code	88.0%	77.6%	75th–90th	NA
Procedure Code Modifier	94.2%	99.5%	<10th	—
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	73.7%	68.6%	25th–75th	NA
All-Element Accuracy	0.0%	4.3%	0–≤25th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be moderately accurate for CenCal, with three of four reported element accuracy rates higher than the respective statewide rates. When comparing performance among the assessed MCPs, *Procedure Code Modifier* received a percentile ranking of “<10th”, *Billing Provider Name* and *Diagnosis Code* received a percentile ranking of “25th–75th”, and *Procedure Code* received a percentile ranking of “75th–90th”. For the *Diagnosis Code* data element, 98.7 percent of the errors were associated with inaccurate codes.

At 0.0 percent, CenCal’s all-element accuracy rate was lower than the statewide rate, with none of the dates of service present in both data sources accurately representing all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for 100 percent of the dates of service reviewed in this study. While all five key data elements contributed to CenCal’s relatively low all-element accuracy rate, the *Rendering Provider Name* data element contributed most to the inaccuracy.

Medical Record Review Recommendations

Based on the study findings for CenCal, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, CenCal should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider

identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.

- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields. CenCal should ensure that the additional diagnosis codes are submitted to DHCS after the system transition.
- ◆ CenCal should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ Out of 266 dates of service identified in the DHCS encounter data, only four of the visits had rendering provider names identifiable from the DHCS data system. CenCal should work with DHCS to investigate the reasons why so few rendering provider names could be identified using DHCS encounter and provider data.
- ◆ CenCal should investigate the reasons for the relatively high medical record omission rates for the Procedure Code Modifier data element and develop strategies to improve rates.
- ◆ CenCal should explore the reasons for the relatively high encounter data omission rates for the Rendering Provider Name and Diagnosis Code data elements and take actions to improve rates.
- ◆ CenCal should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with CenCal.
- ◆ CenCal should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For

example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.

- ◆ The findings for the data elements Billing Provider Name and Rendering Provider Name should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

CenCal's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to PACES. Based on review of CenCal's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist CenCal with improving its encounter data quality. DHCS followed up with CenCal regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:

If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.

If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.
3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:

If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.

If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of CenCal's performance in the three domains of care—quality, access, and timeliness.

Quality

As in previous years, CenCal maintained its quality committee structure, which uses the expertise of staff and practitioners from multiple disciplines to ensure quality care for beneficiaries.

During the MCP's October 2014 medical audit, findings were identified in the areas of Quality Management and Administrative and Organizational Capacity, which could impact the quality of care provided to beneficiaries.

The rates exceeded the HPLs for the following quality measures in Santa Barbara County:

- ◆ *Childhood Immunization Status—Combination 3* (fifth consecutive year)
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* (fifth consecutive year)
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* (fifth consecutive year)
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*

The rates exceeded the HPLs for the following quality measures in San Luis Obispo County:

- ◆ *Use of Imaging Studies for Low Back Pain*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*

The rates improved significantly from RY 2014 to RY 2015 for the following quality measures:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Luis Obispo County, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* in Santa Barbara County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total* in San Luis Obispo and Santa Barbara counties
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total* in Santa Barbara County

The rates for the following quality measures declined from RY 2014 to RY 2015. Although the decline was not statistically significant, the change resulted in the rates moving from above the MPLs in RY 2014 to below the MPLs in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in San Luis Obispo County
- ◆ *Both Medication Management for People with Asthma—Medication Compliance* measures in San Luis Obispo and Santa Barbara counties

In addition to the rates below the MPLs listed above, the rate was below the MPL in San Luis Obispo County for the fourth consecutive year for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure, which falls into the quality domain of care.

For quality measures stratified for the SPD and non-SPD populations, the SPD rates were significantly better than the non-SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures in Santa Barbara County.

The SPD rate was significantly worse than the non-SPD rate in Santa Barbara County for the *All-Cause Readmissions* measure, which falls into the quality domain of care; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of CenCal's QIPs fell into the quality domain of care. Both QIPs progressed to the Outcomes stage, and neither QIP achieved statistically significant improvement over baseline at Remeasurement 1. The MCP also tested a PDSA cycle related to each QIP topic. The *All-Cause Readmissions* PDSA cycle was not successful at achieving the desired outcomes; and although the results for the *Annual Monitoring for Patients on Persistent Medications* PDSA cycle were positive, the MCP could not attribute the successful outcomes to the intervention tested as part of the PDSA cycle.

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

Access

As in previous years, CenCal included access-related goals in its work plan. The MCP's 2014 work plan evaluation document indicated that CenCal met all access goals except one related to the MCP's provider services representatives visiting provider offices. In the evaluation document, CenCal noted that the MCP maintained access levels without an increase in beneficiary complaints, despite the increase in administrative burden for providers based on program changes related to the Affordable Care Act, the SPD population, and Medi-Cal expansion.

During the MCP's October 2014 SPD medical survey and October 2014 medical audit, findings were identified in the areas of Availability and Accessibility of Services, Access and Availability of Care, and Case Management and Coordination of Care, all of which could impact beneficiary access to care.

The rates exceeded the HPLs in Santa Barbara County for the following measures falling into the access domain of care:

- ◆ *Childhood Immunization Status—Combination 3* (fifth consecutive year)
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* (fifth consecutive year)
- ◆ *Prenatal and Postpartum Care—Postpartum Care*

The rates improved significantly from RY 2014 to RY 2015 for the following access measures:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* in Santa Barbara County
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* in Santa Barbara County

The rates declined significantly from RY 2014 to RY 2015 for the following access measures:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in San Luis Obispo and Santa Barbara counties, resulting in the rate for San Luis Obispo County moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* in San Luis Obispo and Santa Barbara counties, resulting in the rate for San Luis Obispo County moving from above the MPL in RY 2014 to below the MPL in RY 2015

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The SPD rates were significantly worse than the non-SPD rates for the following access measures:

- ◆ *All-Cause Readmissions* in Santa Barbara County
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years and 12 to 19 Years* in San Luis Obispo County

As noted above, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners* measures in San Luis Obispo County may be attributed to children and adolescents in the SPD population in the specified age groups relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care providers.

The MCP's *All-Cause Readmissions* QIP fell into the access domain of care. As noted above, the QIP progressed to the Outcomes stage; however, it did not achieve statistically significant improvement at Remeasurement 1, and the PDSA cycle did not meet its goal.

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

Timeliness

As in previous years, HSAG's review of CenCal's quality improvement documents determined that the MCP appears to have an organizational structure that supports the delivery of timely care to beneficiaries. Additionally, the MCP's *Utilization Management Program Description 2015* included details regarding CenCal's processes to ensure timely utilization management decisions.

During the MCP’s October 2014 SPD medical survey and October 2014 medical audit, findings were identified in the areas of Utilization Management and Members’ Rights, which could impact the timeliness of care delivered to beneficiaries.

Five of the required External Accountability Set performance measures fall into the timeliness domain of care. The rates for all five measures in San Luis Obispo County were between the MPLs and HPLs. In Santa Barbara County, the rates were above the HPLs for two of the timeliness measures:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*

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

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with CenCal’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—CenCal’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. To improve the HEDIS audit process:</p> <ul style="list-style-type: none"> a. Implement a formal policy to support the MCP’s new claims audit process. b. Develop methods to obtain and store source documentation for all cases entered into the MCP’s diabetes registry for future use of the documentation. c. Update the MCP’s data security and back-up procedures. d. Implement a thorough review process for DHCS-required rates prior to submission to ensure that the rates accurately reflect the MCP’s performance. 	<p>1.</p> <ul style="list-style-type: none"> a. The <i>Audit Process Protocols</i> document originally created on 3/28/14 was updated on 4/1/15 to describe the new claims audit process in detail. b. CenCal Health presently uses only standard supplemental administrative databases for HEDIS reporting; thus, source documentation is maintained in accordance with industry standards for sampled cases required to demonstrate database reliability. c. CenCal Health’s data security and backup procedures are up-to-date and are being followed in accordance with Hewlett Packard Enterprise Services protocols for business continuity and recovery. d. The MCP has implemented the addition of a review prior to every data submission to confirm that all rates reflect the most current data available for measurement.

2013–14 External Quality Review Recommendation Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>2. Assess the factors leading to the rates for the following measures continuing to be below the MPLs, and determine if current improvement strategies should be discontinued or modified or if new strategies should be implemented to improve outcomes:</p> <ul style="list-style-type: none"> a. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i> for San Luis Obispo County b. <i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i> for Santa Barbara County c. <i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i> for San Luis Obispo County 	<p>2.</p> <ul style="list-style-type: none"> a. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i> (San Luis Obispo County): This measure remains below the 25th percentile. A multidisciplinary team of staff have evaluated the former interventions and revised them with an aim to achieve improved performance. b. <i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i> (Santa Barbara County): The eligible population for this measure is presently too small to reliably report. The measure result is not statistically significant. c. <i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i> (San Luis Obispo County): Performance for this aspect of care and measurement is near the NCQA 75th percentile for Medicaid plans. Previous interventions have been continued to further improve performance.
<p>3. Assess the factors leading to the rate for the <i>Controlling High Blood Pressure</i> measure for San Luis Obispo County declining significantly from 2013 to 2014 to prevent further decline in the measure’s rate.</p>	<p>This aspect of care and measure result have improved significantly since 2014, with the rate now at 59.9%. The decline noted from 2013 to 2014 has not been sustained.</p>
<p>4. Assess if the MCP needs to implement new strategies to ensure that the needs of the SPD population are being met.</p>	<p>Measurements suggest that quality of care is higher for the SPD subpopulation of membership, with higher utilization expected for the SPD segment of membership with generally greater health care risks and needs. Access for pediatric members categorized as SPD is lower in San Luis Obispo County, and CenCal Health continues efforts to increase utilization for both SPD and non-SPD pediatric members in that county.</p>
<p>5. Implement strategies, including referencing the QIP Completion Instructions and previous QIP validation tools, to ensure that all required documentation is included in the QIP Summary Form.</p>	<p>CenCal Health implemented strategies to ensure all required documentation is included in the QIP Summary Form. QIPs submitted in the recent period have been fully accepted by HSAG without further revision.</p>

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 declining or poor performance and implement strategies to prevent further decline in performance or improve performance on the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in San Luis Obispo County
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in San Luis Obispo County
 - *Both Medication Management for People with Asthma—Medication Compliance* measures in San Luis Obispo and Santa Barbara counties
 - *Children and Adolescents' Access to Primary Care* measures (While DHCS does not hold MCPs accountable to meet the MPLs, the MCP should assess the reasons for the rates declining significantly from RY 2014 to RY 2015 for the *12 to 24 Months* and *25 Months to 6 Years* measures in San Luis Obispo and Santa Barbara counties and the rates for both measures being below the MPLs in San Luis Obispo County and implement strategies to improve performance.)
- ◆ Assess the factors leading to the significantly higher rate of hospital readmissions for the SPD population in Santa Barbara County to ensure that the MCP is meeting the needs of this population.
- ◆ Although CenCal will not be continuing the formal QIPs, the MCP should:
 - Continue to monitor the planned improvement efforts as documented in the *All-Cause Readmissions* PDSA cycle.
 - Consider testing the outreach call through additional PDSA cycles to improve the rate for *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review 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.

Medi-Cal Managed Care Technical Report

**Appendix I:
Performance Evaluation Report
Central California Alliance for Health
July 1, 2014 – June 30, 2015**

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Appendix I: Performance Evaluation Report Central California Alliance for Health July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Central California Alliance for Health (“CCAH” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

CCAH is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a County Organized Health System (COHS).

CCAH became operational to provide MCMC services in Santa Cruz County in January 1996, in Monterey County in October 1999, and in Merced County in October 2009. As of June 30, 2015, CCAH had 121,805 beneficiaries in Merced County, 143,607 in Monterey County, and 66,144 in Santa Cruz County—for a total of 331,556 beneficiaries.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: November 10, 2015.

1115 Waiver Seniors and Persons with Disabilities Enrollment Survey

The Department of Managed Health Care (DMHC) conducted an 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey (hereafter referred to as “SPD medical survey”) for CCAH September 8, 2014, through September 11, 2014, covering the review period of January 1, 2014, through May 31, 2014. DHCS assessed the following areas related to CCAH’s delivery of care to the SPD population:

- ◆ Utilization Management
- ◆ Continuity of Care
- ◆ Availability and Accessibility of Services
- ◆ Member Rights
- ◆ Quality Management

DMHC issued a report to DHCS April 27, 2015. In the report, DMHC indicated that it had identified potential deficiencies in all areas except Continuity of Care. Additionally, DMHC summarized policies and procedures CCAH has instituted to support the MCP’s SPD population. CCAH’s follow-up to the SPD medical survey occurred outside the review period for this report. HSAG will summarize the follow-up information in CCAH’s 2015–16 MCP-specific evaluation report.

Medical and State Supported Services Audit

DHCS conducted two audits in tandem—a medical audit and a State Supported Services audit—of CCAH September 8, 2014, through September 19, 2014, covering the review period of June 1, 2013, through May 31, 2014. DHCS assessed the following areas:

- ◆ Compliance with State Supported Services contract and regulations
- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Members’ Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

DHCS issued two reports on March 5, 2015—one for the medical audit and one for the State Supported Services audit. In the reports, DHCS identified findings and made recommendations for all areas reviewed under the scope of the audit.

Documentation provided to HSAG by DHCS dated April 20, 2015, indicated that CCAH provided the required documentation regarding the deficiency identified during the State Supported Services audit and that DHCS had; therefore, closed the deficiency.

In a letter dated August 19, 2015, DHCS indicated that on August 6, 2015, CCAH submitted to DHCS the MCP's most recent response regarding the remaining open items from the corrective action plan (CAP) for the medical audit originally issued on March 16, 2015. The letter indicated that DHCS provisionally closed 12 deficiencies. Additionally, the letter indicated that DHCS reviewed all other items and found them to be in compliance. Therefore, DHCS closed the CAP. Note: Although the August 19, 2015, letter is outside the review dates of this report, HSAG included the information since it was available and indicated that the MCP had resolved all findings from the September 2014 medical audit.

Strengths

During CCAH's September 2014 SPD medical survey, DMHC identified no findings in the area of Continuity of Care. Additionally, DMHC identified several processes that the MCP is implementing to support the needs of the SPD population. Finally, CCAH resolved the deficiencies which DHCS identified during the September 2014 medical and State Supported Services audits.

Opportunities for Improvement

CCAHA has the opportunity to fully resolve all findings from the MCP's most recent SPD medical survey. The findings span all domains of care—quality, access, and timeliness.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Central California Alliance for Health* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that CCAH followed the appropriate specifications to produce valid rates; however, the auditor identified one issue of concern that caused minimal impact on measure reporting. During the on-site audit, the auditor noted an issue with provider billing/coding that was impacting the *Prenatal and Postpartum Care* measure. CCAH was provided a workaround, which appeared to remedy the issue.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 and Table 3.2 for CCAH's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1 and Table 3.2

The reader should note the following regarding Table 3.1 and Table 3.2:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).

- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
 CCAH—Merced County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	12.73%	12.78%	18.49%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	49.09	53.69	52.70	50.58	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	320.62	324.06	321.41	297.12	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	86.41%	87.14%	86.87%	87.32%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	NA	83.33%	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	87.31%	86.97%	86.43%	84.93%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	11.61%	16.23%	18.62%	25.14%	↑
Cervical Cancer Screening	Q,A	—	—	65.63%	64.96%	↔
Childhood Immunization Status—Combination 3	Q,A,T	64.72%	64.74%	68.68%	67.88%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	96.92%	97.42%	97.63%	95.28%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	91.25%	90.39%	91.65%	89.48%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	89.54%	89.82%	90.31%	90.80%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	87.63%	90.19%	88.46%	88.98%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	64.48%	64.96%	62.53%	66.18%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	56.20%	54.74%	53.53%	52.31%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	87.83%	84.91%	83.94%	86.37%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	51.34%	46.72%	44.28%	45.99%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	82.48%	84.91%	81.27%	84.91%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	37.23%	45.99%	45.74%	43.80%	↔
Controlling High Blood Pressure	Q	—	52.80%	53.66%	62.04%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	50.12%	55.96%	64.86%	62.04%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	48.30%	54.14%	50.53%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	26.16%	29.04%	26.98%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	59.61%	58.79%	60.35%	57.91%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	85.40%	83.92%	82.79%	83.45%	↔
Use of Imaging Studies for Low Back Pain	Q	84.15%	79.33%	82.49%	78.62%	↓

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	58.88%	77.62%	82.24%	85.40%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	64.23%	66.91%	68.13%	66.91%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	44.28%	44.77%	43.07%	47.20%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	72.51%	74.33%	76.32%	73.97%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.2—Multi-Year Performance Measure Results*
 CCAH—Monterey/Santa Cruz Counties**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	12.06%	11.58%	14.30%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	51.95	52.10	46.64	45.17	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	320.58	318.74	303.75	290.72	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	88.31%	85.86%	87.34%	88.16%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	87.93%	89.47%	87.76%	50.00%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	88.95%	85.58%	87.02%	88.70%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	27.95%	22.27%	28.07%	25.24%	↔
Cervical Cancer Screening	Q,A	—	—	72.22%	65.45%	↓
Childhood Immunization Status—Combination 3	Q,A,T	84.18%	83.84%	82.48%	77.62%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	97.42%	98.49%	98.31%	95.99%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	91.05%	91.29%	92.11%	90.19%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	89.57%	90.89%	93.18%	92.44%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	88.93%	91.00%	90.94%	89.95%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	76.64%	71.05%	75.18%	67.40%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	67.40%	63.02%	56.45%	59.85%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	91.97%	87.35%	86.86%	87.83%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	61.80%	51.09%	51.82%	46.96%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	79.81%	79.32%	79.32%	82.00%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	28.22%	36.98%	38.20%	43.80%	↔
Controlling High Blood Pressure	Q	—	55.96%	59.46%	64.72%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	63.99%	77.60%	80.29%	78.10%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	49.96%	52.98%	54.49%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	24.42%	30.21%	27.53%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	77.62%	70.27%	69.83%	70.07%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	86.13%	81.76%	93.10%	86.13%	↓

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	85.12%	88.00%	85.20%	86.47%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	79.08%	81.89%	81.02%	86.86%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	80.29%	81.63%	78.59%	78.35%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	61.31%	66.58%	65.21%	65.21%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	83.21%	82.08%	80.29%	81.27%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.3 through Table 3.6 present a summary of the RY 2015 SPD measure results reported by CCAH. Table 3.3 and Table 3.4 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.3—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CCAH—Merced County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	14.39%	22.57%	▼	18.49%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.14%	88.89%	↔	87.32%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.73%	86.44%	↔	84.93%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	95.35%	NA	Not Comparable	95.28%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	89.46%	90.30%	↔	89.48%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	90.67%	93.41%	↔	90.80%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	89.23%	84.97%	↓	88.98%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

⁴ HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD Compared to Non-SPD” column in Table 3.3 and Table 3.4.

Table 3.4—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CCAH—Monterey/Santa Cruz Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	11.32%	17.51%	▼	14.30%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.21%	91.91%	↑	88.16%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	45.71%	Not Comparable	50.00%
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.83%	91.83%	↑	88.70%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.05%	84.38%	↓	95.99%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.14%	93.44%	↑	90.19%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	92.42%	93.24%	↔	92.44%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	89.98%	89.19%	↔	89.95%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the All-Cause Readmissions measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly higher SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly lower SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A Not Applicable audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.5—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures CCAH—Merced County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
280.19	48.28	509.74	79.54

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

**Table 3.6—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
CCAH—Monterey/Santa Cruz Counties**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
275.69	43.18	520.95	75.65

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

Table 3.7 and Table 3.8 present the three-year trending information for the SPD population, and Table 3.9 and Table 3.10 present the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.7—RY 2015 (MY 2014) HEDIS SPD Trend Table
CCAH—Merced County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	14.40%	15.78%	22.57%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	75.54	76.83	79.54	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	536.12	539.90	509.74	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.83%	90.10%	88.89%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.28%	91.17%	86.44%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	90.32%	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.17%	91.03%	90.30%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.89%	94.07%	93.41%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.74%	86.86%	84.97%	↔

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

NA = A Not Applicable audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the All-Cause Readmissions measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant decline in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant improvement in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.8—RY 2015 (MY 2014) HEDIS SPD Trend Table
 CCAH—Monterey/Santa Cruz Counties**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	14.47%	13.89%	17.51%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	79.25	74.76	75.65	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	543.55	549.69	520.95	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.32%	89.63%	91.91%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	89.13%	87.80%	45.71%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.86%	90.06%	91.83%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.67%	NA	84.38%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	92.76%	95.29%	93.44%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	91.46%	92.34%	93.24%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	88.47%	87.52%	89.19%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.9—RY 2015 (MY 2014) Non-SPD Trend Table
 CCAH—Merced County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.86%	8.00%	14.39%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	51.12	50.05	48.28	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	299.06	297.38	280.19	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.26%	82.92%	86.14%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.96%	79.91%	83.73%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	97.51%	97.66%	95.35%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	90.37%	91.67%	89.46%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	89.76%	90.11%	90.67%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	90.30%	88.58%	89.23%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.10—RY 2015 (MY 2014) Non-SPD Trend Table
 CCAH—Monterey/Santa Cruz Counties**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.78%	7.69%	11.32%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	49.10	44.17	43.18	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	293.93	282.10	275.69	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.15%	83.28%	85.21%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.84%	80.85%	85.83%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.50%	98.32%	96.05%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.26%	92.06%	90.14%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.86%	93.21%	92.42%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	91.17%	91.08%	89.98%	↓

* Member months are a member’s “contribution” to the total yearly membership.

NA = A Not Applicable audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the All-Cause Readmissions measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant decline in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant improvement in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rates for the following measures were above the HPLs for at least the third consecutive year:

- ◆ *Use of Imaging Studies for Low Back Pain* in Monterey/Santa Cruz counties
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in Merced County and Monterey/Santa Cruz counties
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* in Monterey/Santa Cruz counties

The rates for the following measures improved significantly from RY 2014 to RY 2015:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Merced County
- ◆ *Controlling High Blood Pressure* in Merced County

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total* in Monterey/Santa Cruz counties

The rates for the following measures were below the MPLs in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Merced County
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in Merced County

The rates for the following measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions* in Merced County and Monterey/Santa Cruz counties
- ◆ *Cervical Cancer Screening* in Monterey/Santa Cruz counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in Merced County and Monterey/Santa Cruz counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* in Merced County and Monterey/Santa Cruz counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* in Monterey/Santa Cruz counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in Monterey/Santa Cruz counties
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg* in Monterey/Santa Cruz counties
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Monterey/Santa Cruz counties
- ◆ *Use of Imaging Studies for Low Back Pain* in Merced County

Seniors and Persons with Disabilities Findings

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

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*

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

- ◆ *All-Cause Readmissions* in Merced County and Monterey/Santa Cruz counties

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in Monterey/Santa Cruz counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in Merced County

Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rates for the two *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population in the specified age groups relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Across all measures stratified for the SPD and non-SPD populations, the following variations were noted:

- ◆ The RY 2015 SPD rates and non-SPD rates were significantly worse than the RY 2014 SPD rates and non-SPD rates for Merced County and Monterey/Santa Cruz counties for the *All-Cause Readmissions* measure.
- ◆ The SPD rate declined significantly from RY 2014 to RY 2015 for Merced County for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure.
- ◆ The non-SPD rate for Monterey/Santa Cruz counties for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure was significantly better in RY 2015 when compared to RY 2014.
- ◆ The non-SPD rates declined significantly from RY 2014 to RY 2015 for Monterey/Santa Cruz counties for all four *Children and Adolescents' Access to Primary Care Practitioners* measures, and the non-SPD rates declined significantly from RY 2014 to RY 2015 for Merced County for the *12 to 24 Months* and *25 Months to 6 Years* measures.

Assessment of Improvement Plans

Based on RY 2014 rates, CCAH initially submitted an improvement plan (IP) for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure for Merced County. After the MCP submitted the initial IP information to DHCS, the MCP was informed that DHCS was no longer requiring MCPs to submit IPs and subsequent Plan-Do-Study-Act (PDSA) cycles for this measure. CCAH therefore discontinued the IP.

Required Improvement Plans for RY 2015

Based on DHCS requirements and CCAH's performance in RY 2015, the MCP will be required to submit an IP for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure for Merced County.

Strengths

CCAH followed the appropriate specifications to produce valid rates. Four rates were above the HPLs in RY 2015, and the rates for three measures improved significantly from RY 2014 to RY 2015.

CCAH provided documentation of actions the MCP has taken to ensure that the MCP is meeting the needs of the SPD population (See Table 6.1). Specifically, the CCAH described improvements to the MCP's Care Transitions program to reduce hospital readmissions for the SPD population. Additionally, CCAH described beneficiary outreach and provider incentive activities designed to improve the rates of children and adolescents attending their primary care practitioner appointments.

Opportunities for Improvement

CCAH has the opportunity to assess the factors causing the rates for 12 measures declining significantly from RY 2014 to RY 2015 and the rates for two measures being below the MPLs in RY 2015 and to implement strategies to improve performance on the measures.

Quality Improvement Project Objectives

CCAH participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists CCAH'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, and timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for CCAH
July 1, 2014, through June 30, 2015**

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

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

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

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
 CCAH—Merced and Monterey/Santa Cruz Counties
 July 1, 2014, through June 30, 2015**

Name of Project/Study	Counties	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>	Merced	Annual Submission	88%	100%	<i>Met</i>
	Monterey/ Santa Cruz	Annual Submission	92%	100%	<i>Met</i>
Internal QIPs					
<i>Improving Asthma Health Outcomes</i>	Merced	Annual Submission	85%	100%	<i>Met</i>
	Monterey/ Santa Cruz	Annual Submission	93%	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, 2014, through June 30, 2015, showed that both CCAH’s annual submissions of its *All-Cause Readmissions* and *Improving Asthma Health Outcomes* QIPs received a *Met* validation status in all counties, with 100 percent of the critical evaluation elements receiving a *Met* score.

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

**Table 4.3—Quality Improvement Project Average Rates*
 CCAH—Merced and Monterey/Santa Cruz Counties
 (Number = 4 QIP Submissions, 2 QIP Topics)
 July 1, 2014, through June 30, 2015**

QIP Study Stages	Activity	<i>Met</i> Elements	<i>Partially Met</i> Elements	<i>Not Met</i> Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		100%	0%	0%

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Implementation	VII: Sufficient Data Analysis and Interpretation	97%	3%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		98%	2%	0%
Outcomes	IX: Real Improvement Achieved**	38%	19%	44%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total**		38%	19%	44%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for both CCAH’s *All-Cause Readmissions* and *Improving Asthma Health Outcomes* QIP annual submissions.

CCAH demonstrated an excellent application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP demonstrated a strong application of the Implementation stage, meeting 98 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *Improving Asthma Health Outcomes* QIP, CCAH reported an incorrect rate for Study Indicator 3 in Merced County, resulting in slightly lowered score for Activity VII.

Both QIPs progressed to the Outcomes stage during the reporting period. However, CCAH received a low score for Activity IX because most study indicators for both QIPs did not achieve statistically significant improvement over baseline. Only Study Indicator 1 for the *Improving Asthma Health Outcomes* QIP in Merced County achieved statistically significant improvement over baseline. While all study indicators for the *Improving Asthma Health Outcomes* QIP in Monterey/Santa Cruz demonstrated improvement, the change was not statistically significant. In addition, while the *All-Cause Readmissions* QIP demonstrated a decline in the readmissions rate in Monterey/Santa Cruz counties, the change was not statistically significant. Activity X was not assessed since sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for CCAH—
Merced and Monterey/Santa Cruz Counties
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions			
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]			
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement[‡]
Merced	12.7%	12.8%	‡
Monterey/Santa Cruz	12.1%	11.6%	‡
QIP #2—Improving Asthma Health Outcomes			
Study Indicator 1: The percentage of members, ages 5–64, who remained on an asthma controller medication for at least 50 percent of their treatment period			
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement[‡]
Merced	48.3%	54.1%*	‡
Monterey/Santa Cruz	50.0%	53.0%	‡
Study Indicator 2: The percentage of members with one or more ER admissions for asthma (ICD-9 dx 493.xx) [^]			
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement[‡]
Merced	13.5%	15.5%	‡
Monterey/Santa Cruz	13.2%	11.5%	‡
Study Indicator 3: The percentage of members with one or more inpatient admissions with a diagnosis of asthma (ICD-9 dx 493.xx) [^]			
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement[‡]
Merced	0.9%	1.0%	‡
Monterey/Santa Cruz	1.2%	0.9%	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement from the baseline period (*p* value < 0.05).

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

All-Cause Readmissions QIP

CCA’s goal for the *All-Cause Readmissions* QIP was to achieve a statistically significant decline in readmissions rates from baseline to Remeasurement 1 in each county. Unfortunately, for all counties, the MCP did not meet the project’s goal. Although the readmissions rate declined in Monterey/Santa Cruz counties, the change was not statistically significant. A review of the MCP’s QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ The readmissions rates remained statistically unchanged for both SPD and non-SPD populations during Remeasurement 1.
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions CCAH indicated it implemented during the Remeasurement 1 time period:
 - Alliance Telephonic Care Transitions Program: Care coordinators conducted post-discharge telephonic assessment with all beneficiaries in Santa Cruz and Merced counties who had a diagnosis of heart failure, myocardial infarction, diabetes, asthma, or pneumonia. An initial call was made within three days of discharge, which included verification of a primary care provider (PCP) follow-up appointment within 14 days after discharge, medication inventory, an advance care plan, and a beneficiary satisfaction survey. Additional telephone care coordination was provided up to 30 days post discharge.
 - Discharge Follow-up Program: Care coordinators conducted post-discharge telephonic assessment with all beneficiaries in Santa Cruz and Merced counties who did not meet criteria for the Alliance Telephonic Care Transition Program and had been identified as needing discharge follow-ups.
 - Provider Fax Notification: Concurrent review nurses faxed admission notifications to PCPs upon beneficiaries' inpatient admissions.

Improving Asthma Health Outcomes QIP

CCAH's goal for the *Improving Asthma Health Outcomes* QIP was to increase the rate for Study Indicator 1 by 5 percentage points, decrease the rate for Study Indicator 2 by 2 percentage points, and decrease the rate for Study Indicator 3 by 2.44 percentage points from baseline to Remeasurement 1 in each county. CCAH met the project's goal for Study Indicator 1 in Merced County and Study Indicator 3 in Monterey/Santa Cruz counties. In addition, Study Indicator 1 in Merced County achieved statistically significant improvement. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ The QIP was successful in improving the rates in both counties for Study Indicator 1, *Medication Management for People with Asthma—Medication Compliance 50% Total*; however, the change was not statistically significant.
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions CCAH indicated it implemented during the Remeasurement 1 time period:
 - Conducted provider education on the Asthma Action Plan at provider workshops and site visits as well as through the provider bulletin.
 - Enhanced the MCP's Healthy Breathing for Life monthly report available to PCPs on the Provider Portal to include the Asthma Action Plan indicator. The indicator provides an

opportunity for the PCP to complete the Asthma Action Plan with the beneficiary the next time the beneficiary has a PCP appointment.

- Revised the MCP's work flow to have the health educators review and approve beneficiaries' asthma action plans.
- Created an electronic printable version of the Asthma Action Plan for providers to complete electronically for better legibility.
- Added a three-month follow-up call to Healthy Breathing for Life beneficiaries to allow for extended continuity of care.

Strengths

CCAH demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Improving Asthma Health Outcomes* QIPs. The MCP also demonstrated a strong application of the Implementation stage, meeting 98 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. Both QIPs achieved a *Met* validation status on the first submission. The *Improving Asthma Health Outcomes* QIP achieved statistically significant improvement for Study Indicator 1 for Merced County.

Opportunities for Improvement

Although CCAH will not be continuing the formal QIPs, the MCP should continue to monitor whether or not the Alliance Telephonic Care Transitions Program and the Discharge Follow-up Program impact the *All-Cause Readmissions* rates. In addition, the MCP should continue to assess if the utilization of the Asthma Action Plans impacts the health outcomes of Medi-Cal beneficiaries living with asthma.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

CCAH’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for CCAH. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for CCAH

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	9.1%	26.3%	≥90th	7.2%	9.2%	25th–75th
Diagnosis Code	13.8%	31.6%	≥90th	32.3%	34.6%	25th–75th
Procedure Code	16.2%	43.8%	≥90th	19.9%	22.5%	25th–75th
Procedure Code Modifier	26.6%	58.5%	≥90th	26.6%	46.0%	75th–90th
Rendering Provider Name	NA	25.0%	NA	96.8%	68.1%	>25th–<75th
Billing Provider Name	19.0%	35.0%	≥90th	8.0%	8.6%	25th–75th

Note: HSAG displayed “NA” when the denominator was less than 30.

Overall, the medical record omission rates for CCAH ranged from 9.1 percent (*Date of Service*) to 26.6 percent (*Procedure Code Modifier*). All five of CCAH’s reportable medical record omission rates were better than the respective statewide rates by more than 16 percentage points each. When compared to other MCPs’ performance, CCAH received a percentile ranking of “≥90th” for all five reported medical record omission rates. These findings suggest a relatively high level of completeness among key encounter data elements when compared to beneficiaries’ medical records. At the county level, some variations existed (i.e., the rate difference for each data element among CCAH’s three counties was no more than 11 percentage points).

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for CCAH contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, CCAH's rates varied from 7.2 percent (*Date of Service*) to 96.8 percent (*Rendering Provider Name*). Five of CCAH's encounter data omission rates were better than the respective statewide rates with the *Procedure Code Modifier* encounter omission rate being better than the statewide rate by 19.4 percentage points (75th–90th percentile). However, CCAH performed worse than the statewide encounter data omission rate by 28.7 percentage points for the *Rendering Provider Name* data element. An opportunity exists for CCAH to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information. At the county level, some variations existed (i.e., the rate difference for each data element among CCAH's three counties was less than 11 percentage points).

The most common reasons for encounter data omissions were:

- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in CCAH's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to CCAH (and/or the data subsequently being submitted to DHCS).
- ◆ CCAH populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files CCAH submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for CCAH. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for CCAH

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	87.1%	83.6%	25th–75th	Inaccurate Code (88.6%)
Procedure Code	83.7%	77.6%	25th–75th	Higher level of Services in Medical Records (45.4%); Lower level of Services in Medical Records (45.1%);
Procedure Code Modifier	97.7%	99.5%	25th–75th	—
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	73.2%	68.6%	25th–75th	Incorrect Names (97.8%)
All-Element Accuracy	1.0%	4.3%	>25th–<75th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be moderately accurate for CCAH—with three of four reported element accuracy rates higher than the respective statewide rates. When comparing CCAH’s performance among the assessed MCPs, all four reported key data elements received a percentile ranking of “25th–75th”. For the *Diagnosis Code* data element, 88.6 percent of diagnosis-related errors involved discrepancies in the use of certain codes compared to national coding standards rather than specificity errors. For the *Procedure Code* data element, 45.4 percent of identified errors were associated with lower-level procedure codes having been documented in the DHCS encounter data than were documented in the medical records; and 45.1 percent of the errors were associated with higher-level procedure codes having been documented in the DHCS encounter data than were documented in the medical records. The majority of billing provider name errors were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records.

CCAHA’s all-element accuracy rate was lower than the statewide rate. Only 1 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for 99 percent of the dates of service reviewed in this study. While all five key data elements contributed to CCAH’s relatively low all-element accuracy rate, the *Rendering Provider Name* data element contributed most.

Medical Record Review Recommendations

Based on the study findings for CCAH, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, CCAH should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields. CCAH should ensure that the additional diagnosis codes are submitted to DHCS after the system transition.
- ◆ CCAH should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ Out of 422 dates of service identified in the DHCS encounter data, only 12 of the visits had rendering provider names identifiable from the DHCS data system. CCAH should work with DHCS to investigate the reasons why so few rendering provider names could be identified using DHCS encounter and provider data.
- ◆ CCAH should explore the reasons for the relatively high encounter data omission rates for the *Rendering Provider Name* and *Diagnosis Code* data elements and take actions to improve rates.
- ◆ CCAH should investigate the reasons for the relatively low element accuracy rate for the *Billing Provider Name* data element and develop strategies to improve rates.
- ◆ CCAH should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with CCAH.
- ◆ CCAH should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP’s Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

CCAH’s SFY 2014–15 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the EDV study, which assessed the MCP’s operational and infrastructure changes in support of DHCS’s transition to PACES. Based on review of CCAH’s Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist CCAH with improving its encounter data quality. DHCS followed up with CCAH regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of CCAH's performance in the three domains of care—quality, access, and timeliness.

Quality

As part of the process for producing this report, DHCS provided available quality documents to HSAG for review. For CCAH, DHCS provided the MCP's *2014 Quality Improvement Work Plan and Evaluation* and *2015 Quality Improvement Work Plan and Evaluation* documents. For both years, CCAH included work plan goals designed to improve the quality of care delivered to beneficiaries and, for 2014, reported accomplishments related to goals in addition to challenges and next steps.

DHCS identified findings in almost all areas reviewed during CCAH's September 2014 SPD medical survey and 2014 medical and State Supported Services audit. The findings in the areas of

Quality Management and Administrative and Organizational Capacity could impact the quality of care delivered to beneficiaries.

The rates for the following quality measures were above the HPLs for at least the third consecutive year:

- ◆ *Use of Imaging Studies for Low Back Pain* in Monterey/Santa Cruz counties
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in Merced County and Monterey/Santa Cruz counties
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* in Monterey/Santa Cruz counties

The rates for the following quality measures improved significantly from RY 2014 to RY 2015:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Merced County
- ◆ *Controlling High Blood Pressure* in Merced County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in Monterey/Santa Cruz counties

The rate for Merced County for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure, which falls into the quality domain of care, was below the MPL in RY 2015.

The rates for the following quality measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions* in Merced County and Monterey/Santa Cruz counties
- ◆ *Cervical Cancer Screening* in Monterey/Santa Cruz counties
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Monterey/Santa Cruz counties
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Monterey/Santa Cruz counties
- ◆ *Use of Imaging Studies for Low Back Pain* in Merced County

For quality measures stratified by the SPD and non-SPD populations, the SPD rates in Monterey/Santa Cruz counties for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures were significantly better than the non-SPD. The SPD rates for Merced County and Monterey/Santa Cruz counties for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate; however, the higher readmissions rate for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of CCAH's QIPs fell into the quality domain of care. Only Study Indicator 1 in Merced County measuring the percentage of beneficiaries ages 5–64 who remained on an asthma controller medication for at least 50 percent of their treatment for the *Improving Asthma Health Outcomes* QIP achieved statistically significant improvement over baseline at Remeasurement 1. No other study indicators achieved statistically significant improvement over baseline.

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

Access

CCAH's 2014 *Quality Improvement Work Plan and Evaluation* and 2015 *Quality Improvement Work Plan and Evaluation* documents included access-related goals. The 2014 document described accomplishments related to goals in addition to challenges and next steps.

DHCS identified findings in almost all areas reviewed during CCAH's September 2014 SPD medical survey and 2014 medical and State Supported Services audit. Findings that could affect beneficiary access to care were in the areas of Availability and Accessibility of Services, Access and Availability of Care, and Case Management and Coordination of Care.

The rate in Merced County for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measure, which falls into the access domain of care, was below the MPL in RY 2015.

The rates for the following access measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions* in Merced County and Monterey/Santa Cruz counties
- ◆ *Cervical Cancer Screening* in Monterey/Santa Cruz counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in Merced County and Monterey/Santa Cruz counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* in Merced County and Monterey/Santa Cruz counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* in Monterey/Santa Cruz counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in Monterey/Santa Cruz counties
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Monterey/Santa Cruz counties

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The SPD rate in Monterey/Santa Cruz counties for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure was significantly better than the non-SPD

rate, and the SPD rates for the following measures were significantly worse than the non-SPD rates:

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

As previously noted, the higher readmissions rates for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rates for the two *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population in the specified age groups relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Both of CCAH's QIPs fell into the access domain of care. As noted above, only Study Indicator 1 in Merced County for the *Improving Asthma Health Outcomes* QIP achieved statistically significant over baseline at Remeasurement 1. No other study indicators achieved statistically significant improvement over baseline.

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

Timeliness

The quality documents provided to HSAG as part of the process for producing this report did not include information that would allow HSAG to assess whether the MCP's quality improvement program includes processes to ensure the delivery of timely care to beneficiaries.

DHCS identified findings in almost all areas reviewed during CCAH's September 2014 SPD medical survey and 2014 medical and State Supported Services audit. Findings that could affect timeliness of care were in the areas of Utilization Management and Members' Rights.

The rates for all timeliness measures were between the MPLs and HPLs. The rate in Monterey/Santa Cruz counties for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure, which falls into the timeliness domain of care, declined significantly from RY 2014 to RY 2015.

Overall, CCAH 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with CCAH’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—CCAH’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
1. Explore ways to capture rendering provider/specialist information to reduce the burden on medical record review during the HEDIS audit process.	The Alliance began the process of a core business system conversion in 2014, with an implementation date of early 2016. The new system will allow for capture and cross checking of rendering providers/specialists.
2. Assess the factors leading to the rate for the <i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i> measure for Merced County being below the MPL, and identify strategies to improve the measure’s rate.	CCAH found that a small number (10) of Merced County providers with the largest number of noncompliant members led to the low rate for <i>Annual Monitoring for Patients on Persistent Medication—Digoxin</i> . In August 2014, CCAH sent a memo to these providers indicating that our records did not show compliance with annual monitoring for the prescribed persistent medication. Our request included the member’s name, date of birth, and the required lab test for ACE/ARB or digoxin or diuretics as prescribed per individual member. In addition, information on appropriate lab monitoring for digoxin was included in the September 2014 Provider Bulletin.
3. Assess the factors leading to the rate for the <i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i> measure declining significantly from 2013 to 2014, and identify strategies to prevent further decline on the rate.	<p><i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i> for Santa Cruz/Monterey region rates were reported at 91.00 percent (HEDIS 2013), 90.94 percent (HEDIS 2014), and 89.95 percent (HEDIS 2015)—statistically unchanged through this time. In Merced, rates were reported at 90.19 percent (HEDIS 2013); 88.46 percent (HEDIS 2014)—a significant decrease; and then, most recently, at 88.98 percent (HEDIS 2015). Chi-square (Yates corrected) indicated no statistically significant change for Merced County from HEDIS 2014 to 2015.</p> <p>The Alliance continues to outreach to members with annual well-child visit reminder letters for adolescents 12 through 19 years of age. In addition, the Care Based Incentive program incentivizes providers for the well-adolescent visits for members 12 through 21 years of age. A monthly list of noncompliant members is available to each provider on the provider portal.</p> <p>Furthermore, due to a low rate for the <i>Immunization for Adolescents (IMA)</i> in Merced County, a recent mailing (June 2015) was completed to the families of members (including Santa Cruz and Monterey) who</p>

2013–14 External Quality Review Recommendation Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>are 12 years of age now and who do not have evidence of one or more of the following: a well-adolescent visit or a Tdap or MCV vaccine dosing to date. To complement the letters, 500 members were randomly selected to also receive phone calls with a similar message for ongoing intervention and promotion of the patient-centered medical home.</p>
<p>4. Assess actions already taken to determine if and which efforts are making a positive impact to ensure the MCP is meeting the SPD population’s needs, since four SPD rates continued to be significantly worse than the non-SPD rates.</p>	<p>There is an ongoing Readmission Workgroup that develops strategies and implements improvements to reduce readmission across all counties. As part of the effort to improve the work flow, on June 11, 2015, Care Transitions and Care Management implemented a change to our Care Transitions program. All members, including SPD members with three admissions in six months are referred to Complex Case Management for continued intervention. Prior to this, they were only sent to the Complex Case Management program if they had continued needs. For the <i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i> for Monterey/Santa Cruz counties, the Alliance continues to outreach to members with annual well-child visit reminder letters. In addition, the Care Based Incentive program incentivizes providers for the well-adolescent visits for members 12 through 21 years of age. A monthly list of noncompliant members is available to each provider on the provider portal. For <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> for Merced County, reminder letters were sent out to diabetic members to complete the screenings and promote healthy behaviors. The Chronic Disease Self-Management program was offered to diabetes members for goal setting, healthy eating, and managing their health through peer-to-peer support. In addition, a provider and member incentive is offered which promotes diabetes screening and self-management.</p>
<p>5. Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.</p>	<p>The QIP for asthma and readmissions achieved an overall validation status of <i>Met</i> in the most recent submissions without the need for a resubmission. A timeline was developed to ensure timely submission of the QIP and to reference the QIP Completion Instructions and validation tools prior to submission. The <i>Asthma</i> QIP due for submission in August 2015 is in draft form and ready for review before its final submission. The <i>Asthma</i> QIP metrics have been continuously monitored on a quarterly basis and documented on the work plan. The results were discussed at the Asthma Performance Improvement meetings held on a monthly basis to allow feedback for root causes of the results. In addition to the QIP metrics, process measures (rates of asthma education and Asthma Action Plan submission) are also reviewed on a quarterly basis.</p>

Recommendations

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

- ◆ Fully resolve all findings from the MCP's September 2014 SPD medical survey.
- ◆ Assess the factors causing the rates for 12 measures declining significantly from RY 2014 to RY 2015 and the rates for two measures being below the MPLs in RY 2015, and implement strategies to improve performance on the measures. Although improved performance is important for all measures, CCAH may want to consider initially focusing on measures for which DHCS holds MCPs accountable to meet the MPLs:
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Merced County
 - *Cervical Cancer Screening* in Monterey/Santa Cruz counties
 - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Monterey/Santa Cruz counties
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Monterey/Santa Cruz counties
 - *Use of Imaging Studies for Low Back Pain* in Merced County
- ◆ Although CCAH will not be continuing the formal QIPs, the MCP should:
 - Continue to monitor whether or not the Alliance Telephonic Care Transitions Program and the Discharge Follow-up Program impact the *All-Cause Readmissions* rates.
 - Consider assessing if adopting the use of the Asthma Action Plans impacts the health outcomes of beneficiaries living with asthma.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix J:
Performance Evaluation Report
Community Health Group
Partnership Plan
July 1, 2014 – June 30, 2015**

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Appendix J: Performance Evaluation Report Community Health Group Partnership Plan July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Community Health Group Partnership Plan (“CHG” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

CHG is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) under a Geographic Managed Care (GMC) model. The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within a specified geographic area (county).

For San Diego County, beneficiaries may select from the following MCPs in addition to CHG:

- ◆ Care1st Partner Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Kaiser SoCal
- ◆ Molina Healthcare of California Partner Plan, Inc.

CHG became operational in San Diego County to provide MCMC services in August 1998. As of June 30, 2015, CHG had 246,248 beneficiaries.¹ This represents 40 percent of the beneficiaries enrolled in this county.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: October 26, 2015.

2. **MANAGED CARE HEALTH PLAN COMPLIANCE** *for Community Health Group Partnership Plan*

Medical Audit

The most recent medical audit for CHG was conducted by DHCS June 22, 2015, through July 3, 2015, covering the review period April 1, 2014, through March 31, 2015. At the time of this report, DHCS had not yet issued the audit report. HSAG will include a summary of the medical audit results in CHG's 2015–16 MCP-specific evaluation report.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Community Health Group Partnership Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that CHG followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of notable findings and opportunities for improvement is included below.

- ◆ As was recommended to CHG during the MCP's HEDIS 2014 compliance audit, the auditor suggested that, due to the large volume of paper claims CHG receives, the MCP may want to consider re-exploring the use of optical character recognition technology to minimize manual data entry or work with its providers to increase the volume of claims submitted electronically.
- ◆ The auditor recommended that CHG establish appropriate oversight of its clearinghouse activities.
- ◆ The auditor noted that CHG initiated an annual *HEDIS Data Analysis Report* and recommended that the MCP update the report by product line after all data needed for HEDIS production have been incorporated.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 for CHG's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
CHG—San Diego County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	14.37%	13.28%	18.76%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	32.73	37.42	36.42	46.22	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	329.00	310.89	293.39	288.23	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	87.07%	84.99%	87.41%	84.37%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	91.23%	95.71%	60.87%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	85.01%	85.04%	88.16%	85.87%	↓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	14.08%	32.02%	39.69%	44.60%	↔
Cervical Cancer Screening	Q,A	—	—	65.21%	59.37%	↔
Childhood Immunization Status—Combination 3	Q,A,T	73.97%	73.97%	70.07%	75.91%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	96.21%	97.32%	95.95%	93.48%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	90.27%	89.85%	89.92%	87.21%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	89.61%	89.90%	89.41%	90.19%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	88.45%	88.64%	85.47%	85.92%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	57.18%	64.72%	45.99%	56.45%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	53.28%	55.47%	55.47%	54.74%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	87.35%	90.02%	86.13%	91.00%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	47.69%	56.45%	45.01%	54.26%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	79.08%	83.21%	81.27%	89.29%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	43.80%	34.31%	40.88%	36.01%	↔
Controlling High Blood Pressure	Q	—	52.07%	52.07%	50.86%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	73.48%	79.32%	76.40%	75.67%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	35.41%	47.09%	47.00%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	18.66%	27.95%	26.26%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	60.10%	55.23%	57.91%	57.66%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	77.86%	82.24%	80.29%	77.86%	↔
Use of Imaging Studies for Low Back Pain	Q	75.03%	79.24%	77.32%	72.17%	↓

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	73.48%	78.10%	87.59%	84.18%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	71.53%	71.29%	75.43%	69.34%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	55.96%	63.99%	70.32%	66.42%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	77.13%	77.86%	78.10%	73.24%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 SPD measure results reported by CHG. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CHG—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	15.62%	22.31%	▼	18.76%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.85%	86.30%	↑	84.37%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	64.52%	59.02%	↔	60.87%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.57%	88.70%	↑	85.87%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	93.46%	NA	Not Comparable	93.48%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	87.21%	87.44%	↔	87.21%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	90.27%	88.08%	↓	90.19%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	85.99%	84.25%	↔	85.92%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

⁴ 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 3.2.

**Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
CHG—San Diego County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
265.64	44.00	488.98	65.87

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
CHG—San Diego County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	17.03%	14.88%	22.31%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	62.49	46.05	65.87	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	495.48	384.72	488.98	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.05%	89.03%	86.30%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	90.24%	95.31%	59.02%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.76%	90.33%	88.70%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	NA	97.37%	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	88.46%	88.30%	87.44%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	94.09%	89.97%	88.08%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	87.12%	84.81%	84.25%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
CHG—San Diego County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	10.79%	10.38%	15.62%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	34.30	35.06	44.00	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	287.97	280.48	265.64	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.91%	83.18%	82.85%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	64.52%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.06%	81.92%	83.57%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	97.34%	95.94%	93.46%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	89.87%	89.97%	87.21%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	89.76%	89.39%	90.27%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	88.70%	85.50%	85.99%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rates for the following measures were above the HPLs in RY 2015:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total* (fifth consecutive year)

The rates for the following measures improved significantly from RY 2014 to RY 2015:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015

- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

The rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure improved slightly from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rates for the following measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Use of Imaging Studies for Low Back Pain*

In addition to the measures noted above, the rate for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure declined slightly; and although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015.

Seniors and Persons with Disabilities Findings

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

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*

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

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*

Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the

significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure may be attributed to children and adolescents in this age group in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Across all measures stratified for the SPD and non-SPD populations, little notable variation occurred in the SPD and non-SPD rates from RY 2014 to RY 2015.

Assessment of Improvement Plans

CHG was required to submit an improvement plan (IP) for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure based on RY 2014 performance measure rates. A summary of the IP follows:

CHG identified the following barriers to the rate being above the MPL:

- ◆ Practitioner failure to adjust drug regimens to achieve blood pressure control (i.e., switching to combination therapy if monotherapy was proving to be inadequate for lowering high blood pressure)
- ◆ Beneficiary noncompliance
- ◆ Beneficiary lack of consistent follow-up

CHG implemented the following interventions to address the barriers:

- ◆ Generated a report of beneficiaries with diabetes who were noncompliant for blood pressure control during 2013 and still active CHG beneficiaries during 2014.
- ◆ Used pharmacy data to identify which noncompliant beneficiaries were being treated with monotherapy anti-hypertensive medication.
- ◆ Sent providers a list of noncompliant beneficiaries and a letter signed by the chief medical officer informing the providers that their beneficiaries could possibly benefit from combination anti-hypertensive therapy.
- ◆ Sent noncompliant beneficiaries letters regarding the importance of high blood pressure treatment and follow-up with their physicians.
- ◆ Conducted follow-up calls to noncompliant beneficiaries to address questions they had regarding controlling their blood pressure.

CHG also submitted a Plan-Do-Study-Act (PDSA) cycle for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure. The MCP implemented a three-pronged outreach approach to beneficiaries that included personalized letters, follow-up telephone calls, and informing physicians about the beneficiary outreach and that beneficiaries would be calling for

appointments. The MCP determined that the outreach approach was successful and planned to modify the approach by following up with beneficiaries who did not make appointments with their physicians.

The MCP's improvement efforts resulted in the rate for the measure improving significantly from RY 2014 to RY 2015 and the rate moving to above the MPL in RY 2015. CHG will not be required to continue the IP.

Required Improvement Plans for RY 2015

Based on RY 2015 performance measure rates, CHG will be required to submit IPs/PDSA cycles for the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*

Strengths

HSAG auditors determined that CHG followed the appropriate specifications to produce valid rates, and no issues of concern were identified. The MCP had three measures with rates above the HPLs, and the rates for five measures improved significantly from RY 2014 to RY 2015. The rates for two measures improved from below the MPLs in RY 2014 to above the MPLs in RY 2015.

CHG provided documentation of actions the MCP has taken to ensure that the MCP is meeting the needs of the SPD population (See Table 6.1). CHG provided descriptions of several interventions the MCP has implemented to ensure that the MCP is thoroughly assessing SPD beneficiaries' needs and that SPD beneficiaries have access to all needed health care services.

Opportunities for Improvement

CHG has the opportunity to consider making changes in response to the recommendations made by HSAG's auditor to ensure complete and accurate data.

CHG has the opportunity to assess the factors leading to the significant decline in the MCP's performance for six measures and in the rates for three measures being below the MPLs, and to implement strategies to improve performance.

Quality Improvement Project Objectives

CHG participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

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

**Table 4.1—Quality Improvement Projects for CHG
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Increasing Postpartum Care Visits within 6 Weeks of Delivery</i>	Clinical	Q, A, T

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

The *Increasing Postpartum Care Visits within 6 Weeks of Delivery* QIP aimed to improve the rate of postpartum visits occurring between 21 and 56 days after delivery, because ensuring that a mother is seen postpartum is important to her physical and mental health.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
CHG—San Diego County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	88%	100%	<i>Met</i>
Internal QIPs				
<i>Increasing Postpartum Care Visits within 6 Weeks of Delivery</i>	Annual Submission	91%	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, 2014, through June 30, 2015, showed that CHG’s *All-Cause Readmissions* QIP annual submission achieved an overall validation status of *Met*, with 88 percent of evaluation elements and 100 percent of critical elements met. The MCP’s *Increasing Postpartum Care Visits within 6 Weeks of Delivery* QIP annual submission also achieved an overall validation status of *Met*, with 91 percent of evaluation elements and 100 percent of critical elements met.

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

**Table 4.3—Quality Improvement Project Average Rates*
CHG—San Diego County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015**

QIP Study Stages	Activity	<i>Met</i> Elements	<i>Partially Met</i> Elements	<i>Not Met</i> 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	100%	0%	0%
Design Total		100%	0%	0%

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Implementation	VII: Sufficient Data Analysis and Interpretation	94%	0%	6%
	VIII: Appropriate Improvement Strategies**	88%	13%	0%
Implementation Total		92%	4%	4%
Outcomes	IX: Real Improvement Achieved	50%	0%	50%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		50%	0%	50%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for both CHG’s *All-Cause Readmissions* and *Increasing Postpartum Care Visits within 6 Weeks of Delivery* QIP annual submissions.

CHG demonstrated a strong application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP demonstrated a solid application of the Implementation stage, meeting 92 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *All-Cause Readmissions* QIP annual submission, CHG did not identify factors that threatened the internal or external validity of the Remeasurement 1 findings—resulting in a lower score for Activity VII. In addition, for the annual submission of the *Postpartum Care Visits within 6 Weeks of Delivery* QIP, CHG did not accurately evaluate individual interventions—resulting in a lowered score for Activity VIII.

Both QIPs progressed to the Outcomes stage during the reporting period. However, neither the *All-Cause Readmissions* nor the *Postpartum Care Visits within 6 Weeks of Delivery* QIP achieved statistically significant improvement over baseline, resulting in the MCP meeting only 50 percent of the requirements for all applicable evaluation elements for Activity IX. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for CHG—San Diego County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions		
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement*
14.4%	13.3%	‡
QIP #2—Increasing Postpartum Care Visits within 6 Weeks of Delivery		
Study Indicator: The percentage of postpartum visits within 21 to 56 days of delivery		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement*
55.2%	57.9%	‡

[^]A lower percentage indicates better performance.

[¥] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

All-Cause Readmissions QIP

CHG’s goal for the *All-Cause Readmissions* QIP was to decrease the readmissions rate from 14.4 percent (baseline) to 10.0 percent (Remeasurement 1). While the readmissions rate declined to 13.3 percent at Remeasurement 1, the change was not statistically significant; and CHG did not meet the QIP’s goal. A review of the MCP’s QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ CHG identified potential barriers and evaluated the effectiveness of the planned interventions monthly. The following barriers were identified and prioritized as a result of the periodic monitoring:
 - CHG experienced several staff changes within the Case Management department during 2013; and it was difficult to find experienced, bilingual, registered nurses to fill the positions.
 - Planned interventions were inconsistently implemented by case management staff.
 - CHG’s migration to a new core operating system impacted the development of a case management module for electronic documentation.
 - Planned interventions were modified, partially implemented, or delayed to meet the Medicaid expansion and Coordinated Care Initiative regulatory guidelines.
- ◆ The following is a brief description of the interventions CHG indicated it implemented during the Remeasurement 1 time period:
 - Increased staffing and structure of Case Management department.

- Added a flag to the beneficiary eligibility screen in the core operating system to identify Multiple Admitters Program (MAP) beneficiaries. The core operating system captures the daily inpatient census and alerts case management staff when MAP beneficiaries are admitted and discharged from the hospital.
- Provided authorization for a post-discharge home health visit once a MAP beneficiary was admitted to the hospital.
- Provided the home health vendor with the latest medication profile from CHG's pharmacy claims system and a discharge summary from the facility upon discharge for each MAP beneficiary.

Postpartum Care Visits within 6 Weeks of Delivery QIP

CHG's goal for the *Postpartum Care Visits within 6 Weeks of Delivery* QIP was to increase the postpartum visit rate from 55.2 percent (baseline) to 58.7 percent (Remeasurement 1). While the postpartum visit rate increased to 57.9 percent at Remeasurement 1, the change was not statistically significant and CHG did not meet the QIP's goal. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ CHG referred 660 beneficiaries for in-home postpartum visits from October through December 2013. Of the beneficiaries referred, the majority were unable to be reached or had inaccurate contact information. The intervention resulted in 125 in-home postpartum visits.
- ◆ The following is a brief description of the additional interventions CHG indicated it implemented during the Remeasurement 1 time period:
 - Sent a post-delivery congratulatory and educational letter for each live birth.
 - Provided beneficiaries with a \$25 incentive gift card for completing the postpartum visit during the required time frame.
 - Offered providers a \$100 incentive for encounter data for postpartum visits conducted during the required time frame.
 - Contacted providers who bill for global delivery charges to obtain the specific dates of the postpartum visits.
 - Assisted beneficiaries who had delivered with scheduling their postpartum visits 21 to 56 days after delivery, and provided taxi transportation to and from the visits.
 - Obtained the beneficiary's hospital face sheet to compare the most current demographic data with data in the beneficiary profile, and updated the information if necessary.

Strengths

CHG demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Postpartum Care Visits within 6 Weeks of Delivery* QIPs. Both QIPs achieved a *Met* validation status on the first submission. Although the improvement was not statistically significant, both QIPs' study indicators moved in the right direction.

Opportunities for Improvement

Although CHG will not be continuing the formal QIPs, the MCP should reassess the barriers and implement strategies to address the significant increase in the number of readmissions since the rate for *All-Cause Readmissions* measure was significantly worse in RY2015 when compared to RY 2014. In addition, the MCP should evaluate each individual intervention implemented in the *Postpartum Care Visits within 6 Weeks of Delivery* QIP and consider adopting or adapting the intervention that resulted in improvement.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

CHG’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10 th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10 th –25 th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25 th –75 th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75 th –90 th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90 th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10 th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10 th –25 th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25 th –75 th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75 th –90 th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90 th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for CHG. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for CHG

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	22.2%	26.3%	25th–75th	18.7%	9.2%	<10th
Diagnosis Code	26.0%	31.6%	25th–75th	43.9%	34.6%	10th–25th
Procedure Code	38.1%	43.8%	25th–75th	30.3%	22.5%	10th–25th
Procedure Code Modifier	71.7%	58.5%	10th–25th	74.0%	46.0%	10th–25th
Rendering Provider Name	NA	25.0%	NA	89.0%	68.1%	>25th–<75th
Billing Provider Name	27.6%	35.0%	75th–90th	19.3%	8.6%	<10th

Note: HSAG displayed “NA” when the denominator was less than 30.

Overall, the medical record omission rates for CHG ranged from 22.2 percent (*Date of Service*) to 71.7 percent (*Procedure Code Modifier*). Four of CHG’s five reported medical record omission rates were somewhat better than the respective statewide rates, and the remaining rate (*Procedure Code Modifier*) was worse than the statewide rate by 13.2 percentage points. When compared to other MCPs’ performance, CHG received a percentile ranking of “25th–75th” for three of the five reported medical record omission rates. The *Procedure Code Modifier* element received a percentile ranking of “10th–25th”, and the *Billing Provider Name* element received a percentile ranking of “75th–90th”. These findings suggest a moderate level of completeness among key encounter data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for CHG contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, CHG's rates varied from 18.7 percent (*Date of Service*) to 89.0 percent (*Rendering Provider Name*). All six of CHG's encounter data omission rates were higher than the respective statewide rates, indicating worse performance than the statewide average rates. The *Procedure Code Modifier* encounter data omission rate was 28 percentage points worse than the statewide rate. The most common reasons for encounter data omissions were:

- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in CHG's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to CHG (and/or the data subsequently being submitted to DHCS).
- ◆ CHG populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files CHG submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for CHG. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for CHG

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	93.7%	83.6%	≥90th	NA
Procedure Code	85.7%	77.6%	75th–90th	NA
Procedure Code Modifier	NA	99.5%	NA	–
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	75.5%	68.6%	25th–75th	NA
All-Element Accuracy	0.7%	4.3%	>25th<75th	–

Note: HSAG displayed "NA" when the denominator was less than 30. HSAG displayed "–" when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be quite accurate for CHG—with all reported element accuracy rates higher than the respective statewide rates. When compared to the performance among the assessed MCPs, two of

the three key data elements received a percentile ranking of “75th–90th” or “≥90th”, and the *Billing Provider Name* data element received a rank of “25th–75th”.

Despite relatively high accuracy rates for the *Diagnosis Code*, *Procedure Code*, and *Billing Provider Name* data elements, the all-element accuracy rate for CHG was worse than the statewide rate, and only 0.7 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 99 percent of the dates of service reviewed in this study. While all five key data elements contributed to CHG’s low all-element accuracy rate, the *Rendering Provider Name* data element contributed most.

Medical Record Review Recommendations

Based on the study findings for CHG, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, CHG should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data submitted to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. CHG should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ CHG should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ CHG should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code Modifier* data element and develop strategies to improve rates.
- ◆ Out of 142 dates of service identified in the DHCS encounter data, only 28 of the visits had identifiable rendering provider names from the DHCS data system. CHG should work with DHCS to investigate the reasons why so few rendering provider names could be identified using the DHCS encounter and provider data.

- ◆ CHG should explore the reasons for the relatively high encounter data omission rates for the *Procedure Code Modifier* and *Rendering Provider Name* data elements and take actions to improve rates.
- ◆ CHG should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with CHG.
- ◆ CHG should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

2014–15 Encounter Data Validation Study—Assessing the MCP’s Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

CHG’s SFY 2014–15 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the EDV study, which assessed the MCP’s operational and infrastructure changes in support of DHCS’s transition to PACES. Based on review of CHG’s Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist CHG with improving its encounter data quality. DHCS followed up with CHG regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

6. OVERALL FINDINGS AND RECOMMENDATIONS

for Community Health Group Partnership Plan

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of CHG's performance in the three domains of care—quality, access, and timeliness.

Quality

As in previous years, HSAG's review of CHG's quality improvement program documents revealed detailed descriptions of processes and goals that support the provision of quality care to beneficiaries, including mechanisms for monitoring the quality of care provided.

The rates for the following quality measures were above the HPLs:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total* (fifth consecutive year)

The rates for the following quality measures improved significantly from RY 2014 to RY 2015:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

The rates for the following quality measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Use of Imaging Studies for Low Back Pain*

In addition to the measures noted above, the rate for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure, which falls into the quality domain of care, declined slightly. Although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015.

For quality measures stratified by the SPD and non-SPD populations, the SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARB* and *Diuretics* measures were significantly better than the non-SPD rates. Additionally, the SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of CHG's QIPs fell into the quality domain of care. Neither QIP achieved statistically significant improvement at Remeasurement 1, suggesting that the MCP has opportunity to improve its strategies for ensuring that quality care is provided to beneficiaries discharged from an inpatient facility and beneficiaries in need of postpartum care services.

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

Access

As in previous years, CHG provided documentation in the MCP's quality improvement documents that reflects the MCP's commitment to ensuring access to health care services for its beneficiaries. CHG includes goals in its work plan related to access and availability of services and provided detailed information on the MCP's success at achieving access-related goals in the MCP's 2014 Annual Quality Improvement Program Summary document. Based on HSAG's review of the summary document, the MCP met or exceeded many of its access-related goals in 2014.

The rates for the following access measures improved significantly from RY 2014 to RY 2015:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*, resulting in the rate moving to above the HPL in RY 2015

The rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure, which falls into the access domain of care, improved slightly from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rates for the following access measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. As stated above, the SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate, which is to be expected. Additionally, the rate for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure was significantly worse than the non-SPD, which may be attributed to children and adolescents in this age group in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Both of CHG's QIPs fell into the access domain of care. As noted above, neither QIP achieved statistically significant improvement at Remeasurement 1. The outcomes suggest that the MCP has opportunities to improve its strategies for ensuring access to care for beneficiaries discharged from an inpatient facility and beneficiaries in need of postpartum care services.

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

Timeliness

CHG’s 2015 Quality Improvement Program Description includes information about the MCP’s processes related to enrollee rights; grievances; continuity and coordination of care; and utilization management, which all affect the timeliness of care delivered to beneficiaries. CHG provides a high level of detail regarding its monitoring and oversight processes, both designed to ensure timely care.

Five of the required performance measures fall into the timeliness domain of care, and the rates for all measures were between the MPLs and HPLs.

CHG’s *Increasing Postpartum Care Visits within 6 Weeks of Delivery* QIP fell into the timeliness domain of care. As noted above, the QIP did not achieve statistically significant improvement at Remeasurement 1. The outcome suggests that the MCP has opportunities to improve its strategies for ensuring timeliness of care for beneficiaries in need of postpartum care services.

Overall, CHG 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with CHG’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—CHG’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to CHG	Self-Reported Actions Taken by CHG during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
1. Due to CHG’s large volume of paper claims, the MCP may want to consider implementing the use of optical character recognition technology to minimize manual data entry.	In early 2015, CHG began an aggressive three-month campaign to encourage providers to submit claims electronically (Electronic Data Interchange). As of July 15, 2015, the percentage of claims submitted electronically has increased from an average of 40 percent to approximately 60 percent. Within the next three months, we expect this percentage to increase to approximately 80 percent.
2. Assess the factors leading to the rate for the <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> measure declining significantly, resulting in the rate being below the MPL in 2014; and identify strategies to improve the measure’s rate.	Submitted IP and received approval from Medical Quality and Oversight Section, Managed Care Quality and Monitoring Division. Identified #1 barrier as: Practitioner’s failure to adjust drug regimens to achieve control (i.e., use of combination therapy if monotherapy is proving inadequate for lowering blood pressure)

2013–14 External Quality Review Recommendation Directed to CHG	Self-Reported Actions Taken by CHG during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>To validate this barrier, the full medical record sample from the hybrid HEDIS 2014 sample and oversample were analyzed for medication therapy.</p> <ul style="list-style-type: none"> • 473 member records were reviewed from the <i>Comprehensive Diabetes Care – Blood Pressure Control (<140/90)</i> measure. • 218 members were found to be compliant with blood pressure control (<140/90). • 255 members were found to be noncompliant with blood pressure control (<140/90). • 30 members in the non-controlled group were no longer active. • 225 non-controlled members’ medication profiles were reviewed. • 106 (47 percent) of the non-controlled members were prescribed combination blood pressure control drug therapy. • 119 (53 percent) of the non-controlled members were not prescribed combination blood pressure control drug therapy. • 70 (31 percent of the total non-controlled members and 59 percent of the non-controlled members not prescribed combination blood pressure control drug therapy) were only prescribed monotherapy blood pressure control medications. • 49 (22 percent of the total non-controlled members and 41 percent of the non-controlled members not prescribed combination blood pressure control drug therapy) were not prescribed any blood pressure control medications. <p>Identified as a rapid-improvement goal: By June 30, 2015, 10 percent of the diabetic members identified as noncompliant for blood pressure control and who were able to be contacted by the plan will be re-evaluated by their physician for blood pressure medication management after notification to physician and member by the health plan and follow-up with member.</p> <p>Submitted PDSA rapid improvement update June 30, 2015. Found that 72 percent of the members who were successfully contacted had had a visit with their physician and documentation of medication review and/or discussion.</p>
<p>3. Assess the factors leading to the rates for the following four measures declining significantly from 2013 to 2014, and identify strategies that will prevent further decline in the rates:</p> <ol style="list-style-type: none"> a. <i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months</i> b. <i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i> c. <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> 	<ol style="list-style-type: none"> a. From 2013 (97.32) to 2014 (95.95) a decrease of 1.37 points/1.4 percent occurred. Review of demographic data shows small variance in enrollment as well. Unable to identify any root cause for small shift in rate. Have implemented sending a personalized letter to members’ parents in birth month encouraging them to schedule a wellness visit. This is followed up with an IVR call message and birthday card reminder. b. From 2013 (88.64) to 2014 (85.47) a decrease of 3.17 points/3.6 percent occurred. The decline in this measure is believed to be linked to discontinuing the use of an incentive for members to get annual wellness exams. Have implemented the use of an IVR call message and birthday card reminder for members in this age group.

2013–14 External Quality Review Recommendation Directed to CHG	Self-Reported Actions Taken by CHG during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>d. <i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i></p>	<p>c. Submitted IP for CDC B/P Control and received approval from Medical Quality and Oversight Section, Managed Care Quality and Monitoring Division, as noted above.</p> <p>d. From 2013 (56.45) to 2014 (45.01) a decrease of 11.44 points/20.3 percent occurred. Decline was determined to be due to the decrease in results obtained from the primary noncontracted laboratory vendor and from not receiving laboratory data from primary care community clinics capitated for basic laboratory services.</p> <p>e. Have established process to receive lab data feeds from the primary care community clinics using a non-CHG contracted laboratory vendor. Also investigating opportunities to receive laboratory data from hospitals and pathology vendors.</p>
<p>4. Assess the factors leading to the SPD rate for the <i>All-Cause Readmissions</i> measure being significantly worse than the non-SPD rate to ensure that the MCP is meeting the needs of the SPD population.</p>	<p>Evaluation showed that the SPD population has a significantly higher rate of members with multiple chronic conditions and who were not scheduling follow-up appointments. SPD members are identified monthly using the following criteria:</p> <ul style="list-style-type: none"> • Chronic diseases—diabetes, congestive heart failure, chronic obstructive pulmonary disease, asthma, cellulitis, chronic kidney disease • Utilization pattern—three or more hospital admissions within a 12 month period <p>The following interventions were implemented:</p> <ul style="list-style-type: none"> • SPD members are assigned to personal care coordinators (PCCs) to assist in coordinating care (for the member) such as making doctor appointments, coordinating transportation, and educating on the managed care referral process. • PCC staff members discuss completed assessments with assigned high-risk case manager (HRCM) for internal review and follow-up. • Care plans—PCC and HRCM develop a member-specific care plan. • The registered nurse (RN) works with concurrent review and hospital staff to secure an order from the admitting physician for a home health referral as part of discharge plan. • Home health visit post-discharge—Contracted agencies conduct a home visit within 24 hours of discharge (agency contracts have a built-in incentive to ensure access to RNs for same day and weekend referrals—members pay 25 percent more for these visits). • Home visits by health educator—On a case-by-case basis, for members with the four targeted disease management conditions, home visits are done by MedEd staff to provide specialty health education. • Medication and dressing supply delivery—Through a special arrangement with Medical Center Pharmacy, medications and dressing change supplies are delivered to either the hospital or home, case by case. Injectables (i.e., Lovenox) may be delivered to the hospital prior to discharge or are delivered to members’ homes on the day of discharge.

2013–14 External Quality Review Recommendation Directed to CHG	Self-Reported Actions Taken by CHG during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<ul style="list-style-type: none"> • Outpatient physician follow up—PCC helps schedule members for primary care physician and/or specialty follow-up appointments within seven days of discharge. • Extensive member education—RN works with members, PCPs, health educators, and other community resources to encourage members to comply with treatment plans. • Other resources—Based on member needs, to ensure compliance with outpatient follow-up and to prevent further complications, additional benefits are accessed (i.e., extra pressure stockings for members with lymphedema and cellulitis and short term transportation via taxi cab).
<p>5. Ensure that all required documentation is included in the QIP Summary Form. The MCP should reference the QIP Completion Instructions and previous QIP validation tools to ensure that all documentation requirements for each activity have been addressed prior to submission.</p>	<p>All required documentation will be included in the QIP Summary Form. CHG will reference the QIP Completion Instructions and previous QIP validation tools to ensure that all documentation requirements for each activity have been addressed prior to submission.</p>

Recommendations

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

- ◆ To ensure complete and accurate data, consider making changes in response to the following recommendations made by HSAG’s auditor:
 - Consider re-exploring the use of optical character recognition technology to minimize manual data entry, or work with the MCP’s providers to increase the volume of claims submitted electronically.
 - Establish appropriate oversight of the MCP’s clearinghouse activities.
 - Update the MCP’s *HEDIS Data Analysis Report* by product line after all data needed for HEDIS production have been incorporated.
- ◆ Assess the factors leading to declining or poor performance for the following measures and implement strategies to prevent further decline in performance or to improve performance:
 - *All-Cause Readmissions*
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics*
 - *Children and Adolescents’ Access to Primary Care Physicians—12 to 24 Months and 25 Months to 6 Years*
 - *Medication Management for People with Asthma—Medication Compliance 50% Total*
 - *Use of Imaging Studies for Low Back Pain*

- ◆ Although CHG will not be continuing the formal QIPs, consider evaluating each individual intervention implemented in the *Postpartum Care Visits within 6 Weeks of Delivery* QIP, adopting or adapting the interventions that resulted in improvement.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix K:
Performance Evaluation Report
Contra Costa Health Plan
July 1, 2014 – June 30, 2015**

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Appendix K: Performance Evaluation Report – Contra Costa Health Plan July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Contra Costa Health Plan (“CCHP” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

CCHP is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in CCHP, the LI MCP; or in Anthem Blue Cross partnership Plan, the alternative commercial plan (CP).

CCHP became operational in Contra Costa County to provide MCMC services effective February 1997. As of June 30, 2015, CCHP had 159,700 beneficiaries in Contra Costa County.¹ This represents 86 percent of the beneficiaries enrolled in Contra Costa County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: December 16, 2015.

1115 Waiver Seniors and Persons with Disabilities Enrollment Survey

The most recent 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey (hereafter referred to as “SPD medical survey”) for CCHP was conducted March 4, 2013, through March 6, 2013, covering the review period of December 1, 2011, through November 30, 2012. HSAG included a summary of the findings from the SPD medical survey in CCHP’s 2013–14 MCP-specific evaluation report. As part of the process for producing CCHP’s 2014–15 MCP-specific evaluation report, DHCS provided to HSAG a letter from DHCS to CCHP dated April 6, 2015. The letter indicated that on April 8, 2014, CCHP provided DHCS with a response to its corrective action plan (CAP), originally issued December 2013. The letter further indicated that DHCS had reviewed all remaining open items and found CCHP to be in compliance, resulting in DHCS closing the CAP.

Medical Audit

The most recent medical audit for CCHP was conducted March 4, 2013, through March 15, 2013, covering the review period of December 1, 2011, through November 30, 2012. HSAG included a summary of the findings from the audit in CCHP’s 2013–14 MCP-specific evaluation report. DHCS requested a CAP from CCHP on September 9, 2013. As part of the process for producing CCHP’s 2014–15 MCP-specific evaluation report, DHCS provided to HSAG a letter from DHCS to CCHP dated April 6, 2015. The letter indicated that DHCS had reviewed all remaining open items from the audit and found CCHP to be in compliance, resulting in DHCS closing the CAP from the audit.

Strengths

CCHP fully resolved all findings from the March 2013 SPD medical survey and March 2013 medical audit.

Opportunities for Improvement

Since CCHP fully resolved all findings from the most recent reviews, HSAG has no recommendations for the MCP in the area of compliance reviews.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Contra Costa Health Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that CCHP followed the appropriate specifications to produce valid rates; however, the auditor identified some issues of concern that caused minimal impact on measure reporting. A brief summary of the notable findings and opportunities for improvement is included below.

- ◆ To facilitate payments to providers, CCHP automatically assigned a code for children's primary care services on the Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM 160 form). This process interfered with the integrity of data for measure reporting since the MCP was unable to distinguish between codes billed by the provider and codes automatically added by CCHP's process. To ensure that data integrity is not compromised, the auditor recommended that the MCP revise the process of auto-assigning codes to the PM 160 forms.
- ◆ Kaiser (KP Cal, LLC) is CCHP's delegated service partner for 18.5 percent of CCHP's beneficiaries. Kaiser implemented several changes in its data submission to CCHP, which impacted CCHP's ability to ensure that the data were complete and accurate. The auditor recommended that CCHP implement ongoing monitoring and oversight of all delegated partners to enable the MCP to proactively identify any partner's process changes. This will allow the MCP sufficient time to test new data processes and ensure data completeness and accuracy.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 for CCHP's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on*

Persistent Medications—Digoxin measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.

- All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
CCHP—Contra Costa County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	Q, A	—	16.99%	12.95%	17.35%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months**</i>	‡	59.47	60.94	53.25	56.21	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months**</i>	‡	274.88	217.23	246.81	257.12	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	Q	85.62%	83.77%	86.52%	85.55%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	Q	NA	85.71%	95.45%	77.11%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	Q	80.95%	83.68%	85.11%	84.60%	↔
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	Q	26.52%	43.27%	44.09%	47.06%	↔
<i>Cervical Cancer Screening</i>	Q,A	—	—	54.99%	55.47%	↔
<i>Childhood Immunization Status—Combination 3</i>	Q,A,T	85.40%	84.47%	74.70%	77.86%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	A	93.97%	86.74%	94.62%	93.94%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	A	84.54%	76.18%	86.07%	84.21%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	A	84.07%	77.96%	86.71%	86.56%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	A	83.25%	74.86%	83.44%	83.80%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	Q	54.99%	59.37%	61.31%	60.44%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	Q,A	52.80%	51.09%	51.34%	55.10%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	Q,A	84.91%	85.40%	84.43%	83.98%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	Q	53.04%	49.88%	48.18%	44.17%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	Q,A	87.35%	82.00%	83.94%	82.52%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	Q	36.98%	40.39%	41.61%	41.26%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
Controlling High Blood Pressure	Q	—	51.34%	53.28%	64.23%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	59.85%	71.61%	73.24%	72.51%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	56.90%	43.46%	59.10%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	33.95%	22.79%	37.92%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	64.96%	62.53%	60.34%	67.15%	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.21%	86.86%	83.45%	85.89%	↔
Use of Imaging Studies for Low Back Pain	Q	88.58%	92.06%	87.85%	87.31%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	59.37%	56.20%	62.29%	69.34%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	55.72%	55.96%	59.37%	67.64%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	46.47%	46.23%	50.85%	66.67%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	77.86%	73.31%	74.45%	79.81%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 SPD measure results reported by CCHP. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CCHP—Contra Costa County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	10.62%	23.03%	▼	17.35%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.66%	87.44%	↑	85.55%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	77.14%	77.08%	↔	77.11%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	82.04%	87.23%	↑	84.60%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	94.03%	NA	Not Comparable	93.94%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	84.22%	83.71%	↔	84.21%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	86.51%	87.52%	↔	86.56%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	83.96%	81.82%	↔	83.80%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

⁴ 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 3.2.

**Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
CCHP—Contra Costa County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
242.58	52.20	338.92	78.73

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
CCHP—Contra Costa County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	19.48%	14.13%	23.03%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	83.56	74.83	78.73	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	299.06	342.59	338.92	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.68%	87.41%	87.44%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	86.54%	95.00%	77.08%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.83%	85.24%	87.23%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	74.13%	87.47%	83.71%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	82.34%	86.49%	87.52%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	79.63%	82.72%	81.82%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
CCHP—Contra Costa County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	12.72%	9.53%	10.62%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	55.98	48.06	52.20	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	199.28	223.77	242.58	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	78.37%	83.51%	83.66%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	77.14%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	77.84%	84.67%	82.04%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	86.81%	94.62%	94.03%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	76.24%	86.03%	84.22%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	77.74%	86.72%	86.51%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	74.46%	83.50%	83.96%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rates improved significantly from RY 2014 to RY 2015 for the following measures:

- ◆ *Controlling High Blood Pressure*
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*
- ◆ All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

The rates for the following measures were below the MPLs in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ All four *Children and Adolescents' Access to Primary Care Practitioners* measures (fourth consecutive year)

The rates for the following measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures. The SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

The SPD rate was significantly worse in RY 2015 when compared to the SPD rate in RY 2014 for the *All-Cause Readmissions* measure, and the non-SPD rate was significantly worse in RY 2015 when compared to the non-SPD rate in RY 2014 for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure.

Assessment of Improvement Plans

Based on RY 2014 rates, CCHP was required to submit an improvement plan (IP) and a Plan-Do-Study-Act (PDSA) cycle for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure. CCHP identified the following barriers to the rate being above the MPL in RY 2014:

- ◆ Receiving poor data quality from one of the MCP's delegated service partners.
- ◆ CCHP's inability to identify the data quality issues in a timely manner.

CCHP implemented the following interventions to address the poor data quality from the delegated partner:

- ◆ Worked with the delegated partner to identify and correct the root cause of CCHP not receiving accurate and complete data.
- ◆ Obtained the HEDIS software from the vendor to allow CCHP to process the delegated partner's test data to give CCHP increased confidence that the rates will return to accurate levels.
- ◆ Assigned hours to CCHP's HEDIS project manager to address the data quality issues.
- ◆ Obtained commitment from CCHP's upper management staff members that a solution to the data quality issues will be identified and implemented.

For the PDSA cycle, CCHP worked with the delegated partner and the HEDIS vendor to improve the quality of the data provided by Kaiser to CCHP. CCHP's initial assessment was that the rate for the measure improved; however, the MCP was unable to determine whether or not the improvement was attributed to the delegated partner's data.

CCHP's efforts resulted in the rate for the measure improving significantly from RY 2014 to RY 2015 and the rate moving from below the MPL to above the MPL. CCHP will not be required to continue the IP and PDSA cycle for this measure based on the RY 2015 rate.

Required Improvement Plans for RY 2015

Based on RY 2015 performance measure rates, CCHP will be required to submit IPs for the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*

While the rates were below the MPLs for all four *Children and Adolescents' Access to Primary Care Practitioners* measures, DHCS requires no IPs or PDSA cycles for these measures due to the small range of variation between the MPL and HPL threshold for each measure.

Strengths

HSAG auditors determined that CCHP followed the appropriate specifications to produce valid performance measure rates.

The rates for seven measures improved significantly from RY 2014 to RY 2015. The rates for two measures improved from below the MPLs in RY 2014 to above the MPLs in RY 2015.

Opportunities for Improvement

To ensure that data integrity is not compromised, CCHP has the opportunity to revise the process of auto-assigning codes to the PM 160 forms. Additionally, CCHP has the opportunity to implement ongoing monitoring and oversight of all delegated partners to enable the MCP to proactively identify any partner's process changes and ensure data completeness and accuracy.

CCHP has the opportunity to assess the factors leading to the significant decline in performance for two measures and the rates for six measures being below the MPLs and to implement strategies to prevent further decline in performance and improve performance.

Note that CCHP's declining performance on the *All-Cause Readmissions* measure can be attributed to the SPD population's readmissions rate. This assessment is based on the SPD rate being significantly worse than the non-SPD rate and the SPD rate being significantly worse in RY 2015 when compared to RY 2014, while the non-SPD rate remained stable. Therefore, CCHP has the opportunity to assess the factors leading to the significant increase in readmissions for the SPD population to improve performance on the *All-Cause Readmissions* measure.

Quality Improvement Project Objectives

CCHP participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists CCHP’s QIPs and indicates whether the QIP was clinical or nonclinical and the domains of care (i.e., quality, access, and timeliness) the QIP addressed.

**Table 4.1—Quality Improvement Projects for CCHP
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Improving Perinatal Access and Care</i>	Clinical	Q, A, T

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

CCHP’s *Improving Perinatal Access and Care* QIP focused on improving the care women receive during and post pregnancy. Being able to maintain regular prenatal care visits throughout a pregnancy may help identify and treat any problems that may arise. Providing postpartum care may lead to successful health outcomes.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
CCHP—Contra Costa County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	88%	86%	<i>Partially Met</i>
Internal QIPs				
<i>Improving Perinatal Access and Care</i>	Annual Submission	100%	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, 2014, through June 30, 2015, showed that CCHP’s annual submission of its *All-Cause Readmissions* QIP received a *Partially Met* validation status. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, CCHP conducted a PDSA cycle for the *All-Cause Readmissions* QIP. The *Improving Perinatal Access and Care* QIP annual submission achieved an overall validation status of *Met*, with 100 percent of evaluation elements (critical and noncritical) receiving a *Met* score.

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

Table 4.3—Quality Improvement Project Average Rates*
CCHP—Contra Costa County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

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	100%	0%	0%
Design Total		100%	0%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	77%	15%	8%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		84%	11%	5%
Outcomes	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		100%	0%	0%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

HSAG validated Activities I through IX for CCHP’s *All-Cause Readmissions* annual submission and Activities I through VIII for the MCP’s *Improving Perinatal Access and Care* QIP annual submission.

CCHP demonstrated an excellent application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage. The MCP demonstrated an adequate application of the Implementation stage for these QIPs, meeting 84 percent of the requirements for all applicable evaluation elements within the study stage. For the *All-Cause Readmissions* QIP, CCHP provided a Remeasurement 1 rate inconsistent with the audited rate reported to DHCS and did not identify the factors that affected the ability to compare the baseline with Remeasurement 1 rates, resulting in a lowered score for Activity VII. CCHP met all requirements for the applicable evaluation elements for the *Improving Perinatal Access and Care* QIP.

Only the *All-Cause Readmissions* QIP progressed to the Outcomes stage during the reporting period. CCHP’s *All-Cause Readmissions* QIP achieved statistically significant improvement over baseline at Remeasurement 1, resulting in the QIP meeting 100 percent of the requirements for all applicable evaluation elements for Activity IX. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

Improving Perinatal Access and Care QIP

The *Improving Perinatal Access and Care* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in the report. Following is a summary of the interventions that CCHP indicated it planned to implement during the Remeasurement 1 time period:

- ◆ Work with outside hospitals to set up a process to schedule appropriately timed postpartum appointments prior to discharge.
- ◆ Pilot an intervention to call new mothers to ensure postpartum visit appointments are scheduled and remind them of those appointments.
- ◆ Work with the MCP’s largest network to develop a process that ensures providers will complete postpartum visit requirements if beneficiaries are seen for any reason between three and eight weeks postpartum.
- ◆ Work with the MCP’s largest network to improve the provision of contraception.

All-Cause Readmissions QIP

The *All-Cause Readmissions* QIP progressed to the Outcomes stage during the review period. Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

**Table 4.4—Quality Improvement Project Outcomes for CCHP—Contra Costa County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions		
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
17.0%	13.0%*	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement from the baseline period (p value < 0.05).

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

CCHP's goal for the *All-Cause Readmissions* QIP was to achieve statistically significant decline in readmissions rates from baseline to Remeasurement 1. The MCP met the project's goal by decreasing the readmissions rate to 13.0 percent at Remeasurement 1. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ CCHP revisited the barriers identified at baseline and found no significant changes. The MCP continued to focus on care coordination, limited care management resources, inconsistencies in the discharge process, and beneficiaries not understanding how to navigate the health care system.
- ◆ The MCP established a call center with a nurse available weekdays to assist discharge staff at area hospitals with ensuring that all required services and follow-up care were arranged before the beneficiary was discharged.
- ◆ The MCP's nurse called beneficiaries post discharge from the county hospital to ensure that all care needs were met.
- ◆ The MCP implemented a new initiative to provide a family nurse practitioner to visit beneficiaries in skilled nursing facilities and to be available to skilled nursing facilities when a potential need to prevent a readmission was identified.

Plan-Do-Study-Act Review

The *All-Cause Readmissions* QIP did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for the QIP topic.

CCHP set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By March 31, 2015, increase to 50 percent the number of patients seen in each of the La Clinica and Lifelong federally quality health centers (FQHCs) who are called by clinical staff to follow up after a hospital discharge, by providing information on the discharges to the clinics and working collaboratively with the clinics (CCHP Quality Director and FQHC quality staff) to design and institute a reliable and measurable process for ensuring this follow-up by FQHC clinical staff.

The purpose of the *All-Cause Readmissions* PDSA cycle was to test if providing discharge data and instituting a plan for clinical follow-up with the FQHCs would increase the percentage of post-discharge follow-up visits.

CCHP completed the *All-Cause Readmissions* PDSA cycle and reported that the MCP encountered difficulty in getting the FQHCs to submit data to enable the MCP to calculate compliance rates. Only one FQHC seemed to have succeeded in making follow-up calls to patients as part of the

regular work flow. The other FQHCs appeared to be integrating the follow-up calls into their permanent work flow; however, the process change took more time than anticipated. At the end of the PDSA cycle, CCHP was unable to evaluate the test of change.

Strengths

CCHP demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Improving Perinatal Access and Care* QIPs. In addition, CCHP was one of six MCPs that achieved statistically significant improvement over baseline at Remeasurement 1 for the statewide collaborative *All-Cause Readmissions* QIP. Lastly, the *Improving Perinatal Access and Care* QIP achieved a *Met* validation status on the first submission, meeting 100 percent of the requirements for all applicable evaluation elements.

Opportunities for Improvement

Although CCHP will not be continuing the formal QIP, the MCP should continue to reassess the barriers to improvement since the rate for the *All-Cause Readmissions* measure was significantly worse in RY 2015 when compared to RY 2014. Since the MCP was unable to evaluate the *All-Cause Readmissions* PDSA cycle, CCHP should retest the intervention to determine if partnering with FQHCs will increase the rate of post-discharge follow-up visits and prevent readmissions. In addition, CCHP should evaluate the interventions initiated in Remeasurement 1 of the *Improving Perinatal Access and Care* QIP and continue efforts to improve *Prenatal and Postpartum Care* measures.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

CCHP’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for CCHP. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for CCHP

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	26.9%	26.3%	10th–25th	7.8%	9.2%	25th–75th
Diagnosis Code	38.6%	31.6%	10th–25th	31.2%	34.6%	25th–75th
Procedure Code	42.5%	43.8%	25th–75th	25.2%	22.5%	25th–75th
Procedure Code Modifier	56.8%	58.5%	25th–75th	25.2%	46.0%	75th–90th
Rendering Provider Name	34.6%	25.0%	10th–25th	70.4%	68.1%	>25th–<75th
Billing Provider Name	34.6%	35.0%	10th–25th	7.0%	8.6%	25th–75th

Overall, the medical record omission rates for CCHP ranged from 26.9 percent (*Date of Service*) to 56.8 percent (*Procedure Code Modifier*). Three of CCHP’s medical record omission rates were slightly better than the respective statewide rates, although the three elements’ rates were less than 2 percentage points better than the statewide rate. The remaining three elements were as much as 9.6 percentage points (*Rendering Provider Name*) worse than the statewide rates. When comparing the performance among the MCPs, CCHP received a percentile ranking of “25th–75th” for two of the six medical record omission rates and a percentile ranking of “10th–25th” for four medical record omission rates. These findings suggest a relatively low to average level of completeness among key encounter data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for CCHP contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, CCHP’s rates varied from 7.0 percent (*Billing Provider Name*) to 70.4 percent (*Rendering Provider Name*). Four of CCHP’s encounter data omission rates were better than the respective statewide rates, with the *Procedure Code Modifier* encounter data omission rate being better than the statewide rate by 20.8 percentage points (i.e., received a percentile ranking of “75th–90th”). However, CCHP performed worse than the statewide encounter data omission rates by 2.7 percentage points and 2.3 percentage points for the *Procedure Code* and *Rendering Provider*

Name data elements, respectively. An opportunity exists for CCHP to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider’s billing office made a coding error.
- ◆ DHCS’s encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in CCHP’s encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider’s performance of the service and submission of the encounter to CCHP (and/or the data subsequently being submitted to DHCS).
- ◆ CCHP populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files CCHP submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for CCHP. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for CCHP

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	86.1%	83.6%	25th–75th	NA
Procedure Code	84.0%	77.6%	25th–75th	NA
Procedure Code Modifier	95.1%	99.5%	10th–25th	—
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	77.5%	68.6%	25th–75th	NA
All-Element Accuracy	6.6%	4.3%	>25th–<75th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were

found to be relatively accurate for CCHP, with three of the four reportable element accuracy rates higher than the respective statewide rates. When comparing the performance among MCPs, three of the four key data elements with reportable rates received a percentile ranking of “25th–75th” and one element received a percentile ranking of “10th–25th”.

Although CCHP’s all-element accuracy rate was better than the statewide rate, only 6.6 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 93 percent of the dates of service reviewed in this study. While all five key data elements contributed to CCHP’s low all-element accuracy rate, the *Rendering Provider Name* data element contributed most.

Medical Record Review Recommendations

Based on the study findings for CCHP, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, CCHP should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. CCHP should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ CCHP should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ CCHP should investigate the reasons for the relatively high medical record omission rates for all key data elements and develop strategies to improve rates.
- ◆ CCHP should explore the reasons for the relatively high encounter data omission rate for the *Rendering Provider Name* data element and take actions to improve rates.

- ◆ CCHP should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with CCHP.
- ◆ CCHP should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP’s Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

CCHP’s SFY 2014–15 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the EDV study, which assessed the MCP’s operational and infrastructure changes in support of DHCS’s transition to PACES. Based on review of CCHP’s Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist CCHP with improving its encounter data quality. DHCS followed up with CCHP regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of CCHP's performance in the three domains of care—quality, access, and timeliness.

Quality

As in previous years, CCHP's *Quality and Performance Improvement Program Description* included brief summaries of the MCP's quality program organizational structure. The document indicates that the MCP's quality program provides a structure to monitor quality of care, to prioritize opportunities for improvement, to recommend improvement activities, and to track improvement efforts to ensure resolution.

The rates improved significantly from RY 2014 to RY 2015 for the following quality measures:

- ◆ *Controlling High Blood Pressure*
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*
- ◆ All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents* measures

The rates for the following quality measures were below the MPLs in RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The rate was significantly worse in RY 2015 when compared to RY 2014 for the *All-Cause Readmissions* measure, which falls into the quality domain of care.

For quality measures stratified for the SPD and non-SPD populations, the SPD rates were significantly better than the non-SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures. Additionally, the SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure. While the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries, please note that CCHP's declining performance on the *All-Cause Readmissions* measure can be attributed to the SPD population's readmissions rate. This assessment is based on the SPD rate being significantly worse than the non-SPD rate and the SPD rate being significantly worse in RY 2015 when compared to RY 2014, while the non-SPD rate remained stable.

Both of CCHP's QIPs fell into the quality domain of care; however, only the *All-Cause Readmissions* QIP progressed to the Outcomes stage. While the QIP achieved a statistically significant reduction in readmissions from baseline (RY 2013) to Remeasurement 1 (RY 2014), the readmissions rate increased significantly from RY 2014 to RY 2015, suggesting that the MCP should reassess barriers to improvement and identify and implement strategies to reduce readmissions and ensure quality of care for beneficiaries.

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

Access

As part of the process for producing this report, HSAG reviewed CCHP's 2014 *Annual Quality Management Program Overview and Evaluation of Effectiveness* report, which indicated that the MCP experienced challenges with access to care issues. The report indicated that two of the MCP's contracted provider networks met the access and availability goals; however, another provider network frequently fell short of meeting the goals. The report stated that the provider is constructing additional clinic space and redesigning its health care processes to address barriers to meeting the access and availability goals. Note that this exact information was included in the MCP's 2013 *Annual Quality Management Program Overview and Evaluation of Effectiveness* report.

The rates improved significantly from RY 2014 to RY 2015 for the *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the access domain of care.

The rates were below the MPLs for the fourth consecutive year for all four *Children and Adolescents' Access to Primary Care Practitioners* measures, which fall into the access domain of care.

The rates for the following access measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The *All-Cause Readmissions* measure is one of the measures and, as noted above, the SPD rate was significantly worse than the non-SPD rate. Also as noted above, while the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries, CCHP's declining performance on the *All-Cause Readmissions* measure can be attributed to the SPD population's readmissions rate.

The non-SPD rate declined significantly in RY 2015 when compared to the non-SPD rate in RY 2014 for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure.

Both of CCHP's QIPs fell into the access domain of care and, as stated above, only the *All-Cause Readmissions* QIP progressed to the Outcomes stage. While the QIP achieved a statistically significant reduction in readmissions from baseline (RY 2013) to Remeasurement 1 (RY 2014), the readmissions rate increased significantly from RY 2014 to RY 2015, suggesting that the MCP should reassess barriers to improvement and identify and implement strategies to ensure access to care for beneficiaries discharged from the hospital.

Overall, CCHP showed below-average performance related to the access domain of care.

Timeliness

As in the previous year, CCHP's *Quality and Performance Improvement Program Description* included information on the MCP's utilizations management and grievances activities and processes, which affect the timeliness of care delivered to beneficiaries.

Five of the required performance measures fall into the timeliness domain of care, and the rates for all five measures were between the MPLs and HPLs. Additionally, the rate improved significantly from RY 2014 to RY 2015 for the *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the timeliness domain of care.

The MCP's *Improving Perinatal Access and Care* QIP fell into the timeliness domain of care. Since the QIP did not progress to the Outcomes stage, HSAG was unable to assess the QIP's success at ensuring timeliness of prenatal and postpartum care for beneficiaries.

Overall, CCHP 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with CCHP's self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP's self-reported actions.

Table 6.1—CCHP’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Address all potential deficiencies identified during the March 2013 SPD medical survey in the areas of:</p> <ul style="list-style-type: none"> a. Utilization Management b. Access and Availability of Health Care Services c. Member Rights d. Quality Management 	<ul style="list-style-type: none"> a. The MCP provided its 2013 Interrater Reliability (IRR) Survey doc. along with its Authorization Decision Tracking matrix. These supporting documents adequately address this finding. This item is closed. b. The MCP provided screen shots of its internet portal demonstrating the use of levels of access to medical equipment. The MCP also provided a segment of its provider directory demonstrating access levels. These supporting documents adequately address this finding. This item is closed. c. The MCP provided a revised copy of its Patient Complaint/Grievance Form. The MCP provided documentation indicating the new form was adopted and implemented on May 8, 2014. This item is closed. d. Contra Costa Regional Medical Center (CCRM) is now responsive to CAP requests and has consistently been submitting CAPs when required.
<p>2. Address all findings from the March 2013 medical audit in the areas of:</p> <ul style="list-style-type: none"> a. Utilization Management b. Continuity of Care c. Access and Availability to Care d. Member’s Rights e. Quality Management f. Administrative and Organizational Capacity 	<ul style="list-style-type: none"> a. The MCP provided samples of requested reports, narratives, interreliability surveys, authorization/decision tracking logs, and notification letters and has taken other action deemed adequate to close all findings for Utilization Management. b. There were no findings regarding Continuity of Care. c. Supporting documents were provided that adequately addressed findings related to Access and Availability to Care. This item is closed. d. The MCP provided revised policies and procedures containing the required modifications. The MCP provided its Epic Grievance Flow and revised policies and procedures containing the required modifications. The MCP provided three actual resolution letters generated after the policy change that demonstrate the health plan’s system is now generating resolution letters that address all issues raised in the grievance. All items are closed. e. <ul style="list-style-type: none"> 2.2.4 Initial health assessment completion is still a challenge. We await the result of our recent DHCS audit to determine how to proceed. It was unclear whether we should continue to use the methodology (originally provided by the State) that was problematic at the audit. 3.3.1 We fielded a survey of a sample of pregnant women to determine whether they had been able to be seen within two weeks of request. All responded “yes.” For ongoing monitoring, we are calling all new members who are pregnant. One of the things we assess on the call is whether they were able to get an initial prenatal appointment within two weeks. 5.5.1 Quality Council documentation has been improved. (We received all related points in NCQA Accreditation.) Kaiser attendance has been improved with the option of attending by phone.

2013–14 External Quality Review Recommendation Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>5.5.3 The <i>Third Next Available Appointment</i> report is functional and reviewed monthly.</p> <p>5.5.4 Delegates are audited annually, and CAPs are tracked to ensure completion. We have executed formal delegation agreements.</p> <p>6.6.3 CCRMC Health Education has been improved and now meets standards. We are currently working with them on a revised policy that will clarify expectations and simplify monitoring of them.</p> <p>f. There were no findings for Administrative and Organizational Capacity.</p>
<p>3. Revise the MCP’s policies and procedures to be compliant with State Supported Services abortion services requirements.</p>	<p>CCHP’s policies and procedures have been brought into compliance with all State Supported Services abortion requirements.</p>
<p>4. To improve the HEDIS audit process:</p> <ul style="list-style-type: none"> a. Implement additional coding details to provide immediate feedback to the providers. b. Work with the MCP’s vendor to obtain complete encounter data. c. Implement a formal HEDIS process to ensure consistency from year to year. d. Implement protocols to ensure that all sources of data are verified prior to loading into the database. 	<p>Opportunities for improvement are identified each HEDIS season. We have engaged our HEDIS certified software vendor to pilot its data integration product. This product allows the health plan to extract and evaluate encounter and claims data in real time. This will allow us to provide immediate feedback to providers and Quality Assurance and investigate our potential data source errors before HEDIS production data is generated. We have also implemented many new medical record review (MRR) safeguards. MRR training protocols have been standardized and the training time line extended to ensure competence prior to MRR initiation.</p>
<p>5. Continue to implement the strategies that resulted in the rates improving significantly from 2013 to 2014 for all four <i>Children and Adolescents’ Access to Primary Practitioners</i> measures, because the rates for all four measures continued to be below the MPLs.</p>	<p>CCHP continues to work to improve access to primary care for children and adolescents by working closely with the Regional Medical Center network ambulatory redesign team and by ongoing recruitment in the Community Provider Network. We have also developed options other than face-to-face appointments, when appropriate, in order to make more appointments available. Note that this measure is not truly measuring access. It measures whether there was a visit and which requires action on the part of members. In order to encourage members to seek care for themselves or their children, we publish articles in the member newsletter about the importance of care, such as adhering to the schedule for preventive care. We also send reminders about needed care.</p>
<p>6. Assess the factors leading to the rate declining significantly for the <i>Medication Management for People with Asthma—Medication Compliance 50% Total</i> measure, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014, and identify strategies to improve the rate.</p>	<p>Poor performance was caused entirely by incomplete data from Kaiser. We, and other plans, worked with Kaiser to improve provision of data. In the subsequent HEDIS year, the rates were again accurate and above the Medi-Cal mean.</p>

2013–14 External Quality Review Recommendation Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>7. For the following measures with rates that declined significantly from 2013 to 2014 but were still above the MPLs, assess the factors leading to the decline and implement strategies to ensure that the rates for the measures remain above the MPLs:</p> <p>a. <i>Childhood Immunization Status—Combination 3</i></p> <p>b. <i>Medication Management for People with Asthma—Medication Compliance 75% Total</i></p>	<p>a. We have been unable to determine the root cause for this decline. We reacted by educating providers, ensuring that the immunizations were included in Regional Medical Center network’s electronic health record flags for preventive care, and providing reminders to families and an article in the member newsletter.</p> <p>b. Same as #6.</p>
<p>8. Continue implementing interventions that are contributing to a reduction in hospital readmissions for members in the SPD population.</p>	<p>Interventions continue. For the period under review, a nurse practitioner was hired to provide care to our members in skilled nursing facilities in order to reduce readmissions and emergency room visits.</p>
<p>9. Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.</p>	<p>We make sure to be guided by the Completion Instructions to ensure all elements are included.</p>

Recommendations

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

- ◆ To ensure that data integrity is not compromised, revise the process of auto-assigning codes to the PM 160 forms.
- ◆ Implement ongoing monitoring and oversight of all delegated partners to enable the MCP to proactively identify any partner’s process changes and ensure data completeness and accuracy.
- ◆ Assess the factors leading to declining or poor performance and implement strategies to prevent further decline in performance and improve performance for the following measures:
 - *All-Cause Readmissions*, including:
 - Assessing the factors leading to the significant increase in readmissions for the SPD population since the significant decline in performance on this measure is attributed to the SPD readmissions rate increasing significantly from RY 2014 to RY 2015.

- Retesting the intervention from the *All-Cause Readmissions* PDSA cycle to determine if partnering with FQHCs will increase the rate of post-discharge follow-up visits and prevent readmissions.
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs.*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics.*
- While DHCS does not hold MCPs accountable to meet the MPLs for the *Children and Adolescents' Access to Primary Care* measures, the MCP should assess the reasons for the rate for the *25 Months to 6 Years* measure declining significantly from RY 2014 to RY 2015 and the rates being below the MPLs for all four *Children and Adolescents' Access to Primary Care* measures and then implement strategies to improve performance.
- ◆ Although CCHP will not be continuing the formal QIPs, the MCP should evaluate the interventions initiated in Remeasurement 1 of the *Improving Perinatal Access and Care* QIP and continue efforts to improve *Prenatal and Postpartum Care* measures.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix L:
Performance Evaluation Report
Family Mosaic Project
July 1, 2014 – June 30, 2015**

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Appendix L: Performance Evaluation Report – Family Mosaic Project

July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Family Mosaic Project (“FMP” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

FMP is a specialty MCP which provides intensive case management and wraparound services for Medi-Cal Managed Care (MCMC) children and adolescents in San Francisco County who are at risk of out-of-home placement. FMP is part of the Child, Youth, and Family System of Care operated by the City & County of San Francisco Department of Public Health (SFDPH), Community Behavioral Health Services. To receive services from FMP, a beneficiary must meet specific enrollment criteria, including being a San Francisco resident between 3 and 18 years of age, having serious mental health care needs, and being at imminent risk of (or already in) out-of-home placement. The MCP submits appropriate clients to DHCS for approval to be enrolled in FMP’s MCMC. Once a client is approved and included under FMP’s contract with DHCS, the MCP receives a per-beneficiary, per-month capitated rate to provide mental health and related wraparound services to these beneficiaries.

FMP became operational in San Francisco County to provide MCMC services in December 1992. As of June 30, 2015, FMP had 37 MCMC beneficiaries (referred to as “beneficiaries” in this report).¹

Due to the MCP’s unique membership, some of FMP’s contract requirements have been modified from DHCS’s full-scope MCP contracts.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: January 10, 2016.

Compliance Reviews

On April 21, 2014, through May 1, 2014, DHCS's Mental Health Services Division completed an on-site review of San Francisco County Mental Health Plan—FMP's governmental umbrella agency. The purpose of the review was to verify that FMP was providing services in compliance with the California Code of Regulations, Title 9, Chapter 11, section 1810.380. DHCS assessed the following areas:

- ◆ Access
- ◆ Authorization
- ◆ Beneficiary Protection
- ◆ Funding, Reporting, and Contracting Requirements
- ◆ Target Populations and Array of Services
- ◆ Interface with Physical Health Care
- ◆ Provider Relations
- ◆ Program Integrity
- ◆ Quality Improvement
- ◆ Mental Health Services Act (MHSA)
- ◆ Chart Review—Non-hospital Services

DHCS submitted a final report to the MCP October 10, 2014. The final report indicated that DHCS is recouping dollars based on the assessment and provided a summary detailing the items to be recouped. The report stated that FMP was out of compliance with one or more requirements in the following areas:

- ◆ Access
- ◆ Authorization
- ◆ Provider Relations
- ◆ Chart Review—Non-hospital Services

DHCS stated in the report that FMP was required to submit a plan of correction (POC) for all out-of-compliance items within 60 days after the receipt of the final report. As part of the process for producing this MCP-specific evaluation report, DHCS provided HSAG with a copy of the POC

for review. In the POC, FMP documented detailed plans related to each finding from the on-site review.

Strengths

During DHCS's 2014 Mental Health Services Division on-site review, DHCS found FMP to be in compliance with all assessed requirements in the following areas:

- ◆ Beneficiary Protection
- ◆ Funding, Reporting, and Contracting Requirements
- ◆ Target Populations and Array of Services
- ◆ Interface with Physical Health Care
- ◆ Program Integrity
- ◆ Quality Improvement
- ◆ Mental Health Services Act (MHSA)

FMP provided to DHCS a POC for all findings DHCS identified during the on-site review.

Opportunities for Improvement

Since FMP submitted to DHCS the POC for the findings from DHCS's 2014 Mental Health Services Division on-site review, HSAG has no recommendations for the MCP in the area of compliance reviews.

Performance Measure Validation

For reporting year (RY) 2015, FMP was required to report two performance measures—*Out-of-Home Placements* and *School Attendance*. Since neither is a HEDIS^{®2} measure, HSAG conducted performance measure validation for the two performance measures selected, calculated, and reported by the MCP. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services' (CMS's) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012³ (i.e., CMS Performance Measure Validation Protocol). The validation process included three phases:

- ◆ The pre-on-site phase included a review of the Information Systems Capabilities Assessment (ISCA) tool completed by FMP, supportive documentation, and source code used to calculate the performance measures. The pre-on-site phase was also used to plan for the on-site visit.
- ◆ The on-site visit included system evaluation and demonstration, review of data integration and data control, evaluation of data output files, and primary source verification of performance measure beneficiary-level files.
- ◆ The post-on-site phase included both review of follow-up documentation and preliminary performance measure results and final approval of calculations and final results.

Performance Measure Validation—Findings

The *2015 Performance Measure Validation Final Report of Findings for Family Mosaic Project* contains the detailed findings and recommendations from HSAG's performance measure validation of the two measures that FMP was required to report. HSAG auditors determined that each performance measure was fully compliant with the written specifications and that FMP accurately calculated the rates. Additionally, the auditor identified no issues of concern.

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: Feb 19, 2013.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. Table 3.1 and Table 3.2 present summaries of FMP’s performance measure results. Table 3.1 provides a summary of FMP’s *Out-of-Home Placements* measure results for RY 2012 through RY 2015, and Table 3.2 provides the *School Attendance* results for RYs 2014 and 2015.

DHCS establishes minimum performance levels (MPLs) and high performance levels (HPLs) for required HEDIS measures. However, FMP’s measures were developed by the MCP (i.e., they are not HEDIS measures); therefore, DHCS had no national benchmark data from which to derive MPLs or HPLs for FMP’s measures.

Out-of-Home Placements

Measure Definition

The *Out-of-Home Placements* measure indicates the percentage of beneficiaries enrolled in FMP who were discharged to an out-of-home placement (foster care, group home, or residential treatment facility) during the measurement period. The *Out-of-Home Placements* measure falls into the quality and access domains of care. For this measure, a low rate indicates better performance.

**Table 3.1—Multi-Year Performance Measure Results
FMP—San Francisco County
Out-of-Home Placements**

Year	RY 2012 ¹	RY 2013 ²	RY 2014 ³	RY 2015 ⁴	RYs 2014–15 Rate Difference ⁵
Rate	6.3%	4.1%	S	S	↔

¹ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

² RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

³ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁴ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁵ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

S = The MCP’s measure was reportable based on performance measure validation audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

School Attendance

Measure Definition

The *School Attendance* measure indicates the number of capitated beneficiaries enrolled into FMP with a 2 or 3 in school attendance on the initial Child and Adolescent Needs and Strengths (CANS) outcome/assessment tool and a 2 or 3 in school attendance on the most recent closing CANS during the measurement period.

- ◆ 0 = Child/youth attends school regularly.
- ◆ 1 = Child/youth has some problems attending school but generally goes to school. May miss up to one day per week on average OR may have moderate to severe problem in the past six months but has been attending school regularly in the past month.
- ◆ 2 = Child/youth is having problems with school attendance. He/she is missing at least two days per week.
- ◆ 3 = Child/youth is generally truant or refusing to go to school/mental health admission to an inpatient hospital facility during the measurement period.

The *School Attendance* measure falls into the quality domain of care. For this measure, a low rate indicates better performance.

**Table 3.2—Multi-Year Performance Measure Results
FMP—San Francisco County
School Attendance**

Year	RY 2014 ¹	RY 2015 ²	RYs 2014–15 Rate Difference ³
Rate	S	S	↔

¹RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

²RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

³ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

S = The MCP’s measure was reportable based on performance measure validation audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

Performance Measure Findings

The rates showed no statistically significant change from RY 2014 to RY 2015 for the *Out-of-Home Placements* or *School Attendance* measures.

Strengths

HSAG auditors determined that each performance measure was fully compliant with the written specifications and that FMP accurately calculated the rates. Additionally, the auditor identified no issues of concern.

Opportunities for Improvement

FMP has been reporting the *Out-of-Home Placements* measures for four years and will report the measure for a fifth year in RY 2016; therefore, the MCP should work with DHCS to assess whether or not the opportunity exists for FMP to identify a new area in need of improvement.

Quality Improvement Project Objectives

Specialty MCPs must be engaged in two quality improvement projects (QIPs) at all times. However, because specialty MCPs serve unique populations limited in size, DHCS does not require them to participate in the statewide collaborative QIP. Instead, specialty MCPs are required to design and maintain two internal QIPs with the goal of improving health care quality, access, and/or timeliness for the specialty MCP's beneficiaries. FMP had two internal QIPs in progress during the review period of July 1, 2014, through June 30, 2015.

Table 4.1 below lists FMP's QIPs and indicates whether the QIP was clinical or nonclinical and the domains of care (i.e., quality, access, and timeliness) the QIP addressed.

**Table 4.1—Quality Improvement Projects for FMP
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>Child and Adolescent Needs and Strengths (CANS) Depression Rating</i>	Clinical	Q
<i>Increase the Rate of School Attendance</i>	Nonclinical	Q

FMP's *Child and Adolescent Needs and Strengths (CANS) Depression Rating* QIP focused on decreasing the rate of depression for all FMP beneficiaries. By using the CANS outcome/assessment tool, the MCP can assess the beneficiary's needs requiring action, implement a care plan, and determine if that care plan leads to a positive outcome. FMP's data clearly showed that depression is a marked problem for children and youth within FMP. At the initiation of the QIP, approximately 61 percent of FMP's beneficiaries were experiencing problems with depression. FMP aimed to achieve a statistically significant reduction in *CANS Depression Rating* from initial assessment to reassessment.

FMP's *Increase the Rate of School Attendance* QIP focused on increasing the rate of school attendance for beneficiaries ages 5 to 18 years. Poor school attendance correlates to school dropout, substance use and abuse, delinquency connections to adult crime, and additional risky behaviors. Using the CANS outcome/assessment tool, the MCP aimed to reduce the percentage of beneficiaries identified through the tool as either having missed school at least two days per week on average, being generally truant, or refusing to go to school.

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
FMP—San Francisco County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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
Internal QIPs				
<i>Child and Adolescent Needs and Strengths (CANS) Depression Rating</i>	Annual Submission	88%	86%	<i>Partially Met</i>
	Annual Resubmission 1	100%	100%	<i>Met</i>
<i>Increase the Rate of School Attendance</i>	Annual Submission	82%	86%	<i>Partially Met</i>
	Annual Resubmission 1	100%	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, 2014, through June 30, 2015, showed that FMP’s annual submissions of both its *Child and Adolescent needs and Strengths (CANS) Depression Rating* and *Increase the Rate of School Attendance* QIPs each initially received overall validation statuses of *Partially Met*. DHCS requires MCPs to resubmit their QIPs until each QIP achieves an overall *Met* validation status. Based on HSAG’s validation feedback, FMP resubmitted the QIPs; and each achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a *Met* score.

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

Table 4.3—Quality Improvement Project Average Rates*
FMP—San Francisco County
(Number = 4 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	94%	6%	0%
Design Total		98%	2%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation**	88%	0%	13%
	VIII: Appropriate Improvement Strategies	75%	25%	0%
Implementation Total**		83%	8%	8%
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		Not Assessed	Not Assessed	Not Assessed

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through VIII for both of FMP’s *Child and Adolescent Needs and Strengths (CANS) Depression Rating* and *Increase the Rate of School Attendance* QIP annual submissions.

FMP demonstrated a strong application of the Design stage, meeting 98 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP initially did not provide an explanation for how the estimated degree of administrative data completeness and quality was calculated for the *Increase the Rate of School Attendance* QIP, but corrected the documentation in its resubmission.

The MCP demonstrated an adequate application of the Implementation stage, meeting 83 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. FMP did not document the factors that threatened the internal or external validity of baseline results and did not prioritize the barriers identified through the causal/barrier analysis in its initial annual submissions of both the *Child and Adolescent Needs and Strengths (CANS) Depression Rating* and *Increase the Rate of School Attendance* QIPs, resulting in lowered scores for Activities VII and VIII. The MCP corrected the deficiencies in the resubmissions, resulting in each QIP achieving an overall *Met* validation status.

Quality Improvement Project Outcomes and Interventions

The *Child and Adolescent Needs and Strengths (CANS) Depression Rating* and *Increase the Rate of School Attendance* QIPs did not progress to the Outcomes stage during the reporting period; therefore, no outcomes information is included in this report. Following is a summary of the interventions FMP indicated it planned to implement during the Remeasurement 1 time period:

Child and Adolescent Needs and Strengths (CANS) Depression Rating QIP

- ◆ Make referrals to the FMP child psychiatrist for those beneficiaries with a *CANS Depression Rating* of 2 or 3. In partnership with a care coordinator, the psychiatrist will develop and execute a comprehensive care plan.
 - The psychiatrist will be responsible for mental health and medication treatments.
 - The care coordinator will be responsible for all nonclinical aspects of care.

Increase the Rate of School Attendance QIP

- ◆ Make referrals to the FMP educational evaluator for educational testing of those beneficiaries identified as having missed school at least two days per week on average, generally truant, or who refused to go to school.
 - The evaluator will assess the beneficiary's academic skills and deficiencies and recommend a specialized or intensive instruction to improve competency.
 - The evaluator will meet with the care manager, parent/caregiver, and other providers to identify the beneficiary's learning style and develop an individualized education plan.

Strengths

FMP demonstrated a strong application of the Design stage, meeting most applicable evaluation elements within the study stage for both the *Child and Adolescent Needs and Strengths (CANS) Depression Rating* and *Increase the Rate of School Attendance* QIPs.

Opportunities for Improvement

Although FMP will not be continuing the formal QIPs, the MCP should evaluate the interventions initiated in Remeasurement 1 of the *Child and Adolescent Needs and Strengths (CANS) Depression Rating* and *Increase the Rate of School Attendance* QIPs and continue its improvement efforts in the two focus areas.

Encounter Data Validation Studies

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct encounter data validation (EDV) studies in State Fiscal Year (SFY) 2013–14 and SFY 2014–15.

As FMP does not have encounter data, the MCP was not included in the EDV studies. Therefore, no information about the EDV studies is included in this report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Although HSAG uses a standardized scoring process to evaluate each full-scope Medi-Cal MCP's performance measure rates and QIP performance in the areas of quality, access, and timeliness domains of care, HSAG does not use this scoring process for specialty MCPs due to the small size of the specialty MCPs' populations.

Quality

As in previous years, the quality improvement documents submitted by FMP are from the County of San Francisco Department of Public Health, Community Behavioral Health Services since the MCP is part of San Francisco Department of Public Health's network. The documents include descriptions of activities and processes that support the provision of quality behavioral health services to the MCP's beneficiaries.

While FMP met the requirements for most areas assessed during the 2014 DHCS Program Oversight and Compliance Branch, Compliance Section on-site review, DHCS identified findings in the areas of Provider Relations and Chart Review—Non-hospital Services that could affect the quality of care delivered to beneficiaries.

Both of FMP's performance measures fall into the quality domain of care. The rates for both measures showed no statistically significant change from RY 2014 to RY 2015. The consistency in performance suggests that the MCP is experiencing success at implementing strategies that prevent out-of-home placements and support beneficiaries in attending school.

Both of FMP's QIPs fell into the quality domain of care; however, neither QIP progressed to the Outcomes stage during the reporting period.

Access

The quality improvement documents submitted to HSAG for FMP include descriptions of processes designed to monitor and ensure beneficiary access to needed services.

During the 2014 DHCS Program Oversight and Compliance Branch, Compliance Section on-site review, DHCS identified findings in the area of Access which, if not resolved, could affect beneficiaries' access to needed services.

The *Out-of-Home Placements* measure falls into the access domain of care; and, as stated above, the rate for the measure showed no statistically significant change from RY 2014 to RY 2015. FMP's consistent performance suggests that the MCP is ensuring beneficiary access to needed resources to support beneficiaries in remaining in their homes rather than being discharged to out-of-home placements.

Timeliness

As in previous years, FMP's quality improvement documents include descriptions of processes, goals, and objectives related to beneficiary rights, grievances, and utilization management, which can all affect the timeliness of services delivered to beneficiaries.

During the 2014 DHCS Program Oversight and Compliance Branch, Compliance Section on-site review, DHCS identified findings in the area of Authorization which, if not resolved, could affect the timelines of services delivered to beneficiaries.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with FMP's self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP's self-reported actions.

Table 6.1—FMP’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to FMP	Self-Reported Actions Taken by FMP during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
1. To improve the performance measure validation process, based on lessons learned from the first reporting year, work with DHCS and HSAG to make modifications to the <i>School Attendance</i> measure for future reporting years.	Clear guidelines have been established that the school attendance item, as part of the CANS assessment, be rated for every youth at baseline and every six months thereafter. During FY 2014-15 there were 77 youth with a follow-up CANS completed; of those, 27 (35 percent) had a need (rating of 2 or 3) related to school attendance at the previous time point. In addition, FMP and SFDPH Quality Management (QM) staff will make any modifications needed to ensure the data are valid based on feedback from DHCS and HSAG after the next submission.
2. Continue to assess factors leading to the improvement on the <i>Out-of-Home Placements</i> measure to ensure that efforts leading to this positive outcome are continued.	FMP has continued the use of the wraparound model. Several strategies used in the wraparound model impact the factors related to <i>Out-of-Home Placements</i> . The model includes clinicians <i>and</i> behavioral support counselors (this is a new position at FMP) on the treatment team to assist with behavioral interventions in the home, community, and school. The behavioral support counselors help children and youth with coping skills, anger management, and other behavioral intervention they may need to stabilize their placements and reduce their risks of needing a higher level of care.
3. Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.	FMP leadership and SFDPH QM staff have reviewed the QIP summary forms submitted as well as the instructions and validation tools. They will continue to seek guidance from DHCS and HSAG as needed when completing the QIP summary forms and make modifications as needed.

Recommendations

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

- ◆ Since FMP has been reporting the *Out-of-Home Placements* measures for four years and will report the measure for a fifth year in RY 2016, work with DHCS to assess whether or not the opportunity exists for the MCP to identify a new area in need of improvement.
- ◆ Although FMP will not be continuing the formal QIPs, the MCP should evaluate the interventions initiated in Remeasurement 1 of the *Child and Adolescent Needs and Strengths (CANS) Depression Rating* and *Increase the Rate of School Attendance* QIPs and continue improvement efforts in the two focus areas.

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

Medi-Cal Managed Care Technical Report

**Appendix M:
Performance Evaluation Report
Gold Coast Health Plan
July 1, 2014 – June 30, 2015**

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Appendix M: Performance Evaluation Report – Gold Coast Health Plan July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Gold Coast Health Plan (“Gold Coast” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

Gold Coast is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a County Organized Health System (COHS).

Gold Coast became operational to provide MCMC services in Ventura County in July 2011. As of June 30, 2015, Gold Coast had 191,358 beneficiaries.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: January 5, 2016.

Medical Audit

The most recent DHCS medical audit for Gold Coast was conducted February 17, 2015, through February 27, 2015, covering the review period December 1, 2013 through November 30, 2014. DHCS issued the report for the audit outside the review dates for this report. Therefore, HSAG will include a summary of the medical audit findings and DHCS follow-up in Gold Coast's 2015–16 MCP-specific report.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Gold Coast Health Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that Gold Coast followed the appropriate specifications to produce valid rates, and no issues of concern were identified. The auditor noted that despite continuous membership increase and a few mapping changes in the State's beneficiary eligibility files, the MCP experienced no backlogs in processing eligibility files.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 for Gold Coast's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
Gold Coast—Ventura County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	19.17%	13.08%	17.87%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	49.21	38.12	39.21	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	317.16	205.78	209.28	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	86.73%	88.47%	82.14%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	88.46%	93.33%	56.25%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	86.28%	89.51%	83.27%	↓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	13.87%	18.24%	21.15%	↔
Cervical Cancer Screening	Q,A	—	—	60.58%	61.77%	↔
Childhood Immunization Status—Combination 3	Q,A,T	—	80.05%	75.43%	69.97%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	82.51%	97.37%	95.42%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	63.09%	86.27%	83.12%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	NA	82.26%	83.31%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	NA	79.18%	82.01%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	62.29%	61.31%	63.75%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	42.58%	45.74%	60.10%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	81.75%	85.16%	90.51%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	37.96%	45.50%	57.91%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	79.81%	78.10%	83.70%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	56.20%	45.50%	32.85%	▲
Controlling High Blood Pressure	Q	—	61.56%	54.01%	55.01%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	65.21%	60.34%	63.80%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	NA	48.92%	54.16%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	NA	28.03%	31.79%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	63.99%	59.37%	62.81%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	80.78%	83.94%	85.68%	↔
Use of Imaging Studies for Low Back Pain	Q	—	76.95%	77.07%	75.71%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	42.09%	43.80%	80.05%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	42.09%	43.31%	54.26%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	30.41%	28.71%	41.85%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	61.80%	64.23%	67.11%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 Seniors and Persons with Disabilities (SPD) measure results reported by Gold Coast. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

⁴ 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 3.2.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Gold Coast—Ventura County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	12.80%	22.83%	▼	17.87%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	79.63%	86.29%	↑	82.14%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	56.25%
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.29%	88.34%	↑	83.27%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.54%	84.21%	↓	95.42%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.04%	86.37%	↔	83.12%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	83.01%	89.29%	↑	83.31%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	81.92%	83.31%	↔	82.01%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the All-Cause Readmissions measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly higher SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly lower SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A Not Applicable audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures Gold Coast—Ventura County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
196.26	37.05	397.29	70.45

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
Gold Coast—Ventura County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	23.16%	15.06%	22.83%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	70.16	64.02	70.45	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	493.66	361.16	397.29	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.46%	89.11%	86.29%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	88.37%	92.50%	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.97%	90.10%	88.34%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	75.00%	89.74%	84.21%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	61.92%	83.61%	86.37%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	NA	77.69%	89.29%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	NA	72.72%	83.31%	↑

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
Gold Coast—Ventura County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	11.32%	9.53%	12.80%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	46.49	35.36	37.05	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	294.22	189.20	196.26	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.26%	87.52%	79.63%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.15%	88.58%	80.29%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	82.60%	97.46%	95.54%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	63.12%	86.35%	83.04%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	NA	82.53%	83.01%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	NA	79.68%	81.92%	↑

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rates for the following measures were significantly better in RY 2015 when compared to RY 2014:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*; however, the rate remained below the MPL.
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*; however, the rate remained below the MPL.
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing.*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent).*

- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy.*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent).*
- ◆ All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents* measures. The improvement resulted in the rates for the *Nutrition Counseling: Total* and *Physical Activity Counseling: Total* measures moving from below the MPLs in RY 2014 to above the MPLs in RY 2015.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure improved from RY 2014 to RY 2015. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rates for the following measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions.*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015.
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015.
- ◆ *Children and Adolescents' Access to Primary Care Practitioners Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015.
- ◆ *Children and Adolescents' Access to Primary Care Practitioners Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*, and the rate remained below the MPL for the third consecutive year.

Seniors and Persons with Disabilities Findings

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

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*

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

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*

Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measure may be attributed to children and adolescents in the SPD population in the specified age group relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care providers (PCPs).

When comparing the RY 2015 SPD rates to the RY 2014 SPD rates and the RY 2015 non-SPD rates to the RY 2014 non-SPD rates, HSAG noted the following variations:

- ◆ The SPD rates were significantly better in RY 2015 when compared to RY 2014 for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure.
- ◆ The SPD and non-SPD rates were significantly better in RY 2015 when compared to RY 2014 for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure.
- ◆ The SPD rate was significantly worse in RY 2015 when compared to RY 2014 for the *All-Cause Readmissions* measure.
- ◆ The non-SPD rates declined significantly from RY 2014 to RY 2015 for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics*
 - *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*

Assessment of Improvement Plans

Gold Coast was required to submit improvement plans (IPs) and a Plan-Do-Study-Act (PDSA) cycle for the following measures based on RY 2014 performance measure rates:

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling: Total*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling: Total*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Gold Coast identified identical barriers, implemented the same interventions, and conducted the same PDSA cycle for all three measures. The following is a summary of the IP and PDSA cycle implemented by the MCP.

Gold Coast identified the following barriers to the rates for the measures being above the MPLs:

- ◆ Providers not scheduling annual child and adolescent well-care visits for Child Health and Disability Prevention (CHDP) program beneficiaries due to CHDP guidelines.
- ◆ Parents only scheduling child and adolescent well-care visits when the child or adolescent needs immunizations.
- ◆ Providers lacking training regarding HEDIS measure specifications and documentation/coding guidelines.
- ◆ Providers not knowing their HEDIS rates and, therefore, not being aware of the need to develop improvement strategies.

Gold Coast implemented the following interventions to address the barriers:

- ◆ Conducted provider education on the MCP's coverage guidelines versus CHDP guidelines.
- ◆ Provided mid-year 2014 proactive performance feedback reports to providers.
- ◆ Conducted provider HEDIS measure training.
- ◆ Produced provider report cards.

Gold Coast's PDSA cycle tested if meeting with providers to distribute and discuss the results of the HEDIS 2014 provider report cards and to provide advice on improving the measures' rates would engage providers to schedule child and adolescent well-care exams. The MCP determined that the intervention was successful and planned to adopt the intervention. Additionally, the MCP indicated that it planned to disseminate the provider report cards quarterly instead of annually.

The MCP was successful at improving the rates for all three measures to above the MPLs in RY 2015 and will not be required to continue the IP/PDSA cycle for the measures.

Required Improvement Plans for RY 2015

Based on RY 2015 performance measure rates, Gold Coast will be required to submit IPs for the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*

Although the rates were below the MPLs in RY 2015 for all four *Children and Adolescents' Access to Primary Care Practitioners* measures, the MCP will not be required to submit IPs for these measures because DHCS did not require MCPs to meet the MPLs due to the small range of variation between the MPL and HPL thresholds for the measures.

Strengths

Gold Coast followed the appropriate specifications to produce valid performance measure rates, and the HSAG auditor identified no issues of concern. The auditor noted that despite continuous membership increase and a few mapping changes in the State's beneficiary eligibility files, the MCP experienced no backlogs in processing eligibility files.

The rates improved significantly for 10 measures from RY 2014 to RY 2015, and the MCP's improvement efforts resulted in the rates for three measures moving from below the MPLs in RY 2014 to above the MPLs in RY 2015.

Opportunities for Improvement

Gold Coast has the opportunity to identify the factors leading to the decline in performance for five measures and the rates for six measures being below the MPLs and to implement strategies to improve these measures' rates.

Gold Coast's declining performance on the *All-Cause Readmissions* measure can be attributed to the SPD population's readmissions rate. This assessment is based on the SPD rate being significantly worse than the non-SPD rate and the SPD rate being significantly worse in RY 2015 when compared to RY 2014, while the non-SPD rate remained stable. Therefore, Gold Coast has the opportunity to assess the factors leading to the significant increase in readmissions for the SPD population to improve performance on the *All-Cause Readmissions* measure. While Gold Coast provided documentation of actions the MCP has taken to address the readmissions rates (See Table 6.1), the significant increase in readmissions for the SPD population from RY 2014 to RY 2015 suggests that the MCP may need to reassess its improvement efforts to ensure that the strategies adequately address the SPD population's needs.

Quality Improvement Project Objectives

Gold Coast participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists Gold Coast’s QIPs and the QIP conducted; whether the QIP was clinical or nonclinical; and the domains of care (i.e., quality, access, and timeliness) the QIP addressed.

**Table 4.1—Quality Improvement Projects for Gold Coast
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Increasing the Rate of Annual Diabetic Eye Exam</i>	Clinical	Q, A

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

The *Increasing the Rate of Annual Diabetic Eye Exam* QIP targeted the beneficiaries with diabetes and focused on increasing retinal eye exams. Ongoing management of beneficiaries with diabetes is critical both to preventing complications and to ensuring optimal health for these beneficiaries.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
Gold Coast—Ventura County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	77%	86%	<i>Partially Met</i>
Internal QIPs				
<i>Increasing the Rate of Annual Diabetic Eye Exam</i>	Annual Submission	77%	100%	<i>Partially 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, 2014, through June 30, 2015, showed that Gold Coast’s annual submission of both its *All-Cause Readmissions* and *Increasing the Rate of Annual Diabetic Eye Exam* QIPs received an overall validation status of *Partially Met*. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, Gold Coast conducted a PDSA cycle for both the *All-Cause Readmissions* and *Increasing the Rate of Annual Diabetic Eye Exam* QIPs.

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

Table 4.3—Quality Improvement Project Average Rates*
Gold Coast—Ventura County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

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)	67%	33%	0%
	VI: Accurate/Complete Data Collection	70%	20%	10%
Design Total		82%	14%	4%
Implementation	VII: Sufficient Data Analysis and Interpretation**	65%	24%	12%
	VIII: Appropriate Improvement Strategies**	88%	0%	13%
Implementation Total		72%	16%	12%
Outcomes	IX: Real Improvement Achieved	75%	0%	25%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		75%	0%	25%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for Gold Coast’s *All-Cause Readmissions* and *Increasing the Rate of Annual Diabetic Eye Exam* QIPs annual submissions.

Gold Coast demonstrated a sufficient application of the Design stage, meeting 82 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *Increasing the Rate of Annual Diabetic Eye Exam* QIP, the MCP did not accurately document the population size, resulting in a lowered score for Activity V. In addition, for both the *All-Cause Readmissions* and *Increasing the Rate of Annual Diabetic Eye Exam* QIPs, the MCP did not document the accuracy and completeness of administrative data, resulting in a lowered score for Activity VI.

The MCP demonstrated an adequate application of the Implementation stage for both QIPs, meeting 72 percent of the requirements for all applicable evaluation elements within the study stage. For both QIPs, Gold Coast did not document the factors that threatened the internal or external validity of Remeasurement 1 results and miscalculated the *p* values comparing the baseline and Remeasurement 1 rates. Additionally, for the *All-Cause Readmissions* QIP, the MCP provided a baseline rate inconsistent with the audited rate reported to DHCS, resulting in a lowered score for Activity VII. For the *Increasing the Rate of Annual Diabetic Eye Exam* QIP, Gold Coast did not

document an evaluation of each intervention implemented during Remeasurement 1, resulting in a lowered score for Activity VIII.

Both QIPs progressed to the Outcomes stage during the reporting period, meeting 75 percent of the requirements for all applicable evaluation elements for both QIPs. Gold Coast’s *All-Cause Readmissions* QIP achieved statistically significant improvement over baseline at Remeasurement 1. In contrast, the *Increasing the Rate of Annual Diabetic Eye Exam* QIP did not achieve statistically significant improvement over baseline at Remeasurement 1. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for Gold Coast—Ventura County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions		
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older.^		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
19.2%	13.1%*	‡
QIP #2—Increasing the Rate of Annual Diabetic Eye Exam		
Study Indicator: The percentage of members receiving a diabetic retinal eye exam during the measurement year.		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
42.6%	45.7%	‡

^A lower percentage indicates better performance.

‡ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement from the baseline period (*p* value < 0.05).

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

All-Cause Readmissions QIP

Gold Coast met the goal for the *All-Cause Readmissions* QIP by achieving statistically significant decline in readmission rates from baseline to Remeasurement 1. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ Gold Coast conducted a causal/barrier analysis by revisiting the original fishbone diagram developed during baseline, reviewing HEDIS 2013 rate outcomes, and researching medical literature for readmission reduction efforts.
- ◆ The MCP identified the top barrier as the unavailability of a transition of care program at the hospital with the highest admission of beneficiaries. As a result, Gold Coast hired a transition of care nurse to be stationed at the highest-admitting hospital.
- ◆ During the Remeasurement 1 time period, the MCP staff called beneficiaries within 72 hours of discharge to:
 - Ensure that the beneficiaries made and kept their follow-up appointments.
 - Ask if discharge instructions were understood and explain discharge instructions further, as needed.
 - Ask if the beneficiaries filled their prescriptions.
 - Ask how medications were taken to see if beneficiaries understood and complied.
 - Send and provide additional educational material if needed or requested.
 - Provide education in a way that addressed language or educational barriers.

Increasing the Rate of Annual Diabetic Eye Exam QIP

The MCP also met the goal for the *Increasing the Rate of Annual Diabetic Eye Exam* QIP by exceeding the DHCS-established MPL for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure. However, although the rate of annual retinal eye exam moved from below the MPL to above the MPL from baseline to Remeasurement 1, the change was not statistically significant. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ Gold Coast conducted a causal/barrier analysis and prioritized the following barriers:
 - Lack of referral to VSP providers for retinal eye exam
 - Beneficiaries' noncompliance with medical treatment
 - Lack of beneficiary awareness and understanding of diabetes care
 - Lack of provider awareness of the HEDIS measures
 - Missing encounter data

- ◆ Although the interventions were not successful at resulting in statistically significant improvement for the QIP outcomes, the following is a brief description of the interventions Gold Coast implemented during the Remeasurement 1 time period:
 - Sent letters to providers indicating which beneficiaries with diabetes had completed or were pending diabetic screening tests.
 - Provided educational materials in both English and Spanish to beneficiaries with diabetes.
 - Worked with a claims vendor to provide membership files to providers.
 - Collected more detailed and complete medical and vision claims data to improve capture of vision services provided to beneficiaries with diabetes.
 - Increased beneficiaries' awareness of available transportation services.
 - Increased beneficiaries' awareness of vision coverage.

Plan-Do-Study-Act Review

Neither the *All-Cause Readmissions* nor the *Increasing the Rate of Annual Diabetic Eye Exam* QIP achieved a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for each QIP topic.

All-Cause Readmissions

For the *All-Cause Readmissions* PDSA cycle, Gold Coast set the SMART (Specific, Measureable, Achievable, Relevant, Time-bound) Objective as follows:

By March 31, 2015, the MCP will identify top barriers to follow-up care for 80 percent of our high-risk beneficiaries contacted by the MCP discharge nurse by implementing a questionnaire.

The purpose of the *All-Cause Readmissions* PDSA cycle was to test implementing a questionnaire to identify the barriers to follow-up care. The MCP targeted high-risk beneficiaries discharged from Community Memorial Hospital.

Gold Coast completed the *All-Cause Readmissions* PDSA cycle as planned. However, the MCP was only able to reach 29 percent of beneficiaries within three days of discharge. The MCP identified the top two barriers to follow-up care: (1) experiencing a disruption in medication (17.2 percent) and (2) homelessness (14.8 percent). The MCP plans to adopt the intervention and implement it at Ventura County Medical Center. The MCP also indicated that it plans to learn more about the root causes of medication disruption in order to develop solutions.

Annual Diabetic Eye Exam Rate

For the *Annual Diabetic Eye Exam Rate* PDSA cycle, Anthem set the SMART Objective as follows:

By December 31, 2014, increase the number of retinal eye exams among full-scope Medi-Cal beneficiaries diagnosed with diabetes by at least 5 percent (through an incentive program—by offering two free movie tickets [\$25 value] if the beneficiary completes his or her annual eye exam before December 31, 2014).

The purpose of the *Annual Diabetic Eye Exam Rate* PDSA cycle was to test if beneficiary incentives (two free movie tickets [\$25 value]) would increase the number of annual retinal eye exams completed among beneficiaries diagnosed with diabetes.

Gold Coast completed the *Annual Diabetic Eye Exam Rate* PDSA cycle as planned. The results showed that 113 beneficiaries responded and 96 beneficiaries completed the incentive form accurately according to the criteria. Gold Coast compared the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* rates from RY 2014 and RY 2015, and the annual rate demonstrated a statistically significant increase of 16.38 percentage points. Gold Coast concluded that the incentive has the potential to motivate beneficiaries to complete an annual diabetic eye exam; however, additional time is needed to evaluate the effectiveness of the intervention.

Strengths

Gold Coast was one of six MCPs that achieved statistically significant improvement over baseline at Remeasurement 1 for the statewide collaborative *All-Cause Readmissions* QIP.

Opportunities for Improvement

Although Gold Coast will not be continuing the formal QIP, the MCP should continue to reassess the barriers to improvement since the rate for the *All-Cause Readmissions* measure was significantly worse in RY 2015 when compared to RY 2014. In addition, the MCP should evaluate if the incentive offered to beneficiaries who complete their retinal eye exams tested through the *Annual Diabetic Eye Exam Rate* PDSA cycle contributed to the statistically significant improvement in the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure rate.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

Gold Coast’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for Gold Coast. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for Gold Coast

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	34.9%	26.3%	<10th	8.6%	9.2%	25th–75th
Diagnosis Code	42.8%	31.6%	<10th	34.9%	34.6%	25th–75th
Procedure Code	47.6%	43.8%	10th–25th	27.2%	22.5%	25th–75th
Procedure Code Modifier	65.5%	58.5%	25th–75th	44.0%	46.0%	25th–75th
Rendering Provider Name	37.7%	25.0%	10th–25th	19.9%	68.1%	≥90th
Billing Provider Name	37.5%	35.0%	10th–25th	8.9%	8.6%	25th–75th

Overall, the medical record omission rates for Gold Coast ranged from 34.9 percent (*Date of Service*) to 65.5 percent (*Procedure Code Modifier*). All six of Gold Coast’s medical record omission rates were worse than the respective statewide rates, with *Diagnosis Code* and *Rendering Provider Name* worse by 11.2 percentage points and 12.7 percentage points, respectively. When compared to other MCPs’ performance, Gold Coast received a percentile ranking of “<10th” or “10th–25th” for five of the six medical record omission rates and a percentile ranking of “25th–75th” for the remaining rate. These findings suggest a low level of completeness among key encounter data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located, which was the primary reason for Gold Coast.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for Gold Coast contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, Gold Coast’s rates varied from 8.6 percent (*Date of Service*) to 44.0 percent (*Procedure Code Modifier*). Three of Gold Coast’s encounter data omission rates were better than the respective statewide rates, with the *Rendering Provider Name* encounter omission rate being better than the statewide rate by 48.2 percentage points (i.e., received a percentile ranking of “≥90th”). However, Gold Coast performed worse than the statewide encounter data omission rate by 4.7 percentage points for the *Procedure Code* data element. An opportunity exists for Gold Coast

to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider’s billing office made a coding error.
- ◆ DHCS’s encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in Gold Coast’s encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes rather than the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider’s performance of the service and submission of the encounter to Gold Coast (and/or the data subsequently being submitted to DHCS).
- ◆ Gold Coast populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files Gold Coast submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for Gold Coast. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for Gold Coast

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	83.2%	83.6%	25th–75th	NA
Procedure Code	82.0%	77.6%	25th–75th	NA
Procedure Code Modifier	NA	99.5%	NA	—
Rendering Provider Name	88.4%	63.0%	75th–90th	NA
Billing Provider Name	76.2%	68.6%	25th–75th	NA
All-Element Accuracy	18.9%	4.3%	≥90th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were

found to be relatively accurate for Gold Coast, with three of four reportable element accuracy rates higher than the respective statewide rates. Gold Coast's accuracy rate for the *Rendering Provider Name* data element was better than the statewide rate by 25.4 percentage points. When comparing performance among the MCPs, three of the four key data elements with reportable rates received a percentile ranking of "25th–75th", and one element received a percentile ranking of "75th–90th" (*Rendering Provider Name*).

Although Gold Coast's all-element accuracy rate was substantively better than the statewide rate by 14.6 percentage points, only 18.9 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries' medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 81 percent of the dates of service reviewed in this study. While all five key data elements contributed to Gold Coast's relatively low all-element accuracy rate, the *Diagnosis Code* and *Procedure Code* data elements contributed more than the other three key data elements.

Medical Record Review Recommendations

Based on the study findings for Gold Coast, HSAG recommends the following:

- ◆ Accuracy of rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, Gold Coast should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. Gold Coast should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ Gold Coast should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.

- ◆ Gold Coast should investigate the reasons for the relatively high medical record omission rates for all key data elements and develop strategies to improve rates.
- ◆ Gold Coast should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with Gold Coast.
- ◆ Gold Coast should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ Although encounters containing non-standard procedure codes were included in the study, HSAG could not evaluate those encounters due to no criteria existing for comparison.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.

- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP’s Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

Gold Coast’s SFY 2014–15 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the EDV study, which assessed the MCP’s operational and infrastructure changes in support of DHCS’s transition to PACES. Based on review of Gold Coast’s Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist Gold Coast with improving its encounter data quality. DHCS followed up with Gold Coast regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of Gold Coast's performance in the three domains of care—quality, access, and timeliness.

Quality

As in prior years, Gold Coast's quality improvement program description included details about the MCP's organizational structure, which supports the provision of quality care to beneficiaries.

The rates for the following quality measures were significantly better in RY 2015 when compared to RY 2014:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing.*

- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent).*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy.*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent).*
- ◆ All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures. The improvement resulted in the rates for the *Nutrition Counseling: Total* and *Physical Activity Counseling: Total* measures moving from below the MPLs in RY 2014 to above the MPLs in RY 2015.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which falls into the quality domain of care, improved from RY 2014 to RY 2015. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rates for the following quality measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015

For quality measures stratified by the SPD and non-SPD populations, the SPD rates were significantly better than the non-SPD rates for the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*

Additionally, the SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of the MCP's QIPs fell into the quality domain of care. Both QIPs progressed to the Outcomes stage. Only the *All-Cause Readmissions* QIP had achieved statistically significant improvement from baseline (RY 2013) at Remeasurement 1 (RY 2014). However, the readmissions rate increased significantly from RY 2014 to RY 2015, suggesting that the MCP should modify its strategies for reducing readmissions, including targeting efforts toward the SPD population based on the significant increase in readmissions for this population.

Gold Coast conducted a PDSA cycle for each QIP topic. For the *All-Cause Readmissions* topic, to identify barriers to follow-up care, the MCP implemented a questionnaire with high-risk beneficiaries discharged from a targeted hospital. The MCP only reached a small percentage of beneficiaries and indicated that it planned to adopt the intervention and implement it at another hospital. Additionally, the MCP indicated that it would conduct further assessment on the root causes of beneficiaries experiencing a disruption in medication, which was the top barrier identified from the survey.

The PDSA cycle for the *Annual Diabetic Eye Exam Rate* topic tested if providing beneficiary incentives would increase the number of annual retinal eye exams among beneficiaries with diabetes. The rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure improved significantly from RY 2014 to RY 2015, suggesting that the incentive may motivate beneficiaries to complete the exams.

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

Access

Gold Coast's 2015 quality improvement work plan includes access-related goals. Additionally, the MCP's quality improvement program evaluation indicated that all evaluated access standards were met.

The rates for the following access measures were significantly better in RY 2015 when compared to RY 2014:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*; however, the rate remained below the MPL.
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*; however, the rate remained below the MPL.
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing.*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy.*

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which falls into the access domain of care, improved from RY 2014 to RY 2015. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rates for the following access measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions.*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015.
- ◆ *Children and Adolescents' Access to Primary Care Practitioners Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*, and the rate remained below the MPL for the third consecutive year.

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The following was noted in the comparison of the SPD and non-SPD rates:

- ◆ The SPD rate was significantly better than the non-SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure.
- ◆ The SPD rates were significantly worse than the non-SPD rates for the following measures:
 - *All-Cause Readmissions*
 - *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*

As stated above, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measure may be attributed to children and adolescents in the SPD population in the specified age group relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from PCPs.

Both of the MCP's QIPs fell into the access domain of care and, as indicated above, both QIPs progressed to the Outcomes stage. Although the *All-Cause Readmissions* QIP achieved statistically significant improvement at Remeasurement 1, since the readmissions rate significantly increased from RY 2014 to RY 2015, Gold Coast should modify its strategies for reducing readmissions, including targeting efforts toward the SPD population based on the significant increase in readmissions for this population.

As indicated above, to identify the barriers to follow-up care, Gold Coast implemented a questionnaire with high-risk beneficiaries discharged from a targeted hospital. Also, the MCP indicated that it would conduct further assessment on the root causes of beneficiaries experiencing a disruption in medication, which may reveal access issues that beneficiaries may face in obtaining adequate medication treatments.

As described above, Gold Coast provided beneficiary incentives to increase the number of annual retinal eye exams among beneficiaries with diabetes. The significant improvement in the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure from RY 2014 and RY 2015 suggests that beneficiaries with diabetes have adequate access to retinal eye exams.

Overall, Gold Coast showed below-average performance related to the access domain of care.

Timeliness

Gold Coast's quality improvement program description includes brief summaries of the MCP's objectives and processes related to utilization management, grievances and appeals, and coordination and continuity of care, all of which may affect the timeliness of care delivered to beneficiaries.

Five of the required performance measures fall into the timeliness domain of care. The rates for all five measures were between the MPLs and HPLs. The rate for one of these measures, the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

Overall, Gold Coast 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with Gold Coast's self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP's self-reported actions.

Table 6.1—Gold Coast’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation																
<p>1. To improve the HEDIS audit process, reconcile the MCP’s data to ensure enrollment data integrity.</p>	<p>Gold Coast Health Plan’s contract claims vendor, Xerox, runs an audit report every other month to look for discrepancies between the State membership files and the Ika Systems (cases that disappeared from the monthly files without any indication in the daily transactional files).</p>																
<p>2. Assess the factors leading to the rates being below the MPLs for six measures, and identify strategies to improve the rates. Given DHCS and MCP priorities, the MCP may want to initially focus efforts on the following measures:</p> <ul style="list-style-type: none"> a. <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i> b. <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i> c. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i> 	<p>The Quality Improvement (QI) Department developed a performance improvement plan that included the following interventions to improve the rates for these measures:</p> <ul style="list-style-type: none"> • HEDIS 2014 Provider Report Cards were distributed to providers during the summer of 2014. The report cards listed their officially reported HEDIS rates for these measures and were intended to educate physicians on their performance and to engage them in improving their rates. • HEDIS 2015 Performance Feedback Reports listed the providers’ 2015 tentative rates and listed which members had and had not had their well-child visits as of June 2015. These were also distributed to providers during the summer months of 2014. The intent of this intervention was to help providers identify which members were still missing their well-child exams in 2014 in order to engage them in reaching out to their members to schedule well-child exam visits. • Provider Education was given in 2014. One of the barriers to improved rates was deficient documentation and coding of well-child exams, especially for the <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i> measure. The QI Department provided the following provider education: <ul style="list-style-type: none"> 1. In August 2014, we updated the <i>Intro to HEDIS</i> PowerPoint presentation to include sections on coding guidelines, re-published the presentation on the Gold Coast website, and sent an e-blast memo to the providers emphasizing the updates. 2. In September 2014, we created a <i>HEDIS: Annual Children & Adolescent Wellness Measures</i> presentation to educate providers on these measures and how to improve them. The presentation was also sent via an e-blast and posted on the Gold Coast website. 3. We continued educating providers that Gold Coast does not follow CHDP’s periodicity schedule and that providers should schedule member wellness exams annually. <p>The table below shows that the HEDIS 2015 rates for the measures did improve in 2014.</p> <table border="1" data-bbox="673 1680 1380 1900"> <thead> <tr> <th>HEDIS Measure</th> <th>2012 Rate</th> <th>2013 Rate</th> <th>2014 Rate</th> </tr> </thead> <tbody> <tr> <td><i>WCC_Nutrition</i></td> <td>42.09</td> <td>43.31</td> <td>54.26</td> </tr> <tr> <td><i>WCC_Physical Activity</i></td> <td>30.41</td> <td>28.71</td> <td>41.85</td> </tr> <tr> <td><i>W34</i></td> <td>61.80</td> <td>64.23</td> <td>67.11</td> </tr> </tbody> </table>	HEDIS Measure	2012 Rate	2013 Rate	2014 Rate	<i>WCC_Nutrition</i>	42.09	43.31	54.26	<i>WCC_Physical Activity</i>	30.41	28.71	41.85	<i>W34</i>	61.80	64.23	67.11
HEDIS Measure	2012 Rate	2013 Rate	2014 Rate														
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2013–14 External Quality Review Recommendation Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation																																									
<p>3. Assess the factors leading to the rate declining significantly from 2013 to 2014 for the <i>Controlling High Blood Pressure</i> measure to ensure that the rate remains above the MPL.</p>	<p>Due to significant staffing shortages in 2014, the QI Department did not have the resources to assess the factors leading to the significant rate decline for the CBP measure from 2013 to 2014. Although the rate has remained stable between 2014 and 2015 (please see table below), the QI Department is currently in the process of evaluating the cause of the decline and working with our Health Services department to implement disease management and/or case management strategies to improve this measure.</p> <table border="1" data-bbox="667 611 1382 743"> <thead> <tr> <th>HEDIS Measure</th> <th>2012 Rate</th> <th>2013 Rate</th> <th>2014 Rate</th> </tr> </thead> <tbody> <tr> <td>CBP</td> <td>61.56</td> <td>54.01</td> <td>55.01</td> </tr> </tbody> </table>	HEDIS Measure	2012 Rate	2013 Rate	2014 Rate	CBP	61.56	54.01	55.01																																	
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<p>4. For the following measures with SPD rates significantly worse than the non-SPD rates, assess the factors leading to the significantly worse SPD rates to ensure that the MCP is meeting the SPD population’s needs:</p> <p>a. <i>All-Cause Readmissions</i>—Note that the SPD rate for this measure improved significantly from 2013 to 2014. The MCP should continue to implement the strategies that resulted in improvement on the SPD rate for this measure.</p> <p>b. <i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months</i></p> <p>c. <i>Children and Adolescents’ Access to Primary Care Practitioners—7 to 11 Years</i></p> <p>d. <i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i></p>	<p>For the <i>All-Cause Readmissions</i>, the QI department had implemented an intervention to contact members, post discharge, to ensure that their post-discharge needs were met and assess for any patients at risk for readmission. In 2014, the effectiveness of this intervention was reassessed and the patient questionnaire was revised to include more open-ended questions to improve gauging the patients’ needs and a nurse was assigned to screen these calls.</p> <p>For the <i>Children and Adolescents’ Access to Primary Care Practitioners</i> measure, the interventions listed in Question #2 were intended to help increase PCP utilization by increasing annual well-child exams. The table below shows that there has been improvement in the SPD population.</p> <table border="1" data-bbox="667 1205 1344 1667"> <thead> <tr> <th rowspan="2">CAP Measure</th> <th colspan="2">2012 Rates</th> <th colspan="2">2013 Rates</th> <th colspan="2">2014 Rates</th> </tr> <tr> <th>SPD</th> <th>Non-SPD</th> <th>SPD</th> <th>Non-SPD</th> <th>SPD</th> <th>Non-SPD</th> </tr> </thead> <tbody> <tr> <td>12–24 Mos.</td> <td>75.00</td> <td>82.60</td> <td>89.74</td> <td>97.46</td> <td>84.21</td> <td>95.54</td> </tr> <tr> <td>25 Mos. – 6 Years</td> <td>61.92</td> <td>63.12</td> <td>83.61</td> <td>86.35</td> <td>86.37</td> <td>83.04</td> </tr> <tr> <td>7–11 Years</td> <td>NR</td> <td>NR</td> <td>77.69</td> <td>82.53</td> <td>89.29</td> <td>83.01</td> </tr> <tr> <td>12–19 Years</td> <td>NR</td> <td>NR</td> <td>72.72</td> <td>79.68</td> <td>83.31</td> <td>81.92</td> </tr> </tbody> </table>	CAP Measure	2012 Rates		2013 Rates		2014 Rates		SPD	Non-SPD	SPD	Non-SPD	SPD	Non-SPD	12–24 Mos.	75.00	82.60	89.74	97.46	84.21	95.54	25 Mos. – 6 Years	61.92	63.12	83.61	86.35	86.37	83.04	7–11 Years	NR	NR	77.69	82.53	89.29	83.01	12–19 Years	NR	NR	72.72	79.68	83.31	81.92
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<p>5. Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.</p>	<p>Due to staffing changes, some of the QIP documentation for the <i>All-Cause Readmissions</i> was saved on personal computer drives of employees who resigned from Gold Coast, making the documentation inaccessible to the current employees. The QI Department has implemented a process to centralize the collection of all QI project documents in the QI Department’s network drive to ensure that all required documentation is included in the QIPs.</p>																																									

Recommendations

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

- ◆ Gold Coast has the opportunity to identify the factors leading to the decline in performance or poor performance for the following measures and to implement strategies to improve these measures' rates.
 - *All-Cause Readmissions*, with a specific focus on assessing the factors leading to the significant increase in hospital readmissions for the SPD population. While it is expected that the SPD population would have a higher readmissions rate, it is important that Gold Coast ensure that the MCP is meeting the needs of this population.
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics*
 - All four *Children and Adolescents' Access to Primary Care Practitioners* measures (While DHCS does not hold MCPs accountable to meet the MPLs for these measures due to the small range of variation between the MPL and HPL thresholds for each measure, the MCP should strive to improve performance to ensure that children and adolescents are being seen by their PCPs in accordance with HEDIS specifications.)
- ◆ Although Gold Coast will not be continuing the formal QIP, the MCP should evaluate if the incentive offered to beneficiaries who complete retinal eye exams tested through the *Annual Diabetic Eye Exam Rate* PDSA cycle contributed to the statistically significant improvement in the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure rate.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix N:
Performance Evaluation Report
Health Net Community Solutions, Inc.
July 1, 2014 – June 30, 2015**

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Appendix N: Performance Evaluation Report

Health Net Community Solutions, Inc.

July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Health Net Community Solutions, Inc. (“Health Net” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

Health Net is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) in which Health Net serves as the commercial MCP under the Two-Plan Model (TPM) and as a Geographic Managed Care (GMC) model.

Table 1.1 shows the counties in which Health Net provided services to beneficiaries under the TPM and denotes which MCP is the “Local Initiative” (LI). Beneficiaries may enroll in Health Net, the commercial MCP; or in the alternative LI.

Table 1.1—Local Initiative Plans in Counties Health Net Serves Under the Two-Plan Model as the Commercial Managed Care Plan

County	Local Initiative Plan
Kern	Kern Family Health Care
Los Angeles	L.A. Care Health Plan
San Joaquin	Health Plan of San Joaquin
Stanislaus	Health Plan of San Joaquin
Tulare	Anthem Blue Cross Partnership Plan

Health Net operates under the GMC model in the counties of Sacramento and San Diego. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within a specified geographic area (county).

For Sacramento County, beneficiaries may select from the following MCPs in addition to Health Net:

- ◆ Anthem Blue Cross Partnership Plan
- ◆ Kaiser NorCal
- ◆ Molina Healthcare of California Partner Plan, Inc.

For San Diego County, beneficiaries may select from the following MCPs in addition to Health Net:

- ◆ Care1st Partner Plan
- ◆ Community Health Group Partnership Plan
- ◆ Kaiser SoCal
- ◆ Molina Healthcare of California Partner Plan, Inc.

Health Net became operational in Sacramento County to provide MCMC services in 1994 and then expanded into its additional contracted counties, the most recent being San Joaquin County in January 2013. Table 1.2 shows the number of beneficiaries enrolled in Health Net for each county, the percentage of beneficiaries enrolled in Health Net for each county, and the MCP's total number of beneficiaries as of June 30, 2015.¹

Table 1.2—Health Net Enrollment as of June 30, 2015

County	Enrollment as of June 30, 2015	Health Net's Percentage of Beneficiaries Enrolled in the County
Kern	74,339	27%
Los Angeles	941,309	35%
Sacramento	120,812	30%
San Diego	69,201	11%
San Joaquin	25,061	20%
Stanislaus	75,370	27%
Tulare	98,561	53%
Total	1,404,653	

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: November 24, 2015.

2. MANAGED CARE HEALTH PLAN COMPLIANCE

for Health Net Community Solutions, Inc.

Medical Audit

The most recent medical audit for Health Net was conducted May 14, 2013, through May 24, 2013, covering the review period of March 1, 2012, through February 28, 2013. HSAG provides a summary of the audit and findings below.

DHCS assessed the following areas:

- ◆ Utilization Management
- ◆ Continuity of Care
- ◆ Access and Availability
- ◆ Member's Rights & Responsibilities
- ◆ Quality Improvement System
- ◆ Organization and Administration of Plan

DHCS identified findings and made recommendations in all areas reviewed. In a letter dated October 20, 2014, DHCS stated that on October 10, 2014, Health Net provided DHCS with its latest response to the corrective action plan (CAP) originally issued by DHCS on January 9, 2014. DHCS stated that it had reviewed all open items and found Health Net to be in compliance. Therefore, DHCS closed the CAP.

Strengths

Health Net fully resolved all findings from the May 2013 medical audit.

Opportunities for Improvement

Since Health Net has no outstanding findings from its most recent medical audit, HSAG has no recommendations related to the area of compliance.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Health Net Community Solutions, Inc.* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that Health Net followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the notable findings is included below.

- ◆ Despite a significant increase (42 percent) in membership during the reporting year (RY), Health Net experienced no backlogs or delays in beneficiary data processing.
- ◆ Health Net implemented a team approach using trained analysts to conduct quality checks that ensured data integration and integrity for HEDIS reporting.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 through Table 3.7 for Health Net's performance measure results for RYs 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1 through Table 3.7

The reader should note the following regarding Table 3.1 through Table 3.7:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
Health Net—Kern County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	10.40%	11.50%	15.94%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	47.52	53.28	54.16	36.06	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	269.41	200.09	350.94	229.06	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	77.67%	75.85%	82.19%	87.74%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	83.33%	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	79.57%	76.59%	81.82%	88.10%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	17.23%	26.00%	23.14%	21.77%	↔
Cervical Cancer Screening	Q,A	—	—	49.64%	49.64%	↔
Childhood Immunization Status—Combination 3	Q,A,T	71.35%	68.71%	65.28%	67.29%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	93.78%	89.78%	92.95%	90.50%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	80.79%	70.48%	79.16%	79.39%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	78.17%	68.16%	67.96%	72.20%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	81.18%	76.57%	67.50%	71.83%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	65.82%	50.12%	50.36%	55.72%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	54.04%	44.28%	42.34%	47.93%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	78.52%	73.24%	76.89%	83.21%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	40.88%	38.20%	33.33%	42.82%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	83.14%	80.78%	79.32%	86.13%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	50.58%	52.80%	60.10%	45.74%	▲
Controlling High Blood Pressure	Q	—	51.34%	47.20%	64.48%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	60.58%	71.90%	73.39%	75.00%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	69.12%	55.20%	50.76%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	51.47%	35.29%	22.90%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	62.41%	53.09%	54.15%	60.15%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	89.47%	78.87%	71.71%	72.13%	↔
Use of Imaging Studies for Low Back Pain	Q	75.26%	73.53%	74.70%	75.47%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	55.28%	72.02%	78.65%	78.04%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	71.24%	81.02%	86.98%	81.42%	↓
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	51.24%	63.99%	77.86%	72.97%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	69.21%	65.54%	71.54%	68.13%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.2—Multi-Year Performance Measure Results*
Health Net—Los Angeles County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	11.93%	11.64%	17.29%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	33.03	36.51	35.29	22.52	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	241.22	251.36	274.97	170.14	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	74.03%	76.09%	80.35%	84.62%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	76.99%	85.92%	86.38%	48.23%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	74.07%	76.27%	80.78%	84.19%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	21.40%	40.16%	27.72%	31.32%	↑
Cervical Cancer Screening	Q,A	—	—	61.80%	51.53%	↓
Childhood Immunization Status—Combination 3	Q,A,T	87.62%	81.63%	76.15%	75.74%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	96.13%	94.29%	94.47%	91.83%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	88.17%	81.11%	81.18%	80.84%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	87.98%	83.12%	81.99%	84.33%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	85.90%	82.82%	77.41%	79.54%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	67.53%	50.12%	59.61%	59.85%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	58.82%	47.69%	50.36%	55.72%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	83.53%	78.10%	79.81%	86.37%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	48.47%	39.90%	45.26%	45.74%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	82.35%	82.97%	81.27%	86.13%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	39.76%	48.42%	48.66%	38.20%	▲
Controlling High Blood Pressure	Q	—	57.91%	56.33%	63.46%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	65.02%	73.67%	78.66%	73.26%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	72.65%	53.36%	51.01%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	49.52%	33.05%	29.19%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	52.34%	48.05%	45.01%	51.82%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.64%	73.41%	68.37%	73.97%	↔
Use of Imaging Studies for Low Back Pain	Q	81.09%	78.01%	76.76%	76.71%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	71.53%	75.78%	70.35%	76.23%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	79.86%	80.73%	75.47%	74.86%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	63.66%	66.41%	67.65%	71.31%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	83.10%	77.08%	69.26%	70.90%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant decline in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant improvement in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.3—Multi-Year Performance Measure Results*
Health Net—Sacramento County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	12.15%	12.69%	17.19%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	38.10	45.02	44.04	30.09	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	241.00	300.55	305.99	172.89	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	59.33%	67.16%	72.60%	79.88%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	82.46%	84.75%	38.18%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	55.59%	67.40%	70.56%	79.52%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	20.21%	51.66%	27.62%	30.96%	↔
Cervical Cancer Screening	Q,A	—	—	48.91%	51.34%	↔
Childhood Immunization Status—Combination 3	Q,A,T	69.55%	66.67%	59.57%	62.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	95.41%	92.53%	92.57%	88.84%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	84.73%	80.19%	81.06%	80.16%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	84.22%	80.69%	79.43%	80.97%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	83.57%	81.64%	75.02%	76.97%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	62.91%	48.91%	45.99%	59.12%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	48.36%	40.63%	37.96%	39.90%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	83.57%	77.86%	77.62%	78.59%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	52.82%	43.55%	48.18%	47.69%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	82.63%	83.45%	80.29%	84.67%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	35.92%	45.26%	46.23%	40.15%	↔
Controlling High Blood Pressure	Q	—	54.50%	45.72%	58.88%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	54.61%	63.08%	62.76%	62.37%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	78.74%	58.83%	55.97%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	55.94%	40.03%	31.96%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	60.78%	53.16%	49.02%	58.15%	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.58%	81.77%	77.07%	82.00%	↔
Use of Imaging Studies for Low Back Pain	Q	87.52%	87.00%	85.49%	78.12%	↓

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	69.51%	77.32%	59.06%	72.82%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	77.58%	76.34%	72.95%	70.32%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	52.69%	57.07%	58.81%	63.84%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	78.20%	71.18%	67.54%	68.58%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Performance Measure Results*
Health Net—San Diego County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	15.96%	15.90%	24.12%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	44.10	50.92	46.66	25.76	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	258.60	317.66	354.48	207.58	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	78.12%	83.68%	89.08%	83.46%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	100.00%	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	77.56%	83.82%	88.33%	84.51%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	18.46%	44.85%	28.18%	33.82%	↔
Cervical Cancer Screening	Q,A	—	—	39.66%	41.12%	↔
Childhood Immunization Status—Combination 3	Q,A,T	77.30%	72.30%	67.46%	74.32%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	94.01%	93.98%	95.87%	92.46%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	85.83%	85.27%	87.67%	84.80%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	85.38%	84.91%	86.20%	87.52%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	82.99%	82.51%	82.09%	81.01%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	64.38%	52.07%	46.23%	57.91%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	51.91%	45.99%	44.77%	49.15%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.48%	85.40%	77.13%	77.62%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	48.35%	50.85%	38.69%	47.20%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	78.63%	82.24%	78.10%	80.54%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	41.48%	41.61%	54.01%	43.31%	▲
Controlling High Blood Pressure	Q	—	55.23%	44.72%	61.56%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	65.29%	76.86%	66.23%	70.08%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	75.28%	57.50%	54.44%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	55.06%	40.00%	34.36%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	54.77%	53.75%	41.11%	44.12%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.38%	76.67%	62.78%	60.29%	↔
Use of Imaging Studies for Low Back Pain	Q	77.40%	76.04%	64.79%	74.80%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	67.56%	72.99%	77.32%	80.46%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	67.78%	74.70%	74.59%	74.14%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	49.56%	67.15%	70.77%	73.56%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	70.00%	74.43%	76.64%	69.18%	↓

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—Multi-Year Performance Measure Results*
Health Net—San Joaquin County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	18.60%	21.67%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	53.47	31.01	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	266.70	143.82	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	67.00%	74.48%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	65.45%	79.21%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	NA	26.32%	Not Comparable
Cervical Cancer Screening	Q,A	—	—	20.92%	36.25%	↑
Childhood Immunization Status—Combination 3	Q,A,T	—	—	NA	57.59%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	92.11%	86.51%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	76.97%	69.64%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	77.40%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	75.12%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	34.96%	54.39%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	39.02%	53.82%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	73.17%	81.87%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	29.27%	45.33%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	81.30%	84.70%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	65.04%	41.08%	▲
Controlling High Blood Pressure	Q	—	—	30.86%	54.38%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	NA	59.33%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	NA	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	NA	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	46.38%	49.12%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	71.01%	78.95%	↔
Use of Imaging Studies for Low Back Pain	Q	—	—	NA	80.72%	Not Comparable

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	61.07%	68.80%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	68.37%	73.22%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	55.72%	63.39%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	59.12%	66.08%	↑

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.6—Multi-Year Performance Measure Results*
Health Net—Stanislaus County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	8.71%	10.97%	15.37%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	49.38	55.13	62.40	41.14	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	349.91	369.94	392.65	230.36	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	75.91%	83.73%	83.17%	80.74%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	NA	NA	50.00%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	79.78%	84.46%	84.38%	85.11%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	29.55%	32.31%	22.19%	30.69%	↑
Cervical Cancer Screening	Q,A	—	—	48.18%	54.99%	↔
Childhood Immunization Status—Combination 3	Q,A,T	68.52%	71.67%	70.18%	65.52%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	97.18%	97.04%	95.59%	92.99%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	88.90%	87.15%	85.89%	84.31%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	87.88%	85.24%	86.39%	86.38%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	85.93%	86.00%	83.84%	82.60%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	67.30%	58.39%	58.64%	63.75%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	50.00%	41.61%	41.36%	46.47%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.60%	88.32%	87.10%	80.29%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	53.08%	56.93%	51.82%	47.20%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	77.01%	78.59%	78.35%	75.43%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	36.49%	31.87%	37.23%	41.36%	↔
Controlling High Blood Pressure	Q	—	56.20%	56.30%	63.46%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	54.18%	65.77%	56.65%	59.01%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	77.04%	57.78%	51.68%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	52.55%	38.22%	33.02%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	60.10%	58.73%	55.61%	58.72%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	91.52%	91.90%	83.29%	83.78%	↔
Use of Imaging Studies for Low Back Pain	Q	83.83%	83.22%	77.33%	80.41%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	58.68%	70.56%	66.83%	80.67%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	65.75%	65.69%	62.59%	67.53%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	40.18%	58.15%	66.08%	67.01%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	71.11%	70.47%	70.11%	71.26%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.7—Multi-Year Performance Measure Results*
Health Net—Tulare County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	11.86%	11.74%	12.75%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	39.30	41.73	42.27	27.13	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	386.74	467.09	505.10	311.82	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	83.59%	83.50%	84.77%	84.34%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	NA	91.43%	42.11%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	79.73%	84.60%	84.10%	85.51%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	22.85%	26.14%	24.05%	23.25%	↔
Cervical Cancer Screening	Q,A	—	—	59.85%	63.32%	↔
Childhood Immunization Status—Combination 3	Q,A,T	78.93%	78.47%	75.69%	74.44%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	97.32%	97.76%	97.60%	95.94%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	92.25%	92.37%	91.99%	89.77%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	92.76%	91.72%	91.23%	90.35%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	91.48%	93.05%	89.42%	88.53%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	67.45%	54.26%	55.96%	61.80%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	56.84%	41.85%	50.12%	50.61%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	83.02%	86.62%	79.56%	84.18%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	47.88%	49.64%	45.26%	49.39%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	82.78%	82.00%	79.56%	87.83%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	43.40%	43.55%	47.45%	40.88%	↔
Controlling High Blood Pressure	Q	—	54.01%	49.39%	64.72%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	61.80%	78.32%	76.04%	77.70%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	72.85%	52.92%	43.13%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	47.68%	32.82%	22.27%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	67.93%	65.57%	57.98%	63.03%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	93.75%	90.16%	88.56%	88.34%	↔
Use of Imaging Studies for Low Back Pain	Q	82.72%	80.00%	83.22%	81.70%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	77.57%	76.64%	65.94%	86.13%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	66.36%	66.42%	65.69%	75.67%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	45.33%	49.15%	49.88%	69.10%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	77.32%	73.31%	80.18%	78.89%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.8 through Table 3.21 present a summary of the RY 2015 Seniors and Persons with Disabilities (SPD) measure results reported by Health Net. Table 3.8 through Table 3.14 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.15 through Table 3.21 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.8—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—Kern County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	13.78%	17.40%	▼	15.94%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.59%	87.92%	↔	87.74%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.56%	89.45%	↔	88.10%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	90.57%	NA	Not Comparable	90.50%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	79.49%	75.34%	↔	79.39%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	71.93%	76.60%	↔	72.20%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	72.05%	69.12%	↔	71.83%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

⁴ 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 3.8 through 3.14.

Table 3.9—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—Los Angeles County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	12.52%	20.98%	▼	17.29%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.53%	84.74%	↔	84.62%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	43.75%	50.23%	↔	48.23%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.58%	84.98%	↑	84.19%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	92.03%	69.34%	↓	91.83%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	80.93%	77.43%	↓	80.84%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	84.42%	82.75%	↓	84.33%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	79.84%	75.34%	↓	79.54%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

Table 3.10—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—Sacramento County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	12.34%	19.25%	▼	17.19%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	76.78%	81.51%	↑	79.88%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	37.25%	Not Comparable	38.18%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	74.42%	82.32%	↑	79.52%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	89.13%	73.17%	↓	88.84%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	80.12%	81.67%	↔	80.16%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	80.76%	84.02%	↔	80.97%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	76.93%	77.37%	↔	76.97%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.11—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	13.39%	26.64%	▼	24.12%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	74.66%	86.09%	↑	83.46%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	77.67%	86.53%	↑	84.51%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	92.45%	NA	Not Comparable	92.46%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	85.13%	75.36%	↓	84.80%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	88.08%	80.08%	↓	87.52%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	81.69%	75.00%	↓	81.01%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.12—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—San Joaquin County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	15.96%	27.18%	▼	21.67%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	74.48%	74.47%	↔	74.48%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.23%	81.48%	↔	79.21%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	86.67%	NA	Not Comparable	86.51%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	69.42%	NA	Not Comparable	69.64%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	76.98%	NA	Not Comparable	77.40%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	75.17%	NA	Not Comparable	75.12%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.13—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—Stanislaus County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	12.35%	17.13%	▼	15.37%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	78.65%	82.29%	↔	80.74%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	50.00%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.29%	86.23%	↔	85.11%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	93.01%	NA	Not Comparable	92.99%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	84.22%	86.89%	↔	84.31%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	86.31%	87.26%	↔	86.38%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	82.44%	84.42%	↔	82.60%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.14—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Health Net—Tulare County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	10.34%	14.81%	▼	12.75%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.43%	85.33%	↔	84.34%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	42.11%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.07%	87.97%	↑	85.51%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	95.95%	NA	Not Comparable	95.94%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	89.74%	90.75%	↔	89.77%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	90.28%	91.46%	↔	90.35%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	88.49%	88.97%	↔	88.53%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.15—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures Health Net—Kern County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
226.19	33.30	248.74	55.00

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

Table 3.16—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures Health Net—Los Angeles County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
173.02	21.65	150.49	28.53

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

Table 3.17—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures Health Net—Sacramento County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
169.33	28.31	191.02	39.16

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

Table 3.18—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures Health Net—San Diego County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
218.65	24.93	155.22	29.69

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

**Table 3.19—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net—San Joaquin County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
142.99	29.20	153.04	51.30

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

**Table 3.20—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net—Stanislaus County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
225.96	38.34	261.19	60.78

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

**Table 3.21—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net—Tulare County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
305.08	25.50	375.32	42.48

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

Table 3.22 through Table 3.28 present the three-year trending information for the SPD population, and Table 3.29 through Table 3.35 present the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.22—RY 2015 (MY 2014) HEDIS SPD Trend Table
Health Net—Kern County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	11.72%	12.18%	17.40%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	80.74	83.64	55.00	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	219.48	302.99	248.74	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	78.34%	80.38%	87.92%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.90%	81.49%	89.45%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	68.83%	73.87%	75.34%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	72.27%	70.16%	76.60%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	73.89%	63.26%	69.12%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.23—RY 2015 (MY 2014) HEDIS SPD Trend Table
Health Net—Los Angeles County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	14.16%	13.40%	20.98%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	55.77	52.60	28.53	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	267.73	262.13	150.49	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	77.01%	81.62%	84.74%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	86.48%	87.45%	50.23%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.39%	82.59%	84.98%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	86.07%	73.01%	69.34%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	76.93%	78.05%	77.43%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	83.57%	81.11%	82.75%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	78.40%	73.04%	75.34%	↑

* Member months are a member’s “contribution” to the total yearly membership.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.24—RY 2015 (MY 2014) HEDIS SPD Trend Table
Health Net—Sacramento County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	14.03%	13.70%	19.25%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	65.06	64.11	39.16	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	399.51	358.78	191.02	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	69.20%	74.02%	81.51%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	83.93%	84.75%	37.25%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	71.03%	72.64%	82.32%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	NA	97.22%	73.17%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	78.66%	79.88%	81.67%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	86.48%	83.38%	84.02%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	81.16%	73.71%	77.37%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.25—RY 2015 (MY 2014) HEDIS SPD Trend Table
Health Net—San Diego County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	17.88%	17.37%	26.64%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	71.22	69.30	29.69	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	406.58	319.25	155.22	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.17%	90.18%	86.09%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.79%	90.62%	86.53%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	81.31%	75.61%	75.36%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.96%	81.54%	80.08%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	80.42%	77.03%	75.00%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.26—RY 2015 (MY 2014) HEDIS SPD Trend Table
Health Net—San Joaquin County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	25.00%	27.18%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	104.16	51.30	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	344.91	153.04	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	75.47%	74.47%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	NA	81.48%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	NA	NA	Not Comparable

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.27—RY 2015 (MY 2014) HEDIS SPD Trend Table
Health Net—Stanislaus County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	10.12%	13.24%	17.13%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	82.73	93.41	60.78	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	491.16	470.09	261.19	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.26%	84.15%	82.29%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.47%	86.17%	86.23%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.27%	86.32%	86.89%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	90.98%	87.57%	87.26%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	94.25%	83.08%	84.42%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.28—RY 2015 (MY 2014) HEDIS SPD Trend Table
Health Net—Tulare County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	15.86%	12.77%	14.81%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	71.55	70.74	42.48	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	602.84	651.79	375.32	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.74%	84.40%	85.33%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	90.00%	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.50%	85.63%	87.97%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	94.74%	90.20%	90.75%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	94.50%	94.23%	91.46%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	92.00%	90.40%	88.97%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.29—RY 2015 (MY 2014) Non-SPD Trend Table
Health Net—Kern County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	7.36%	9.35%	13.78%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	47.99	48.90	33.30	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	196.35	359.51	226.19	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	70.82%	86.73%	87.59%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	70.73%	82.89%	86.56%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	89.99%	93.14%	90.57%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	70.52%	79.32%	79.49%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	68.00%	67.84%	71.93%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	76.72%	67.83%	72.05%	↑

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.30—RY 2015 (MY 2014) Non-SPD Trend Table
Health Net—Los Angeles County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	7.58%	6.53%	12.52%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	33.35	32.38	21.65	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	248.68	277.13	173.02	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	74.64%	77.70%	84.53%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	83.33%	80.00%	43.75%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	72.64%	76.55%	83.58%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	94.35%	94.70%	92.03%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	81.21%	81.27%	80.93%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	83.10%	82.04%	84.42%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	83.01%	77.67%	79.84%	↑

* Member months are a member’s “contribution” to the total yearly membership.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.31—RY 2015 (MY 2014) Non-SPD Trend Table
Health Net—Sacramento County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	6.02%	9.16%	12.34%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	39.84	39.23	28.31	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	274.99	293.32	169.33	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	61.52%	67.61%	76.78%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	56.74%	63.48%	74.42%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	92.71%	92.50%	89.13%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	80.23%	81.11%	80.12%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	80.41%	79.18%	80.76%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	81.67%	75.14%	76.93%	↑

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.32—RY 2015 (MY 2014) Non-SPD Trend Table
Health Net—San Diego County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.38%	7.87%	13.39%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	46.14	41.81	24.93	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	296.72	362.03	218.65	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	76.98%	83.47%	74.66%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	75.42%	78.26%	77.67%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	94.45%	96.17%	92.45%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	85.41%	88.28%	85.13%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	84.87%	86.55%	88.08%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	82.60%	82.56%	81.69%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.33—RY 2015 (MY 2014) Non-SPD Trend Table
Health Net—San Joaquin County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	NA	15.96%	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	46.94	29.20	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	256.64	142.99	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	57.45%	74.48%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	NA	78.23%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	91.89%	86.67%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	76.48%	69.42%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	NA	76.98%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	NA	75.17%	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.34—RY 2015 (MY 2014) Non-SPD Trend Table
Health Net—Stanislaus County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	5.66%	S	12.35%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	50.77	56.78	38.34	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	350.80	378.60	225.96	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.65%	81.05%	78.65%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.25%	79.47%	83.29%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.12%	95.53%	93.01%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.18%	85.74%	84.22%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	84.96%	86.32%	86.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	85.74%	83.89%	82.44%	↔

* Member months are a member’s “contribution” to the total yearly membership.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.35—RY 2015 (MY 2014) Non-SPD Trend Table
Health Net—Tulare County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	5.79%	9.62%	10.34%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	37.86	38.64	25.50	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	449.45	486.43	305.08	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.16%	85.29%	83.43%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	79.55%	81.40%	83.07%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.78%	97.57%	95.95%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	92.30%	92.05%	89.74%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	91.58%	91.06%	90.28%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	93.09%	89.35%	88.49%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

RY 2014 was the first year that Health Net reported rates for San Joaquin County; therefore, the MCP was not held accountable to meet the MPLs in San Joaquin County in RY 2014.

Nevertheless, HSAG includes comparisons of RY 2015 to RY 2014 rates in the analyses and findings that follow.

Across all counties, Health Net's rates were above the HPLs for the following measures:

- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Tulare County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in Tulare County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* in Kern County (third consecutive year)

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* in Kern, Los Angeles (fourth consecutive year), and San Diego (third consecutive year) counties

Across all counties, 49 of 181 comparable rates (27 percent) were significantly better in RY 2015 when compared to RY 2014. The number of measures with rates that improved significantly by county follows:

- ◆ San Joaquin County—11 measures
- ◆ Kern County—9 measures
- ◆ Los Angeles County—8 measures
- ◆ Sacramento County—8 measures
- ◆ San Diego County—5 measures
- ◆ Tulare County—5 measures
- ◆ Stanislaus County—3 measures

The significant improvement for 21 of 181 comparable rates (12 percent) resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015. Ten additional rates (6 percent) improved from RY 2014 to RY 2015. Although the improvement was not significant, the change resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015.

Across all counties, 59 of 180 rates (33 percent) for which an assessment of performance relative to the MPLs was made were below the MPLs. The number of measures with rates below the MPLs by county follows:

- ◆ Sacramento County—10 measures, with 8 having rates below the MPLs for at least three consecutive years
- ◆ San Diego County—10 measures, with 4 having rates below the MPLs for at least three consecutive years
- ◆ San Joaquin County—10 measures
- ◆ Los Angeles County—9 measures, with 8 having rates below the MPLs for at least three consecutive years
- ◆ Stanislaus County—9 measures, with 2 having rates below the MPLs for at least three consecutive years
- ◆ Kern County—7 measures, with 5 having rates below the MPLs for at least three consecutive years
- ◆ Tulare County—4 measures

Across all counties, 27 of 181 comparable rates (15 percent) were significantly worse in RY 2015 when compared to RY 2014. By county, the number of measures with rates significantly worse in RY 2015 when compared to RY 2015 follows:

- ◆ Los Angeles County—5 measures
- ◆ San Diego County—5 measures
- ◆ Kern County—4 measures
- ◆ Sacramento County—4 measures
- ◆ Stanislaus County—4 measures
- ◆ Tulare County—4 measures
- ◆ San Joaquin County—1 measure

The significant change for eight rates resulted in them moving from above the MPLs in RY 2014 to below the MPLs in RY 2015. Six additional rates declined from RY 2014 to RY 2015. Although the decline was not statistically significant, the change resulted in the rates moving from above the MPLs in RY 2014 to below the MPLs in RY 2015.

The rates increased significantly for all seven of Health Net's counties for the *Controlling High Blood Pressure* measure. The rate increases for Kern, Sacramento, San Diego, and Tulare counties were likely the result of the HEDIS improvement plan activities that DHCS required Health Net to implement for this measure in these counties. This is discussed further within the Improvement Plan section below.

Health Net demonstrated poor performance across all counties for two measures: *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* and *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*. In all counties, the RY 2015 rates for these two measures were either below the MPLs or declined significantly from RY 2014.

The improvement or decline in performance on measures varied across all counties, which may be attributed to county-specific characteristics and improvement efforts.

Seniors and Persons with Disabilities Findings

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

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Sacramento and San Diego counties
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Los Angeles, Sacramento, San Diego, and Tulare counties

In all counties, the SPD rates were significantly worse than the non-SPD rates for the *All-Cause Readmissions* measure. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

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

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in Los Angeles and Sacramento counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* in Los Angeles and San Diego counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* in Los Angeles and San Diego counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in Los Angeles and San Diego counties

The significantly lower SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be partially attributed to children and adolescents in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Across all counties for measures stratified by the SPD and non-SPD populations, there were no notable variations in the SPD and non-SPD rates that are not already reflected in the analysis above.

Assessment of Improvement Plans

Based on RY 2014 performance measure results and priority areas as determined by DHCS in collaboration with Health Net, the MCP was required to submit improvement plans (IPs) and Plan-Do-Study-Act (PDSA) cycles. The following is a summary of the IPs and PDSA cycles submitted by Health Net.

Childhood Immunization Status—Combination 3

Health Net identified the following barriers to the rate for the *Childhood Immunization Status—Combination 3* measure being above the MPL in Kern and Sacramento counties:

- ◆ Data collection
- ◆ Beneficiaries missing one or more vaccines

- ◆ One or more vaccines being administered out of the required time frame for inclusion in the measure's rate

The MCP implemented the following interventions to address the barriers:

- ◆ Conducted outreach to high-volume providers to encourage participation in the immunization registries and to submit encounter data in addition to the *Child Health and Disability Prevention Program Confidential Screening/Billing Report* (PM 160 form).
- ◆ Revised the *Childhood Immunization Status—Combination 3* measure abstraction tool, and flagged noncompliant sites for follow-up.
- ◆ Notified providers of beneficiaries who turned 12 months old with a list of vaccines due in the next six months, and informed them of their patients' immunization statuses.
- ◆ For beneficiaries turning 12 months old, mailed a reminder to their caregivers to attend well-child visits; and emphasized the importance of completing the vaccination series.

Health Net also submitted three PDSA cycles for the *Childhood Immunization Status—Combination 3* measure. A summary of each cycle follows:

- ◆ The MCP conducted a provider survey for five Kern County providers and 10 Sacramento County providers to assess immunization registry participation and identify common challenges to participation in order to determine ways the MCP can support providers in meeting the HEDIS standards for childhood and adolescent immunizations. The main barriers to registry participation included limited staffing or resources, concerns about the security of the registries, and providers using electronic medical records which have their own immunizations record modules. The MCP also identified lower compliance rates among Russian-speaking beneficiaries. Health Net decided to adapt the intervention by conducting provider site visits and expanding the number of providers targeted.
- ◆ The MCP sought to increase the percentage of beneficiaries in Kern and Sacramento counties with immunization registry data by expanding provider outreach efforts to educate providers on the benefits of immunization registry participation, connecting providers with local immunization registries, and gathering best practice strategies. The results were mixed in that some providers showed an increase in registry participation and others showed a decrease in participation rates. Health Net decided to adopt the intervention, continue to distribute beneficiary educational mailings, and address cultural disparities observed among Russian-speaking beneficiaries in Sacramento County.
- ◆ The MCP mailed provider profiles to all Health Net Medi-Cal providers that included information on their HEDIS performance, a list of patients turning 12 months old during the measurement period whose vaccines were due in the next six months, a list of patients up to date on immunizations by 9 months old, and information on best practices to support performance improvement. While the intervention results were mixed, the MCP decided to

adopt the provider profiles mailings. Additionally, Health Net will add information on the percentage of beneficiaries with available immunization registry data to the profiles to increase providers' awareness of registry participation.

Health Net's interventions resulted in the following:

- ◆ The rate improved in Kern County; and although the improvement was not statistically significant, the change resulted in the rate moving to above the MPL in RY 2015.
- ◆ The rate in Sacramento County remained below the MPL in RY 2015.

Additionally, the rates for the measure were below the MPL in San Joaquin and Stanislaus counties in RY 2015. The MCP will be required to continue the IP PDSA cycles for Sacramento County and to add San Joaquin and Stanislaus counties.

Comprehensive Diabetes Care

Health Net submitted four PDSA cycles to address the rates for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure being below the MPL in RY 2014 for Kern, Sacramento, and Stanislaus counties and the rates for the *Comprehensive Diabetes Care—HbA1c Testing* measure being below the MPL in RY 2014 for Kern, Sacramento, and San Diego counties. A summary of each cycle follows:

- ◆ The MCP conducted beneficiary outreach to identify barriers to beneficiary participation in diabetes educational sessions. Barriers included transportation issues, conflicts with work schedules, health issues, and forgetting to attend the session. Health Net planned to continue the educational sessions with modifications that included offering the sessions at multiple locations, offering the sessions in the evening and on weekends, partnering with providers serving high-risk beneficiaries, obtaining input from Health Net's Community Advisory Committee on strategies to address transportation issues, and analyzing pre- and post-survey data to determine the curricula's impact on beneficiaries' knowledge of diabetes, HbA1c, and diabetic retinal exams.
- ◆ The MCP expanded its diabetes provider profiles to include data on beneficiaries in need of HbA1c testing. To increase the percentage of beneficiaries compliant with HbA1c testing, the MCP mailed the diabetes provider profiles to providers on a quarterly basis. The MCP found that mailing the expanded profiles to providers had some positive effect on increasing beneficiary compliance with HbA1c testing. Health Net planned to adopt the intervention and continue to evaluate its effectiveness.
- ◆ The MCP continued to test the effectiveness of mailing the expanded diabetes provider profiles to determine if they helped to improve HbA1c testing and diabetic retinal exam rates. The results indicated that provider profile mailings had limited impact on improving the rates. Health

Net planned to continue the intervention, but planned to evaluate value by assessing provider familiarity with the profiles.

- ◆ The MCP surveyed high-volume providers to assess their familiarity and preferred distribution method for the diabetes provider profiles. Based on the results of the survey, Health Net planned to continue sending the diabetes provider profiles and is considering modifications (including sending the profiles by fax or in person and using an alternative provider notification method such as HEDIS gap lists).

Health Net's interventions resulted in the following for the *Eye Exam (Retinal) Performed* measure in RY 2015:

- ◆ The rates improved in Kern and Stanislaus counties; and although the improvement was not statistically significant, the change resulted in the rates moving to above the MPL.
- ◆ The rate remained below the MPL in Sacramento County.

Health Net's interventions resulted in the following for the *HbA1c Testing* measure in RY 2015:

- ◆ The rate improved significantly in Kern County, resulting in the rate moving to above the MPL.
- ◆ The rate remained below the MPL in Sacramento and San Diego counties.

Health Net will be required to continue the IP for the *Eye Exam (Retinal) Performed* measure for Sacramento County and for the *HbA1c Testing* measure for Sacramento and San Diego counties.

Controlling High Blood Pressure

Health Net identified the following barriers to the rates for the *Controlling High Blood Pressure* measure being below the MPL for Kern, Sacramento, San Diego, and Tulare counties in RY 2014:

- ◆ Challenges obtaining complete and timely medical record data from providers
- ◆ Beneficiaries having difficulty adhering to complex drug regimens to control hypertension

Health Net implemented the following interventions to address the barriers:

- ◆ Worked closely with the MCP's HEDIS vendor to develop a CAP that included improvements to the communication systems among all HEDIS staff, implementation of a standardized chart copying system, and electronic medical record training.
- ◆ Implemented a targeted educational mailing to beneficiaries identified as taking multiple types of antihypertensive medications.

Health Net also submitted three PDSA cycles for the *Controlling High Blood Pressure* measure. A summary of each cycle follows:

- ◆ The MCP implemented a process to track on the successful completion of the CAP with the HEDIS vendor and found that 91 percent of the key elements needed for improving the data collection process were completed. With the successful completion of the CAP, the MCP discontinued monitoring the CAP and established a new PDSA cycle with a focus on beneficiaries.
- ◆ The MCP set out to conduct a survey of beneficiaries to assess health outcomes; however, the MCP experienced significant delays in conducting the survey. As a result, the MCP decided to set the goal of conducting the survey in the subsequent quarter.
- ◆ The MCP conducted an interactive voice response survey to establish the baseline for the post-intervention survey that will be conducted after beneficiary education is completed. The MCP's results showed that all counties achieved the goal of improving the measure's rate to above the MPL.

Health Net's interventions resulted in the following for the *Controlling High Blood Pressure* measure in RY 2015:

- ◆ The rates improved significantly in Kern, Sacramento, San Diego, and Tulare counties, resulting in the rates moving to above the MPL. The MCP will not be required to continue the IP and PDSA cycles for this measure based on RY 2015 performance measure rates.

Postpartum Care

Health Net had a *Postpartum Care* QIP in place during the review period that included Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, and Tulare counties. Additionally, the MCP submitted three PDSA cycles for the *Prenatal and Postpartum Care—Postpartum Care* measure for Kern, Los Angeles, Sacramento, San Diego, and Stanislaus counties. All three PDSA cycles tested whether faxing to providers notification of beneficiaries' live births would improve the rate of postpartum visits scheduled. For the second PDSA cycle, the MCP added a checklist for providers to complete regarding reasons why the appointments were not scheduled. For the third cycle, the MCP augmented the fax communication with contacting the providers directly to ask about barriers to following up on the fax notifications. Health Net indicated that it also had started a pilot program in which the MCP sends a list of beneficiaries due for postpartum visits to a provider group for follow-up and oversight of the provider group's affiliated providers.

Health Net's interventions resulted in the following for the *Postpartum Care* measure in RY 2015:

- ◆ The rate improved significantly in Sacramento County, bringing the rate to above the MPL.
- ◆ The rate improved in Kern and Stanislaus counties; and although the improvement was not statistically significant, the change resulted in the rate moving to above the MPL.
- ◆ The rates remained below the MPL in Los Angeles and San Diego counties.

Health Net will be required to continue the PDSA cycles for Los Angeles and San Diego counties. Additionally, the rate for this measure in San Joaquin County was below the MPL in RY 2015, so the MCP will need to add this county to the required PDSA cycles.

Prenatal Care

Health Net was required to submit PDSA cycles for the *Timeliness of Prenatal Care* measure for Kern, Los Angeles, Sacramento, and San Diego counties. The MCP submitted three PDSA cycles. For each cycle, the MCP mailed pregnant beneficiaries a reminder letter to schedule their prenatal visits. The letter indicated that if the beneficiary attended her visit within the specified time frame and returned a completed raffle form with her provider's signature, she would be entered into a drawing to win a gift card.

After the first mailing, Health Net modified the letter for easier readability and added a flyer on the importance of the prenatal visit. Additionally, the MCP reminded providers to mention the beneficiary incentive program at the prenatal visit. During the third PDSA cycle, the MCP experienced some delays with mailing the letters and planned to make modifications to the incentive program in 2016.

Health Net's interventions resulted in the following for the *Timeliness of Prenatal Care* measure in RY 2015:

- ◆ The rate improved in Sacramento County; and although the improvement was not statistically significant, the change resulted in the rate moving to above the MPL.
- ◆ The rates remained below the MPL in Kern, Los Angeles, and San Diego counties.

Health Net will be required to continue the PDSA cycles for these three counties.

Use of Imaging Studies for Low Back Pain

Health Net identified the following barriers to the rate for the *Use of Imaging Studies for Low Back Pain* measure being below the MPL in San Diego County in RY 2014:

- ◆ Providers being noncompliant with evidence-based practice guidelines on the use of imaging studies for beneficiaries with new low back pain diagnoses
- ◆ Disproportionate rates for women and seniors in San Diego County

Health Net implemented the following interventions to address the barriers:

- ◆ Conducted a meeting with the two poorest-performing participating provider groups to present information on San Diego County and to provide rates and policies regarding the appropriate use of imaging studies.

- ◆ Created a provider report card on use of imaging studies for low back pain to send to high-volume, low-performing physicians.
- ◆ Included an article in the MCP's Medi-Cal newsletter with information on how to avoid low back strains and injuries, tips for self-care treatment for low back pain, and information on how to decide if seeking professional care is necessary.

Health Net's interventions were effective at bringing the rate to above the MPL in San Diego County in RY 2015, and the MCP will not be required to continue the IP for this measure.

Required Improvement Plans for RY 2015

Based on RY 2015 performance measure rates, Health Net will work with DHCS to prioritize quality improvement activities and interventions to address targeted measures with rates below the MPLs.

Strengths

HSAG auditors determined that Health Net followed the appropriate specifications to produce valid rates and identified no issues of concern. Despite a significant increase in membership during the reporting year, the MCP experienced no backlogs or delays in beneficiary data processing. Additionally, the MCP implemented a team approach using trained analysts to conduct quality checks that ensured data integration and integrity for HEDIS reporting.

Six performance measure rates were above the HPLs in RY 2015, and 49 of 181 comparable rates were significantly better in RY 2015 when compared to RY 2014. Across all counties, 31 of 181 comparable rates improved from below the MPLs in RY 2014 to above the MPLs in RY 2015.

Opportunities for Improvement

As in previous years, Health Net continued to perform poorly on a significant number of measures, showing many opportunities for improvement. HSAG recommends that the MCP continue to work with DHCS to prioritize areas for improvement rather than trying to improve on all measures at the same time. Once the priority areas are identified, the MCP should use quality improvement tools to identify improvement strategies to implement. Tools to consider include key driver diagram, process mapping, and failure modes and effects analysis.

Since Health Net's improvement efforts were successful at achieving statistically significant improvement and moving some rates to above the MPLs, the MCP has the opportunity to identify lessons learned and apply successful strategies across all counties, as applicable. For example, the rates improved significantly from RY 2014 to RY 2015 in Kern, Los Angeles, San Diego, and San

Joaquin counties for the *Comprehensive Diabetes Care—HbA1c Testing* measure; therefore, Health Net should assess if the strategies implemented in these counties would be appropriate to duplicate in Sacramento, Stanislaus, and Tulare counties.

Although higher hospital readmissions rates are expected for the SPD population, Health Net has the opportunity to assess the factors leading to the SPD rates in all counties being significantly worse than the non-SPD rates for the *All-Cause Readmissions* measure to ensure that the MCP is meeting the health care needs of the SPD population.

Quality Improvement Project Objectives

Health Net participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists Health Net’s QIPs and indicates the county in which the QIP was conducted; whether the QIP was clinical or nonclinical; and the domains of care (i.e., quality, access, and timeliness) the QIP addressed.

**Table 4.1—Quality Improvement Projects for Health Net
July 1, 2014, through June 30, 2015**

QIP	Counties	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, and Tulare	Clinical	Q, A
<i>Postpartum Care</i>	Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, and Tulare	Clinical	Q, A, T

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

The *Postpartum Care* QIP aimed to improve the rate of postpartum visits for women between 21 and 56 days after delivery because ensuring that women are seen postpartum is important to their physical and mental health. The rates for the *Prenatal and Postpartum Care—Postpartum Care* measure fell below the DHCS-established MPL for four of the seven counties included in this QIP during RY 2013. The MCP’s objective is to exceed the DHCS-established MPL or to achieve statistically significant improvement over baseline in all counties.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

Table 4.2—Quality Improvement Project Validation Activity
Health Net—Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, and Tulare Counties
July 1, 2014, through June 30, 2015

Name of Project/Study	Counties	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>	Kern, Sacramento, and Stanislaus counties received the same score.	Annual Submission	77%	86%	<i>Partially Met</i>
	Los Angeles and San Diego counties received the same score.	Annual Submission	88%	100%	<i>Met</i>
	San Joaquin	Annual Submission	88%	86%	<i>Partially Met</i>
	Tulare	Annual Submission	81%	86%	<i>Partially Met</i>
Internal QIP					
<i>Postpartum Care</i>	All counties received the same score.	Annual Submission	100%	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, 2014, through June 30, 2015, showed that Health Net’s annual submission of its *All-Cause Readmissions* QIP received a *Met* validation status in two counties and a *Partially Met* validation status in five counties. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for

validation. As a result, Health Net conducted a PDSA cycle for the *All-Cause Readmissions* QIP for Tulare County. The *Postpartum Care* QIP annual submission achieved an overall validation status of *Met* in all seven counties, with 100 percent of evaluation elements receiving a *Met* score.

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

Table 4.3—Quality Improvement Project Average Rates*
Health Net—Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, and Tulare Counties
(Number = 14 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

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	100%	0%	0%
Design Total		100%	0%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	88%	12%	0%
	VIII: Appropriate Improvement Strategies	85%	15%	0%
Implementation Total		87%	13%	0%
Outcomes	IX: Real Improvement Achieved**	38%	0%	63%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total**		38%	0%	63%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

For Health Net’s *All-Cause Readmissions* QIP annual submission, HSAG validated Activities I through IX for Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties and Activities I through VIII for San Joaquin County. HSAG also validated Activities I through VIII for the MCP’s *Postpartum Care* QIP annual submission for all seven counties.

Health Net demonstrated a strong application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. Both the *All-Cause Readmissions* and *Postpartum Care* QIPs progressed to the Implementation stage during the reporting period. The MCP demonstrated an adequate application of the Implementation stage, meeting 87 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *All-Cause Readmissions* QIP, Health Net reported rates inconsistent

with the audited rates reported to DHCS, resulting in a lower score for Activity VII. In addition, the MCP did not provide the evaluation results for each intervention implemented for the *All-Cause Readmissions* QIP, resulting in a lower score for Activity VIII.

The *All-Cause Readmissions* QIP progressed to the Outcomes stage for all counties except San Joaquin County during the reporting period. The QIP's study indicator did not achieve statistically significant improvement over baseline in any of the six counties, resulting in only 38 percent of the requirements for all applicable elements being met for Activity IX. Activity X was not assessed since sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

Postpartum Care QIP

The *Postpartum Care* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcomes information is included in this report. The MCP indicated conducting the following activities during the baseline period in all seven counties:

- ◆ Initiated a CAP with the vendor responsible for obtaining medical record data. The multifaceted CAP included specific improvement strategies focused on data abstraction, optimizing the use of the data abstraction tool, project management, standardization and quality assurance for copying records, electronic file layout quality assurance processes, a new urgent flagging system for noncompliant providers, special handling for data retrieval requiring secondary pursuits, and facilitating communication.
- ◆ Incentivized postpartum care provider office staff to schedule timely postpartum visits with beneficiaries.
- ◆ Provided weekly postpartum visit fax notifications to providers that included a list of beneficiaries due for a postpartum visit. Providers were asked to fax a response to the MCP indicating the date and time of the beneficiaries' scheduled postpartum visits.
- ◆ Made interactive voice response calls to beneficiaries who recently had a live birth with an option to transfer to a member services representative who discussed the importance of postpartum visits and assisted with appointment scheduling.
- ◆ Offered beneficiaries to participate in a monthly raffle for a gift card for completing their postpartum visits.

In addition to the statewide activities, Health Net also initiated a county-specific intervention in Los Angeles County during the baseline period. The MCP offered incentives to provider groups to improve encounter data volume and quality.

All-Cause Readmissions QIP

The *All-Cause Readmissions* QIP progressed to the Outcomes stage for all counties except San Joaquin County since San Joaquin County was a newly added Medi-Cal county for Health Net as of January 1, 2013. Thus, the reporting period was the baseline measurement year for San Joaquin’s *All-Cause Readmissions* QIP. The MCP indicated it implemented the same interventions in San Joaquin County as it did in all contracted counties to reduce readmissions during the reporting period.

Table 4.4 summarizes the *All-Cause Readmissions* QIP study indicator results for six of the seven counties that reached the Outcomes stage and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

**Table 4.4—Quality Improvement Project Outcomes for Health Net—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions			
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older^			
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement*
Kern	10.4%	11.5%	‡
Los Angeles	11.9%	11.6%	‡
Sacramento	12.2%	12.7%	‡
San Diego	16.0%	15.9%	‡
Stanislaus	8.7%	11.0%	‡
Tulare	11.9%	11.7%	‡

^A lower percentage indicates better performance.

* Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

Health Net’s goal for the *All-Cause Readmissions* QIP was to achieve statistically significant decline in the readmissions rates from baseline to Remeasurement 1 in each county. Unfortunately, for all six counties, the MCP did not meet the project’s goal. Although the readmissions rate declined in Los Angeles, San Diego, and Tulare counties, the change was not statistically significant. A review of the MCP’s QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ Health Net experienced a notable increase in the number of admissions in Los Angeles, Sacramento, and Stanislaus counties due to the influx of SPD beneficiaries that enrolled in MY

2012. However, the readmissions rate of the SPD population remained relatively unchanged at Remeasurement 1 compared to baseline.

- ◆ The MCP's *All-Cause Readmissions* QIP team and sub-workgroups identified and prioritized the following barriers during Remeasurement 1:
 - Beneficiaries are not knowledgeable about their chronic diseases or co-morbid conditions.
 - Beneficiaries lack understanding of their medications.
 - A lack of coordinated communication exists among beneficiaries, primary care providers (PCPs), provider groups, hospitals, and the MCP.
 - Beneficiaries are not scheduled follow-up appointments post hospital discharge.
 - PCPs are not adequately equipped with beneficiaries' full medical histories or recent hospital discharges.
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions Health Net indicated it implemented during the Remeasurement 1 time period:
 - Continued the Be In Charge!SM program that provides specific interventions to beneficiaries depending on their ages and severity of conditions. The disease management program adheres to a whole-person approach with a focus on removing barriers to care and providing guidance for beneficiaries' chronic illnesses.
 - Placed on-site case management/concurrent review nurses at Kaweah Delta and Tulare District hospitals to support the smooth transition for beneficiaries' continuums of care.
 - Resumed the Transitional Care Management program to improve the transitions of care by providing beneficiaries with the tools and support which promote knowledge and self-management of their conditions as they are discharged from the hospital and move to their homes. The program focused on the following four components:
 - Facilitation of appointment scheduling with PCP post hospital discharge
 - Beneficiary empowerment and engagement
 - Coordination of discharge plan (e.g. home health, transportation, PCP/specialty access, ancillary services access)
 - Medication reconciliation
 - Made interactive voice response calls to beneficiaries admitted and discharged from a hospital for any condition. The reminder calls advised the beneficiaries to make follow-up appointments with their PCPs within seven days of discharge, to call their PCPs or the Nurse Advise Line for any health care needs or questions, and to take their medications with them to their PCP appointments.

- Mailed educational materials to beneficiaries discharged from a hospital for congestive heart failure or chronic obstructive pulmonary disease diagnosis. The mailing included a reminder letter for beneficiaries to make a follow-up appointment with their PCP within seven days of discharge.
- Mailed to beneficiaries non-adherent to medication regimen letters which contained condition-specific suggestions on how to stay adherent and advised beneficiaries to make an appointment with their PCP.

Plan-Do-Study-Act Review

The *All-Cause Readmissions* QIP did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for the QIP topic.

Health Net set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By March 31, 2015, reduce hospital readmission rate by 10 percent from baseline at two participating hospitals in Tulare County by providing on-site interventions for beneficiaries who have an acute care admission for any diagnosis.

The purpose of the *All-Cause Readmissions* PDSA cycle was to test if having an on-site nurse helps decrease readmissions rates within two participating hospitals.

Health Net completed the *All-Cause Readmissions* PDSA cycle as planned, and the on-site concurrent review readmissions rate showed improvement from 18.92 percent to 10.34 percent. However, the MCP specified that due to claim data lag and technical data collection issues experienced by the vendor, the Remeasurement rate could be underreported. Health Net also reported challenges that may have affected the results, including underlying patient psychosocial issues such as homelessness and a transition of fee-for-service beneficiaries to shared risk in March 2014. Health Net indicated plans to adopt the change for the remainder of 2015. The MCP documented that although the preliminary results showed that the change was effective, more time is needed to monitor the long-term effects of the intervention.

Strengths

Health Net demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Postpartum Care* QIPs. The *Postpartum Care* QIP achieved a *Met* validation status the first submission.

The *All-Cause Readmissions* PDSA cycle results indicated that Health Net's test of change was successful at decreasing the readmissions rate.

Opportunities for Improvement

Although Health Net will not be continuing the formal QIPs, the MCP should continue with its documented plans to adopt the on-site nurse intervention tested through the *All-Cause Readmissions* PDSA cycle. The MCP should also continue to monitor the long-term effects of the on-site nurse placed in two hospitals in Tulare County. Lastly, Health Net should evaluate the interventions conducted during Remeasurement 1 of the *Postpartum Care* QIP to determine their effectiveness and continue implementing interventions that improve postpartum care visit rates.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

Health Net’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for Health Net. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for Health Net

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	31.1%	26.3%	10th–25th	7.3%	9.2%	25th–75th
Diagnosis Code	35.6%	31.6%	10th–25th	36.6%	34.6%	25th–75th
Procedure Code	43.8%	43.8%	25th–75th	12.4%	22.5%	75th–90th
Procedure Code Modifier	65.9%	58.5%	25th–75th	35.1%	46.0%	25th–75th
Rendering Provider Name	30.9%	25.0%	25th–75th	79.8%	68.1%	>25th–<75th
Billing Provider Name	45.4%	35.0%	10th–25th	5.0%	8.6%	75th–90th

Overall, the medical record omission rates for Health Net ranged from 30.9 percent (*Rendering Provider Name*) to 65.9 percent (*Procedure Code Modifier*). None of Health Net’s medical record omission rates were better than the respective statewide rates, one medical record omission rate was equal to the statewide rate (*Procedure Code*), and the remaining five rates were worse than the statewide rates by at least 4.0 percentage points. When compared to other MCPs’ performance, Health Net received a percentile ranking of “25th–75th” for three medical record omission rates and a percentile ranking of “10th–25th” for the remaining medical record omission rates. These findings suggest a relatively low level of completeness among key encounter data elements when compared to beneficiaries’ medical records. There are some variations in medical record omission rates among Health Net’s six counties, with Kern County generally having high omission rates and Tulare County generally having low omission rates.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for Health Net contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, Health Net's rates varied from 5.0 percent (*Billing Provider Name*) to 79.8 percent (*Rendering Provider Name*). Four of Health Net's encounter data omission rates were better than the respective statewide rates, with the *Procedure Code Modifier* encounter omission rate being better than the statewide rate by 10.9 percentage points. However, Health Net performed worse than the statewide encounter data omission rate by 11.7 percentage points for the *Rendering Provider Name* data element. An opportunity exists for Health Net to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information. Encounter data omission rates varied at the county level, with a range of at least 13 percentage points between the counties with the highest and lowest rates for each data element.

The most common reasons for encounter data omissions were:

- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in Health Net's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to Health Net (and/or the data subsequently being submitted to DHCS).
- ◆ Health Net populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files Health Net submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for Health Net. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for Health Net

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	84.6%	83.6%	25th–75th	Inaccurate Code (84.4%)
Procedure Code	79.5%	77.6%	25th–75th	Lower Level of Services in Medical Records (63.6%); Inaccurate Code (25.1%)
Procedure Code Modifier	100.0%	99.5%	≥75th	—
Rendering Provider Name	57.5%	63.0%	25th–75th	Incorrect Names (75.1%)
Billing Provider Name	45.3%	68.6%	<10th	Incorrect Names (96.7%)
All-Element Accuracy	1.1%	4.3%	>25th–<75th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were generally found to be of average accuracy for Health Net, with the exception of the *Billing Provider Name* data element (23.3 percentage points lower than the statewide rate). When compared to the other MCPs’ performance, Health Net’s results showed a range of performance, with one element receiving a percentile ranking of “≥75th” (*Procedure Code Modifier*), three elements receiving a percentile ranking of “25th–75th” (*Diagnosis Code*, *Procedure Code*, and *Rendering Provider Name*), and one element (*Billing Provider Name*) receiving a percentile ranking of “<10th”. The majority of diagnosis-related errors involving discrepancies in the use of inaccurate codes compared to national coding standards rather than specificity errors. For the *Procedure Code* data element, 63.6 percent of the errors were associated with higher-level procedure codes in the DHCS encounter data than were documented in the beneficiaries’ medical records (i.e., the procedure code was considered an error due to a lower level service documented in the medical record). The majority of errors for both the *Rendering Provider Name* and *Billing Provider Name* data elements (75.1 percent and 96.7 percent, respectively) were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records.

Health Net’s all-element accuracy rate was lower than the statewide rate by 3.2 percentage points. Only 1.1 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 98 percent of the dates of service reviewed in this study. While all five key data elements contributed to Health Net’s relatively low all-element accuracy rate, the *Rendering Provider Name* data element contributed most and *Procedure Code Modifier* contributed the least.

Medical Record Review Recommendations

Based on the study findings for Health Net, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, Health Net should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. Health Net should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ Of the 826 dates of service identified in the DHCS encounter data, only 179 of the visits had rendering provider names identifiable from the DHCS data system. Health Net should work with DHCS to investigate the reasons why so few rendering provider names could be identified using DHCS encounter and provider data.
- ◆ Health Net should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ Health Net should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code Modifier* and *Billing Provider Name* data elements and develop strategies to improve rates.
- ◆ Health Net should explore the reasons for the relatively high encounter data omission rates for the *Rendering Provider Name* data element and take actions to improve rates.
- ◆ Health Net should explore the reasons for the relatively low element accuracy rates for the *Billing Provider Name* data element and take actions to improve rates.
- ◆ Health Net should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with Health Net.

- ◆ Health Net should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP’s Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

Health Net’s SFY 2014–15 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the EDV study, which assessed the MCP’s operational and infrastructure changes in support of DHCS’s transition to PACES. Based on review of Health Net’s Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist Health Net with improving its encounter data quality. DHCS followed up with Health Net regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

6. OVERALL FINDINGS AND RECOMMENDATIONS

for Health Net Community Solutions, Inc.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of Health Net's performance in the three domains of care—quality, access, and timeliness.

Quality

As in previous years, Health Net's quality improvement program description provides details of the MCP's structure, which includes components that support the delivery of quality care to beneficiaries.

For RY 2015, 23 measures fell into the quality domain of care. The following are notable findings across all counties for measures falling into the quality domain of care:

- ◆ Six of 152 rates (4 percent) for which an assessment of performance relative to the MPLs and HPLs could be made were above the HPLs in RY 2015:

- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Tulare County
 - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in Tulare County
 - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* in Kern County (third consecutive year)
 - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* in Kern, Los Angeles (fourth consecutive year), and San Diego (third consecutive year) counties
- ◆ Forty-three of 155 rates (28 percent) for which comparisons can be made between RY 2014 and RY 2015 improved significantly from RY 2014 to RY 2015. Additionally, the rates for 31 of 52 measures (60 percent) with rates below the MPLs in RY 2014 improved to above the MPLs in RY 2015. The *Controlling High Blood Pressure* measure showed a significant increase in rates across all seven Health Net counties.
 - ◆ Thirty-five of 152 rates (23 percent) for which an assessment of performance relative to the MPLs and HPLs could be made were below the MPLs, with 11 of the 35 rates (31 percent) being below the MPLs for at least three consecutive years. When comparing RY 2015 to RY 2014, 17 of 155 rates (11 percent) were significantly worse in RY 2015 and 11 of 95 rates (12 percent) that were above the MPLs in RY 2014 moved to below the MPLs in RY 2015.
 - ◆ For quality measures stratified by the SPD and non-SPD populations, the SPD rates were significantly better than the non-SPD rates for the following measures:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Sacramento and San Diego counties
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Los Angeles, Sacramento, San Diego, and Tulare counties
 - ◆ In all counties, the SPD rates were significantly worse than the non-SPD rates for the *All-Cause Readmissions* measure, which falls into the quality domain of care. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of Health Net’s QIPs fell into the quality domain of care. Only the *All-Cause Readmissions* QIP progressed to the Outcomes stage, and the QIP did not achieve a statistically significant reduction in readmissions in any county at Remeasurement 1. The MCP conducted a PDSA cycle for the QIP topic to test whether or not providing on-site interventions for beneficiaries at two participating hospitals would reduce readmissions rates. While the results showed a decrease in readmissions, Health Net reported data collection issues which may have caused underreporting of the readmissions.

Overall, Health Net showed below-average performance related to the quality domain of care.

Access

As part of the process of producing this report, HSAG reviewed Health Net’s 2015 quality improvement program description, 2015 work plan, and 2014 quality improvement program evaluation documents. The documents described ways the MCP ensures and monitors access to care, and the work plan included access-related goals. The 2014 evaluation results showed opportunities for improvement related to access to care.

For RY 2015, 14 measures fell into the access domain of care. The following are notable findings across all counties for measures falling into the access domain of care:

- ◆ The rate was above the HPL in Tulare County for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure.
- ◆ Sixteen of 94 rates (17 percent) for which comparisons can be made between RY 2014 and RY 2015 improved significantly from RY 2014 to RY 2015. Additionally, the rates for 13 of 47 measures (28 percent) with rates below the MPLs in RY 2014 improved to above the MPLs in RY 2015.
- ◆ Forty-four of 91 rates (48 percent) for which an assessment of performance relative to MPLs and HPLs could be made were below the MPLs, with 23 of the 44 rates (52 percent) being below the MPLs for three or more consecutive years. When comparing RY 2015 to RY 2014, 18 of 94 rates (19 percent) for which comparisons can be made between RY 2014 and RY 2015 were significantly worse in RY 2015 when compared to RY 2014; and the rates for the following measures moved from above the MPLs in RY 2014 to below the MPLs in RY 2015:
 - *Cervical Cancer Screening* in Los Angeles County
 - *Childhood Immunization Status—Combination 3* in Stanislaus County
 - *Children and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months* in San Diego and Stanislaus counties
 - *Children and Adolescents’ Access to Primary Care Practitioners—25 Months to 6 Years* in San Diego County
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Stanislaus County
- ◆ Health Net demonstrated poor performance across all counties for two measures: *Children and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months* and *Children and Adolescents’ Access to Primary Care Practitioners—25 Months to 6 Years*. In all counties, the RY 2015 rates for these two measures were either below the MPLs or declined significantly from RY 2014.
- ◆ Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. As noted previously, in all counties the SPD rates were significantly worse than the non-SPD rates for the *All-Cause Readmissions* measure, which falls into the access domain of

care. Also as noted, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

- ◆ Additionally, the SPD rates were significantly worse than the non-SPD rates for the following access measures:
 - *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in Los Angeles and Sacramento counties
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* in Los Angeles and San Diego counties
 - *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* in Los Angeles and San Diego counties
 - *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in Los Angeles and San Diego counties

Note that the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be partially attributed to children and adolescents in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Both of Health Net's QIPs fell into the access domain of care. As noted above, only the *All-Cause Readmissions* QIP progressed to the Outcomes stage; and the QIP did not achieve a statistically significant reduction in readmissions in any county at Remeasurement 1. While the PDSA cycle the MCP conducted showed a reduction in readmissions, the results may not be accurate based on the reported data collection issues.

Overall, Health Net showed below-average performance related to the access domain of care.

Timeliness

As in previous years, Health Net's quality improvement program description includes information on the MCP's structure and processes related to beneficiary rights, appeals and grievances, continuity and coordination of care, and utilization management—all of which are areas of operation that affect timeliness of care.

For RY 2015, five measures fell into the timeliness domain of care. The following are notable findings across all counties for measures falling into the timeliness domain of care:

- ◆ No rates were above the HPLs.
- ◆ The rates for the following measures improved significantly from RY 2014 to RY 2015:
 - *Childhood Immunization Status—Combination 3* in San Diego County

- *Prenatal and Postpartum Care—Postpartum Care* in Sacramento County, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in San Joaquin County, moving the rate from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ The rates for the following measures improved from RY 2014 to RY 2015. Although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015:
 - *Childhood Immunization Status—Combination 3* in Kern County
 - *Prenatal and Postpartum Care—Postpartum Care* in Kern and Stanislaus counties
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Sacramento and San Joaquin counties
- ◆ The rates for the following measures were below the MPLs:
 - *Childhood Immunization Status—Combination 3* in Sacramento, San Joaquin, and Stanislaus counties
 - *Immunizations for Adolescents—Combination 1* in San Joaquin and Stanislaus counties
 - *Prenatal and Postpartum Care—Postpartum Care* in Los Angeles (fourth consecutive year), San Diego (fourth consecutive year), and San Joaquin counties
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Kern (third consecutive year), Los Angeles (third consecutive year), and San Diego (third consecutive year) counties
- ◆ In San Diego County, the rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure declined significantly from RY 2014 to RY 2015.
- ◆ In Stanislaus County, the rate for the *Childhood Immunization Status—Combination 3* measure declined from RY 2014 to RY 2015. Although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015.

The *Postpartum Care* QIP fell into the timeliness domain of care; however, the QIP did not progress to the Outcomes stage during the reporting period; therefore, HSAG cannot assess the QIP's impact on the timeliness of prenatal care for beneficiaries.

Overall, Health Net showed below-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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with Health Net’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—Health Net’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendations
<p>1. Since Health Net continued to perform poorly on a significant number of measures, HSAG recommends that the MCP have ongoing interaction with DHCS to continue prioritizing areas for improvement rather than trying to make improvements on all measures at once. For measures that Health Net has been successful at performing above the MPLs or improving the rates, the MCP has the opportunity to apply successful strategies across all counties, as applicable.</p>	<p>Health Net engaged directly with DHCS to identify the priority areas for 2014–15. We maintained existing plans for existing areas below the MPL and implemented new interventions for new measures below the MPL. As for successful performance, Health Net continues to apply interventions across all counties. As Health Net identifies RY 2015 rate improvements and successful interventions as well as continues to implement the PDSA process, it will apply successes to all counties as applicable.</p>
<p>2. Continue to reference the QIP Completion Instructions to ensure that all required information is included in the QIP Summary Form on the first QIP submission.</p>	<p>In 2014, for the <i>All Cause Readmissions</i> QIP, DHCS and HSAG fully approved two of seven of the 2014 reports (San Diego and LA). For Kern, Sacramento, San Joaquin, Stanislaus, and Tulare, a Plan-Do-Study-Act process was implemented to address a <i>Partially Met</i> status.</p> <p>For the <i>Postpartum</i> QIP, DHCS and HSAG fully approved 100 percent of the 2014 reports.</p> <p>Health Net will continue to reference the current QIP Completion Instructions.</p>

Recommendations

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

- ◆ Based on Health Net’s continued poor performance on a significant number of measures, continue to work with DHCS to prioritize areas for improvement rather than trying to improve on all measures at once. Once priority areas have been identified, use quality improvement tools to identify improvement strategies to implement (e.g., key driver diagram, process mapping, failure modes and effects analysis).
- ◆ For areas in which the MCP has made improvements, identify lessons learned and apply successful strategies across all counties, as applicable. For example, assess if the strategies to improve HbA1c testing rates implemented in Kern, Los Angeles, San Diego, and San Joaquin counties would be appropriate to duplicate in Sacramento, Stanislaus, and Tulare counties.
- ◆ Assess the factors leading to the SPD rates in all counties being significantly worse than the non-SPD rates for the *All-Cause Readmissions* measure to ensure that the MCP is meeting the health care needs of the SPD population.
- ◆ Although Health Net will not be continuing the formal QIPs, the MCP should:
 - Continue with its documented plans to adopt the on-site nurse intervention tested through the *All-Cause Readmissions* PDSA cycle. The MCP should monitor the long-term effects of the on-site nurse placed in two hospitals in Tulare County.
 - Evaluate the interventions conducted during Remeasurement 1 of the *Postpartum Care* QIP to determine their effectiveness, and continue implementing interventions that improve postpartum care visit rates.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

In the next annual review, HSAG will evaluate Health Net’s progress with these recommendations along with its continued successes.

Medi-Cal Managed Care Technical Report

**Appendix O:
Performance Evaluation Report
Health Plan of San Joaquin
July 1, 2014 – June 30, 2015**

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Appendix O: Performance Evaluation Report – Health Plan of San Joaquin July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Health Plan of San Joaquin (“HPSJ” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

HPSJ is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in HPSJ, the LI MCP; or in Health Net Community Solutions, Inc., the alternative commercial plan (CP).

HPSJ became operational in San Joaquin County to provide MCMC services effective February 1996 and in Stanislaus County effective January 2013. As of June 30, 2015, HPSJ had 103,457 beneficiaries in San Joaquin County and 203,430 in Stanislaus County—for a total of 306,887 beneficiaries.¹ This represents 81 percent of the beneficiaries enrolled in San Joaquin County and 73 percent in Stanislaus County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: October 22, 2015.

Medical and State Supported Services Audit

DHCS conducted a medical and State Supported Services audit for HPSJ June 23, 2014, through July 3, 2014, covering the review period of April 1, 2013, through March 31, 2014. DHCS assessed the following areas:

- ◆ Compliance with State Supported Services contract and regulations
- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Member's Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

Reports were issued April 22, 2015, and DHCS included detailed findings and recommendations for all areas it assessed. In a letter dated May 13, 2015, DHCS requested from the MCP a corrective action plan (CAP) to address the findings from the audits. In a letter dated October 27, 2015, DHCS indicated that on October 22, 2015, HPSJ provided DHCS with the most recent response to its CAP. The letter stated that DHCS had either closed or provisionally closed all deficiencies. Therefore, DHCS closed the CAP. Note that while DHCS issued the October 27, 2015, letter outside the review dates for this MCP-specific evaluation report, HSAG included the information because it was in reference to audits that occurred within the review dates for this report and because the MCP resolved all findings related to the audits.

1115 Waiver Seniors and Persons with Disabilities Enrollment Survey

The most recent Department of Managed Health Care 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey (hereafter referred to as "SPD medical survey") for HPSJ was conducted February 21, 2012, through February 23, 2012, covering the review period of November 1, 2010, through October 31, 2011. HSAG included a summary of the review in HPSJ's 2012–13 MCP-specific evaluation report and follow-up information in HPSJ's 2013–14 MCP-specific evaluation report. In a letter dated October 1, 2014, DHCS stated that on September 2, 2014, HPSJ provided DHCS with the MCP's final response to the corrective action plan originally issued on August 15, 2012. DHCS stated that it had reviewed all remaining open items and found them to be in compliance and, therefore, closed the CAP on October 1, 2014.

Strengths

HPSJ fully resolved all findings from the February 2012 SPD medical survey and June 2014 medical and State Supported Services audit.

Opportunities for Improvement

Since HPSJ resolved all findings from the most recent SPD medical survey and medical and State Supported Services audit, HSAG has no recommendations for the MCP in the area of compliance reviews.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Health Plan of San Joaquin* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that HPSJ followed the appropriate specifications to produce valid rates; however, the auditor identified some issues of concern that had minimal impact on measure reporting. A brief summary of the findings and opportunities for improvement is included below.

- ◆ HPSJ continued to experience claims processing backlogs during 2014; however, in the summer a new claims director was hired, and over the next several months the number of backlogs was reduced.
- ◆ Kaiser (KP Cal, LLC) is HPSJ's delegated service partner for 3.18 percent of HPSJ's beneficiaries in San Joaquin County. Kaiser implemented several changes in its data submission to HPSJ, which impacted HPSJ's ability to ensure that the data were complete and accurate. The auditor recommended that HPSJ implement ongoing monitoring and oversight of all delegated partners to enable the MCP to proactively identify any partner's process changes. This will allow the MCP sufficient time to test new data processes and ensure data completeness and accuracy.
- ◆ HPSJ reported challenges with getting timely payment information from the State (820 files), which resulted in the MCP's inability to reconcile the information with the eligibility files. The auditor recommended that HPSJ work with DHCS to see if DHCS is able to provide the 820 files more promptly.
- ◆ The auditor requested that HPSJ confirm whether or not the identification of the rendering provider (i.e., specialty or type) was required on claims or encounters received from federally qualified health centers (FQHCs) in order for the MCP to process the claim. The MCP did not immediately address this inquiry, and the auditor recommended that HPSJ investigate to ensure that the information is required so that all services are appropriately captured for HEDIS reporting.
- ◆ HPSJ experienced key staff turnover just prior to the end of the HEDIS reporting season. The auditor noted that the MCP did not appear to have conducted cross-training on HEDIS management activities and therefore recommended that HPSJ build an internal MCP knowledge base regarding HEDIS policies and procedures, and ensure formal process documentation exists to train new staff members.

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of the NCQA.

- ◆ HPSJ should ensure that the HEDIS team meets regularly and works together as a group to accomplish HEDIS reporting.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 and Table 3.2 for HPSJ's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1 and Table 3.2

The reader should note the following regarding Table 3.1 and Table 3.2:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended

by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).

- Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
- All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
HPSJ—San Joaquin County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	7.07%	11.06%	12.78%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	38.16	46.68	45.89	45.82	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	283.73	274.87	249.11	241.84	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	85.56%	83.69%	83.80%	80.51%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	92.11%	94.12%	44.23%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	85.05%	84.58%	84.29%	81.60%	↓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	25.42%	29.24%	25.10%	29.46%	↑
Cervical Cancer Screening	Q,A	—	—	61.12%	57.18%	↔
Childhood Immunization Status—Combination 3	Q,A,T	77.13%	76.40%	75.91%	69.59%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	96.66%	97.49%	97.04%	96.17%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	86.82%	87.59%	87.79%	85.04%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	84.17%	85.71%	86.70%	86.27%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	83.53%	84.94%	83.23%	82.56%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	77.62%	78.28%	65.69%	70.56%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	53.28%	45.62%	44.77%	47.20%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	81.51%	80.66%	79.08%	79.32%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	55.96%	52.37%	51.82%	46.72%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	80.29%	82.12%	79.08%	81.75%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	36.74%	39.60%	40.15%	42.09%	↔
Controlling High Blood Pressure	Q	—	66.42%	65.45%	61.80%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	63.99%	67.15%	72.02%	70.80%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	40.72%	43.45%	40.38%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	21.82%	23.04%	19.12%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	68.61%	64.48%	60.83%	59.61%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	88.08%	85.64%	82.24%	80.78%	↔
Use of Imaging Studies for Low Back Pain	Q	80.67%	81.80%	84.03%	82.67%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	73.48%	69.10%	70.32%	76.64%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	72.51%	72.75%	68.37%	70.56%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	65.69%	61.80%	55.96%	61.31%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	80.54%	76.16%	76.89%	76.40%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.2—Multi-Year Performance Measure Results*
HPSJ—Stanislaus County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	13.11%	14.29%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	56.07	60.36	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	272.99	274.08	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	84.64%	85.88%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	87.39%	86.26%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	16.95%	18.65%	↔
Cervical Cancer Screening	Q,A	—	—	41.08%	50.12%	↑
Childhood Immunization Status—Combination 3	Q,A,T	—	—	64.96%	60.58%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	97.23%	92.46%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	88.43%	84.31%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	88.90%	87.59%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	86.60%	84.54%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	67.88%	72.26%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	37.23%	36.25%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	85.40%	80.78%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	52.31%	51.82%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	80.29%	77.13%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	36.98%	39.90%	↔
Controlling High Blood Pressure	Q	—	—	56.20%	67.64%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	58.15%	56.20%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	51.65%	49.78%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	21.98%	23.68%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	54.99%	57.18%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	73.24%	79.81%	↑

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	—	—	76.51%	78.90%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	54.01%	61.80%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	41.85%	56.45%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	39.17%	44.77%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	68.61%	65.21%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.3 through Table 3.6 present a summary of the RY 2015 SPD measure results reported by HPSJ. Table 3.3 and Table 3.4 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.5 and Table 3.6 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.3—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for HPSJ—San Joaquin County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	7.91%	16.82%	▼	12.78%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	79.93%	81.04%	↔	80.51%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	50.00%	Not Comparable	44.23%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.50%	84.20%	↑	81.60%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.14%	100.00%	↔	96.17%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	85.08%	83.28%	↔	85.04%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	86.21%	87.42%	↔	86.27%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	82.44%	84.27%	↔	82.56%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

▲▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

⁴ HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD Compared to Non-SPD” column in Table 3.3 and Table 3.4.

Table 3.4—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for HPSJ—Stanislaus County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.95%	20.55%	▼	14.29%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.84%	89.02%	↑	85.88%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.86%	88.44%	↑	86.26%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	92.42%	NA	Not Comparable	92.46%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	84.35%	82.25%	↔	84.31%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	87.48%	92.06%	↔	87.59%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.41%	89.64%	↑	84.54%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

Table 3.5—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures HPSJ—San Joaquin County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
225.18	43.63	401.82	70.82

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

**Table 3.6—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
HPSJ—Stanislaus County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
254.18	56.92	535.60	105.69

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

Table 3.7 and Table 3.8 present the three-year trending information for the SPD population, and Table 3.9 and Table 3.10 present the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.7—RY 2015 (MY 2014) HEDIS SPD Trend Table
HPSJ—San Joaquin County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	13.75%	13.65%	16.82%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	72.22	71.99	70.82	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	474.21	438.00	401.82	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.44%	85.07%	81.04%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	90.91%	93.18%	50.00%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.39%	86.24%	84.20%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.30%	100.0%	100.0%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	89.90%	86.09%	83.28%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	88.53%	87.37%	87.42%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	87.69%	85.91%	84.27%	↔

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

= Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.8—RY 2015 (MY 2014) HEDIS SPD Trend Table
HPSJ—Stanislaus County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	—	15.88%	20.55%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	105.58	105.69	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	585.69	535.60	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	87.72%	89.02%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	89.27%	88.44%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	—	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	—	93.20%	82.25%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	—	NA	92.06%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	—	NA	89.64%	Not Comparable

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.9—RY 2015 (MY 2014) Non-SPD Trend Table
HPSJ—San Joaquin County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	6.27%	6.86%	7.91%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	43.01	42.34	43.63	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	246.24	223.43	225.18	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.70%	81.28%	79.93%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.44%	80.14%	78.50%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.51%	97.00%	96.14%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.52%	87.86%	85.08%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.55%	86.67%	86.21%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.77%	83.07%	82.44%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.10—RY 2015 (MY 2014) Non-SPD Trend Table
HPSJ—Stanislaus County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	—	8.67%	8.95%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	51.51	56.92	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	244.19	254.18	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	80.48%	82.84%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	84.05%	83.86%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	—	97.21%	92.42%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	—	88.33%	84.35%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	—	88.87%	87.48%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	—	86.62%	84.41%	↓

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

Note that in RY 2014 DHCS did not hold HPSJ accountable to meet the MPL in Stanislaus County because RY 2014 was the first year the MCP reported rates for Stanislaus County; however, for purposes of analysis of the RY 2015 results, HSAG makes some references to rates below the MPLs in RY 2014 for Stanislaus County.

The rates for the following measures improved significantly from RY 2014 to RY 2015:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Joaquin County
- ◆ *Cervical Cancer Screening* in Stanislaus County, although the rate remained below the MPL
- ◆ *Controlling High Blood Pressure* in Stanislaus County

- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Stanislaus County, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in San Joaquin County and Stanislaus County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* in Stanislaus County, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015

The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure in Stanislaus County improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

Across both counties, the rates for 19 measures were below the MPLs in RY 2015, and the following measures in San Joaquin County had rates below the MPLs for three or more consecutive years:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years and 12 to 19 Years*
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*

The rates for the following measures declined significantly from RY 2014 to RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in San Joaquin County
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in San Joaquin County, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Childhood Immunization Status—Combination 3* in San Joaquin County
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in San Joaquin County and Stanislaus County, resulting in the rate for Stanislaus County moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* in San Joaquin County and Stanislaus County, resulting in the rates in both counties moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in Stanislaus County, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015

- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total* in San Joaquin County, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015

The rates for the following measures in Stanislaus County declined from RY 2014 to RY 2015; and although the decline was not statistically significant, the changes resulted in the rates moving from above the MPLs in RY 2014 to below the MPLs in RY 2015:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Seniors and Persons with Disabilities Findings

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

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Stanislaus County
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in San Joaquin County and Stanislaus County
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in Stanislaus County

For both counties, the SPD rates for the *All-Cause Readmissions* measure were significantly worse than the non-SPD rates; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Across both counties, few measures showed significant change in SPD rates from RY 2014 to RY 2015, with three measures having SPD rates significantly worse in RY 2015 when compared to RY 2014. The non-SPD rates for five measures declined significantly from RY 2014 to RY 2015.

Assessment of Improvement Plans

HPSJ was required to submit improvement plans (IPs) for the following measures for San Joaquin County based on RY 2014 rates:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* (IP continued from the previous year)
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*

Although the rate for the *Comprehensive Diabetes Care—HbA1c Testing* measure was below the MPL in RY 2014, the MCP was not required to submit an IP for the measure because it already had a QIP in place for the measure. A summary of each required IP follows.

Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs

HPSJ identified many barriers to the rate for the measure being above the MPL, including:

- ◆ The MCP experiencing many delays related to implementation of the planned interventions.
- ◆ The MCP having had a laboratory contracting change, resulting in new laboratory locations needing to be established.
- ◆ Provider knowledge deficit related to the monitoring requirements for ACE inhibitors.
- ◆ The MCP not having a process for tracking beneficiaries in need of medication monitoring or identifying low-performing providers.
- ◆ Beneficiary lack of knowledge regarding monitoring requirements.
- ◆ Beneficiary noncompliance with completing ordered tests.
- ◆ Beneficiary lack of transportation.

The MCP implemented the following interventions to address the barriers:

- ◆ Conducted provider education through a fax-blast to providers' offices followed by ongoing provider outreach and education on monitoring requirements and best practices.
- ◆ The MCP's pharmacy department generated reports to send to providers identifying beneficiaries in need of monitoring.
- ◆ The MCP's pharmacy department assisted the MCP's quality improvement staff in developing an educational program for providers.
- ◆ Conducted beneficiary outreach and education on the need for medication monitoring and provided assistance to beneficiaries in need of monitoring.

HPSJ also submitted a Plan-Do-Study-Act (PDSA) cycle for this measure. The MCP conducted outreach to targeted providers to increase awareness of the need for annual lab testing and monitoring. The MCP met the PDSA cycle goal and plans to adapt the intervention based on the MCP's analysis of the results.

The MCP's improvement efforts were not successful at improving the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure, and the rate declined significantly from RY 2014 to RY 2015. The MCP will be required to continue this IP.

Medication Management for People with Asthma—Medication Compliance 50% Total

HPSJ identified the following barriers to the rate being above the MPL:

- ◆ Beneficiary lack of education and awareness of the proper use of a daily inhaled corticosteroid, asthma controller, and rescue asthma inhaler.
- ◆ Beneficiary lack of education concerning the disease process and proper disease management.
- ◆ Limited availability of asthma and allergy specialists.
- ◆ Primary care physician lack of awareness of proper diagnostic testing, which could lead to improper medication management.
- ◆ Lack of a robust MCP disease management program.
- ◆ Poor air quality in the area in which the MCP's beneficiaries live.

HPSJ conducted the following interventions to address the barriers:

- ◆ Implemented a more robust disease management program to help identify beneficiaries in need of disease management and outreach services for asthma. As part of the program, the MCP will educate the beneficiaries on the role and importance of daily use of inhaled corticosteroids. Additionally, the program will serve as a resource for providers.
- ◆ Sent alerts to providers informing them of best practice guidelines in the diagnosis and treatment of asthma.

HPSJ's improvement efforts were not effective in bringing the rate to above the MPL. The MCP will be required to continue the IP for this measure.

Required Improvement Plans for RY 2015

Based on RY 2015 rates, HPSJ will be required to submit IPs for the following measures. Note that DHCS may allow the MCP to implement improvement strategies for one or more of the measures through the performance improvement project (PIP) process (known as the QIP process for the current review period).

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* for San Joaquin County
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* for San Joaquin County
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* for Stanislaus County
- ◆ *Cervical Cancer Screening* for Stanislaus County
- ◆ *Childhood Immunization Status—Combination 3* for Stanislaus County

- ◆ *Comprehensive Diabetes Care—HbA1c Testing* for San Joaquin County
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Stanislaus County
- ◆ *Immunizations for Adolescents—Combination 1* for Stanislaus County
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total* for San Joaquin County
- ◆ *Medication Compliance 75% Total* for San Joaquin County and Stanislaus County
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* for Stanislaus County

Strengths

HSAG auditors determined that HPSJ followed the appropriate specifications to produce valid rates. Across both counties, the rates for seven measures improved significantly from RY 2014 to RY 2015, and the rates for three measures improved from below the MPL in RY 2014 to above the MPL in RY 2015. HPSJ provided documentation of actions the MCP has taken to improve rates on measures and to implement strategies to ensure that the needs of the SPD population are met. The MCP stated that the interventions have resulted in a reduction in the readmissions for this population. (See Table 6.1.)

Opportunities for Improvement

HPSJ has the opportunity to address issues the auditor identified during the HEDIS audit process. While the issues had minimal impact on measure reporting, it is important that the MCP address the issues to ensure an efficient audit process moving forward. HPSJ also has the opportunity to identify the factors leading to poor performance on several measures and to implement strategies to improve the measures' rates. For measures for which HPSJ has already been implementing improvement strategies, the MCP has the opportunity to assess the effectiveness of the strategies to determine whether they should be expanded, modified, or eliminated.

Quality Improvement Project Objectives

HPSJ participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists HPSJ’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, and timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for HPSJ
July 1, 2014, through June 30, 2015**

QIP	Counties	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	San Joaquin and Stanislaus	Clinical	Q, A
<i>Improving the Percentage Rate of HbA1c Testing</i>	San Joaquin	Clinical	Q, A

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

HPSJ’s internal QIP, *Improving the Percentage Rate of HbA1c Testing*, attempted to increase HbA1c testing to minimize the development of diabetes complications. At the start of the QIP, 80.5 percent of the MCP’s beneficiaries with diabetes had received an HbA1c test within the measurement year. Blood glucose monitoring assists in the development of appropriate treatment plans to decrease the risk of diabetes complications. Lack of appropriate testing in people with diabetes may indicate suboptimal care and case management.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
HPSJ—San Joaquin and Stanislaus Counties
July 1, 2014, through June 30, 2015**

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>	San Joaquin	Annual Submission	81%	100%	<i>Met</i>
	Stanislaus	Annual Submission	94%	100%	<i>Met</i>
Internal QIPs					
<i>Improving the Percentage Rate of HbA1c Testing</i>	San Joaquin	Annual Submission	77%	80%	<i>Partially 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, 2014, through June 30, 2015, showed that HPSJ’s annual submission of its *All-Cause Readmissions* QIP achieved an overall validation status of *Met* in both San Joaquin and Stanislaus counties, with 100 percent of the critical evaluation elements receiving a *Met* score. The *Improving the Percentage Rate of HbA1c Testing* QIP annual submission received a *Partially Met* validation status in San Joaquin County; the HPSJ did not conduct the *Improving the Percentage Rate of HbA1c Testing* QIP for Stanislaus County. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, HPSJ conducted a PDSA cycle for the *Improving the Percentage Rate of HbA1c Testing* QIP.

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

Table 4.3—Quality Improvement Project Average Rates*
HPSJ—San Joaquin and Stanislaus Counties
(Number = 3 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

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	93%	7%	0%
Design Total		97%	3%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	86%	0%	14%
	VIII: Appropriate Improvement Strategies	50%	30%	20%
Implementation Total		74%	10%	16%
Outcomes	IX: Real Improvement Achieved**	38%	0%	63%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total**		38%	0%	63%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for HPSJ’s *All-Cause Readmissions* QIP annual submission for San Joaquin County and Activities I through VIII for Stanislaus County. In addition, HSAG validated Activities I through IX for the MCP’s *Improving the Percentage Rate of HbA1c Testing* QIP annual submission for San Joaquin County.

HPSJ demonstrated a strong application of the Design stage, meeting 97 percent of the requirements for all applicable evaluation elements within the stage for both QIPs. The MCP did not provide the manual data collection tool for the *Improving the Percentage Rate of HbA1c Testing* QIP, resulting in a lower score for Activity VI. HPSJ met all requirements for all applicable evaluation elements within the Design stage for its *All-Cause Readmissions* QIP.

The MCP demonstrated a sufficient application of the Implementation stage, meeting 74 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. In the annual submission of the *All-Cause Readmissions* QIP, HPSJ identified neither the factors that threatened the internal or external validity of the findings nor factors that affected the ability to compare the baseline rate with the Remeasurement 1 rate, resulting in a lowered score for Activity VII. The MCP also did not document an evaluation of the interventions for the *All-Cause*

Readmissions QIP and did not properly document the causal/barrier analyses, implemented interventions, or evaluation of the interventions for the *Improving the Percentage Rate of HbA1c Testing* QIP—resulting in a lower score for Activity VIII.

Both QIPs in San Joaquin County progressed to the Outcomes stage during the reporting period. Although the study indicator for the *All-Cause Readmissions* QIP improved for San Joaquin County, the improvement was not statistically significant. In addition, the rate for the *Improving the Percentage Rate of HbA1c Testing* QIP’s study indicator decreased from Remeasurement 2 to Remeasurement 3. As a result, HPSJ only met 38 percent of the requirements for all applicable evaluation elements within Activity IX. Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

The *All-Cause Readmissions* QIP did not progress to the Outcomes stage in Stanislaus County during the reporting period; therefore, no outcome information is included in this report. HPSJ indicated its plans to start the transition of care (TOC) program through the TOC grant awarded from Blue Cross for the *All-Cause Readmissions* QIP in Stanislaus County. However, since HPSJ’s expansion into Stanislaus County is in its early stages, the MCP still faces numerous barriers in implementing a robust TOC program.

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

**Table 4.4—Quality Improvement Project Outcomes for HPSJ—San Joaquin County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions				
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]				
Baseline Period 1/1/12–12/31/12		Remeasurement 1 1/1/13–12/31/13		Sustained Improvement [*]
7.1%		11.1%*		‡
QIP #2—Improving the Percentage of HbA1c Testing				
Study Indicator: Percentage of diabetic members with at least one HbA1c test				
Baseline Period 1/1/10–12/31/10	Remeasurement 1 1/1/11–12/31/11	Remeasurement 2 1/1/12–12/31/12	Remeasurement 3 1/1/13–12/31/13	Sustained Improvement [*]
80.5%	81.5%	80.7%	79.1%	‡

[^]A lower percentage indicates better performance.

[¥] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

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

All-Cause Readmissions QIP

HPSJ indicated in the *All-Cause Readmissions* QIP annual submission that the MCP had reported to DHCS an incorrect baseline readmissions rate for San Joaquin County. The MCP indicated that the baseline rate for the QIP should be 11.5 percent rather than 7.1 percent. HPSJ indicated as its goal for the *All-Cause Readmissions* QIP to decrease the readmission rate from 11.5 percent (baseline) to 9.4 percent (Remeasurement 1). However, HPSJ did not meet the project's goal. Although the readmission rate declined in San Joaquin County, the change was not statistically significant. In addition, the official readmission rate for San Joaquin County reported to DHCS through the HEDIS audit process was 7.07 percent, which is the rate that has been used in all analyses and reports. Regardless of which baseline rate is used, the *All-Cause Readmissions* QIP did not achieve statistically significant improvement at Remeasurement 1. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ The readmissions rate for the SPD population decreased from 14.84 percent (baseline) to 13.65 percent (Remeasurement 1).
- ◆ HPSJ held meetings with stakeholders to identify and document barriers identified throughout the Remeasurement 1 period. Stakeholders expressed the following barriers during the meetings:
 - No mechanism exists for the MCP to learn about beneficiaries' needs; thus, the MCP cannot address beneficiaries' needs.
 - Comorbidities such as substance use, mental health, or additional medical conditions may impact and/or complicate beneficiaries' recovery and lead to readmissions.
 - Nonskilled family members or friends may not provide post-discharge care as planned.
 - Home health services are not coordinated for beneficiaries who are homebound due to staff unavailability and beneficiaries refusing the services.
- ◆ Although the interventions were not successful in improving the QIP outcomes, following is a brief description of the interventions implemented by HPSJ:
 - Case managers worked with beneficiaries to coordinate post-discharge care and follow-up.
 - Case managers worked closely with hospital staff to address any transitions of care issues.

Improving the Percentage of HbA1c Testing

The *Improving the Percentage of HbA1c Testing* QIP project goal for Remeasurement 3 was a 5 percent increase from the baseline rate. However, at Remeasurement 3, the QIP still had not achieved statistically significant improvement over baseline. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- ◆ As discussed in the previous years' reports, HPSJ continues to struggle with the effect of the influx of the SPD population on the outcomes of this QIP.
- ◆ HPSJ identified issues with claims data in mid to late 2013, when processing claims had slowed and become backlogged.
- ◆ Based on the annual submission, it was not clear which interventions were new, which were continued, and which were deleted since HPSJ did not document the month and year each intervention was implemented and the status of each intervention during Remeasurement 3.
- ◆ HPSJ did not provide an evaluation of individual interventions to determine which interventions were successful at impacting the study indicator rates.

Plan-Do-Study-Act Review

The *Improving the Percentage of HbA1c Testing* QIP did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for the QIP topic.

HPSJ set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By December 31, 2014, increase HbA1c testing for high-volume, low-performing providers by two points by addressing the gap in care report training during the last three months of the year.

The purpose of the *Improving the Percentage of HbA1c Testing* PDSA cycle was to test whether or not identifying diabetes beneficiaries in need of HbA1c testing among high-volume and low-performing providers on HbA1c testing would increase the HbA1c compliance rate.

HPSJ completed the *Improving the Percentage of HbA1c Testing* PDSA cycle as planned. The results demonstrated increases from February 2015 to April 2015 in both San Joaquin County (from 71.2 percent to 78.6 percent) and Stanislaus County (from 77.8 percent to 79.8 percent). The improvement showed that the test of change was successful and may help, over time, to improve the rate for the measure in San Joaquin County to above the MPL. HPSJ received feedback from providers that they were pleased that lists of noncompliant beneficiaries were being generated but displeased about the expectation for providers to conduct outreach to beneficiaries. In addition, the MCP encountered challenges in meeting with providers. HPSJ plans to develop a year-round provider training and outreach approach. The MCP will use fact sheets, focused training, and specific tools for providers. The MCP will also generate noncompliant beneficiary lists regularly.

Strengths

HPSJ demonstrated a strong application of the QIP Design stage, meeting 97 percent of all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Improving the Percentage of HbA1c Testing* QIPs. The *All-Cause Readmissions* QIP achieved a *Met* validation status the first submission.

Opportunities for Improvement

Although HPSJ will not be continuing the formal QIPs, the MCP should continue to reassess the barriers to improvement and implement strategies to reduce *All-Cause Readmissions* rates. In addition, the MCP should continue with its modified plans to test interventions documented in the *Improving the Percentage of HbA1c Testing* PDSA Cycle Worksheet.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

HPSJ’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for HPSJ. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for HPSJ

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	17.7%	26.3%	75th–90th	8.6%	9.2%	25th–75th
Diagnosis Code	26.6%	31.6%	25th–75th	28.5%	34.6%	75th–90th
Procedure Code	36.8%	43.8%	25th–75th	16.5%	22.5%	25th–75th
Procedure Code Modifier	47.9%	58.5%	25th–75th	NA	46.0%	NA
Rendering Provider Name	NA	25.0%	NA	100.0%	68.1%	0–≤25th
Billing Provider Name	24.7%	35.0%	75th–90th	8.1%	8.6%	25th–75th

Note: HSAG displayed “NA” when the denominator was less than 30 cases.

Overall, the medical record omission rates for HPSJ ranged from 17.7 percent (*Date of Service*) to 47.9 percent (*Procedure Code Modifier*). All five reported medical record omission rates for HPSJ were better than the respective statewide rates. When compared to other MCPs’ performance, HPSJ received a percentile ranking of “25th–75th” for three medical record omission rates and a percentile ranking of “75th–90th” for the other two medical record omission rate elements. These findings suggest a moderate level of completeness among key encounter data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for HPSJ contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, HPSJ’s rates varied from 8.1 percent (*Billing Provider Name*) to 100 percent (*Rendering Provider Name*). Four encounter data omission rates reported for HPSJ were better than the respective statewide rates, with the *Diagnosis Code* encounter omission rate being

better than the statewide rates by 6.1 percentage points (a percentile ranking of “75th–90th”). However, HPSJ performed worse than the statewide encounter data omission rate by 31.9 percentage points for the *Rendering Provider Name* data element. An opportunity exists for HPSJ to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider’s billing office made a coding error.
- ◆ DHCS’s encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields or DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in HPSJ’s encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider’s performance of the service and submission of the encounter to HPSJ (and/or the data subsequently being submitted to DHCS).
- ◆ HPSJ populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files HPSJ submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for HPSJ. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for HPSJ

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	78.9%	83.6%	10th–25th	NA
Procedure Code	86.0%	77.6%	75th–90th	NA
Procedure Code Modifier	NA	99.5%	NA	—
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	65.0%	68.6%	10th–25th	Incorrect Names (75.9%)
All-Element Accuracy	0.8%	4.3%	>25th–<75th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were

found to be variable in their relative accuracy for HPSJ, with the all-element accuracy rate lower than the respective statewide rate. When comparing the performance among the assessed MCPs, two of the three key data elements ranked in the “10th–25th” percentile, while one element (*Procedure Code*) received a percentile ranking of “75th–90th”. The majority of billing provider name errors were associated with name discrepancies between the medical record and the DHCS data system rather than names being illegible in medical records.

HPSJ’s all-element accuracy rate was lower than the statewide rate, and only 0.8 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 99 percent of the dates of service reviewed in this study. While all five key data elements contributed to HPSJ’s relatively low all-element accuracy rate, the *Rendering Provider Name* data element contributed the most to the inaccuracy.

Medical Record Review Recommendations

Based on the study findings for HPSJ, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, HPSJ should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounter Systems (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. HPSJ should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ HPSJ should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ Out of 133 dates of service identified in DHCS’s encounter data, none of the visits had rendering provider names identifiable from DHCS’s data system. HPSJ should work with DHCS

to investigate the reasons why none of the rendering provider names could be identified using DHCS's encounter data and provider data.

- ◆ HPSJ should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code Modifier* and *Procedure Code* data elements and develop strategies to improve rates.
- ◆ HPSJ should explore the reasons for the relatively high encounter data omission rate for the *Rendering Provider Name* data element and take actions to improve the rate.
- ◆ HPSJ should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with HPSJ.
- ◆ HPSJ should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.

- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

HPSJ's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to PACES. Based on review of HPSJ's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist HPSJ with improving its encounter data quality. DHCS followed up with HPSJ regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of HPSJ's performance in the three domains of care—quality, access, and timeliness.

Quality

HSAG reviewed HPSJ's available quality improvement documents and found detailed information on goals, objectives, and processes designed to ensure that quality health care services are provided to beneficiaries. The MCP's work plan provides status updates and documentation of next steps needed to meet the identified goals.

DHCS identified findings in all areas assessed during the June 2014 medical and State Supported Services audit. The areas with findings that could impact quality of care include Quality Management and Administrative and Organizational Capacity.

The rates for the following quality measures improved significantly from RY 2014 to RY 2015:

- ◆ *Avoidance of Antibiotic treatment in Adults With Acute Bronchitis* in San Joaquin County
- ◆ *Cervical Cancer Screening* in Stanislaus County, although the rate remained below the MPL
- ◆ *Controlling High Blood Pressure* in Stanislaus County
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Stanislaus County, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in San Joaquin County and Stanislaus County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* in Stanislaus County, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015

The rate in Stanislaus County for the *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the quality domain of care, improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

Across both counties, the rates for 12 quality measures were below the MPLs in RY 2015; and the following quality measures in San Joaquin County had rates below the MPLs for three or more consecutive years:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*

The rates for the following quality measures declined significantly from RY 2014 to RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in San Joaquin County
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in San Joaquin County, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Childhood Immunization Status—Combination 3* in San Joaquin County
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total* in San Joaquin County, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015

The rates for the following quality measures in Stanislaus County declined from RY 2014 to RY 2015; and although the decline was not statistically significant, the changes resulted in the rates moving from above the MPLs in RY 2014 to below the MPLs in RY 2015:

- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

For quality measures stratified by the SPD and non-SPD populations, the SPD rates were significantly better than the non-SPD rates for the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Stanislaus County
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in San Joaquin County and Stanislaus County

The SPD rates for the *All-Cause Readmissions* measure for both counties were significantly worse than the non-SPD rates; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of HPSJ's QIPs fell into the quality domain of care, and both progressed to the Outcomes stage. Neither QIP achieved statistically significant improvement over the baseline results. The MCP's *Improving the Percentage of HbA1c Testing* PDSA cycle resulted in improved HbA1c testing rates for the three-month test of change, and the MCP indicated that it will adapt the tested changes moving forward to build on the successful outcomes.

Overall, HPSJ showed below-average performance related to the quality domain of care.

Access

HPSJ's quality improvement program documents include descriptions of many activities in which the MCP is engaged to ensure access to care for beneficiaries. Additionally, the MCP's 2014 annual evaluation document states that the MCP has received no beneficiary complaints regarding access.

DHCS identified findings in all areas assessed during the June 2014 medical and State Supported Services audit. The areas with findings that could impact access to care include compliance with State Supported Services contract and regulations, Case Management and Coordination of Care, Access and Availability of Services, and Administrative and Organizational Capacity.

The rates for the following access measures improved significantly from RY 2014 to RY 2015:

- ◆ *Cervical Cancer Screening* in Stanislaus County, although the rate remained below the MPL
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Stanislaus County, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015

The rate in Stanislaus County for the *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the access domain of care, improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

Across both counties, the rates for 13 access measures were below the MPLs in RY 2015, with the rates for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* and *12 to 19 Years* measures in San Joaquin County being below the MPL for the fourth consecutive year.

The rates for the following access measures declined significantly from RY 2014 to RY 2015:

- ◆ *Childhood Immunization Status—Combination 3* in San Joaquin County
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* in San Joaquin County and Stanislaus County, resulting in the rate for Stanislaus County moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* in San Joaquin County and Stanislaus County, resulting in the rates in both counties moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in Stanislaus County, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015

The rates for the following access measures in Stanislaus County declined from RY 2014 to RY 2015; and although the decline was not statistically significant, the changes resulted in the rates moving from above the MPLs in RY 2014 to below the MPLs in RY 2015:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The SPD rate for one of the measures in Stanislaus County (*Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*) was significantly better than the non-SPD rate. The *All-Cause Readmissions* measure also falls into the access domain of care and, as stated above, the SPD rates for both counties were significantly worse than the non-SPD rates. Also as noted above, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of HPSJ's QIPs fell into the access domain of care. As indicated above, both QIPs progressed to the Outcomes stage and neither QIP achieved statistically significant improvement over the baseline results. Also as stated, the MCP's *Improving the Percentage of HbA1c Testing PDSA*

cycle resulted in improved HbA1c testing rates for the three-month test of change. HPSJ indicated that the MCP will adapt the tested changes moving forward to build on the successful outcomes.

Overall, HPSJ showed below-average performance related to the access domain of care.

Timeliness

HSAG's review of HPSJ's quality improvement program documents identified that the MCP appears to have a structure that supports the assessment and delivery of timely care to beneficiaries. HPSJ established a separate work plan for utilization management, which helps the MCP track timely access goals and next steps.

DHCS identified findings in all areas assessed during the June 2014 medical and State Supported Services audit. The areas with findings that could impact timeliness of care include compliance with State Supported Services contract and regulations, Utilization Management, Case Management and Coordination of Care, Member's Rights, and Administrative and Organizational Capacity.

The *Prenatal and Postpartum Care* measures fall into the timeliness domain of care. The rate for the *Timeliness of Prenatal Care* measure in Stanislaus County improved significantly from RY 2014 to RY 2015, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015. The rate for the *Postpartum Care* measure in Stanislaus County improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rate in San Joaquin County for the *Childhood Immunization Status—Combination 3* measure, which falls into the timeliness domain of care, declined significantly from RY 2014 to RY 2015. The rates for the following timeliness measures in Stanislaus County were below the MPL in RY 2015:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Overall, HPSJ showed below-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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with HPSJ’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—HPSJ’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Ensure that the actions the MCP has taken to address the potential deficiencies identified during the February 2012 DMHC SPD medical survey in the areas of Access and Availability and Member Rights are acceptable to DHCS.</p>	<p>All corrective action plans have been reviewed and closed by DHCS.</p>
<p>2. Formalize and document the MCP’s steps for data extraction and file transfers to its software vendor to make tracking these functions easier from year to year and to ensure these processes are well-documented.</p>	<p>Health Plan of San Joaquin (HPSJ) contracts with Verisk as its HEDIS vendor. HPSJ created mapping specifications for each required table on the Verisk Input Specification document. The tables from HPSJ’s Data Warehouse are mapped, and any transformation logic is documented on the mapping specifications. Structured Query Language (SQL) code was written using the mapping specifications and followed the transformation logic to ensure that correct logic was used. The Verisk Audit Tool was run using the files extracted from the tables from the Data Warehouse. Any error exceptions are corrected via modifications to the SQL code, and the file is then extracted and validated against the tool again. The files are then uploaded to the Verisk secured file transfer protocol (FTP) site for another round of validation by Verisk.</p>
<p>3. Assess the factors leading to poor performance on several measures and identify improvement strategies that have the potential to result in positive outcomes. Based on priorities established by DHCS, HSAG recommends that for San Joaquin County, the MCP focus on the following measures:</p> <ul style="list-style-type: none"> a. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i> b. <i>Comprehensive Diabetes Care—HbA1c Testing</i> c. <i>Medication Management for People with Asthma—Medication Compliance 50% Total</i> 	<p>The IP developed in 2013 was revised, and a new plan was developed for 2014/2015 FY regarding <i>MPM-ACE/ARB’s</i>. A detailed analysis was conducted, and provider interventions and member interventions were implemented. HPSJ continues to fall short and will be implementing a PDSA cycle of improvement in 2015.</p> <p>Regarding <i>CDC –HbA1c</i>, a QIP has existed for this topic for three years; HPSJ has been right at or below the MPL. Efforts have been made, but results fail to reflect the desired outcomes. This is a topic for PDSA and interventions.</p> <p>For the <i>MMA-50%</i> measure, an IP was developed in 2014. The PDSA was developed and implemented. The numbers reflected a slight improvement, but remain close to the MPL.</p> <p>This area needs to be reviewed and new PDSAs established for it.</p>

2013–14 External Quality Review Recommendation Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>4. Assess the factors leading to eight measures having rates below the MPLs for Stanislaus County and identify strategies with the potential to result in improvement so that the rates are above the MPLs in 2015 when DHCS will hold HPSJ accountable to meet the MPLs in this county.</p>	<p>Stanislaus County was new to HPSJ in 2013, and a great deal of education and transition needed to occur to get the primary care physicians (PCPs) on board. Now HPSJ needs to focus on the three largest clinic setting providers (HSA, Golden Valley and Oak Valley Community) to see that they understand all the measures and requirements for care. HPSJ made a 25 percent improvement in the number of measures below the MPL in RY2015.</p>
<p>5. Assess the factors leading to a significantly higher rate of readmissions for the SPD population for San Joaquin and Stanislaus counties to ensure the needs of the SPD population are being met.</p>	<p>The higher rate of SPD readmissions was analyzed and noted to be much higher among the SPDs and especially in the county new to HPSJ, Stanislaus County. This was addressed by the following actions:</p> <ul style="list-style-type: none"> - Implementation of the Transition of Care (TOC) program, where patients ready for discharge from the hospital are transitioned to a TOC registered nurse who works with the patient and family for at least two weeks following discharge, ensuring that all post-discharge meds and equipment and follow-up appointments with PCPs/specialists are in place. If it is determined that the patient would benefit from a long-term Case Management (CM) program, the patient is referred to the CM department. - The Inpatient Review area was strengthened with the addition of nurse reviewers and a supervisor (hired in December 2014) who all work closely with the hospital staff to ensure quality care and safe discharges. - MD Rounds had been implemented at Doctors Medical Center. <p>All these interventions have resulted in marked reductions in the re-admission rates for the SPD and Temporary Assistance for Needy Families (TANF) populations.</p>
<p>6. Ensure all required documentation is included in the QIP Summary Form since the MCP continued to have difficulty meeting the validation requirements. The MCP should reference the QIP Completion Instructions and previous QIP Validation Tools to ensure that all documentation requirements for each activity have been addressed prior to submission to avoid incomplete or inaccurate documentation of the various elements.</p>	<p>All forms and details are in the files and have been referenced in preparing the recent QIPs. The last QIP submission was the ACR, and it was accepted with no issues. The HbA1c submissions have been an issue in the past, but the last submission was reviewed and accepted.</p>
<p>7. For the <i>Improving the Percentage Rate of HbA1c Testing</i> QIP, assess if the MCP should discontinue or modify existing interventions or identify new interventions to better address the large influx of SPD beneficiaries.</p>	<p>The 2014 submission noted a recommendation to retire the QIP as it was, with little or no improvement. It was noted that the topic remains an issue and should be addressed in a new QIP so that the MCP can apply new evaluation processes and plans for new interventions.</p>

Recommendations

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

- ◆ Address issues the auditor identified during the HEDIS audit process. While the issues had minimal impact on measure reporting, it is important that the MCP address the issues to ensure an efficient audit process moving forward. Specifically, the auditor recommended the following to the MCP:
 - Implement ongoing monitoring and oversight of all delegated partners to enable the MCP to proactively identify any partner's process changes and allow the MCP sufficient time to test new data processes and ensure data completeness and accuracy.
 - Work with DHCS to see if DHCS is able to provide the State 820 files more promptly.
 - Investigate to ensure that identification of the rendering provider (i.e., specialty or type) is required on claims or encounters received from FQHCs to ensure that all services are appropriately captured for HEDIS reporting.
 - Build an internal MCP knowledge base regarding HEDIS policies and procedures, and ensure formal process documentation exists to train new staff members.
- ◆ Identify the factors leading to poor performance on several measures and implement strategies to improve the measures' rates. For measures for which HPSJ has already been implementing improvement strategies, assess the effectiveness of the strategies to determine whether they should be expanded, modified, or eliminated. Specific measures in need of improvement include:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* for San Joaquin County.
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics* for San Joaquin County.
 - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* for Stanislaus County.
 - *Cervical Cancer Screening* for Stanislaus County.
 - *Childhood Immunization Status—Combination 3* for Stanislaus County.
 - *All four Children and Adolescents' Access to Primary Care Practitioners*—Although DHCS does not hold MCPs accountable to meet the MPLs for these measures, the MCP should assess the factors contributing to the decline in the measures' rates to ensure that beneficiaries in the applicable age groups are receiving needed health care services.
 - *Comprehensive Diabetes Care—HbA1c Testing* for San Joaquin County.
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Stanislaus County.
 - *Immunizations for Adolescents—Combination 1* for Stanislaus County.

- *Medication Management for People with Asthma—Medication Compliance 50% Total* for San Joaquin County and *Medication Compliance 75% Total* for San Joaquin County and Stanislaus County.
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* for Stanislaus County.
- ◆ Although HPSJ will not be continuing the formal QIPs, the MCP should continue to reassess the barriers to improvement and implement strategies to reduce *All-Cause Readmissions* rates.
- ◆ Continue to test adapted plans documented in the *Improving the Percentage of HbA1c Testing* PDSA Worksheet to improve screening rates.
- ◆ Review the 2013–14 *Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix P:
Performance Evaluation Report
Health Plan of San Mateo
July 1, 2014 – June 30, 2015**

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Appendix P: Performance Evaluation Report – Health Plan of San Mateo July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Health Plan of San Mateo (“HPSM” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

HPSM is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a County Organized Health System (COHS).

HPSM became operational to provide MCMC services in San Mateo County in December 1987. As of June 30, 2015, HPSM had 107,048 beneficiaries in San Mateo County.¹

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: November 10, 2015.

Medical and State Supported Services Audit

DHCS conducted a medical and State Supported Services audit for HPSM November 3, 2014, through November 14, 2014, covering the review period of August 1, 2013, through July 31, 2014. DHCS assessed the following areas:

- ◆ Compliance with State Supported Services contract and regulations
- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Member's Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

DHCS issued two reports on April 28, 2015—one for the medical audit portion and one for the State Supported Services audit portion. In the reports, DHCS identified findings and made recommendations for all areas reviewed under the scope of the audit. HPSM's follow-up to the findings and recommendations occurred outside the review period for this report. HSAG will summarize the follow-up information in HPSM's 2015–16 MCP-specific evaluation report.

Opportunities for Improvement

HPSM has the opportunity to fully resolve all findings from the MCP's November 2014 medical and State Supported Services audit. The findings span all domains of care—quality, access, and timeliness.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Health Plan of San Mateo* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that HPSM followed the appropriate specifications to produce valid rates. Although the auditor identified some concerns during the audit, the identified issues had minimal impact on measure reporting. A brief summary of the findings and opportunities for improvement is included below.

- ◆ As in previous years, the auditor recommended that HPSM develop a reconciliation process of paid and reversed pharmacy claims to ensure accuracy of measure rates and consistency of the process across all claims used for measure reporting.
- ◆ The auditor recommended that HPSM institute a formalized documented process to ensure accuracy of provider data between the MCP's provider credentialing system and its provider information systems.

Performance Measure Results

After validating MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 for HPSM's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
HPSM—San Mateo County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	14.52%	15.68%	16.99%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	51.62	52.11	48.80	49.73	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	483.04	546.12	445.65	438.97	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	89.28%	89.51%	90.97%	89.51%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	92.71%	94.95%	94.34%	49.35%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	89.85%	90.57%	91.85%	90.03%	↓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	34.06%	34.46%	37.13%	35.50%	↔
Cervical Cancer Screening	Q,A	—	—	61.80%	55.10%	↔
Childhood Immunization Status—Combination 3	Q,A,T	80.29%	75.56%	82.11%	81.60%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	95.89%	96.70%	97.13%	93.89%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	88.34%	88.32%	90.40%	89.21%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	87.75%	89.36%	89.74%	91.49%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	84.89%	85.61%	85.34%	87.36%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	66.18%	56.93%	46.72%	60.10%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	61.07%	57.42%	60.83%	63.75%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	79.81%	83.70%	87.10%	89.29%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	55.72%	56.45%	54.01%	54.99%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	87.83%	82.97%	90.02%	83.94%	↓
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	37.96%	35.28%	38.69%	38.20%	↔
Controlling High Blood Pressure	Q	—	51.34%	29.93%	61.80%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	68.49%	70.28%	78.45%	77.08%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	48.51%	50.21%	47.09%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	26.38%	27.69%	26.38%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	61.22%	59.18%	59.55%	63.07%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	81.89%	84.18%	82.66%	77.89%	↔
Use of Imaging Studies for Low Back Pain	Q	81.51%	80.07%	79.18%	83.47%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	66.67%	55.47%	67.32%	73.96%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	77.62%	70.05%	73.90%	75.00%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	63.99%	53.91%	63.66%	61.98%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	73.80%	77.13%	75.68%	73.16%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant decline in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant improvement in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 Seniors and Persons with Disabilities (SPD) measure results reported by HPSM. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

⁴ 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 3.2.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for HPSM—San Mateo County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	11.64%	20.91%	▼	16.99%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.99%	90.60%	↑	89.51%
Annual Monitoring for Patients on Persistent Medications—Digoxin	56.67%	47.58%	↔	49.35%
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.47%	91.55%	↑	90.03%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	93.94%	NA	Not Comparable	93.89%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.51%	77.54%	↓	89.21%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	92.37%	72.75%	↓	91.49%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.43%	69.49%	↓	87.36%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the All-Cause Readmissions measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly higher SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly lower SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A Not Applicable audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures HPSM—San Mateo County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
351.81	47.21	803.65	60.26

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
HPSM—San Mateo County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	13.28%	16.78%	20.91%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	58.21	60.39	60.26	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	924.90	797.31	803.65	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.95%	91.58%	90.60%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	94.79%	94.84%	47.58%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.23%	92.65%	91.55%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	79.41%	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	74.72%	77.57%	77.54%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	72.19%	72.88%	72.75%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	65.03%	68.15%	69.49%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
HPSM—San Mateo County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	19.24%	11.52%	11.64%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	49.86	44.87	47.21	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	405.92	326.37	351.81	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.52%	83.57%	86.99%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	56.67%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.70%	82.05%	86.47%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.98%	97.15%	93.94%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.77%	90.80%	89.51%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.72%	90.92%	92.37%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.60%	86.89%	88.43%	↑

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rate for the *Childhood Immunization Status—Combination 3* measure was above the HPL in RY 2015, and the rates for the following measures improved significantly from RY 2014 to RY 2015:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Controlling High Blood Pressure*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*

The rates for the following measures declined significantly from RY 2014 to RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

The rate for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure declined from RY 2014 to RY 2015; although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015.

Seniors and Persons with Disabilities Findings

The SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures were significantly better than the non-SPD rates. The SPD rates for the following measures were significantly worse than the non-SPD rates:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years, 7 to 11 Years, and 12 to 19 Years* (Note that the denominator was too small for the MCP to report an SPD rate for the *12 to 24 Months* measure, so no comparison could be made for this measure.)

Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Across all measures stratified for the SPD and non-SPD populations, no notable variations in the SPD and non-SPD rates occurred from RY 2014 to RY 2015 that are not already reflected in the analysis above.

Assessment of Improvement Plans

Controlling High Blood Pressure

Based on RY 2014 rates, HPSM submitted one improvement plan (IP) to address the rates for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *Controlling High Blood Pressure* measures being below the MPLs in RY 2014. HPSM identified the following barriers to the rates for the measures being above the MPLs:

- ◆ Lack of population management in the primary care network
- ◆ Inability to capture clinical data
- ◆ Lack of beneficiary engagement in the health care process

HPSM implemented the following interventions to address the barriers:

- ◆ Provided lists of beneficiaries with diabetes and hypertension to high-volume practice sites.
- ◆ Continued to work with medical groups and clinics to explore the feasibility of them providing HPSM with regular electronic medical record data (including vitals/blood pressure readings).
- ◆ Provided home visits for high-risk beneficiaries not engaged with their primary care provider (PCP) in order to gather clinical information and perform routine screenings and tests.

HPSM also tested a Plan-Do-Study-Act (PDSA) cycle to improve the rates on the measures. The MCP identified beneficiaries diagnosed with diabetes and hypertension from January 2014 to January 2015 and attempted to contact them to offer a free home blood pressure monitor along with patient education by the clinic pharmacist or nurse educator. The MCP determined the intervention to be successful and indicated it will adapt the change moving forward.

HPSM's improvement efforts were successful at bringing the rates for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *Controlling High Blood Pressure* measures to above the MPLs. The MCP will not be required to continue the IP for these measures based on RY 2015 performance measure results.

Required Improvement Plans for RY 2015

Based on RY 2015 performance measure results, HPSM will be required to submit an IP for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure.

Strengths

HSAG auditors determined that HPSM followed the appropriate specifications to produce valid rates.

The rate for one measure was above the HPL in RY 2015. The rates for five measures improved significantly from RY 2014 to RY 2015, and the improvement resulted in the rates for three of the measures moving from below the MPLs in RY 2014 to above the MPLs in RY 2015.

HPSM provided documentation of actions the MCP has taken to ensure that the MCP is meeting the needs of the SPD population. Specifically, HPSM described enhancements the MCP made to its complex case management services and indicated that the MCP continues to methodically assess the increased needs of SPD beneficiaries (See Table 6.1).

Opportunities for Improvement

While HPSM noted actions to address recommendations made by the auditor in RY 2014 (See Table 6.1), the MCP has the opportunity to sufficiently address the auditor's recommendations from RY 2015 related to paid and reversed pharmacy claims and accuracy of provider data between the MCP's provider credentialing system and its provider information systems.

HPSM has the opportunity to assess the factors causing the rates for five measures to decline significantly from RY 2014 to RY 2015 and the rates for two measures being below the MPLs in RY 2015 and to implement strategies to improve performance on the measures. While HPSM reported actions designed to ensure that the MCP meets the needs of the SPD population, the MCP continues to show opportunities for improvement related to hospital readmissions for the SPD population.

Quality Improvement Project Objectives

HPSM participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 lists HPSM’s QIPs and indicates the QIP conducted; whether the QIP was clinical or nonclinical; and the domains of care (i.e., quality, access, and timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for HPSM
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Increasing Timeliness of Prenatal Care</i>	Clinical	Q, A, T

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

HPSM’s goal for the *Increasing Timeliness of Prenatal Care* QIP was to have women see a provider in their first trimester and then maintain a prenatal “home” throughout the pregnancy. At the initiation of the QIP, HPSM reported that 85.3 percent of eligible beneficiaries received a prenatal visit within the appropriate time frame. Lack of timely prenatal care is associated with poorer pregnancy outcomes, including preterm birth.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
HPSM—San Mateo County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	62%	86%	<i>Partially Met</i>
Internal QIPs				
<i>Increasing Timeliness of Prenatal Care</i>	Annual Submission	80%	90%	<i>Partially 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, 2014, through June 30, 2015, showed that both HPSM’s annual submissions of its *All-Cause Readmissions* and *Increasing Timeliness of Prenatal Care* QIPs received a *Partially Met* validation status. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, HPSM conducted PDSA cycles for the *All-Cause Readmissions* and *Increasing Timeliness of Prenatal Care* QIPs.

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

**Table 4.3—Quality Improvement Project Average Rates*
HPSM—San Mateo County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015**

QIP Study Stages	Activity	<i>Met</i> Elements	<i>Partially Met</i> Elements	<i>Not Met</i> 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	100%	0%	0%
Design Total		100%	0%	0%

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Implementation	VII: Sufficient Data Analysis and Interpretation	76%	6%	18%
	VIII: Appropriate Improvement Strategies**	13%	63%	25%
Implementation Total		56%	24%	20%
Outcomes	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		25%	0%	75%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for both HPSM’s *All-Cause Readmissions* and *Increasing Timeliness of Prenatal Care* QIP annual submissions.

HPSM demonstrated a strong application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP struggled with its application of the Implementation stage, meeting 56 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The *All-Cause Readmissions* and *Increasing Timeliness of Prenatal Care* QIPs had multiple implementation issues, resulting in lower scores for Activities VII and VIII.

Both QIPs progressed to the Outcomes stage during the reporting period. However, the MCP received a low score for Activity IX because neither QIP achieved statistically significant improvement over baseline. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for HPSM—San Mateo County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions					
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]					
Baseline Period 1/1/12–12/31/12		Remeasurement 1 1/1/13–12/31/13			Sustained Improvement [‡]
14.5%		15.7%			‡
QIP #2—Increasing Timeliness of Prenatal Care					
Study Indicator: Percentage of members who had a prenatal care visit in the first trimester or within 42 days of enrollment					
Baseline Period 1/1/09–12/31/09	Remeasurement 1 1/1/10–12/31/10	Remeasurement 2 1/1/11–12/31/11	Remeasurement 3 1/1/12–12/31/12	Remeasurement 4 1/1/13–12/31/13	Sustained Improvement [‡]
85.3%	83.2%	81.9%	84.2%	82.7%	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

All-Cause Readmissions QIP

HPSM’s goal for the *All-Cause Readmissions* QIP was to decrease the readmissions rate from 14.5 percent (baseline) to 10.9 percent (Remeasurement 1). Unfortunately, the MCP did not meet the project’s goal and, instead, the readmissions rate increased to 15.7 percent at Remeasurement 1. A review of the MCP’s QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ HPSM identified and prioritized the following barriers during Remeasurement 1:
 - Inability to contact beneficiaries once they were discharged from an acute setting
 - Beneficiaries often seeing multiple providers and being prescribed medications for their multitude of chronic conditions from multiple specialty providers
 - Beneficiaries unaware of follow-up discharge instructions provided by hospital staff
 - Long-term care beneficiaries discharged not knowing their PCP
 - Elderly and lower socioeconomic population often not knowing how to receive behavioral health treatment in conjunction with their chronic medical conditions
 - PCPs unaware of when beneficiaries are discharged from an acute care facility
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions that HPSM indicated it implemented during the Remeasurement 1 time period:

- Sent notifications by mail to non-SPD beneficiaries within two weeks of discharge that highlight the need for them to contact their PCP for follow-up and include contact information for the MCP's care coordination department.
- Implemented a process to send quarterly reports to PCPs with the highest readmission rates.

Increasing Timeliness of Prenatal Care QIP

The *Increasing Timeliness of Prenatal Care* QIP's goal was to increase by 5 percent the number of eligible beneficiaries having a prenatal visit in the first trimester or within 42 days of enrollment in the MCP over baseline, which the QIP did not achieve. At Remeasurement 4, the indicator still had not achieved statistically significant improvement over baseline. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ As in previous years, HPSM did not provide complete and/or accurate information throughout the QIP Summary Form.
- ◆ HPSM identified the following barriers during Remeasurement 4:
 - Lack of consistent staff for the Prenatal Program
 - Lack of actionable data to identify pregnant beneficiaries
 - Inability to reach beneficiaries
 - Beneficiary confusion about the MCP's Prenatal Incentive Program
 - Lack of participation in provider incentives around prenatal care
- ◆ Although HPSM documented a list of interventions in its QIP annual submission, the MCP did not document the dates the interventions were implemented. Thus, it is unclear if the interventions were new, revised, or existing interventions.

Plan-Do-Study-Act Review

Both the *All-Cause Readmissions* and *Increasing Timeliness of Prenatal Care* QIPs did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for each QIP topic.

All-Cause Readmissions

For the *All-Cause Readmissions* PDSA cycle, HPSM set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By March 31, 2015, the HPSM will contact 75 percent of the 72 identified beneficiaries who have been admitted to Sequoia Medical Center from October 2013 through October 2014 with an admitting diagnosis of congestive heart failure (CHF) to offer a free course on signs and symptoms of CHF along with nurse outreach.

The purpose of the *All-Cause Readmissions* PDSA cycle was to measure how many of the 72 identified beneficiaries with CHF would be willing to attend the offered course on signs and symptoms of CHF.

Only six of the 72 identified beneficiaries were able to attend the class. HPSM identified significant barriers (e.g., older beneficiaries with chronic conditions, language barriers) preventing beneficiaries from attending the class. Fifteen beneficiaries died during the *All-Cause Readmissions* PDSA cycle, resulting in outreach to 57 beneficiaries. Five beneficiaries were either in hospice or a mental health facility; and 17 beneficiaries did not return the MCP's calls, or the MCP had inaccurate contact information on file. HPSM staff noted that beneficiaries who refused the class stated they had a good relationship with their PCP or cardiologist and felt there was no need to attend a class for further education. HPSM indicated abandoning the change. Rather, the MCP will focus its outreach through case management services that can provide education via telephone or home visits.

Improving Postpartum Care

For the *Increasing Timeliness of Prenatal Care* QIP topic, HPSM changed the focus to *Improving Postpartum Care* for the PDSA cycle. By increasing the contact with beneficiaries attending their postpartum visits, the MCP hoped to identify new barriers to the timeliness of prenatal care. The MCP set the SMART Objective as follows:

By March 31, 2015, have a 75 percent success rate outreaching to beneficiaries who have recently delivered within 21–58 days post-delivery time frame through reminder calls.

The purpose of the *Postpartum Care* PDSA cycle was to test if the targeted intervention will increase the number of women reached through reminders calls for postpartum care visits.

HPSM completed the *Postpartum Care* PDSA cycle as planned and indicated an increase in the percentage of women successfully reached with a reminder call after delivery. The MCP identified barriers that included disconnected phone numbers and reaching the beneficiaries due to the timing of the call or someone else answering the phone. HPSM planned to adopt the change.

Strengths

HPSM demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Increasing Timeliness of Prenatal Care* QIPs.

The *Improving Postpartum Care* PDSA cycle results indicated that HPSM's test of change was successful at increasing the percentage of women reached through reminder calls for postpartum care visits.

Opportunities for Improvement

Although HPSM will not be continuing the formal QIPs, the MCP should continue with its modified plans identified at the conclusion of the *All-Cause Readmissions* PDSA cycle to test the case management services that can provide education via telephone or home visits. In addition, the MCP should evaluate how the change tested through the *Improving Postpartum Care* PDSA cycle ultimately impacted the postpartum visit rate and identified new barriers to prenatal care, which were the two goals for the PDSA cycle. The MCP should consider making revisions to the outreach call intervention to facilitate a higher success rate through additional PDSA cycles.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

HPSM’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for HPSM. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for HPSM

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	22.6%	26.3%	25th–75th	14.9%	9.2%	10th–25th
Diagnosis Code	28.8%	31.6%	25th–75th	35.5%	34.6%	25th–75th
Procedure Code	37.1%	43.8%	25th–75th	18.8%	22.5%	25th–75th
Procedure Code Modifier	65.8%	58.5%	25th–75th	NA	46.0%	NA
Rendering Provider Name	NA	25.0%	NA	100.0%	68.1%	0–≤25th
Billing Provider Name	33.1%	35.0%	25th–75th	12.4%	8.6%	10th–25th

Note: HSAG displayed “NA” when the denominator was less than 30.

Overall, the medical record omission rates for HPSM ranged from 22.6 percent (*Date of Service*) to 65.8 percent (*Procedure Code Modifier*). Four of HPSM’s five reported medical record omission rates were slightly better than the respective statewide rates, and the remaining rate (*Procedure Code Modifier*) was worse than the statewide rate by 7.3 percentage points. When compared to other MCPs’ performance, HPSM received a percentile ranking of “25th–75th” for each of the five reported medical record omission rates. These findings suggest a moderate level of completeness among key encounter data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for HPSM contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, HPSM's rates varied from 12.4 percent (*Billing Provider Name*) to 100 percent (*Rendering Provider Name*). Only one of HPSM's encounter data omission rates was better than the respective statewide rate, but the difference was small (*Procedure Code*, by 3.7 percentage points). HPSM performed worse than the statewide encounter data omission rate by 31.9 percentage points for the *Rendering Provider Name* data element. An opportunity exists for HPSM to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in HPSM's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to HPSM (and/or the data subsequently being submitted to DHCS).
- ◆ HPSM populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files HPSM submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for HPSM. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for HPSM

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	67.8%	83.6%	<10th	Inaccurate Code (66.0%)
Procedure Code	70.9%	77.6%	25th–75th	Percent from Lower of Services in Medical Records (80.8%); Inaccurate Code (19.2%)
Procedure Code Modifier	NA	99.5%	NA	—
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	60.4%	68.6%	10th–25th	Incorrect Names (100.0%)
All-Element Accuracy	0.0%	4.3%	0–≤25th	—

Note: HSAG displayed "NA" when the denominator was less than 30. HSAG displayed "—" when the error type analysis was not applicable to a data element.

When key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be relatively inaccurate for HPSM— with all three reported element accuracy rates lower than the respective statewide rates and no rendering provider information available in the encounter data. When compared to the performance among the assessed MCPs, one key data element received a percentile ranking of “<10th” (*Diagnosis Code*), one element received a ranking of “10th–25th” (*Billing Provider Name*), and one element received a ranking of “25th–75th” (*Procedure Code*). Two-thirds (66.0 percent) of the errors for the *Diagnosis Code* data element resulted from inaccurate codes in the encounter data when compared to the medical records. For the *Procedure Code* data element, 80.8 percent of identified errors were associated with higher-level procedure codes having been documented in the DHCS encounter data than were documented in the medical records (i.e., the procedure code was considered an error due to a lower level service documented in the medical record). All billing provider name errors (100 percent) were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records.

HPSM’s all-element accuracy rate was lower than the statewide rate by 4.3 percentage points. No dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. These overall accuracy findings indicated the presence of at least one inaccurate data element for all dates of service present in both data sources. While all five key data elements contributed to HPSM’s relatively low all-element accuracy rate, the *Rendering Provider Name* data element contributed the most.

Medical Record Review Recommendations

Based on the study findings for HPSM, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, HPSM should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS. Because rendering provider information was not submitted in HPSM’s encounter data, record procurement was based on billing provider information.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.

- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields. HPSM should ensure that the additional diagnosis codes are submitted to DHCS after the system transition.
- ◆ HPSM should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ HPSM should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code* and *Procedure Code Modifier* data elements and develop strategies to improve rates.
- ◆ HPSM should explore the reasons for the relatively high encounter data omission rates for the *Diagnosis Code* and *Rendering Provider Name* data elements and take actions to improve rates.
- ◆ HPSM should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with HPSM.
- ◆ HPSM should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.

- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

HPSM's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to PACES. Based on review of HPSM's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist HPSM with improving its encounter data quality. DHCS followed up with HPSM regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of HPSM's performance in the three domains of care—quality, access, and timeliness.

Quality

As in previous years, HPSM's quality improvement program documents described processes and activities the MCP implements to ensure that quality care is provided to beneficiaries.

DHCS identified findings in all areas reviewed during HPSM's November 2014 medical and State Supported Services audit. The findings in the areas of Quality Management and Administrative and Organizational Capacity could impact the quality of care delivered to beneficiaries.

The rate for the *Childhood Immunization Status—Combination 3* measure, which falls into the quality domain of care, was above the HPL in RY 2015; and the rates for the following quality measures improved significantly from RY 2014 to RY 2015:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Controlling High Blood Pressure*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*

The rates for the following quality measures declined significantly from RY 2014 to RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

The rate for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure, which falls into the quality domain of care, declined from RY 2014 to RY 2015.

Although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015.

For quality measures stratified by the SPD and non-SPD populations, the SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures were significantly better than the non-SPD rates. The SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rates; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of HPSM's QIPs fell into the quality domain of care. Neither QIP achieved statistically significant improvement over baseline. While the *All-Cause Readmissions* QIP was at Remeasurement 1, the *Increasing Timeliness of Prenatal Care* QIP was at Remeasurement 4, suggesting that the MCP's strategies to improve the quality of care for pregnant beneficiaries need to be modified.

HPSM submitted a PDSA cycle related to each QIP topic. For the *All-Cause Readmissions* PDSA cycle, HPSM found that the MCP was not successful at getting beneficiaries with CHF who had been admitted to the targeted hospital to attend a free course on signs and symptoms of CHF. The PDSA cycle did not achieve the desired results, and HPSM decided to abandon the change. Rather, the MCP will focus its outreach through case management services that can provide education via telephone or home visits.

For the *Increasing Timeliness of Prenatal Care* QIP topic, HPSM changed the focus to *Improving Postpartum Care* for the PDSA cycle. The MCP found that the targeted intervention resulted in an increase in the percentage of women successfully reached with a reminder call after delivery and therefore decided to adopt the change. The MCP has the opportunity to determine how the success of the intervention ultimately impacted the postpartum visit rate and identified new barriers to prenatal care, which were the initial goals of the PDSA cycle.

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

Access

HPSM's quality improvement program documents include access-related activities and processes, including descriptions of interventions designed to improve access and plans to identify interventions targeted to improve beneficiary awareness of available health care services.

DHCS identified findings in all areas reviewed during HPSM's November 2014 medical and State Supported Services audit. Findings that could affect beneficiary access to care were in the areas of Access and Availability of Care and Case Management and Coordination of Care.

The rate for the *Childhood Immunization Status—Combination 3* measure, which falls into the access domain of care, was above the HPL in RY 2015; and the rates for the following access measures improved significantly from RY 2014 to RY 2015:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015

The rates for the following access measures declined significantly from RY 2014 to RY 2015:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The SPD rates for the following measures were significantly worse than the non-SPD rates:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years, 7 to 11 Years, and 12 to 19 Years*

As noted previously, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Both of HPSM's QIPs fell into the access domain of care. As noted above, neither QIP achieved statistically significant improvement over baseline. The *Timeliness of Prenatal Care* QIP results at Remeasurement 4 suggest that the MCP's strategies to improve access to care for pregnant beneficiaries need to be modified.

Also as noted above, HPSM submitted a PDSA cycle related to each QIP topic, with the *All-Cause Readmissions* PDSA cycle not achieving the desired results and the *Improving Postpartum Care* PDSA cycle achieving positive results that the MCP decided to adopt.

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

Timeliness

As in previous years, HPSM's quality improvement program description included information on the MCP's organizational structure designed to ensure timeliness of care for beneficiaries. Areas described that impact timeliness of care included Utilization Management, Grievances and Appeals, and Coordination of Care.

DHCS identified findings in all areas reviewed during HPSM's November 2014 medical and State Supported Services audit. Findings that could affect timeliness of care were in the areas of Utilization Management and Member's Rights.

Five of the required performance measures fall into the timeliness domain of care; and the rates for four measures were between the MPLs and HPLs. The rate for the *Childhood Immunization Status—Combination 3* measure was above the HPL.

HPSM's *Timeliness of Prenatal Care* QIP fell into the timeliness domain of care and, as noted above, the QIP did not achieve statistically significant improvement at Remeasurement 4. The results suggest that the MCP's strategies to improve timeliness of care for pregnant beneficiaries need to be modified.

Also as noted above, HPSM submitted a PDSA cycle related to the *Timeliness of Prenatal Care* QIP which focused on improving postpartum care, and the PDSA cycle achieved positive results that the MCP decided to adopt.

Overall, HPSM 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with HPSM’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—HPSM’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Implement a process to reconcile paid and reversed pharmacy claims to prevent over-reporting of rates for some measures that use pharmacy data.</p>	<p>As explained on page D-1 in the <i>Self-Reported Follow-Up EQR Recommendations from the July 1, 2012 through June 30, 2013 Report</i>, it is not necessary to implement a process to reconcile paid and reversed claims.</p> <p>“We evaluated this issue and determined that it does not affect HEDIS reporting.</p> <ol style="list-style-type: none"> 1. The matter does not concern reversals, but rather denied claims. 2. We do receive reversals from our pharmacy benefit manager (PBM), and reversing and reversed claims were excluded from HEDIS reporting. 3. We do not receive denied prescription (RX) claims. We have monitored the HEDIS rates for the measures utilizing RX claims data, and the rates are consistent with previous years' rates. Therefore, we believe that excluding denied RX claims does not have significant impact on our HEDIS reporting.” <p>Since the process of handling and preparing pharmacy claims for HEDIS has not changed, the above explanation still applies.</p>
<p>2. Implement a process to reconcile credentialing and claims processing databases to ensure that the MCP has accurate provider data.</p>	<p>HPSM reconciles our current credentialing database, known as “Prime,” with our claims encounters contained within our claims processing system, Healthsuite, in specific instances when provider data changes or a mismatch are found. In addition, on a quarterly basis, we perform reconciliations of our network data from both systems for submission to our State regulatory agencies.</p> <p>During the review period, we sought out an alternative which can more readily and regularly reconcile credentialing data with claims processing data than can the Prime database. Whereas Prime is a “homegrown” database built in Microsoft Access, HPSM will soon be licensing a more advanced credentialing database with features that will better enable validation of provider data against national databases as well as against our own claims data.</p>

2013–14 External Quality Review Recommendation Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>3. Assess the factors leading to the rates being below the MPLs for the following measures, and identify strategies to improve performance:</p> <ul style="list-style-type: none"> a. <i>Children and Adolescents’ Access to Primary Care practitioners—12 to 19 Years</i> b. <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> c. <i>Controlling High Blood Pressure</i> 	<p>a. A causal/barrier analysis was completed this year to assess the primary concerns for the <i>Children and Adolescents’ Access</i> measure, and analysis demonstrated that overall performance of this measure is addressing the following: increased communication with our members and providers, effectiveness of assignment or reassignment of members to network clinics, and accessibility to appointments.</p> <p>Improvement Strategies:</p> <ul style="list-style-type: none"> - Partner with two clinics that have highest volume of members in this age group to create outreach template for pilot sites with identified members, contact information, outreach attempts, success rate, and barrier reasons. - Create targeted messages to teens and parents to reach out to their PCPs for health concerns at this particular age. Messages will be included in identification letters sent out to all new members and members asking for PCP reassignment. - Provider newsletter sent out biannually to PCPs to include importance of outreaching to members and to tie in pay for performance incentive. - Outreach in conjunction with our provider service representatives to provide support to PCPs in comprehending where they can access their panel lists. <p>b. and c. The MCP main driver of the decline in these measures (<i>Comprehensive Diabetes Care-CBP</i> and <i>CBP</i>) was related to HEDIS data collection as mentioned from the previous submission. HEDIS 2015 rates improved with adjusted chase logic for medical record review.</p> <p>Improvement Strategies:</p> <ul style="list-style-type: none"> - MCP entered into collaboration with network clinic staff to provide hypertension classes/clinics to members identified by the MCP. We have targeted 150 members with the following criteria: Care Advantage or Cal MediConnect members, have had a diagnosis of hypertension and diabetes identified through claims beginning January 2014, and whose primary care physician is based at specified network clinic. - Blood pressure monitors are provided to members served at network clinic. Outreach is completed by the nursing staff or the resident pharmacist who leads the program. The members who enroll will sign a contract verifying acceptance of blood pressure monitor and be taught how to take blood pressure in accordance with each individual’s specific needs. The pharmacist and nursing staff will also educate members on signs and symptoms of hypertension, diet, proper medication adherence, and use of the blood pressure monitor. The blood pressure monitors will need to be connected to a gateway “cloud” device to upload the pressure readings via internet. Each

2013–14 External Quality Review Recommendation Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>blood pressure monitor will have a connection with the county clinic’s electronic medical record system so that the primary care physician can view the patient’s medical records along with readings to make any adjustments as necessary. Preliminary data of 14 members shows overall improvement of blood pressure.</p> <p>Baseline blood pressure (BP) (prior to education and receipt of monitor) 151/91 First BP Average: 151/83 Second BP Average: 142/81 Third BP Average: 137/84</p> <p>-Pay for Performance quarterly reports that are provider specific continue to provide PCPs with identified missed opportunities to contact members to follow up on medication adherence, diet, and completion of labs.</p> <p>- Fall 2014 Health Education Newsletter sent to members featured article “7 Steps to Protect Your Health Have High Blood Pressure?” aimed at members to encourage changes in lifestyle to help control their blood pressure.</p>
<p>4. For measures with SPD rates significantly worse than non-SPD rates, assess the factors leading to the rates being significantly worse for the SPD population to ensure that the MCP is meeting this population’s needs.</p>	<p>SPD members often have complex health and social service needs that demand care management interventions above and beyond the scope of services traditionally provided to non-SPD members.</p> <p>To improve the complex case management that is required of the SPD population, the MCP has developed a care plan process that utilizes the tools of the health risk assessment questionnaire, encounter data and data list that identifies high utilizers by last acute inpatient date, emergency department visits, and diagnoses to create metrics for follow-up with members by our care coordination nurses.</p> <p>MCP has also implemented the Coleman model at two of the network hospitals to follow members from admission through the end of their 30-day post-discharge period. There is a huge need for a seamless transition from acute admission to discharge into a long term care facility or skilled nursing facilities for many of our SPD population. As readmission is most likely to occur within the first 30 days of discharge, the care transition coach works side by side with the care coordination nurse coordinating durable medical equipment, follow-up medical appointments, and/or social services for an improved transitional process for the member. The MCP continues to methodically assess the increased needs of SPD members.</p>
<p>5. Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.</p>	<p>We continued to check for completeness and accuracy of all QIP documents as part of our quality assurance process. We also hired a quality support analyst in February 2015 to assist with data analysis related to causal/barrier analysis and intervention evaluation.</p>

2013–14 External Quality Review Recommendation Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>6. Conduct a new causal/barrier analysis for the <i>Increasing Timeliness of Prenatal Care</i> QIP and assess if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.</p>	<p>A causal/barrier analysis was conducted. The most significant barriers to improving timely prenatal care were:</p> <ol style="list-style-type: none"> 1. Inability to directly outreach to a significant portion of pregnant members due to the lack of accurate contact information. Many members targeted for outreach had disconnected phone numbers and/or outdated addresses. 2. Lack of awareness among pregnant members of the importance of early and regular prenatal care and timely postpartum care. 3. Lack of awareness among providers of our Prenatal Care program for our members as well as the Pay for Performance incentives available to them for prenatal care services during the first trimester. <p>Improvement strategies implemented to address these barriers:</p> <ol style="list-style-type: none"> 1. Redesigned Prenatal Care program brochures and posters to be more eye-catching to our members. Distributing brochures to county clinics and provider offices to outreach to members at the place of care, with the aim of reaching members who we are unable to contact directly. 2. Published article in the fall 2014 member newsletter on the importance of getting prenatal care within the first three months of pregnancy and the Prenatal Care Incentive program. 3. Created a referral form for outside agencies and obstetricians/gynecologists to use for enrolling HPSM members into the Prenatal Care program. Since the distribution of the referral form, HPSM has noticed an increase in referrals.

Recommendations

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

- ◆ Fully resolve all findings from the MCP’s November 2014 medical and State Supported Services audit.
- ◆ Sufficiently address the auditor’s recommendations from RY 2015. Specifically:
 - Develop a reconciliation process of paid and reversed pharmacy claims to ensure accuracy of measure rates and consistency of the process across all claims used for measure reporting.
 - Institute a formalized, documented process to ensure accuracy of provider data between the MCP’s provider credentialing system and its provider information systems.
- ◆ Assess the factors causing the rates for five measures to decline significantly from RY 2014 to RY 2015 and the rates for two measures being below the MPLs in RY 2015, and implement

strategies to improve performance on the measures. Although improved performance is important for all measures, HPSM may want to consider initially focusing on measures for which DHCS holds MCPs accountable to meet the MPLs:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics*
 - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
 - *Medication Management for People with Asthma—Medication Compliance 50% Total*
- ◆ Assess the factors leading to a significant increase in the readmissions rate for the SPD population to determine if the MCP's complex case management program has the components necessary to address the needs of this population.
 - ◆ Although HPSM will not be continuing the formal QIPs, the MCP should:
 - Continue with its modified plans identified at the conclusion of the *All-Cause Readmissions* PDSA cycle to test the case management services that can provide education via telephone or home visits.
 - Evaluate how the change tested through the *Improving Postpartum Care* PDSA cycle ultimately impacted the postpartum visit rate and identified new barriers to prenatal care, which were the two goals for the PDSA cycle. The MCP should consider making revisions to the outreach call intervention to facilitate a higher success rate through additional PDSA cycles.
 - ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix Q:
Performance Evaluation Report
Inland Empire Health Plan
July 1, 2014 – June 30, 2015**

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Appendix Q: Performance Evaluation Report – Inland Empire Health Plan July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Inland Empire Health Plan (“IEHP” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

IEHP is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries in San Bernardino and Riverside counties may enroll in IEHP, the LI MCP; or in Molina Healthcare of California Partner Plan, Inc., the alternative commercial plan.

IEHP became operational in Riverside and San Bernardino counties to provide MCMC services effective September 1996. As of June 30, 2015, IEHP had 527,449 beneficiaries in Riverside County and 538,150 in San Bernardino County—for a total of 1,065,599 beneficiaries.¹ This represents 87 percent of the beneficiaries enrolled in Riverside County and 86 percent in San Bernardino County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: October 8, 2015.

Medical Audit

The most recent medical audit for IEHP was conducted by DHCS April 7, 2014, through April 18, 2014, covering the review period of January 1, 2013, through December 31, 2013.

DHCS reviewed the following areas:

- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Members' Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity
- ◆ State Supported Services

The report of findings was issued by DHCS on November 13, 2014. DHCS identified deficiencies in all areas except Access and Availability of Care. The MCP was required to submit a corrective action plan in response to the findings. In a letter to IEHP dated July 6, 2015, DHCS indicated that it deemed most deficiencies as closed and some as provisionally closed. DHCS will continue to work with the MCP until all provisionally closed items are ameliorated. Provisionally closed deficiencies were in the areas of Case Management and Coordination of Care (two deficiencies) and Members' Rights (two deficiencies). Note that while the information regarding resolution of the deficiencies was received outside the review period for this MCP-specific evaluation report, HSAG included the information since the time frame was only six days past the review period and the letter indicated full/provisional resolution of all deficiencies.

Strengths

During IEHP's most recent medical review, DHCS identified no deficiencies in the area of Access and Availability of Care. Additionally, the MCP responded to all deficiencies identified during the review, and DHCS deemed them all closed or provisionally closed.

Opportunities for Improvement

Since IEHP has no outstanding deficiencies from DHCS's most recent medical audit, HSAG identified no opportunities for improvement for the MCP related to compliance reviews.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Inland Empire Health Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that IEHP followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the notable findings is included below.

- ◆ Despite a large increase in enrollment during the measurement year, IEHP processed claims data efficiently and in a timely manner, with no backlogs.
- ◆ IEHP had exceptional processes to monitor encounter data submissions through an extensive incentive program. The auditor noted that this robust incentive will likely lead to improved provider performance.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 for IEHP's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
IEHP—Riverside/San Bernardino Counties**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	14.24%	14.73%	17.89%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	49.54	51.67	48.50	49.83	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	326.35	347.94	288.05	244.43	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	84.22%	86.98%	86.33%	87.85%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	89.45%	91.99%	90.80%	52.36%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	83.53%	86.07%	85.42%	86.93%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	22.10%	22.53%	21.52%	21.75%	↔
Cervical Cancer Screening	Q,A	—	—	70.47%	68.00%	↔
Childhood Immunization Status—Combination 3	Q,A,T	77.78%	78.24%	76.85%	75.46%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	96.33%	96.75%	96.67%	94.72%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	86.92%	86.91%	86.77%	84.75%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	83.53%	83.18%	84.55%	84.36%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	86.30%	86.72%	83.97%	83.06%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	75.76%	71.00%	62.88%	64.35%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	52.68%	59.40%	51.74%	57.41%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	82.98%	85.61%	84.69%	86.11%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	48.72%	50.81%	46.87%	50.23%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	83.68%	84.45%	82.13%	84.49%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	40.79%	36.19%	39.44%	36.57%	↔
Controlling High Blood Pressure	Q	—	62.91%	67.56%	69.25%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	63.66%	71.99%	70.60%	70.60%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	44.25%	52.09%	52.12%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	21.96%	29.48%	27.18%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	63.23%	59.63%	59.02%	61.03%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	86.42%	88.40%	86.42%	86.38%	↔
Use of Imaging Studies for Low Back Pain	Q	75.58%	77.47%	75.14%	75.34%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	77.55%	78.94%	79.86%	78.01%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	79.63%	74.54%	73.84%	76.39%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	52.78%	47.69%	53.01%	65.05%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	72.19%	75.69%	71.53%	71.06%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate. Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 Seniors and Persons with Disabilities (SPD) measure results reported by IEHP. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for IEHP—Riverside/San Bernardino Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	13.43%	21.77%	▼	17.89%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.53%	89.54%	↑	87.85%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	50.35%	53.23%	↔	52.36%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.29%	88.93%	↑	86.93%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	94.73%	93.81%	↔	94.72%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	84.71%	86.10%	↑	84.75%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	84.26%	86.29%	↑	84.36%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	83.10%	82.37%	↔	83.06%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

⁴ 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 3.2.

**Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
IEHP—Riverside/San Bernardino Counties**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
225.61	46.76	452.07	83.70

* Member months are a member’s “contribution” to the total yearly membership.

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
IEHP—Riverside/San Bernardino Counties**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014– 15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	16.95%	17.37%	21.77%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	75.75	82.89	83.70	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	630.72	632.06	452.07	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.22%	88.35%	89.54%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	91.32%	91.64%	53.23%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.78%	87.55%	88.93%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.12%	94.61%	93.81%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.54%	85.58%	86.10%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	87.66%	86.46%	86.29%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	86.60%	82.45%	82.37%	↔

* Member months are a member’s “contribution” to the total yearly membership.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
IEHP—Riverside/San Bernardino Counties**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.82%	9.67%	13.43%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	48.29	44.44	46.76	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	308.23	247.47	225.61	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.14%	82.43%	86.53%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	96.23%	85.19%	50.35%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.24%	80.92%	85.29%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.76%	96.70%	94.73%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.92%	86.81%	84.71%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	82.97%	84.46%	84.26%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	86.73%	84.06%	83.10%	↓

* Member months are a member’s “contribution” to the total yearly membership.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rates for the following measures improved significantly from RY 2014 to 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

The rates for three of the *Children and Adolescents’ Access to Primary Care Practitioners* measures—*12 to 24 Months*, *25 Months to 6 Years*, and *12 to 19 Years*—declined significantly from RY 2014 to RY 2015, resulting in the rates for the *12 to 24 Months* and *25 Months to 6 Years* measures moving from above the MPLs in RY 2014 to below the MPLs in RY 2015. The rate for the *12 to 19 Years* measure has been below the MPL for four consecutive years.

The rates for the following measures also were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total*

Seniors and Persons with Disabilities Findings

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

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*

The SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate, which is to be expected based on the greater and often more complicated health needs of these beneficiaries.

The SPD rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures showed no statistically significant change from RY 2014 to RY 2015.

The following measures showed statistically significant differences between RY 2014 and RY 2015 for the SPD and non-SPD rates:

- ◆ The SPD and non-SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures were significantly better in RY 2015 when compared to RY 2014.
- ◆ The SPD and non-SPD rates for the *All-Cause Readmissions* measure were significantly worse in RY 2015 when compared to RY 2014.
- ◆ The non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, *25 Months to 6 Years*, and *12 to 19 Years* measures declined significantly in RY 2015 when compared to RY 2014.

Assessment of Improvement Plans

IEHP was required to submit no improvement plans (IPs) based on RY 2014 rates and will be required to submit no IPs for RY 2015, due to the fact that the MCP had no measures with rates below the MPLs for which DHCS required IPs. (DHCS required no MCPs to submit IPs for the *Children and Adolescents' Access to Primary Care Practitioners* measures.)

Strengths

HSAG auditors determined that IEHP followed the appropriate specifications to produce valid rates, and no issues of concern were identified. Despite a large increase in enrollment during the measurement year, IEHP processed claims data efficiently and in a timely manner, with no backlogs. Additionally, IEHP had exceptional processes to monitor encounter data submissions through an extensive incentive program.

IEHP provided documentation of actions the MCP has taken to assess the factors causing poor performance on measures in RY 2014 (See Table 6.1). The rates for most measures seeing a significant decline from RY 2013 to RY 2014 improved in RY 2015, demonstrating that the MCP's improvement efforts appear to be making a positive impact.

Opportunities for Improvement

While IEHP identified factors contributing to the MCP's performance related to the *Children and Adolescents' Access to Primary Care Practitioners* measures—*7 to 11 Years* and *12 to 19 Years*—(See Table 6.1), the MCP has the opportunity to assess the factors contributing to the rates for three of the four *Children and Adolescents' Access to Primary Care Practitioners* measures declining significantly from RY 2014 to RY 2015 and the rates for all four measures being below the MPLs. While DHCS does not hold MCPs accountable to meet the MPLs for these measures, the declining rates and performance below the MPLs provide the MCP with the opportunity to ensure beneficiaries in the affected age groups are receiving all recommended health care services.

Quality Improvement Project Objectives

IEHP participated in the statewide collaborative quality improvement project (QIP) and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists IEHP’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, and timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for IEHP
July 1, 2014, through June 30, 2015**

QIP	Counties	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Riverside/San Bernardino	Clinical	Q, A
<i>Comprehensive Diabetes Care</i>	Riverside/San Bernardino	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries ages 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 beneficiaries leading to improved health outcomes.

The *Comprehensive Diabetes Care* QIP targeted the MCP’s beneficiaries with diabetes and focused on increasing the number of HbA1c tests, the percentage of beneficiaries with an HbA1c test result less than or equal to 9 percent (indicating good control), and retinal eye exams. Ongoing management of beneficiaries with diabetes is critical to preventing complications and ensuring optimal health for these beneficiaries, while decreasing medical expenditures.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
IEHP—Riverside/San Bernardino Counties
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	73%	100%	<i>Partially Met</i>
Internal QIPs				
<i>Comprehensive Diabetes Care</i>	Annual Submission	69%	71%	<i>Partially 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, 2014, through June 30, 2015, showed that IEHP’s annual submissions of its *All-Cause Readmissions* and *Comprehensive Diabetes Care* QIPs both received an overall validation status of *Partially Met*. Starting July 1, 2014, DHCS required each MCP with a QIP that did not achieve a *Met* validation status on the annual submission be required to submit a Plan-Do-Study-Act (PDSA) cycle related to the QIP topic rather than to resubmit the QIP for validation. As a result, IEHP conducted a PDSA cycle for the *All-Cause Readmissions* and *Comprehensive Diabetes Care* QIPs.

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

Table 4.3—Quality Improvement Project Average Rates*
IEHP—Riverside/San Bernardino Counties
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		100%	0%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	50%	25%	25%
	VIII: Appropriate Improvement Strategies	50%	50%	0%
Implementation Total		50%	33%	17%
Outcomes	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		25%	0%	75%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

HSAG validated Activities I through IX for IEHP’s *All-Cause Readmissions* QIP and Activities I through VIII for the MCP’s *Comprehensive Diabetes Care* QIP annual submissions.

IEHP demonstrated a strong application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. However, the MCP struggled with its application of the Implementation stage, meeting only 50 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. IEHP did not document factors that affected the MCP’s ability to compare the baseline rate to the Remeasurement 1 rate for the *All-Cause Readmissions* QIP. In addition, IEHP did not document factors that threatened the internal or external validity of the findings, misinterpreted the study indicators, and did not provide rates that matched the MCP’s HEDIS rates for the *Comprehensive Diabetes Care* QIP, all of which resulted in a lower score for Activity VII. IEHP also received a low score for Activity VIII because the MCP did not provide an accurate method to evaluate the interventions for the *All-Cause Readmissions* QIP, and did not prioritize the barriers and indicate the month and year of when each intervention was implemented for the *Comprehensive Diabetes Care* QIP. Although IEHP’s *All-Cause Readmissions* QIP progressed to the Outcomes stage during the reporting period, the study indicator for the QIP did not improve at Remeasurement 1, resulting in a low score for Activity IX. Both QIPs did not progress to Activity X.

Quality Improvement Project Outcomes and Interventions

Comprehensive Diabetes Care QIP

The *Comprehensive Diabetes Care* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP’s interventions for the *Comprehensive Diabetes Care* QIP:

- ◆ Requested all primary care providers (PCPs) to sign standing orders for beneficiaries living with diabetes to receive lab orders for HbA1c testing. The provider service representatives and nurse educators will be following up with all providers who have not signed their standing orders.
- ◆ Mailed beneficiary education and incentive letters to beneficiaries living with diabetes, offering two movie tickets for each beneficiary who completes his or her lab tests.
- ◆ Requested that vision providers conduct outreach to beneficiaries needing a retinal eye exam.
- ◆ Developed a provider toolkit which includes diabetes education materials, a roster of all beneficiaries who did not receive needed services for their diabetes, a list of optometrists for referring beneficiaries, and tools to assist in optimal diabetes care.

All-Cause Readmissions QIP

The *All-Cause Readmissions* QIP progressed to the Outcomes stage during the review period. Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

Table 4.4—Quality Improvement Project Outcomes for IEHP—Riverside/San Bernardino Counties July 1, 2014, through June 30, 2015

QIP #1—All-Cause Readmissions		
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
14.2%	14.7%	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

IEHP was unable to meet the *All-Cause Readmissions* QIP's Remeasurement 1 goal of a 10 percent reduction in the readmissions rate. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ The Remeasurement 1 readmissions rates increased from baseline by 0.5 percentage points, but the increase was not statistically significant.
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions IEHP implemented during the Remeasurement 1 time period:
 - Inpatient review nurses met one-on-one weekly with the medical director to discuss and assess the discharge needs and plans for every inpatient beneficiary.
 - Beneficiaries were referred to the Transition of Care (TOC) team. The TOC team ensures medication reconciliation is completed, ensures discharge-ordered durable medical equipment is in place, confirms the follow-up appointment(s) is made, and assists with connecting the beneficiary with community resources.
 - A TOC nurse conducted on-site bedside assessments twice weekly at Loma Linda University Medical Center.
 - IEHP contracted with an organization that made house calls to beneficiaries post-discharge who were homebound or at high risk for readmissions after acute hospitalization to provide access and continuity of care.

Plan-Do-Study-Act Review

Since the *All-Cause Readmissions* and *Comprehensive Diabetes Care* QIPs did not achieve a *Met* validation status, IEHP was required to conduct a PDSA cycle for each QIP topic.

All-Cause Readmissions

For the *All-Cause Readmissions* PDSA cycle, IEHP set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By March 31, 2015, IEHP will reduce the hospital readmissions rate from 14.73 percent to 12.00 percent by implementing an enhanced TOC program.

The purpose of the *All-Cause Readmissions* PDSA cycle was to test the effectiveness of the operational improvement made to the TOC program.

Although IEHP completed the *All-Cause Readmissions* PDSA cycle as planned, the readmissions rate for beneficiaries referred to the TOC program did not improve. Instead, the readmissions rate increased from 14.73 percent to 18.39 percent. However, IEHP identified several barriers that

may have affected the results including not receiving timely admission data, medication reconciliation issues, and beneficiaries with multiple diagnoses. The MCP also reported a few lessons learned as a result of the PDSA cycle, including that the TOC program should be more interactive, incorporating face-to-face home visits and offering more services beyond current business hours. IEHP determined that beneficiaries who had more contact with the TOC program after discharge were less likely to be readmitted within 30 days. In March 2015, IEHP contracted with Charter Healthcare Group (CHG) to address barriers and support transitions of care. The MCP has adapted the change with an enhanced internal TOC program and CHG TOC services. IEHP indicated that the MCP will test another PDSA cycle.

HbA1c Testing Compliance

For the *Comprehensive Diabetes Care* QIP topic, IEHP narrowed the focus to *HbA1c Testing Compliance* for the PDSA cycle. The MCP set the SMART Objective as follows:

Increase HbA1c testing compliance for two providers whose patient base includes adults ages 18 and over who were diagnosed with type 1 or type 2 diabetes by 5 percent by January 31, 2015.

The purpose of the *HbA1c Testing Compliance* PDSA cycle was to test if a focused nurse education training provided to two PCPs will increase HbA1c testing compliance.

IEHP completed the *HbA1c Testing Compliance* PDSA cycle as planned. The results demonstrated improvement in HbA1c screening rates for both providers (Provider 1: from 38.5 percent to 49 percent, and Provider 2: from 48.5 percent to 57 percent). The point of utilization rates were 25 percent for Provider 1 and 22 percent for Provider 2. IEHP indicated conducting a feedback session with the two providers and adapting the change with the information learned.

Strengths

IEHP demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Comprehensive Diabetes Care* QIPs.

The *HbA1c Testing Compliance* PDSA cycle results indicated that IEHP's test of change was successful at improving HbA1c screening rates for both providers.

Opportunities for Improvement

IEHP should conduct another PDSA cycle to test the adapted change with the enhanced internal TOC program and CHG services, as identified in the *All-Cause Readmissions* PDSA cycle. Additionally, since the *HbA1c Testing Compliance* PDSA cycle demonstrated improvement in providers' HbA1c screening rates, IEHP should consider adopting the change with additional providers.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

IEHP’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for IEHP. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for IEHP

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	29.1%	26.3%	10th–25th	7.2%	9.2%	25th–75th
Diagnosis Code	33.3%	31.6%	10th–25th	29.9%	34.6%	25th–75th
Procedure Code	41.3%	43.8%	25th–75th	22.0%	22.5%	25th–75th
Procedure Code Modifier	48.8%	58.5%	25th–75th	47.4%	46.0%	25th–75th
Rendering Provider Name	NA	25.0%	NA	88.8%	68.1%	>25th–<75th
Billing Provider Name	34.4%	35.0%	10th–25th	5.5%	8.6%	25th–75th

Note: HSAG displayed “NA” when the denominator was less than 30.

Overall, the medical record omission rates for IEHP ranged from 29.1 percent (*Date of Service*) to 48.8 percent (*Procedure Code Modifier*). Three of IEHP’s medical record omission rates (*Procedure Code*, *Procedure Code Modifier*, and *Billing Provider Name*) were better than respective statewide rates by 2.5 percent, 9.7 percent, and 0.6 percent, respectively; two rates (*Date of Service* and *Diagnosis Code*) were slightly worse, by 2.8 and 1.7 percentage points, respectively; and the remaining rate (*Rendering Provider Name*) could not be compared due to a low denominator. When compared to other MCPs’ performance, IEHP received a percentile ranking of “25th–75th” for two of the six medical record omission rates and “10th–25th” for three medical omission rates, with the sixth rate not displayed due to a small denominator. These findings suggest a below-average completeness among key encounter data elements when compared to beneficiaries’ medical records. There are some variations between the two counties for IEHP, although a pattern is not clear due to low denominators for some elements and lack of a trend for elements that were present.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.

- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for IEHP contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, IEHP's rates varied from 5.5 percent (*Billing Provider Name*) to 88.8 percent (*Rendering Provider Name*). Four of IEHP's encounter data omission rates were better than the respective statewide rates (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Billing Provider Name* by 2.0 percent, 4.7 percent, 0.5 percent, and 3.1 percent, respectively). Two rates were lower, indicating better performance than the respective statewide rates (*Procedure Code Modifier* and *Rendering Provider Name* by 1.4 and 20.7 percentage points, respectively). An opportunity exists for IEHP to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information. At the county level, HSAG noted some variations, but the differences were not sufficiently consistent to form a reliable trend.

The most common reasons for encounter data omissions were:

- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in IEHP's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to IEHP (and/or the data subsequently being submitted to DHCS).
- ◆ IEHP populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files IEHP submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for IEHP. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for IEHP

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	82.7%	83.6%	25th–75th	Inaccurate Code (80.2%)
Procedure Code	63.4%	77.6%	10th–25th	Lower Level of Services in Medical Records (53.6%); Inaccurate Code (30.1%)
Procedure Code Modifier	NA	99.5%	NA	—
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	77.2%	68.6%	25th–75th	Incorrect Names (97.1%)
All-Element Accuracy	0.4%	4.3%	>25th–<75th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the reportable key data elements were found to be about average or somewhat below average for IEHP, with the all-element accuracy rate lower than the respective statewide rate by 3.9 percent. Of the three reportable encounter data rates, only *Billing Provider Name* showed a rate that exceeded the statewide rate (by 8.6 percentage points). *Diagnosis Code* and *Procedure Code* were below the statewide rates by 0.9 and 14.2 percentage points, respectively.

When compared to the other MCPs, two of the three key data elements with sufficiently large denominators ranked in the 25th to 75th percentile (*Diagnosis Code* and *Billing Provider Name*). The rate for *Procedure Code* received a percentile ranking of “10th–25th”. Rates for *Procedure Code Modifier* and *Rendering Provider Name* were not displayed due to having fewer than 30 cases in the denominator for each element. For the *Procedure Code* data element, 53.6 percent of the errors involved providers submitting higher-level service codes than were supported in the beneficiaries’ medical records, and 30.1 percent of the identified errors were associated with the use of inaccurate codes which were not supported by national coding standards. The majority of billing provider name errors were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records.

IEHP’s all-element accuracy rate was lower than the overall statewide rate by 3.9 percentage points. Only 0.4 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 99 percent of the dates of service reviewed in this study. While all five key data elements contributed to IEHP’s

relatively low all-element accuracy rate, the *Rendering Provider Name* data element contributed the most.

Medical Record Review Recommendations

Based on the study findings for IEHP, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial for locating medical records for future medical record review activities. Therefore, IEHP should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. IEHP should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ IEHP should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ Of 267 dates of service identified in the DHCS encounter data, only 20 visits had rendering provider names identifiable from the DHCS data system. IEHP should work with DHCS to investigate the reasons why so few rendering provider names could be identified using DHCS encounter and provider data.
- ◆ IEHP should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code* and *Procedure Code Modifier* data elements and develop strategies to improve rates.
- ◆ IEHP should explore the reasons for the relatively high encounter data omission rates for the *Procedure Code Modifier* and *Rendering Provider Name* data elements and take actions to improve rates.
- ◆ IEHP should investigate the reasons for the relatively low element accuracy rate for the *Procedure Code* data element and develop strategies to improve this rate.

- ◆ IEHP should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with IEHP.
- ◆ IEHP should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP’s Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

IEHP’s SFY 2014–15 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the EDV study, which assessed the MCP’s operational and infrastructure changes in support of DHCS’s transition to the Post Adjudicated Claims and Encounters System (PACES). Based on review of IEHP’s Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist IEHP with improving its encounter data quality. DHCS followed up with IEHP regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of IEHP's performance in the three domains of care—quality, access, and timeliness.

Quality

HSAG reviewed the IEHP Quality Management Program Description. As in RY 2014, HSAG found detailed documentation of the MCP's goals and strategies for ensuring that quality care is provided to the MCP's MCMC beneficiaries. Additionally, IEHP described its structure for monitoring the quality of care provided to beneficiaries.

During DHCS's April 2014 medical audit for IEHP, DHCS identified deficiencies in areas that could impact quality of care. IEHP responded to all deficiencies through a corrective action plan

and DHCS deemed all deficiencies closed or provisionally closed. The rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* measure, which falls into the quality domain of care, improved significantly from RY 2014 to RY 2015. Additionally, the rates for the following quality measures improved significantly from RY 2014 to RY 2015, and the SPD rates for the measures were significantly better than the non-SPD rates:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The rates for the following quality measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total*

Additionally, the SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of IEHP's QIPs fell into the quality domain of care. Only the *All-Cause Readmissions* QIP progressed to the Outcomes stage. At Remeasurement 1, the QIP's study indicator had not achieved statistically significant improvement over baseline, demonstrating that the implemented interventions were not effective in reducing hospital readmissions.

IEHP completed one PDSA cycle for each QIP topic. The *All-Cause Readmissions* PDSA cycle was not successful at reducing readmissions for beneficiaries referred to the TOC program; however, based on lessons learned, the MCP adapted the change with an enhanced internal TOC program and CHG TOC services. The PDSA cycle related to the *Comprehensive Diabetes Care* QIP focused on *HbA1c Testing Compliance*, and the results indicated that providing focused nurse education training at two provider sites improved HbA1c screening rates at both sites.

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

Access

HSAG reviewed IEHP's available quality improvement information and found that the MCP continues to include access-related goals in its quality management work plan. IEHP's annual evaluation document indicated that the MCP monitors access to care through review of network status reports, grievance data, beneficiary and provider satisfaction surveys, and utilization trends.

The evaluation document also provided a summary of IEHP's success at achieving access-related goals, and results show that the MCP identified many opportunities for improvement.

The *Children and Adolescents' Access to Primary Care* measures fall into the access domain of care. The rates for all four measures were below the MPLs in RY 2015, and the rates for three of the measures (*12 to 24 Months*, *25 Months to 6 Years*, and *12 to 19 Years*) declined significantly from RY 2014 to RY 2015. While DHCS does not hold MCPs accountable to meet the MPLs for these measures, the declining rates and performance below the MPLs provides the MCP with the opportunity to ensure beneficiaries in the affected age groups are receiving all recommended health care services.

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The *All-Cause Readmissions* measure is one of the measures and as noted above, the SPD rate was significantly worse than the non-SPD rate, which is to be expected. The SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* and *7 to 11 Years* measures were significantly better than the non-SPD rates.

Both of IEHP's QIPs fell into the access domain of care. As noted above, only the *All-Cause Readmissions* QIP progressed to the Outcomes stage. Also as noted above, at Remeasurement 1, the QIP's study indicator had not achieved statistically significant improvement over baseline, demonstrating that the implemented interventions were not effective in reducing hospital readmissions.

As noted above, IEHP completed one PDSA cycle for each QIP topic. The MCP will be implementing lessons learned from the *All-Cause Readmissions* PDSA cycle to reduce readmissions and adapting the change the MCP tested to improve HbA1c screening rates since it was found to be successful.

Overall, IEHP showed below-average performance related to the access domain of care.

Timeliness

IEHP's Quality Management Program Description includes activities related to the areas of grievances and appeals, coordination and continuity of care, and utilization management. Each area has an impact on the timeliness of services delivered to beneficiaries. Additionally, IEHP's quality management work plan includes utilization management goals.

Four of the required performance measures fall into the timeliness domain of care. The rates for all timeliness measures were between the MPLs and HPLs.

Overall, IEHP 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with IEHP’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—IEHP’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Collect and evaluate the outcomes of the initiative designed by IEHP to ensure claims are submitted within the required time frames.</p>	<p>1. The Plan ensures claims are processed in a timely manner. In addition, the Plan trains Providers regarding the submission of claims.</p>
<p>2. Assess the factors causing poor performance on the following measures:</p> <p>a. <i>Children and Adolescents’ Access to Primary Care Practitioners—7 to 11 Years.</i> While the rate improved significantly from 2013 to 2014, the rate remained below the MPL for the third consecutive year.</p> <p>b. <i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years.</i> The rate declined significantly from 2013 to 2014, resulting in the rate moving from above the MPL to below the MPL.</p> <p>c. <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg).</i> The rate declined significantly from 2013 to 2014.</p> <p>d. <i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.</i> The rate declined significantly from 2013 to 2014.</p> <p>e. <i>Use of Imaging Studies for Low Back Pain.</i> The rate declined significantly from 2013 to 2014.</p>	<p>2a. IEHP has identified various factors that may be contributing to the low Children and Adolescents’ Access to Primary Care Practitioners results. IEHP Senior Leadership is working on initiatives to address the poor performance in this area.</p> <p><i>Factors:</i></p> <ul style="list-style-type: none"> Need to add more PCPs to the Riverside/San Bernardino areas to address the growing Medi-Cal population. Long wait times for appointments lead to ED usage for non-emergent care. This age group does not need frequent immunizations, so parents may not seek well care services. <p>2b. IEHP has identified various factors that may be contributing to the low Children and Adolescents’ Access to Primary Care Practitioners results. IEHP Senior Leadership is working on initiatives to address the poor performance in this area.</p> <p><i>Factors:</i></p> <ul style="list-style-type: none"> Need to add more PCPs to the Riverside/San Bernardino areas to address the growing Medi-Cal population. Long wait times for appointments lead to ED usage for non-emergent care. This age group does not need frequent immunizations (especially after age 13), so parents may not seek well-care services.

2013–14 External Quality Review Recommendation Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>2c. Any “control” based measures are difficult to manage from the health plan side. IEHP does not receive blood pressure results via claims or encounters which makes this difficult to implement health plan-related interventions.</p> <p>Another factor is that the diabetic HEDIS population has been growing by over a thousand new Members each month. Prior to 2014, HEDIS diabetic membership was stable over the year. This also makes “control” measures more challenging.</p> <p>In CY 2014, the rate increased 1.5%.</p> <p>2d. IEHP does not believe that we had a “real” decrease in Members getting eye exams. Outreach activities have remained consistent for CY 2012 to current.</p> <p>IEHP does not have an electronic (claims-based) process to get results of eye exams that are negative for diabetic retinal examination. The drop in rate reflects this. When the labor-intensive manual process (for obtaining supplemental data) was reinstated this year, the results for HEDIS 2015 went back up to the 50th percentile. IEHP is working on a process to capture results data at time of claim submission.</p> <p>CY 2013 59.4% CY 2014 51.7% CY 2015 57.4%</p> <p>2e. IEHP’s HEDIS Improvement Committee has reviewed this measure. One factor may be PCPs not coding for reasons test is being done; i.e., neurologic impairment, h/o IVDA, h/o Ca., etc. IEHP has been using the QM nurses to educate PCPs on this measure.</p>
<p>3. Assess the factors leading to the SPD rates for the following measures being significantly worse than the non-SPD rates to ensure the needs of the SPD population are being met:</p> <ul style="list-style-type: none"> a. <i>All-Cause Readmissions</i> b. <i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i> c. <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> 	<p>3a. IEHP expects the care of SPD Members to be more complex and more likely to have more readmissions than non-SPDs. IEHP does a High Risk Assessment (HRA) on all new SPD Members to help address the potential complicated nature of SPD Members.</p> <p>IEHP will monitor these populations separately on a monthly basis for trends and to assist analysis.</p> <p>3b. The identified factors are consistent between SPDs and non-SPDs.</p> <p>IEHP will monitor these populations separately on a monthly basis for trends and to assist analysis.</p> <p>IEHP has identified various factors that may be contributing to the low Children and Adolescents’ Access to Primary Care Practitioners</p>

2013–14 External Quality Review Recommendation Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>results. IEHP Senior Leadership is working on initiatives to address the poor performance in this area.</p> <p><i>Factors:</i></p> <ul style="list-style-type: none"> Need to add more PCPs to the Riverside/San Bernardino areas to address the growing Medi-Cal population. Long wait times for appointments lead to ED usage for non-emergent care. This age group does not need frequent immunizations (especially after age 13), so parents may not seek well-care services. <p>3c. Any “control” based measures are difficult to manage from the health plan side. IEHP does not receive blood pressure results via claims or encounters which makes this difficult to implement health plan-related interventions.</p> <p>The identified factors are consistent between SPDs and non-SPDs.</p> <p>IEHP will monitor these populations separately on a monthly basis for trends and to assist analysis.</p>
<p>4. Ensure all required documentation is included in the QIP Summary Form. IEHP should reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to submission to avoid incomplete or inaccurate documentation of the various elements.</p>	<p>The Plan ensured all required documentation is included in the QIP Summary Form.</p>

Recommendations

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

- ◆ While DHCS does not hold MCPs accountable to meet the MPLs for the *Children and Adolescents’ Access to Primary Care* measures, IEHP should assess the factors contributing to the rates for the *12 to 24 Months*, *25 Months to 6 Years*, and *12 to 19 Years* measures declining significantly from RY 2014 to RY 2015 and the rates for all four measures being below the MPLs to ensure beneficiaries in the affected age groups are receiving all recommended health care services.

- ◆ Although IEHP will not be continuing the QIPs reported for 2014–15, the MCP should:
 - Conduct another PDSA cycle to test the adapted change as identified in the *All-Cause Readmissions* PDSA cycle.
 - Consider adopting in additional settings the provider intervention tested in the *HbA1C Testing Compliance* PDSA cycle, which achieved positive results.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

Appendix R: Performance Evaluation Report Kern Family Health Care July 1, 2014 – June 30, 2015

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Appendix R: Performance Evaluation Report – Kern Family Health Care July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Kern Family Health Care (“KFHC” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

KFHC is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in KFHC, the LI MCP; or in Health Net Community Solutions, Inc., the alternative commercial plan (CP).

KFHC became operational in Kern County to provide MCMC services effective July 1996. As of June 30, 2015, KFHC had 205,830 beneficiaries in Kern County.¹ This represents 73 percent of the beneficiaries enrolled in this county.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: November 12, 2015.

2. **MANAGED CARE HEALTH PLAN COMPLIANCE** *for Kern Family Health Care*

Compliance Reviews

No compliance reviews were conducted for KFHC during the review period. The most recent DHCS medical audit and Department of Managed Health Care 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey for KFHC were conducted September 10, 2013, through September 13, 2013, covering the review period of July 1, 2012, through June 30, 2013. HSAG included the results of the audit and survey in KFHC's 2013–14 MCP-specific evaluation report.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Kern Family Health Care* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that KFHC followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the notable findings and opportunities for improvement is included below.

- ◆ The auditor noted that, despite having a significant increase in its enrollment (more than 20 percent), KFHC experienced no backlog of processing enrollment data during 2014.
- ◆ The auditor recommended that KFHC investigate the volume of data received on the *Child Health and Disability Prevention Program Confidential Screening/Billing Report* (PM 160 form) to ensure that encounters received for children's wellness services are complete and that the MCP is not experiencing any gaps in data that may impact the rates for children's wellness-related measures.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 for KFHC's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this

² Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit™ is a trademark of NCQA.

measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
KFHC—Kern County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	8.77%	14.94%	17.71%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	46.64	51.02	50.26	50.65	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	282.07	255.5	263.68	272.48	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	83.81%	87.71%	88.95%	88.78%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	90.74%	93.48%	48.08%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	84.24%	87.62%	89.62%	87.85%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	15.69%	23.02%	26.35%	21.54%	↓
Cervical Cancer Screening	Q,A	—	—	59.37%	57.91%	↔
Childhood Immunization Status—Combination 3	Q,A,T	68.61%	65.45%	66.67%	60.10%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	94.23%	92.37%	93.24%	92.78%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	84.12%	82.18%	84.37%	82.90%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	79.80%	79.43%	81.39%	82.59%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	81.78%	82.20%	80.60%	81.10%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	72.81%	75.36%	75.67%	65.88%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	52.55%	45.80%	45.01%	49.45%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	82.12%	80.29%	80.05%	83.03%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	45.26%	47.45%	44.53%	39.78%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	80.11%	77.55%	82.48%	81.57%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	45.99%	44.53%	46.96%	51.64%	↔
Controlling High Blood Pressure	Q	—	64.96%	68.37%	53.53%	↓
Immunizations for Adolescents—Combination 1	Q,A,T	62.53%	75.67%	78.83%	72.02%	↓
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	45.85%	49.72%	44.58%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	21.75%	24.01%	20.98%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	60.34%	62.04%	61.07%	60.10%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	81.27%	83.70%	81.02%	79.81%	↔
Use of Imaging Studies for Low Back Pain	Q	76.45%	74.07%	75.41%	79.35%	↑

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	61.80%	64.23%	67.15%	73.97%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	51.58%	66.42%	66.91%	64.72%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	38.44%	48.91%	56.20%	52.80%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	69.10%	67.64%	66.18%	67.64%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 SPD measure results reported by KFHC. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for KFHC—Kern County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	13.32%	23.45%	▼	17.71%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.39%	89.60%	↔	88.78%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	56.67%	Not Comparable	48.08%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.18%	89.09%	↔	87.85%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	92.75%	95.92%	↔	92.78%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	82.85%	85.39%	↔	82.90%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	82.61%	81.69%	↔	82.59%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	81.14%	79.74%	↔	81.10%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance). ▼ denotes a significantly higher SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

⁴ 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 3.2.

**Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
KFHC—Kern County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
259.98	47.95	488.71	97.43

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
KFHC—Kern County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	17.07%	18.74%	23.45%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	95.53	99.42	97.43	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	487.16	492.89	488.71	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	92.05%	90.14%	89.60%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	93.33%	56.67%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.17%	91.41%	89.09%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	87.76%	92.59%	95.92%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.32%	84.46%	85.39%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	85.00%	79.50%	81.69%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	85.37%	78.43%	79.74%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
KFHC—Kern County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	6.27%	11.62%	13.32%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	48.21	46.93	47.95	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	240.89	248.15	259.98	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.38%	88.05%	88.39%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.34%	88.03%	87.18%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	92.43%	93.25%	92.75%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	82.13%	84.37%	82.85%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	79.38%	81.42%	82.61%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	82.19%	80.64%	81.14%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rates for the following measures improved significantly from RY 2014 to RY 2015:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*, although the rate remained below the MPL for the fourth consecutive year
- ◆ *Use of Imaging Studies for Low Back Pain*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure improved from RY 2014 to RY 2015. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rates for the following measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Controlling High Blood Pressure*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015

The rates for the following measures declined from RY 2014 to RY 2015. Although the decline was not statistically significant, the change resulted in the rates moving from above the MPLs in RY 2014 to below the MPLs in RY 2015:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total*

In total, the rates for seven measures were below the MPLs, including the following measures (not already mentioned above) with rates below the MPLs for the fourth consecutive year:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Seniors and Persons with Disabilities Findings

The SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate. Note that the higher rate of readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Across all measures stratified for the SPD and non-SPD populations, the only variation for the SPD population was that the rate for the *All-Cause Readmissions* measure was significantly worse in RY 2015 when compared to RY 2014. Variations for the non-SPD population were:

- ◆ The rate for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure improved significantly from RY 2014 to RY 2015.
- ◆ The rate for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure declined significantly from RY 2014 to RY 2015.

Assessment of Improvement Plans

Well-Child Visits

Based on RY 2014 performance measure results, KFHC was required to submit an improvement plan (IP) for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. The following is a summary of the MCP's improvement efforts and the results:

KFHC identified the following barriers to the rate being above the MPL:

- ◆ First-born children being more likely to be seen according to clinical guidelines and later-born children being more likely to be seen when ill or injured
- ◆ Providers not giving preventive services or conducting a portion of a well-child visit when a child is seen for an acute problem
- ◆ Working parents being unable to take time off during the day to bring their children to well-child visits

KFHC implemented several interventions to address the barriers, including:

- ◆ Sent letters to households of children in the targeted age group stressing the importance of well-child visits.
- ◆ Provided incentives to families who took their children to their primary care provider (PCP) for a well-child visit.
- ◆ Conducted provider education on the definition of a well-child visit and appropriate coding.
- ◆ Conducted on-site provider visits to educate providers on:
 - What constitutes a well-child visit.
 - How to use the MCP's web portal to identify beneficiaries in need of a well-child visit.
 - Pay-for-performance incentives.
- ◆ Issued grants to providers in specific geographical areas to expand access beyond normal working hours.
- ◆ Engaged high-volume providers to identify barriers to performance.

KFHC also submitted the Plan portion of a Plan-Do-Study-Act (PDSA) cycle for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. The MCP planned to test whether providing high-volume PCPs with data showing the number of children not captured by the well-child visit incentive with the corresponding potential dollars earned would improve performance.

KFHC's improvement efforts resulted in the rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure improving to above the MPL in RY 2015, and the MCP will not be required to continue the formal IP/PDSA cycle.

Required Improvement Plans for RY 2015

Based on RY 2015 performance measures results, KFHC will be required to submit IPs for the following measures:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total*

Strengths

KFHC followed the appropriate specifications to produce valid rates, and no issues of concern were identified. Additionally, despite having a significant increase in its enrollment (more than 20 percent), KFHC experienced no backlog of processing enrollment data during 2014.

The rates for three measures improved significantly from RY 2014 to RY 2015, and the MCP's improvement efforts related to the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure resulted in the measure's rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

Opportunities for Improvement

The auditor recommended that KFHC investigate the volume of data received on the PM 160 form to ensure that encounters received for children's wellness services are complete and that the MCP is not experiencing any gaps in data that may impact the rates for children wellness-related measures.

KFHC has the opportunity to assess the factors leading to declining or poor performance on 12 measures and identify strategies to improve performance. Additionally, while KFHC documented actions that the MCP has taken to ensure that the needs of the SPD population are being met (See Table 6.1), the MCP has the opportunity to reassess its strategies since the SPD rate for the *All-Cause Readmissions* measure was significantly worse in RY 2014 when compared to RY 2015.

Quality Improvement Project Objectives

KFHC participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists KFHC’s QIPs and indicates the QIP conducted; whether the QIP was clinical or nonclinical; and the domains of care (i.e., quality, access, and timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for KFHC
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Comprehensive Diabetic Quality Improvement Plan</i>	Clinical	Q, A

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

KFHC’s *Comprehensive Diabetic Quality Improvement Plan* QIP focused on increasing HbA1c testing, LDL-C screening, and retinal eye exams. Blood glucose monitoring, dyslipidemia/lipid management, and retinopathy screening assist in the development of appropriate treatment plans to decrease the risk of diabetes complications. Lack of appropriate testing in beneficiaries with diabetes may indicate suboptimal care and case management.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
KFHC—Kern County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	81%	86%	<i>Partially Met</i>
Internal QIPs				
<i>Comprehensive Diabetic Quality Improvement Plan</i>	Annual Submission	80%	90%	<i>Partially 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, 2014, through June 30, 2015, showed that each of KFHC’s annual submissions of its *All-Cause Readmissions* and *Comprehensive Diabetic Quality Improvement Plan* QIPs received a *Partially Met* validation status. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, KFHC conducted PDSA cycles for the *All-Cause Readmissions* and *Comprehensive Diabetic Quality Improvement Plan* QIPs.

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

Table 4.3—Quality Improvement Project Average Rates*
KFHC—Kern County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

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	100%	0%	0%
Design Total		100%	0%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	82%	18%	0%
	VIII: Appropriate Improvement Strategies**	63%	38%	0%
Implementation Total		76%	24%	0%
Outcomes	IX: Real Improvement Achieved**	25%	13%	63%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total**		25%	13%	63%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for both KFHC’s *All-Cause Readmissions* and *Comprehensive Diabetic Quality Improvement Plan* QIP annual submissions.

KFHC demonstrated a strong application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP demonstrated an adequate application of the Implementation stage, meeting 76 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *All-Cause Readmissions* QIP, the MCP reported a Remeasurement 1 rate inconsistent with the audited rate reported to DHCS, resulting in a lower score for Activity VII. For the *Comprehensive Diabetic Quality Improvement Plan* QIP, KFHC had multiple documentation issues, resulting in lower scores for Activities VII and VIII.

Both QIPs progressed to the Outcomes stage during the reporting period. However, KFHC received a low score for Activity IX because neither QIP achieved statistically significant improvement over baseline. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for KFHC—Kern County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions			
Study Indicator 1: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]			
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	N/A	Sustained Improvement [‡]
8.8%	14.9%*	N/A	‡
QIP #2—Comprehensive Diabetic Quality Improvement Plan			
Study Indicator 1: The percentage of diabetic members 18–75 years of age who had HbA1c testing during the measurement year.			
Baseline Period 1/1/11–12/31/11	Remeasurement 1 1/1/12–12/31/12	Remeasurement 2 1/1/13–12/31/13	Sustained Improvement [‡]
82.1%	80.3%	80.1%	‡
Study Indicator 2: The percentage of diabetic members 18–75 years of age who had LDL-C screening during the measurement year.			
Baseline Period 1/1/11–12/31/11	Remeasurement 1 1/1/12–12/31/12	Remeasurement 2 1/1/13–12/31/13	Sustained Improvement [‡]
79.4%	76.3%	77.9%	‡
Study Indicator 3: The percentage of diabetic members 18–75 years of age who had diabetic retinal eye exam screening during the measurement year or a negative diabetic retinal eye exam result the year prior to the measurement year.			
Baseline Period 1/1/11–12/31/11	Remeasurement 1 1/1/12–12/31/12	Remeasurement 2 1/1/13–12/31/13	Sustained Improvement [‡]
52.6%	45.8%*	45.0%	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

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

All-Cause Readmissions QIP

KFHC's goal for the *All-Cause Readmissions* QIP was to decrease the readmission rate from 8.8 percent (baseline) to 7.6 percent (Remeasurement 1). Unfortunately, the MCP did not meet the project's goal and, instead, the readmissions rate increased significantly at Remeasurement 1. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ KFHC revisited the fishbone diagram developed during baseline to ensure that the Transition of Care (TOC) program launched in Remeasurement 1 addressed the identified barriers.
- ◆ Although the TOC program was not successful at improving the QIP outcomes, the following is a brief description of the program:
 - The TOC program consisted of facility-based case managers, a discharge advocate, post-discharge clinic providers, and a KFHC-based post-discharge care management team.
 - The program was offered to beneficiaries at high risk for readmissions based on KFHC's risk stratification process.
 - Beneficiaries who participated in the TOC program received medication therapy management and post-discharge clinic services.

Comprehensive Diabetic Quality Improvement Plan QIP

KFHC's goal for the *Comprehensive Diabetic Quality Improvement Plan* QIP was to increase the HbA1c screening rate to 86.7 percent, the LDL-C screening rate to 84.3 percent, and the retinal eye exam to 58.8 percent at Remeasurement 2. Unfortunately, the MCP did not meet the project's goal for any of the three study indicators. Instead, the rates for all three indicators remained below the baseline rates for the second consecutive year. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ During Remeasurement 2, the MCP lost two executive leadership staff members who were the champions for the *Comprehensive Diabetic Quality Improvement Plan* QIP. Thus, the QIP lost its momentum for the majority of the year.
- ◆ KFHC identified the following in the MCP's causal/barrier analysis:
 - Lack of data to evaluate the progress of the QIP.
 - Negotiations to expand the diabetes clinic pilot project took much longer than anticipated.
 - Existing disease management staff were not able to keep up with the demand of the large number of referrals.
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions KFHC indicated that it had implemented during the Remeasurement 2 time period:

- Began expanding the Delano Regional Medical Center Diabetic Clinic pilot project to other geographical areas. Negotiations began with the highest volume hospital, but were not concluded by the end of Remeasurement 2.
- Conducted provider education when gaps in care were identified during facility site reviews.
- Continued the Text Message Pilot Program in order to increase HbA1c testing.
- Continued the Pay-for-Performance program for providers.
- Continued to receive monthly laboratory data files from various laboratories to use as supplemental data.

Plan-Do-Study-Act Review

Both the *All-Cause Readmissions* and *Comprehensive Diabetic Quality Improvement Plan* QIPs did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for each QIP topic.

All-Cause Readmissions

For the *All-Cause Readmissions* PDSA cycle, KFHC set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By April 30, 2015, KFHC's Quality Improvement Department will decrease the number of false positive cases reviewed each month by 10 percent. This will be done by using exclusion criteria to prescreen 30-day readmissions and exclude those flagged false positive.

The purpose of the *All-Cause Readmissions* PDSA cycle was to test if pre-screening all 30-day readmissions cases against established exclusion criteria would decrease the volume of readmissions slated for medical record review.

KFHC completed the *All-Cause Readmissions* PDSA cycle as planned. In January 2015, results showed 57 percent of cases were excluded for review as part of the new pre-screening sheet. In February 2015, similarly, 56 percent of cases were excluded for review. The MCP documented that March 2015 monthly data were not generated in time for the PDSA Cycle Worksheet submission. KFHC results for the PDSA cycle reached the goal of 10 percent decrease in the number of false positive cases reviewed. The new process excluded more than 50 percent of the electronically-generated false positive cases and identified six quality of care issues that were immediately reviewed through the notification process and closed by the medical director. In addition, KFHC determined that the registered nurses found the newly designed pre-screening sheet easy to use. KFHC indicated plans to adopt the new tool and change applicable policies to reflect the change.

Diabetes Management

For the *Comprehensive Diabetic Quality Improvement Plan* QIP topic, KFHC shifted the focus to *Diabetes Management* for the PDSA cycle. The MCP set the SMART Objective as follows:

By March 31, 2015, one targeted provider will increase the number of patients with documentation of diabetes screening by 5 percent following targeted coaching. Screening will include HbA1c, LDL-C, retinal eye exam, medical attention to nephropathy, and blood pressure.

The purpose of the *Diabetes Management* PDSA cycle was to test if providing targeted, intensive coaching would increase documentation of diabetes screening.

KFHC completed the *Diabetes Management* PDSA cycle as planned and reported that no improvement occurred in the diabetes screening element. The MCP documented as a challenge that the provider's office was transitioning to electronic health records during the PDSA cycle time frame. KFHC reported that the provider was successful in having beneficiaries return for follow-up visits; unfortunately, screening did not occur as frequently as expected for this intervention. KFHC abandoned this test of change.

Strengths

KFHC demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Comprehensive Diabetic Quality Improvement Plan* QIPs.

The *All-Cause Readmissions* PDSA cycle achieved its goal of a 10 percent decrease in the number of false positive cases reviewed by using new pre-screening exclusion criteria. The new process excluded more than 50 percent of the electronically-generated false positive cases and identified six quality of care issues that were immediately reviewed through the notification process and closed by the medical director.

Opportunities for Improvement

Although KFHC will not be continuing the formal QIPs, the MCP should continue to reassess the barriers to improvement since the rate for the *All-Cause Readmissions* measure was significantly worse in RY 2015 when compared to RY 2014. The MCP should follow the documented plans to adopt the new screening criteria for 30-day readmissions case reviews tested through the *All-Cause Readmissions* PDSA cycle and measure the impact of the new screening criteria on the overall readmissions rate. In addition, KFHC should continue to implement strategies to improve the quality of services provided to beneficiaries living with diabetes.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

KFHC’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for KFHC. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for KFHC

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	23.5%	26.3%	25th–75th	17.3%	9.2%	<10th
Diagnosis Code	28.5%	31.6%	25th–75th	36.1%	34.6%	25th–75th
Procedure Code	33.3%	43.8%	25th–75th	27.4%	22.5%	25th–75th
Procedure Code Modifier	39.3%	58.5%	75th–90th	19.0%	46.0%	≥90th
Rendering Provider Name	25.0%	25.0%	25th–75th	67.4%	68.1%	>25th–<75th
Billing Provider Name	29.1%	35.0%	25th–75th	17.6%	8.6%	10th–25th

Overall, the medical record omission rates for KFHC ranged from 23.5 percent (*Date of Service*) to 39.3 percent (*Procedure Code Modifier*). All six of KFHC’s medical record omission rates were equal to or better than the respective statewide rates, with the rate for the *Procedure Code Modifier* date element 19.2 percentage points better. When compared to other MCPs’ performance, KFHC’s rates were similar to the statewide rates, with better performance (75th–90th percentile ranking) for the *Procedure Code Modifier* date element. These findings suggest a moderate level of completeness among key encounter data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for KFHC contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, KFHC’s rates varied from 17.3 percent (*Date of Service*) to 67.4 percent (*Rendering Provider Name*). Two of KFHC’s encounter data omission rates were better than

the respective statewide rates, with the *Procedure Code Modifier* encounter omission rate being better than the statewide rate by 27.0 percentage points. However, KFHC performed worse than the statewide encounter data omission rate by 9.0 percentage points and 8.1 percentage points for the *Billing Provider Name* and *Date of Service* data elements, respectively. An opportunity exists for KFHC to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider’s billing office made a coding error.
- ◆ DHCS’s encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in KFHC’s encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider’s performance of the service and submission of the encounter to KFHC (and/or the data subsequently being submitted to DHCS).
- ◆ KFHC populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files KFHC submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for KFHC. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for KFHC

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	89.3%	83.6%	75th–90th	NA
Procedure Code	88.7%	77.6%	75th–90th	NA
Procedure Code Modifier	100.0%	99.5%	≥75 th	—
Rendering Provider Name	63.9%	63.0%	>25th–<75th	NA
Billing Provider Name	62.8%	68.6%	10th–25th	Incorrect Names (84.8%)
All-Element Accuracy	3.0%	4.3%	>25th–<75th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be relatively accurate for KFHC with four of the five element accuracy rates higher than the respective statewide rates. When compared to the other MCPs' performance, two of the five key data elements received a percentile ranking of "75th–90th", and one received a percentile ranking of "≥75th". Accuracy for the *Rendering Provider Name* data element was similar to the statewide rate. The accuracy rate for the *Billing Provider Name* data element resulted in a percentile ranking of "10th–25th", with the majority of errors (84.8 percent) involving incorrect names.

KFHC's all-element accuracy rate was worse than the statewide rate by 1.3 percentage points. Only 3.0 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries' medical records. The overall accuracy findings indicated at least one inaccurate data element for 97.0 percent of the dates of service reviewed in this study. While all five key data elements contributed to KFHC's relatively low all-element accuracy rate, the *Rendering Provider Name* data element contributed most to the inaccuracy.

Medical Record Review Recommendations

Based on the study findings for KFHC, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, KFHC should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. KFHC should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ KFHC should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.

- ◆ KFHC should explore the reasons for the relatively high encounter data omission rates for the *Rendering Provider Name* and *Diagnosis Code* data elements and take actions to improve rates. In addition, KFHC's encounter data omission rates for the *Date of Service* and *Billing Provider Name* data elements were relatively high when comparing the performance among the MCPs. These were also areas KFHC can focus on improving.
- ◆ KFHC should explore the reasons for the relatively low element accuracy rate for the *Billing Provider Name* data element and develop strategies to improve the rate.
- ◆ KFHC should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with KFHC.
- ◆ KFHC should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.

- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

KFHC's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to PACES. Based on review of KFHC's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist KFHC with improving its encounter data quality. DHCS followed up with KFHC regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of KFHC's performance in the three domains of care—quality, access, and timeliness.

Quality

HSAG reviewed KFHC's available quality improvement program documentation and, as in previous years, found detailed documentation of both an organizational structure and processes that support the delivery of quality care to the MCP's beneficiaries.

The rates for the following quality measures improved significantly from RY 2014 to RY 2015:

- ◆ *Use of Imaging Studies for Low Back Pain*

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which falls into the quality domain of care, improved from RY 2014 to RY 2015. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rates for the following quality measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Controlling High Blood Pressure*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015

The rates for the following quality measures declined from RY 2014 to RY 2015. Although the decline was not statistically significant, the change resulted in the rates moving from above the MPLs in RY 2014 to below the MPLs in RY 2015:

- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total*

For quality measures stratified by the SPD and non-SPD populations, the SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate; however, the higher rate of readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of KFHC's QIPs fell into the quality domain of care. Neither QIP achieved statistically significant improvement over baseline. The MCP conducted a PDSA cycle for each QIP topic, and the PDSA cycle related to the *All-Cause Readmissions* QIP was successful at decreasing the number of false positive cases identified for medical record review. However, the PDSA cycle related to the *Comprehensive Diabetic Quality Improvement Plan* QIP was not successful at increasing documentation by the targeted provider of diabetes screening.

Overall, KFHC showed below-average performance related to the quality domain of care.

Access

KFHC's 2014 *Quality Improvement Program Evaluation* document describes activities the MCP conducted to improve beneficiary access to care, including collaborating with community-based organizations to make health education programs available and accessible to beneficiaries and promoting awareness of available health care resources.

The rate for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure, which falls into the access domain of care, improved significantly from RY 2014 to RY 2015; however, the rate remained below the MPL for the fourth consecutive year.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which falls into the access domain of care, improved from RY 2014 to RY 2015. Although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rates for the following access measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Immunizations for Adolescents—Combination 1*

The rate for the *Childhood Immunization Status—Combination 3* measure, which falls into the access domain of care, declined from RY 2014 to RY 2015. Although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015.

In total, the rates for five access measures were below the MPLs, including the following measures (not already mentioned above) with rates below the MPLs for the fourth consecutive year:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. As noted above, the SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate, which is to be expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of KFHC's QIPs fell into the access domain of care and, as noted above, neither QIP achieved statistically significant improvement over baseline. Also as noted, the MCP's PDSA cycle related to

the *All-Cause Readmissions* QIP was successful at decreasing the number of false positive cases identified for medical record review and the PDSA cycle related to the *Comprehensive Diabetic Quality Improvement Plan* QIP was not successful at increasing documentation by the targeted provider of diabetes screening.

Overall, KFHC showed below-average performance related to the access domain of care.

Timeliness

KFHC's quality improvement program documents included comprehensive information on the MCP's utilization management processes, which impact the timeliness of care delivered to beneficiaries.

For measures in the timeliness domain of care:

- ◆ The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.
- ◆ The rate for the *Immunizations for Adolescents—Combination 1* measure declined significantly from RY 2014 to RY 2015.
- ◆ The rate for the *Childhood Immunization Status—Combination 3* measure declined from RY 2014 to RY 2015; and although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015.

Overall, KFHC 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with KFHC's self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP's self-reported actions.

Table 6.1—KFHC’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to KFHC	Self-Reported Actions Taken by KFHC during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Assess if current improvement strategies for the <i>Children and Adolescents’ Access to Primary Care Practitioners</i> measures need to be modified or eliminated and if new strategies should be implemented, especially for the <i>12 to 19 Years</i> measure, which had a significant decline in its rate, and the <i>12 to 24 Months</i> measure, which had no significant change in its rate.</p>	<p>Immediately prior to the reporting period, the only improvement strategies for these four measures were a provider incentive and member education via member newsletter/outreach. KFHC reviewed CAP performance and enlisted the assistance of high performing, high- volume providers in brainstorming additional methods to increase performance of this measure. Based on stakeholder input, the following improvement strategies were developed:</p> <ul style="list-style-type: none"> • Continue Pay-for-Performance (P4P), but increase provider education on opportunities and strategies to maximize incentives. • Emergency room (ER) diversion/access grant. <p>The following interventions are planned and/or ongoing:</p> <ul style="list-style-type: none"> • Member incentive—ran Quarter 4, 2014 and recently approved for continuation through 2015. • ER diversion/access grant – awardees named November 2014, and dispersal of monies continued through the first two quarters of 2015. Uses for the grant included: <ul style="list-style-type: none"> ○ Hire additional providers to increase access. ○ Renovate clinic to increase the number of examination rooms. ○ Hire additional office staff to extend hours of operation beyond normal working hours. ○ Hire additional staff to call members and schedule well-visit if not seen within previous 12 months. • Provider education on strategies to maximize incentives—the HEDIS team (consisting of the Chief Medical Officer [CMO]/Medical Director, Quality Improvement [QI], Provider Relations, and Utilization Management) meet with high-volume providers to prioritize care to this problem-prone population.
<p>2. Assess the factors leading to the rate being below the MPL for the <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i> measure, and identify strategies to improve the rate.</p>	<p><u>Factors Leading to the W34 Rate Falling below MPL</u></p> <p>Data analysis showed:</p> <ul style="list-style-type: none"> • 47 percent of the HEDIS 2014 W34 sample found to be numerator negative did not access their PCP in the HEDIS reporting period. • Evaluation of data also showed poor member engagement, with many members subsequently missing a well visit. <p>Based on focus group input from members and strategizing with providers, the following factors were identified as contributing to the W34 rate falling below MPL.</p> <ul style="list-style-type: none"> • Multi-parity (first-born children more likely to be seen per recommendations with later-born children being seen when ill or injured). <ul style="list-style-type: none"> ○ Initiated a member incentive to encourage parents/guardians to take children for well visit.

2013–14 External Quality Review Recommendation Directed to KFHC	Self-Reported Actions Taken by KFHC during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<ul style="list-style-type: none"> • Providers do not consider giving preventive services or doing part of a well-child visit when child is seen for an acute problem. <ul style="list-style-type: none"> ○ Provider education on the elements of a well-child visit ○ Provider education on converting sick visit to well visit as able • Working parents unable to take time off during the day for a well-child visit. <ul style="list-style-type: none"> ○ ER diversion grant to assist providers in expanding clinic hours or rooms <p>Other issues identified:</p> <ul style="list-style-type: none"> • Immediately prior to the reporting period, the only improvement strategies for the W34 measure were a provider incentive and member education via the newsletter/public service announcements. • Offices/clinics did not send reminders prior to the visit or follow-up to reschedule missed visits. • Electronic medical record (EMR) having set templates that did not include the necessary elements of this measure. • Input from high performing, high-volume providers included the following suggestions to increase member engagement: • Offer a member incentive—two movie tickets were given to children who provided documentation of a well-visit during Quarter 4, 2014. This successful intervention will continue through 2015. • Providers agreed to partner with KHS to call members and encourage participation in their health care. <p>Initiatives to increase provider engagement:</p> <ul style="list-style-type: none"> • Provider education on strategies to maximize incentives—the HEDIS team (consisting of the CMO/Medical Director, QI, Provider Relations, and Utilization Management) meet with high-volume providers to encourage use of all visits to provide preventive care and education as applicable. • A high-volume provider agreed to modify its sick-child visit EMR template to include a spot for documenting physical and mental developmental history.
<p>3. Continue to assess whether or not the MCP has sufficient processes in place to meet the SPD population’s health care needs since the SPD rate was significantly worse than the non-SPD rate for the <i>All-Cause Readmissions</i> measure.</p>	<p>Assessment of the process in place to meet the SPD population’s health care needs identified the need for the following additional processes/ interventions:</p> <ul style="list-style-type: none"> • Transitions of Care program showed improvement in the pilot, but this did not translate to improved rates. <ul style="list-style-type: none"> ○ The transition of care program, developed and subsequently trialed at the MCP’s highest volume inpatient provider, was spread to other high-volume hospitals.

2013–14 External Quality Review Recommendation Directed to KFHC	Self-Reported Actions Taken by KFHC during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<ul style="list-style-type: none"> • Delays in data availability. <ul style="list-style-type: none"> ○ New reports were generated to improve access to data. ○ Began using a predictive modeler to identify those at risk of readmission within the SPD population. ○ High-volume, problem-prone SPD members identified through other means are targeted by internal outpatient case management. • Retrospective review of 100 percent of the <i>All-Cause Readmissions (ACR)</i> cases was extremely labor intensive and did not identify any internal or external opportunities for improvement. <ul style="list-style-type: none"> ○ Began real-time referral to Case Management. ○ Exclusion criteria were developed to streamline the process and increase turnaround time. <ul style="list-style-type: none"> ▪ This process allowed timely intervention if a quality of care issue was identified. • Case management vendor for SPD population could only access a small number of these members. <ul style="list-style-type: none"> ○ On September 30, 2014, outpatient case management of the SPD population was totally insourced to better service this high-volume, problem-prone population.
<p>4. Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.</p>	<ul style="list-style-type: none"> • QI supervisor was hired with previous quality improvement organization/Institute for Healthcare Improvement/PSDA experience. • <i>ACR</i> and <i>Disease Management (DM)</i> QIP summary forms were submitted on time and accepted without revisions. The MCP subsequently completed PDSAs on each topic, which were accepted without edits. <p>QIP submissions are now a collaborative process with checks and balances to lessen the likelihood of elements being missed.</p>
<p>5. Conduct a new causal/barrier analysis for the <i>Comprehensive Diabetes Quality Improvement Plan</i> QIP, and assess if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.</p>	<p>Based on causal/barrier analysis for the <i>DM</i> QIP, the following barriers were identified and interventions were developed to address these barriers:</p> <p><u>Small population in the pilot</u></p> <ul style="list-style-type: none"> • Even though the diabetes pilot demonstrated improvement in rates in the limited population, this did not translate to improved MCP rates. <ul style="list-style-type: none"> ○ Spread intervention to geographical area of high-volume hospital. ○ Spread text messaging to other diabetics outside the initial pilot population. <p><u>Provider engagement</u></p> <ul style="list-style-type: none"> • Education to provider office staff did not yield sustained improvement.

2013–14 External Quality Review Recommendation Directed to KFHC	Self-Reported Actions Taken by KFHC during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<ul style="list-style-type: none"> ○ Trialed intensive, face-to-face, and telephonic coaching of high-volume, poor-performing providers and their staff. <ul style="list-style-type: none"> ▪ This intervention, sadly, did not yield positive results; so this intervention has been abandoned. ● P4P DM measure performance was discussed with executives of high-volume providers, and opportunities for improvement were identified. ● If this topic is continued, additional interventions will need to be developed. <p><u>Member engagement</u></p> <ul style="list-style-type: none"> ● Although DM performed outreach to the diabetic population and provided assistance with making appointments for DM care and providing transportation, a large percentage of our members did not keep their appointments. <ul style="list-style-type: none"> ○ For the time being, this labor-intensive program will continue with quarterly review of performance data. ● Case management vendor for SPD population, which makes up a large number of the DM cohort, could only access a small number of these members. <ul style="list-style-type: none"> ○ Case management of SPD population was insured.

Recommendations

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

- ◆ Investigate the volume of data received on the PM 160 form to ensure that encounters received for children’s wellness services are complete and that the MCP is not experiencing any gaps in data that may impact the rates for children wellness-related measures.
- ◆ Assess the factors leading to declining or poor performance on 12 measures, and implement strategies to prevent further decline or improve performance. Specific measures are:
 - *All-Cause Readmissions.*
 - *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis.*
 - *Childhood Immunization Status—Combination 3.*
 - All four *Children and Adolescents’ Access to Primary Care* measures.
 - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg).*
 - *Controlling High Blood Pressure.*
 - *Immunizations for Adolescents—Combination 1.*
 - Both *Medication Management for People with Asthma* measures.

While DHCS does not hold MCPs accountable to meet MPLs for all above-listed measures, KFHC should strive to improve performance on all measures with declining rates and with rates below the national Medicaid 25th percentiles (i.e., MPLs).

- ◆ Reassess the strategies for ensuring that the MCP is meeting the health care needs of the SPD population, since the SPD rate for the *All-Cause Readmissions* measure was significantly worse in RY 2014 when compared to RY 2015.
- ◆ Although KFHC will not be continuing the formal QIPs or PDSA cycles, the MCP should:
 - Follow the documented plans to spread the new pre-screening criteria for 30-day readmissions case reviews tested through the *All-Cause Readmissions* PDSA cycle.
 - Consider evaluating the impact of the new pre-screening criteria on the overall readmissions rate.
 - Continue to implement strategies to improve quality of services provided to beneficiaries living with diabetes.
- ◆ Review the *2013–14 Encounter Data Validation Study Report*, and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix S:
Performance Evaluation Report
Kaiser NorCal (KP Cal, LLC, in
Amador, El Dorado, Placer, and
Sacramento Counties)
July 1, 2014 – June 30, 2015**

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Appendix S: Performance Evaluation Report – Kaiser NorCal

July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), KP Cal, LLC, in Amador, El Dorado, Placer, and Sacramento counties (commonly known as “Kaiser Permanente North” and referred to in this report as “Kaiser NorCal” or “the MCP”). This report is for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

Kaiser NorCal is a full-scope MCP delivering services under two health care models. In Sacramento County, Kaiser NorCal serves Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) under a Geographic Managed Care (GMC) model. The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within a specified geographic area (county).

In addition to Kaiser NorCal, Sacramento County’s beneficiaries may select from the following MCPs:

- ◆ Anthem Blue Cross Partnership Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Molina Healthcare of California Partner Plan, Inc.

In Amador, El Dorado, and Placer counties, Kaiser NorCal delivers services to its beneficiaries under the Regional Model. In all three counties, beneficiaries may enroll in Kaiser NorCal or in the alternative commercial plans, Anthem Blue Cross Partnership Plan or California Health & Wellness Plan.

Kaiser NorCal became operational in Sacramento County to provide MCMC services effective April 1994. As part of MCMC's expansion under Section 1115 of the Social Security Act, Kaiser NorCal contracted to provide MCMC services in Amador, El Dorado, and Placer counties beginning November 1, 2013. As of June 30, 2015, Kaiser NorCal had 69,199 beneficiaries in Sacramento County; 51 in Amador County; 1,140 in El Dorado County; and 4,173 in Placer County—for a total of 74,563 beneficiaries.¹ This represents 17 percent of beneficiaries enrolled in Sacramento County, 1 percent in Amador County, 4 percent in El Dorado County, and 10 percent in Placer County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: December 11, 2015.

1115 Waiver Seniors and Persons with Disabilities Enrollment Survey

DHCS conducted no compliance reviews for Kaiser NorCal during the review period for this report. The most recent Department of Managed Health Care 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey for Kaiser NorCal was conducted September 10, 2012, through September 14, 2012, covering the period June 1, 2011, through May 31, 2012. HSAG summarized the detailed findings from the survey in Kaiser NorCal's 2012–13 MCP-specific evaluation report.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Kaiser NorCal* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that Kaiser NorCal followed the appropriate specifications to produce valid rates, and no issues of concern were identified.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 for Kaiser NorCal's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

For multiple years prior to RY 2015, Kaiser reported rates for Sacramento County. RY 2015 is the first year Kaiser NorCal reported rates for the reporting unit called KP North, consisting of Amador, El Dorado, Placer, and Sacramento. Although the majority of beneficiaries included in the rates are from Sacramento County, HSAG includes no comparative analysis or trending information for any measures in this report because the previous years' rates were limited to Sacramento County.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
Kaiser NorCal—KP North (Amador, El Dorado, Placer, and Sacramento Counties)**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	14.84%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	49.65	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	447.02	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	95.38%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	72.73%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	93.78%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	42.86%	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	79.66%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	82.96%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	98.81%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	89.84%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	89.49%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	90.81%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	83.19%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	64.13%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	94.97%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	57.87%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	92.96%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	27.96%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	84.00%	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	87.71%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	68.90%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	40.48%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	73.95%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	93.28%	Not Comparable
Use of Imaging Studies for Low Back Pain	Q	—	—	—	88.07%	Not Comparable

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	—	94.42%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	—	93.57%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	—	93.52%	Not Comparable
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	—	81.15%	Not Comparable

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 SPD measure results reported by Kaiser NorCal. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

⁴ 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 3.2.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Kaiser NorCal—KP North (Amador, El Dorado, Placer, and Sacramento Counties)

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	14.47%	15.01%	↔	14.84%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	93.34%	96.81%	↑	95.38%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	72.73%
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.06%	95.86%	↑	93.78%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.80%	NA	Not Comparable	98.81%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.69%	94.78%	↑	89.84%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.15%	96.67%	↑	89.49%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	90.57%	94.39%	↑	90.81%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the All-Cause Readmissions measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly higher SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly lower SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A Not Applicable audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures Kaiser NorCal—KP North (Amador, El Dorado, Placer, and Sacramento Counties)

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
383.06	44.28	899.26	87.64

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years. Since RY 2015 was the first year Kaiser NorCal reported rates for KP North, no trending information is available.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
Kaiser NorCal—KP North (Amador, El Dorado, Placer, and Sacramento Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	15.01%	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	87.64	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	899.26	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	96.81%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	95.86%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	94.78%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	96.67%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	94.39%	Not Comparable

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
Kaiser NorCal—KP North (Amador, El Dorado, Placer, and Sacramento Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	14.47%	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	44.28	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	383.06	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	93.34%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	91.06%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	98.80%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	89.69%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	89.15%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	90.57%	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

RY 2015 is the first year Kaiser NorCal reported rates for the reporting unit called KP North, consisting of Amador, El Dorado, Placer, and Sacramento counties. Although reporting rates for KP North for the first year, DHCS held Kaiser NorCal accountable to meet the MPLs since the majority of the beneficiaries included in the rates are from Sacramento County, a county for which the MCP has reported rates for multiple years.

HSAG includes no comparative analyses for any measures in this report. An accurate comparison could not be done because the previous year's rates included only Sacramento County.

The rates for 18 performance measures were above the HPLs in RY 2015. As in previous years, Kaiser NorCal demonstrated exceptional performance across the required External Accountability Set measures.

Seniors and Persons with Disabilities Findings

For RY 2015, Kaiser NorCal's SPD rates were significantly better than the non-SPD rates for the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

No SPD rates were significantly worse than the non-SPD rates.

Assessment of Improvement Plans

Based on RY 2014 performance measure results, Kaiser NorCal was not required to submit any improvement plans (IPs) or Plan-Do-Study-Act (PDSA) cycles. Although the rate was below the MPL in RY 2015 for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure, DHCS did not require MCPs to submit IPs for this measure based on the rationale provided under the “Understanding Table 3.1” heading in the Performance Measures section of this report.

Strengths

Kaiser NorCal continued to demonstrate exceptional performance across the required External Accountability Set measures.

Kaiser NorCal provided documentation of the actions that the MCP took to address the MCP's declining performance for three of the four *Children and Adolescents' Access to Primary Care Practitioners* measures in RY 2014 (*26 Months to 6 Years*, *7 to 11 Years*, and *12 to 19 Years*) and the rates being below the MPLs for the *7 to 11 Years* and *12 to 19 Years* measures (See Table 6.1). While the MCP's RY 2015 rates are not comparable to the RY 2014 rates, it should be noted that the rates were above the MPLs for the *7 to 11 Years* and *12 to 19 Years* measures in RY 2015, suggesting that Kaiser NorCal's efforts were successful at ensuring that beneficiaries in the targeted age groups were seen by their primary care provider (PCP).

Opportunities for Improvement

HSAG has no recommendations for Kaiser NorCal related to its performance on the External Accountability Set measures.

Quality Improvement Project Objectives

Kaiser NorCal participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

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

**Table 4.1—Quality Improvement Projects for Kaiser NorCal
July 1, 2014, through June 30, 2015**

QIP	County	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Sacramento	Clinical	Q, A
<i>Childhood Immunization Status</i>	Sacramento	Clinical	Q, A, T

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

The *Childhood Immunization Status* QIP targeted beneficiaries who will turn 2 years of age during the measurement year. The administration of immunizations has dramatically decreased the occurrence of many diseases including diphtheria, tetanus, pertussis, and small pox. However, due to either misconceptions about immunizations’ side effects or lack of access, the number of children who have not received immunizations has increased. By understanding why children are not receiving life-saving vaccines, Kaiser NorCal hoped to increase the percentage of children who receive the recommended immunizations.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
Kaiser NorCal—Sacramento County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	85%	100%	<i>Met</i>
Internal QIPs				
<i>Childhood Immunization Status</i>	Annual Submission	81%	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, 2014, through June 30, 2015, showed that Kaiser NorCal’s *All-Cause Readmissions* and *Childhood Immunization Status* QIP annual submissions each achieved an overall validation status of *Met*, with 100 percent of critical elements met.

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

**Table 4.3—Quality Improvement Project Average Rates*
Kaiser NorCal—Sacramento County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015**

QIP Study Stages	Activity	<i>Met</i> Elements	<i>Partially Met</i> Elements	<i>Not Met</i> Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		100%	0%	0%

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Implementation	VII: Sufficient Data Analysis and Interpretation**	75%	13%	13%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total**		83%	8%	8%
Outcomes	IX: Real Improvement Achieved**	38%	0%	63%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total**		38%	0%	63%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for both Kaiser NorCal’s *All-Cause Readmissions* and *Childhood Immunization Status* QIP annual submissions.

Kaiser NorCal demonstrated a strong application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP demonstrated an adequate application of the Implementation stage, meeting 83 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For both *All-Cause Readmissions* and *Childhood Immunization Status* QIP annual submissions, Kaiser NorCal did not document the factors that affected the MCP’s ability to compare baseline data with Remeasurement 1 results. In addition, for the annual submission of the *Childhood Immunization Status* QIP, Kaiser NorCal documented an incorrect baseline rate for Study Indicator 1, resulting in an inaccurate interpretation of findings. Lastly, HSAG was unable to replicate the statistical testing for Study Indicator 1 for the *Childhood Immunization Status* QIP. Thus, both QIPs received lowered scores for Activity VII.

Both QIPs progressed to the Outcomes stage during the reporting period, meeting 38 percent of the requirements for all applicable evaluation elements for both QIPs. Neither the *All-Cause Readmissions* nor *Childhood Immunization Status* QIP achieved statistically significant improvement over baseline at Remeasurement 1, resulting in a lowered score for Activity IX. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for Kaiser NorCal—Sacramento County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions		
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [¥]
15.7%	16.1%	‡
QIP #2—Childhood Immunizations Status		
Study Indicator 1: The percentage of children who have had vaccinations per HEDIS CIS-3 measure by their second birthday (age 2)		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [¥]
83.9%	86.1%	‡
Study Indicator 2: The percentage of children who have had vaccinations per HEDIS CIS-10 measure by their second birthday (age 2)		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [¥]
50.1%	51.7%	‡

[^]A lower percentage indicates better performance.

[¥] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

All-Cause Readmissions QIP

Kaiser NorCal’s goal for the *All-Cause Readmissions* QIP was to achieve statistically significant decline in the readmissions rate from baseline to Remeasurement 1. Unfortunately, the MCP did not meet the project’s goal. A review of the MCP’s QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ Kaiser NorCal identified and prioritized the following barriers during Remeasurement 1 time period:
 - Medication management

- Transitional care planning
- Care coordination
- ◆ Data analysis revealed three local Kaiser NorCal hospital medical centers that accounted for 71 percent of the readmissions. Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions Kaiser NorCal indicated it implemented at the three medical centers during the Remeasurement 1 time period:
 - A transition care pharmacist focused on high-risk beneficiaries (defined as those with transition concerns) and conducted medication reconciliations and bedside beneficiary education tailored to fit the needs of the beneficiary/family to ensure beneficiary’s understanding of current and new medications.
 - A registered nurse or hospital-based physician called high-risk beneficiaries within 48 hours of discharge to follow up on key items in the plan of care essential to keeping the beneficiary safely at home. The conversation was tailored to address the beneficiary’s specific discharge instructions/plan.
 - Prior to discharge, the MCP scheduled beneficiaries for follow-up appointments within a maximum of seven days. Appointment information was included in the printed discharge instructions, and a reminder was given to the beneficiary based on his or her preference (i.e., via automated telephone call, email, or text).

Childhood Immunization Status QIP

Kaiser NorCal’s goals for the *Childhood Immunization Status* QIP were to increase rates of *Childhood Immunization Status—Combination 3* and *Childhood Immunization Status—Combination 10* from 83.9 percent (baseline) to 88 percent (Remeasurement 1) and 50.1 percent (baseline) to 60 percent (Remeasurement 1), respectively. While the rates for both study indicators increased at Remeasurement 1, the MCP did not meet the project’s goal and the change was not statistically significant. A review of the MCP’s QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ Kaiser NorCal identified and prioritized the following barriers during the Remeasurement 1 time period:
 - Beneficiaries do not keep appointments for immunizations.
 - Parents/guardians refuse vaccinations for beneficiaries altogether or avoid having their children receive multiple immunizations at the same time.
- ◆ Although the interventions were not successful at meeting the goals set for Remeasurement 1, the following is a brief description of the interventions Kaiser NorCal indicated it implemented during the Remeasurement 1 time period:

- Conducted outreach programs via telephone and/or email to parents/guardians when a child was overdue for immunizations.
- Changed the MCP's workflow to facilitate on-demand requests for immunizations while a child was in the medical office exam room.
- Trained pediatric providers on how to communicate to parents/families who are refusing vaccines for their children, and documented the interactions in the medical record.

Strengths

Kaiser NorCal demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Childhood Immunization Status* QIPs. Both QIPs achieved a *Met* validation status on the first submission.

Opportunities for Improvement

Although Kaiser NorCal will not be continuing the formal QIPs, the MCP should continue to reassess the barriers and implement interventions to improve rates for the *All-Cause Readmissions* and *Childhood Immunization Status* measures.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

Kaiser NorCal’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for Kaiser NorCal. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for Kaiser NorCal

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	14.7%	26.3%	75th–90th	0.0%	9.2%	≥90th
Diagnosis Code	25.9%	31.6%	75th–90th	15.8%	34.6%	≥90th
Procedure Code	27.6%	43.8%	75th–90th	22.2%	22.5%	25th–75th
Procedure Code Modifier	NA	58.5%	NA	NA	46.0%	NA
Rendering Provider Name	NA	25.0%	NA	100.0%	68.1%	0–≤25th
Billing Provider Name	18.0%	35.0%	≥90th	0.0%	8.6%	≥90th

Note: HSAG displayed “NA” when the denominator was less than 30.

For Kaiser NorCal, none of the procedure code modifiers or rendering provider names were identified in the DHCS data system; therefore, the medical record omission rates for these two data elements were not reportable (i.e., noted as “NA” in Table 5.3). The remaining four medical record omission rates for Kaiser NorCal ranged from 14.7 percent (*Date of Service*) to 27.6 percent (*Procedure Code*) and were better than the respective statewide rates. When comparing the performance among the MCPs, Kaiser NorCal received a percentile ranking of “75th–90th” or “≥90th” for all four reportable medical record omission rates. These findings suggest a high level of completeness among these four key data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ Dates of services were omitted from the medical records.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for Kaiser NorCal contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, Kaiser NorCal's rates varied from 0.0 percent (*Date of Service* and *Billing Provider Name*) to 100 percent (*Rendering Provider Name*). The encounter data omission rates of 0.0 percent for the *Date of Service* and *Billing Provider Name* occurred because no procured medical records had a second date of service submitted for validation. Overall, four of Kaiser NorCal's five reportable encounter data omission rates were better than the respective statewide rates, with the *Diagnosis Code* encounter omission rate being better than the statewide rate by 18.8 percentage points (i.e., received a percentile ranking of "≥90th"). However, Kaiser NorCal performed worse than the statewide encounter data omission rate by 31.9 percentage points for the *Rendering Provider Name* data element. An opportunity exists for Kaiser NorCal to improve its electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in Kaiser NorCal's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes rather than the standard procedure codes.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to Kaiser NorCal (and/or the data subsequently being submitted to DHCS).
- ◆ Kaiser NorCal populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files Kaiser NorCal submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for Kaiser NorCal. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for Kaiser NorCal

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	81.7%	83.6%	10th–25th	NA
Procedure Code	58.6%	77.6%	<10th	Higher Level of Services in Medical Records (59.5%); Lower Level of Services in Medical Records (25.6%)
Procedure Code Modifier	NA	99.5%	NA	—
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	90.3%	68.6%	≥90th	NA
All-Element Accuracy	2.4%	4.3%	>25th–<75th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

Because none of the rendering provider names or procedure code modifiers could be identified in the DHCS data system, the element accuracy rates for the *Procedure Code Modifier* and *Rendering Provider Name* were not reportable (i.e., noted as “NA” in Table 5.4 due to a denominator of zero). In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, accuracy results were mixed, with two of the three reported element accuracy rates lower than the respective statewide rates and one rate considerably higher than the statewide rate. When comparing the performance among the MCPs, one of the three elements received a percentile ranking of “<10th”, one element received a percentile ranking of “10th–25th”, and one element received a percentile ranking of “≥90th”. For the *Procedure Code* data element, 59.5 percent of errors were associated with lower-level procedure codes in the DHCS encounter data than were documented in the medical records (i.e., the procedure code was considered an error due to a higher level service documented in the medical record); and 25.6 percent of errors were associated with higher-level procedure codes in the DHCS encounter data than were documented in the medical records (i.e., the procedure code was considered an error due to a lower level service documented in the medical record).

Kaiser NorCal’s all-element accuracy rate was worse than the statewide rate by 1.9 percentage points. Only 2.4 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 97 percent of the dates of service reviewed in this study. While all five key data elements contributed to Kaiser NorCal’s low all-element accuracy rate, the *Rendering Provider Name* contributed most and *Procedure Code Modifier* and *Billing Provider Name* contributed least.

Medical Record Review Recommendations

Based on the study findings for Kaiser NorCal, HSAG recommends the following:

- ◆ Although Kaiser NorCal procured medical records for all sampled beneficiaries, no medical records contained a second date of service. Kaiser NorCal should investigate the reason(s) why a second date of service was not available or was not submitted to HSAG for the EDV study.
- ◆ Kaiser NorCal should review its data collection and submission process to determine if more values for the *Procedure Code Modifier* data element should be submitted to DHCS.
- ◆ Of 120 dates of service identified in the DHCS encounter data, no rendering provider names could be identified by linking the DHCS encounter data and DHCS provider data. Therefore, Kaiser NorCal should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. Kaiser NorCal should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ Kaiser NorCal should avoid using local procedure codes for the encounter data submitted to DHCS.
- ◆ Kaiser NorCal should consider developing periodic education and training regarding encounter data submissions, medical record documentation, and coding practices for the relevant staff. These activities should include a review of both State and national coding requirements and standards, especially for new staff working for Kaiser NorCal.
- ◆ Kaiser NorCal should perform periodic reviews of encounters submitted to DHCS in order to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

Kaiser NorCal's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to PACES. Based on review of Kaiser NorCal's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist Kaiser NorCal with improving its encounter data quality. DHCS followed up with Kaiser NorCal regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of Kaiser NorCal's performance in the three domains of care—quality, access, and timeliness.

Quality

As in previous years, Kaiser NorCal's quality program description provided comprehensive information about the MCP's organizational structure, which supports the provision of quality care to beneficiaries and includes monitoring processes to ensure that quality care is delivered.

Kaiser NorCal's performance across measures falling into the quality domain of care was exceptional, with the rates exceeding the HPLs for 17 quality measures.

For quality measures stratified by the SPD and non-SPD populations, no SPD rates were significantly worse than the non-SPD rates, and the SPD rates were significantly better than the non-SPD rates for the following measures:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*

Both of Kaiser NorCal's QIPs fell into the quality domain of care. Both QIPs progressed to the Outcomes stage; however, neither QIP achieved statistically significant improvement over baseline at Remeasurement 1, suggesting that the MCP has opportunities for improvement related to preventing hospital readmissions and improving childhood immunization rates.

Overall, Kaiser NorCal showed above-average performance related to the quality domain of care.

Access

Kaiser NorCal's quality program description described the MCP's continuing processes to monitor access to care for beneficiaries.

Kaiser NorCal's 2014 *Quality and Utilization Management/Resource Management Program Evaluation* report described many actions the MCP took during 2014 to improve access. Additionally, as in the previous year, the evaluation revealed that Kaiser NorCal exceeded its access-related goals; and the report provided information on next steps Kaiser NorCal will take to continue to evaluate and monitor beneficiary access to care.

The rates for seven access measures exceeded the HPLs in RY 2015, demonstrating that Kaiser NorCal's beneficiaries have access to needed health care services.

Five of the measures stratified by the SPD and non-SPD populations fall into the access domain of care. No SPD rates were significantly worse than the non-SPD rates, and the SPD rates were significantly better than the non-SPD rates for the following access measures:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Both of Kaiser NorCal's QIPs fell into the access domain of care. As indicated above, both QIPs progressed to the Outcomes stage; however, neither QIP achieved statistically significant improvement over baseline at Remeasurement 1, suggesting that the MCP has opportunities for improvement related to preventing hospital readmissions and improving childhood immunization rates.

Overall, Kaiser NorCal showed above-average performance related to the access domain of care.

Timeliness

As in previous years, Kaiser NorCal’s quality improvement program description provided detailed information on the MCP’s structure, which includes comprehensive processes to ensure that timely care is delivered to beneficiaries.

Five of the required External Accountability Set performance measures fall into the timeliness domain of care, and the rates exceeded the HPLs for three of these measures.

The *Childhood Immunization Status* QIP fell into the timeliness domain of care. As stated previously, the QIP did not achieve statistically significant improvement over baseline at Remeasurement 1.

Overall, Kaiser NorCal showed above-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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with Kaiser NorCal’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—Kaiser NorCal’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Since the rates declined significantly from 2013 to 2014 for three of the four <i>Children and Adolescents’ Access to Primary Care Practitioners</i> measures (26 Months to 6 Years, 7 to 11 Years, and 12 to 19 Years), and the rates were below the MPLs for the 7 to 11 Years and 12 to 19 Years measures, assess the factors leading to the decline in rates to ensure the MCP is providing adequate access to primary care for the targeted age groups.</p>	<p>Kaiser NorCal has historically remained within the performance levels for this measure because of timeliness and access standards within The Permanente Medical Group, Inc. The decline in rates below MPLs during this measurement period for these age groups is likely attributed to the significant increase in new GMC members when the Plan removed the permit to enroll requirement and associated with the changes in MediCal eligibility threshold. This is a utilization measure that counts percentage of members who had a PCP visit within the measurement year.</p> <ul style="list-style-type: none"> • The GMC department responded to the membership increase by hiring contractor staff to conduct outreach and onboarding phone calls to parents of new members. • The GMC staff reviewed the medical record for utilization, communicated to members/parents of members if a PCP visit

2013–14 External Quality Review Recommendation Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>was due, and booked well-child and other appointment types with the child's pediatrician.</p> <ul style="list-style-type: none"> In addition, monthly reports are generated for each provider that contain lists of children and adolescents with due or overdue visits. Medical assistants in the provider offices make phone calls member/parent to book appointments as well as give appointment reminders. Medical office hours are sufficient to address access. <p>New providers receive training on coding to facilitate data extraction for this measure from the medical record. HEDIS 2015 rates show improvement and are above the MPL for all age groups.</p>
<p>2. Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.</p>	<p>The <i>Points of Clarification</i> and elements receiving <i>Partially Met</i> ratings noted in HSAG's validation report for the plan's QIP on <i>Childhood Immunization</i> were corrected, and the report was resubmitted—resulting in a <i>Met</i> validation score.</p> <ul style="list-style-type: none"> Strategies were put in place to confirm that the correct verbiage was used when referring to HEDIS technical specifications and when stating reportable rates in the various report sections. The report's author utilized the QIP Completion Instructions and previous validation reports to make corrections and to ensure that similar errors did not occur in future submissions.

Recommendations

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

- ◆ Although Kaiser NorCal will not be continuing the formal QIPs, the MCP should continue to reassess the barriers and implement interventions to improve rates for the *All-Cause Readmissions* and *Childhood Immunization Status* measures.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix T:
Performance Evaluation Report
Kaiser SoCal
(KP Cal, LLC, in San Diego County)
July 1, 2014 – June 30, 2015**

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Appendix T: Performance Evaluation Report – Kaiser SoCal

July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), KP Cal, LLC, in San Diego County (commonly known as “Kaiser Permanente South” and referred to in this report as “Kaiser SoCal” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

Kaiser SoCal is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) under the Geographic Managed Care (GMC) model. The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within a specified geographic area (county).

For San Diego County, in addition to Kaiser SoCal, beneficiaries may select from the following MCPs:

- ◆ Care1st Partner Plan
- ◆ Community Health Group Partnership Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Molina Healthcare of California Partner Plan, Inc.

Kaiser SoCal became operational in San Diego County to provide MCMC services in January 1998. As of June 30, 2015, Kaiser SoCal had 46,793 beneficiaries.¹ This represents 8 percent of the beneficiaries enrolled in this county.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: November 24, 2015.

Compliance Reviews

The most recent review for Kaiser SoCal was a Department of Managed Health Care 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey. The survey was conducted September 10, 2012, through September 14, 2012. HSAG reported on the findings from the survey in Kaiser SoCal's 2012–13 MCP-specific evaluation report. The MCP had no outstanding findings from the survey.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Kaiser SoCal* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that Kaiser SoCal followed the appropriate specifications to produce valid rates, and no issues of concern were identified.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 for Kaiser SoCal's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
Kaiser SoCal—San Diego County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	17.51%	11.42%	16.14%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	37.16	38.94	30.39	33.00	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	478.54	479.83	406.16	469.28	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	92.20%	93.22%	93.76%	93.73%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	91.69%	92.74%	93.57%	93.62%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	38.30%	NA	NA	NA	Not Comparable
Cervical Cancer Screening	Q,A	—	—	87.21%	85.86%	↔
Childhood Immunization Status—Combination 3	Q,A,T	87.02%	87.91%	88.11%	86.75%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	99.48%	99.52%	99.51%	97.84%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	94.39%	94.40%	93.60%	95.61%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	94.52%	95.31%	89.97%	93.09%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	96.49%	96.97%	88.17%	93.00%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	87.95%	85.10%	88.86%	86.34%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	75.15%	76.07%	81.71%	85.70%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	96.23%	94.84%	96.56%	95.72%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	69.73%	69.91%	69.19%	65.85%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	95.18%	93.41%	94.91%	92.71%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	18.98%	18.34%	17.88%	21.04%	↔
Controlling High Blood Pressure	Q	—	84.18%	86.37%	87.59%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	88.30%	89.00%	85.54%	89.36%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	61.18%	62.55%	73.93%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	29.80%	32.73%	42.64%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	73.21%	70.20%	69.86%	79.31%	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	94.74%	91.41%	91.39%	93.10%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	76.00%	83.03%	88.00%	89.89%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	97.80%	99.49%	99.57%	99.60%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	65.11%	91.46%	87.79%	96.16%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	76.31%	94.11%	91.18%	97.51%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	68.55%	70.72%	73.70%	83.94%	↑

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 SPD measure results reported by Kaiser SoCal. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Kaiser SoCal—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.91%	19.04%	▼	16.14%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.89%	95.32%	↑	93.73%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.36%	95.71%	↑	93.62%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	97.83%	NA	Not Comparable	97.84%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	95.54%	98.89%	↔	95.61%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	93.01%	95.28%	↔	93.09%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	92.89%	96.34%	↔	93.00%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

⁴ 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 3.2.

**Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Kaiser SoCal—San Diego County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
408.75	29.60	972.64	61.23

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
Kaiser SoCal—San Diego County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014– 15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	20.74%	11.41%	19.04%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	52.40	59.41	61.23	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	737.64	890.21	972.64	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	94.76%	96.68%	95.32%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	94.24%	96.13%	95.71%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	98.70%	98.80%	98.89%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	97.80%	99.08%	95.28%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	93.57%	96.32%	96.34%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
Kaiser SoCal—San Diego County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	6.67%	11.46%	9.91%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	35.60	26.61	29.60	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	415.75	343.04	408.75	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.74%	90.99%	91.89%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.46%	91.03%	91.36%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	99.51%	99.50%	97.83%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	94.23%	93.49%	95.54%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	95.14%	89.42%	93.01%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	97.23%	87.65%	92.89%	↑

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rates for 21 performance measures exceeded the HPLs, with the rates for 15 measures exceeding the HPLs for three or more consecutive years. For the fourth consecutive year, Kaiser SoCal had no rates below the MPLs. The rates for 11 measures improved significantly from RY 2014 to RY 2015, and the rates for the following measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures. The SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

The non-SPD rates improved significantly from RY 2014 to RY 2015 for the following measures:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

The SPD rate for the *All-Cause Readmissions* measure was significantly worse in RY 2015 when compared to RY 2014, and the non-SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measure declined significantly from RY 2014 to RY 2015.

Assessment of Improvement Plans

Kaiser SoCal had no rates below the MPLs in RY 2014. Therefore, the MCP was not required to submit any improvement plans (IPs). Since Kaiser SoCal had no performance measures with rates below the MPLs in RY 2015, the MCP will be required to submit no IPs in 2015.

Strengths

As in previous years, Kaiser SoCal demonstrated excellent performance, exceeding the DHCS-established MPLs for all measures and exceeding the HPLs for most measures.

Opportunities for Improvement

Kaiser SoCal's declining performance on the *All-Cause Readmissions* measure can be attributed to the SPD population's readmissions rate. This assessment is based on the SPD rate being significantly worse than the non-SPD rate and the SPD rate being significantly worse in RY 2015 when compared to RY 2014, while the non-SPD rate remained stable. Therefore, Kaiser SoCal has the opportunity to assess the factors leading to the significant increase in readmissions for the SPD population to improve performance on the *All-Cause Readmissions* measure.

Quality Improvement Project Objectives

Kaiser SoCal participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists Kaiser SoCal’s QIPs and indicates the QIP conducted; whether the QIP was clinical or nonclinical; and the domains of care (i.e., quality, access, and timeliness) the QIP addressed.

**Table 4.1—Quality Improvement Projects for Kaiser SoCal
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Children’s Access to Primary Care Practitioners</i>	Clinical	Q, A

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

Kaiser SoCal’s *Children’s Access to Primary Care Practitioners* QIP focused on children’s and adolescents’ access to primary care providers (PCPs). This QIP targeted children 25 months to 6 years of age and sought to increase the percentage of these children having a visit with a PCP. An annual visit with a PCP indicates the ability of beneficiaries to access care and provides the proper care setting for receiving preventive services.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
Kaiser SoCal—San Diego County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	96%	100%	<i>Met</i>
Internal QIPs				
<i>Children’s Access to Primary Care Practitioners</i>	Annual Submission	81%	86%	<i>Partially 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, 2014, through June 30, 2015, showed that Kaiser SoCal’s annual submission of its *All-Cause Readmissions* QIP achieved an overall validation status of *Met*, with 100 percent of the critical evaluation elements receiving a *Met* score. The *Children’s Access to Primary Care Practitioners* QIP annual submission received a *Partially Met* validation status. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a Plan-Do-Study-Act (PDSA) cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, Kaiser SoCal conducted a PDSA cycle for the *Children’s Access to Primary Care Practitioners* QIP.

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

Table 4.3—Quality Improvement Project Average Rates*
Kaiser SoCal—San Diego County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection**	88%	13%	0%
Design Total		95%	5%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	94%	6%	0%
	VIII: Appropriate Improvement Strategies**	88%	13%	0%
Implementation Total		92%	8%	0%
Outcomes	IX: Real Improvement Achieved**	63%	38%	0%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total**		63%	38%	0%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for both Kaiser SoCal’s *All-Cause Readmissions* and *Children’s Access to Primary Care Practitioners* QIP annual submissions.

Kaiser SoCal demonstrated a strong application of the Design stage, meeting 95 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP did not specify the type of statistical test to be performed to compare Remeasurement results in its *Children’s Access to Primary Care Practitioners* QIP annual submission, resulting in a lower score for Activity VI.

The MCP also demonstrated a strong application of the Implementation stage, meeting 92 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *All-Cause Readmissions* QIP annual submission, Kaiser SoCal miscalculated the statistical difference between Remeasurement 1 and baseline period, resulting in a lower score for Activity VII. In addition, for the *Children’s Access to Primary Care Practitioners* QIP annual submission, the MCP did not prioritize the barriers identified through causal/barrier analysis during Remeasurement 2, resulting in a lower score for Activity VIII.

Both QIPs progressed to the Outcomes stage during the reporting period, meeting 63 percent of the requirements for all applicable evaluation elements for both QIPs. The *All-Cause Readmissions* QIP met all applicable evaluation elements for Activity IX. However, the *Children’s Access to Primary Care Practitioners* QIP did not achieve statistically significant improvement over baseline at Remeasurement 2 for one of two study indicators, resulting in a lower score for Activity IX. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for Kaiser SoCal—San Diego County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions			
Study Indicator 1: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]			
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	N/A	Sustained Improvement [‡]
17.5%	11.4%*	N/A	‡
QIP #2—Children’s Access to Primary Care Practitioners			
Study Indicator 1: Number of children who have had one or more visits with a PCP during the measurement year			
Baseline Period 1/1/11–12/31/11	Remeasurement 1 1/1/12–12/31/12	Remeasurement 2 1/1/13–12/31/13	Sustained Improvement [‡]
94.4%	94.4%	93.6%	‡
Study Indicator 2: Number of children who have had a well visit during the measurement year			
Baseline Period 1/1/11–12/31/11	Remeasurement 1 1/1/12–12/31/12	Remeasurement 2 1/1/13–12/31/13	Sustained Improvement [‡]
68.6%	70.7%	73.7%*	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement from the baseline period (*p* value < 0.05).

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

All-Cause Readmissions QIP

Kaiser SoCal met its *All-Cause Readmissions* QIP's goal to achieve a statistically significant decline in the readmissions rate from baseline to Remeasurement 1. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ Kaiser SoCal staff continued to meet monthly to revisit major barriers identified at baseline. During Remeasurement 1, the MCP identified the following barriers:
 - Medication management
 - Home and community resources
- ◆ The following is a brief description of the interventions Kaiser SoCal indicated it implemented during the Remeasurement 1 time period:
 - Scheduled follow-up visits within seven days of discharge for beneficiaries at high risk of readmissions.
 - Conducted expedited home health visits within 24 hours for high-risk beneficiaries. The home health visit schedules were front-loaded to provide the most support early in the treatment plan, when the needs are highest.
 - Designed specific hospital units to provide pharmacists bedside to perform medication reconciliation.
 - For high-risk beneficiaries residing within the San Diego central quadrant area, scheduled an appointment with a bridge clinic consisting of a hospitalist physician (which may or may not be the beneficiary's PCP) and a social worker (for needed resources).

Children's Access to Primary Care Practitioners QIP

For the *Children's Access to Primary Care Practitioners* QIP, Kaiser SoCal achieved its goal of the rate for Study Indicator 1 being above the DHCS-established HPL for the second consecutive year. Although above the HPL, the rate for Study Indicator 1 declined during Remeasurement 2 and did not achieve statistically significant improvement over baseline. Conversely, the rate for Study Indicator 2 achieved statistically significant improvement over baseline at Remeasurement 2; however, the improvement was not enough to meet the MCP's goal of surpassing the DHCS-established HPL for the rate of children having a well visit during the measurement year. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ Kaiser SoCal identified the following major barriers to focus on during Remeasurement 2:
 - Physicians do not have sufficient resources to meet well-visit demands.
 - Beneficiaries have a high rate of not keeping or canceling well-visit appointments.
 - PCPs are not included in outreach efforts.

- The after-visit summary form has DHCS's Child Health and Disability Prevention's periodicity, not American Academy of Pediatrics' schedule.
- Data collection and messaging is inconsistent between locations and support staff.
- ◆ Although the intervention was not successful at improving the QIP outcomes, HSAG provides a description of the monthly rounding intervention the MCP implemented during Remeasurement 2:
 - Each month, the State Programs project manager rounded with staff, reviewed clinic monthly performance, observed processes, and provided verbal instruction with written reference materials. Kaiser SoCal indicated that the intervention was very successful in standardizing outreach efforts, messaging, consistent documentation, and accountability.

Plan-Do-Study-Act Review

The *Children's Access to Primary Care Practitioners* QIP did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for the QIP topic.

For the *Children's Access to Primary Care Practitioners* QIP topic, Kaiser SoCal narrowed the focus to the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure for the PDSA cycle. The MCP set the SMART (Specific, Measureable, Achievable, Relevant, Time-bound) Objective as follows:

By March 31, 2015, the Medi-Cal well-child visits for 3-to-6-year-olds will increase at the Otay Mesa Outpatient Medical Center and Vandever Medical Offices as a result of the Pediatric Management Team rounding with all of the outreach staff at those locations.

The purpose of the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PDSA cycle was to test if monthly management rounding with outreach staff would increase effectiveness in compliance rates for well visits.

Kaiser SoCal completed the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PDSA cycle, and the results showed that the intervention appeared to be successful at increasing compliance with well visits. However, since the SMART Objective did not clearly define the increase the PDSA cycle was targeting, whether or not the PDSA cycle resulted in achievement of the SMART Objective cannot be determined. The MCP documented plans to adopt the change in low-performing sites.

Strengths

The *All-Cause Readmissions* QIP achieved a *Met* validation status the first submission, and Kaiser SoCal was one of six MCPs that achieved statistically significant improvement over baseline for the statewide collaborative *All-Cause Readmissions* QIP. In addition, for the *Children's Access to Primary Care Practitioners* QIP, Study Indicator 1 met the project's goal of surpassing the DHCS-established HPL and Study Indicator 2 achieved statistically significant improvement over baseline.

Opportunities for Improvement

Although Kaiser SoCal will not be continuing the formal QIPs, the MCP should continue to reassess the barriers to improvement since the rate for the *All-Cause Readmissions* measure was significantly worse in RY 2015 when compared to RY 2014. In addition, the MCP should consider following its plans to adopt the monthly management rounding for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* compliance in additional settings using additional PDSA cycles with clearly defined SMART Objectives.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

Kaiser SoCal’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for Kaiser SoCal. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for Kaiser SoCal

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	3.3%	26.3%	≥90th	0.0%	9.2%	≥90th
Diagnosis Code	10.8%	31.6%	≥90th	24.2%	34.6%	≥90th
Procedure Code	9.3%	43.8%	≥90th	27.4%	22.5%	25th–75th
Procedure Code Modifier	NA	58.5%	NA	NA	46.0%	NA
Rendering Provider Name	NA	25.0%	NA	100.0%	68.1%	0–≤25th
Billing Provider Name	48.2%	35.0%	<10th	0.0%	8.6%	≥90th

Note: HSAG displayed “NA” when the denominator was less than 30.

For Kaiser SoCal, none of the procedure code modifiers or rendering provider names were identified in the DHCS data system; therefore, the medical record omission rates for these two data elements were not reportable (i.e., noted as “NA” in Table 5.3). The remaining four medical record omission rates for Kaiser SoCal ranged from 3.3 percent (*Date of Service*) to 48.2 percent (*Billing Provider Name*). Three of the four reportable Kaiser SoCal’s medical record omission rates were substantially better than the respective statewide rates, receiving a percentile ranking of “≥90th” each, and all three rates exceeded the respective statewide rates by 20.8 to 34.5 percentage points. One medical record omission rate (*Billing Provider Name*) was worse than the statewide rate by 13.2 percentage points. These findings suggest (as compared to beneficiaries’ medical records) completeness among three key data elements, poor performance for one data element, and potential issues that created two “NA” entries for rates.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ Dates of services were omitted from the medical records.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.

- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for Kaiser SoCal contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, Kaiser SoCal's rates varied from 0.0 percent (*Date of Service* and *Billing Provider Name*) to 100 percent (*Rendering Provider Name*). The encounter data omission rates of 0.0 percent for the *Date of Service* and *Billing Provider Name* were because no procured medical records had a second date of service submitted for validation. Overall, three of the five reportable Kaiser SoCal's encounter data omission rates were better than the respective statewide rates, receiving a percentile ranking of "≥90th". However, Kaiser SoCal performed worse than the statewide encounter data omission rate by 31.9 percentage points for the *Rendering Provider Name* data element. An opportunity exists for Kaiser SoCal to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in Kaiser SoCal's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to Kaiser SoCal (and/or the data subsequently being submitted to DHCS).
- ◆ Kaiser SoCal populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files Kaiser SoCal submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for Kaiser SoCal. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for Kaiser SoCal

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	84.1%	83.6%	25th–75th	NA
Procedure Code	59.1%	77.6%	<10th	Inaccurate Code (43.8%); Lower Level of Services in Medical Records (35.4%)
Procedure Code Modifier	NA	99.5%	NA	—
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	31.1%	68.6%	<10th	Inaccurate Names (100.0%)
All-Element Accuracy	0.0%	4.3%	0–≤25th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

Because no rendering provider names or procedure code modifiers could be identified in the DHCS data system, the element accuracy rates for the *Procedure Code Modifier* and *Rendering Provider Name* were not reportable (i.e., noted as “NA” in Table 5.4 due to a denominator of zero). In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be of mixed accuracy for Kaiser SoCal, with two of the three reported element accuracy rates considerably worse than the respective statewide rates and one rate slightly better than the statewide rate. When comparing the performance among MCPs, two of the three data elements received a percentile ranking of “<10th” and one element received a percentile ranking of “25th–75th”. For the *Procedure Code* data element, 43.8 percent of errors were associated with the use of inaccurate codes, wherein the reported codes were not supported by national coding standards. For the second most common error type, 35.4 percent of errors were associated with higher-level procedure codes in the DHCS encounter data than were documented in the beneficiaries’ medical records (i.e., the procedure code was considered an error due to a lower level service documented in the medical record). For *Billing Provider Name*, all errors were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records.

Kaiser SoCal’s all-element accuracy rate was worse than the statewide rate by 4.3 percentage points. No dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and

Billing Provider Name) when compared to beneficiaries' medical records. The overall accuracy findings indicated the presence of at least one inaccurate data element for all dates of service present in both data sources. While all five key data elements contributed to Kaiser SoCal's relatively low all-element accuracy rate, the *Rendering Provider Name* and *Billing Provider Name* data elements contributed most and the *Procedure Code Modifier* contributed least.

Medical Record Review Recommendations

Based on the study findings for Kaiser SoCal, HSAG recommends the following:

- ◆ Although Kaiser SoCal procured medical records for nearly all sampled beneficiaries, none of the medical records contained a second date of service. Kaiser SoCal should investigate the reason(s) why a second date of service was not available or was not submitted to HSAG for the EDV study.
- ◆ Kaiser SoCal should review its data collection and submission processes to determine if more values for the *Procedure Code Modifier* data element should be submitted to DHCS.
- ◆ Of 120 dates of service identified in the DHCS encounter data, no rendering provider names could be identified by linking the DHCS encounter data and DHCS provider data. Therefore, Kaiser SoCal should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. Kaiser SoCal should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ Kaiser SoCal should avoid using local procedure codes for the encounter data submitted to DHCS.
- ◆ Kaiser SoCal should investigate the reasons for the relatively high medical record omission rate for the *Billing Provider Name* data element and develop strategies to improve rates.
- ◆ Kaiser SoCal should explore the reasons for the relatively low element accuracy rates for the *Procedure Code* and *Billing Provider Name* data elements and take actions to improve rates.

- ◆ Kaiser SoCal should consider developing periodic education and training regarding encounter data submissions, medical record documentation, and coding practices for the relevant staff. These activities should include a review of both State and national coding requirements and standards, especially for new staff working for Kaiser SoCal.
- ◆ Kaiser SoCal should perform periodic reviews of encounters submitted to DHCS in order to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP’s Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

Kaiser SoCal’s SFY 2014–15 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the EDV study, which assessed the MCP’s operational and infrastructure changes in support of DHCS’s transition to PACES. Based on review of Kaiser SoCal’s Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist Kaiser SoCal with improving its encounter data quality. DHCS followed up with Kaiser SoCal regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of Kaiser SoCal's performance in the three domains of care—quality, access, and timeliness.

Quality

As in previous years, Kaiser SoCal's quality program description included details about the MCP's organizational structure, which is designed to ensure that quality care is provided to all beneficiaries. The document also described the MCP's processes to monitor quality of care and ensure continuous quality improvement.

The rates exceeded the HPLs for 20 quality measures, with 14 of the rates exceeding the HPLs for three or more consecutive years. The rates improved significantly from RY 2014 to RY 2015 for the following quality measures:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Both Medication Management for People with Asthma—Medication Compliance measures*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care, was significantly worse in RY 2015 when compared to RY 2014. Additionally, the SPD rate was significantly worse than the non-SPD rate for the measure; and the SPD readmissions rate was significantly worse in RY 2015 when compared to RY 2014. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of Kaiser SoCal's QIPs fell into the quality domain of care, and both progressed to the Outcomes stage. While the *All-Cause Readmissions* QIP achieved statistically significant improvement at Remeasurement 1 (RY 2014), the rate for the measure was significantly worse in RY 2015, suggesting that the MCP needs to reassess its strategies for preventing hospital readmissions. One of the two study indicators for the *Children's Access to Primary Care Practitioners* QIP achieved statistically significant improvement over baseline at Remeasurement 2; however, the other indicator did not.

Kaiser SoCal submitted a PDSA cycle for the *Children's Access to Primary Care Practitioners* QIP topic that focused on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. The MCP tested whether or not conducting monthly management rounds with outreach staff would increase the compliance rate for well visits. The MCP indicated that the intervention resulted in an increase in compliance with well-child visits and that it planned to adopt the intervention in low-performing provider sites.

Overall, Kaiser SoCal showed above-average performance related to the quality domain of care.

Access

Kaiser SoCal's quality program description included details of an organizational structure designed to ensure access to care for all beneficiaries. The results of Kaiser SoCal's evaluation of the MCP's 2014 work plan activities showed that the MCP met or exceeded most access-related goals.

The rates exceeded the HPLs for 10 access measures, with five of the rates exceeding the HPLs for three or more consecutive years. The rates improved significantly from RY 2014 to RY 2015 for the following access measures:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

As noted above, the rate for the *All-Cause Readmissions* measure, which falls into the access domain of care, was significantly worse in RY 2015 when compared to RY 2014. Additionally as noted above, the SPD rate was significantly worse than the non-SPD rate for the measure; and the SPD readmissions rate was significantly worse in RY 2015 when compared to RY 2014. However, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of Kaiser SoCal's QIPs fell into the access domain of care. As noted above, while the *All-Cause Readmissions* QIP achieved statistically significant improvement at Remeasurement 1 (RY 2014), the rate for the measure was significantly worse in RY 2015, suggesting that the MCP needs to reassess strategies for preventing hospital readmissions. Also noted above, one of the two study indicators for the *Children's Access to Primary Care Practitioners* QIP achieved statistically significant improvement over baseline at Remeasurement 2; however, the other indicator did not. Finally as noted above, the PDSA cycle that the MCP tested (which focused on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure) resulted in an increase in compliance with well-child visits. The MCP therefore planned to adopt the intervention at low-performing provider sites.

Overall, Kaiser SoCal showed above-average performance related to the access domain of care.

Timeliness

As in previous years, Kaiser SoCal's quality program description included details of the MCP's processes related to member rights, grievances, continuity and coordination of care, and utilization management—which all affect the timeliness of care delivered to beneficiaries.

Five required performance measures fall into the timeliness domain of care; and the rates for all five were above the HPLs in RY 2015, with the rate for the *Childhood Immunization Status*—

Combination 3 measure above the HPL for the fifth consecutive year. The rates for the following timeliness measures improved significantly from RY 2014 to RY 2015:

- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Overall, Kaiser SoCal showed above-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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with Kaiser SoCal’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—Kaiser SoCal’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
1. Continue to implement strategies to ensure that all required information is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.	Kaiser SoCal demonstrated improvement of its QIP documentation over the past submissions by incorporating steps outlined in the QIP Completion Instructions, technical assistance calls, and ensuring the team follows recommendations from the QIP Summary Form. Kaiser SoCal will continue to participate in the DHCS/HSAG-led QIP meetings and utilize technical assistance resources as necessary.

Recommendations

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

- ◆ Assess the factors leading to the significant increase in hospital readmissions for the SPD population to ensure that the MCP is meeting the needs of this population.
- ◆ Although Kaiser SoCal will not be continuing the formal QIPs, the MCP should consider following the documented plans to test the monthly management rounding to improve well-child visit compliance in new settings through additional PDSA cycles with clearly defined SMART Objectives.

- ◆ Review the *2013–14 Encounter Data Validation Study Report*, and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

In the next annual review, HSAG will evaluate Kaiser SoCal’s progress with these recommendations along with its continued successes.

Medi-Cal Managed Care Technical Report

**Appendix U:
Performance Evaluation Report
L.A. Care Health Plan
July 1, 2014 – June 30, 2015**

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Appendix U: Performance Evaluation Report – L.A. Care Health Plan July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), L.A. Care Health Plan (“L.A. Care” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

L.A. Care is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in L.A. Care, the LI MCP; or in Health Net Community Solutions, Inc., the alternative commercial plan (CP).

L.A. Care became operational in Los Angeles County to provide MCMC services effective March 1997. As of June 30, 2015, L.A. Care had 1,738,495 beneficiaries.¹ This represents 65 percent of the beneficiaries enrolled in Los Angeles County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: November 12, 2015.

Medical and State Supported Services Audit

The most recent medical and State Supported Services audit for L.A. Care was conducted June 25, 2014, through July 9, 2014, covering the review period of April 1, 2013, through March 31, 2014. DHCS assessed the following areas:

- ◆ Compliance with State Supported Services contract and regulations
- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Member's Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

DHCS issued reports on March 11, 2015, and indicated that it found no deficiencies for State Supported Services; however, DHCS identified findings in all areas assessed under the scope of the medical audit. In a letter dated August 31, 2015, DHCS stated that on August 9, 2015, L.A. Care provided DHCS with its most recent response to its corrective action plan (CAP) originally issued on March 27, 2015, regarding the remaining open items. The letter indicated that DHCS had reviewed and either closed or provisionally closed all deficiencies and that the CAP was closed. Note: Although the August 31, 2015, letter is outside the review dates of this report, HSAG included the information since it was available and indicated that the MCP had resolved all findings from the June 25, 2014, through July 9, 2014 medical audit.

Strengths

L.A. Care had no findings identified in the area of State Supported Services during the June 25, 2014, through July 9, 2014, medical and State Supported Services audit and resolved all findings in the areas reviewed under the medical audit.

Opportunities for Improvement

Since L.A. Care has no outstanding findings from the most recent medical and State Supported Services audit, HSAG has no recommendations in the area of compliance.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for L.A. Care Health Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that L.A. Care followed the appropriate specifications to produce valid rates. Although the auditor identified multiple concerns, most identified issues were resolved during the audit process; and the issues had minimal impact on measure reporting. The auditor noted that for the second consecutive year L.A. Care experienced significant challenges with its encounter data processing vendor and recommended that the MCP develop strategies to remedy the issues for reporting year 2016.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 for L.A. Care's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).

- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
L.A. Care—Los Angeles County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	17.05%	15.50%	20.83%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	31.02	32.23	35.61	33.99	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	191.44	185.93	310.27	301.62	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	73.44%	73.03%	78.93%	86.55%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	78.85%	78.09%	80.72%	47.43%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	72.28%	72.87%	78.17%	85.67%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	32.31%	35.44%	27.88%	29.73%	↔
Cervical Cancer Screening	Q,A	—	—	64.25%	61.79%	↔
Childhood Immunization Status—Combination 3	Q,A,T	81.45%	80.15%	77.78%	77.65%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	95.16%	91.06%	91.83%	92.26%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	86.98%	82.93%	82.82%	84.21%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	88.20%	87.15%	83.89%	86.49%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	86.43%	85.89%	79.45%	82.39%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	64.25%	65.94%	60.05%	65.13%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	50.72%	49.76%	46.25%	49.65%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	83.82%	84.30%	83.54%	83.14%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	42.27%	48.07%	41.65%	45.96%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	79.47%	81.64%	84.99%	86.61%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	42.03%	39.37%	47.46%	41.80%	↔
Controlling High Blood Pressure	Q	—	61.59%	57.14%	66.83%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	60.53%	72.15%	73.12%	77.01%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	79.80%	67.42%	46.69%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	57.70%	45.71%	24.85%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	61.26%	55.80%	54.24%	57.04%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	80.63%	85.75%	79.90%	82.16%	↔
Use of Imaging Studies for Low Back Pain	Q	81.64%	80.14%	80.40%	79.73%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	64.65%	71.91%	71.84%	80.15%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	70.22%	74.58%	73.06%	80.15%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	57.63%	67.31%	62.62%	69.35%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	77.54%	72.46%	69.49%	69.52%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 Seniors and Persons with Disabilities (SPD) measure results reported by L.A. Care. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for L.A. Care—Los Angeles County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	13.55%	25.53%	▼	20.83%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.50%	87.63%	↑	86.55%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	40.65%	49.29%	↔	47.43%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.81%	87.55%	↑	85.67%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	92.33%	83.56%	↓	92.26%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	84.21%	84.22%	↔	84.21%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	86.47%	86.87%	↔	86.49%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	82.42%	81.92%	↔	82.39%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

⁴ 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 3.2.

**Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
L.A. Care—Los Angeles County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
284.50	31.16	450.94	58.66

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
L.A. Care—Los Angeles County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	19.69%	18.44%	25.53%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	61.70	57.87	58.66	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	284.56	421.46	450.94	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	73.17%	79.22%	87.63%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	78.75%	79.65%	49.29%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	73.59%	78.52%	87.55%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	77.40%	79.34%	83.56%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	81.54%	81.02%	84.22%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	87.85%	83.01%	86.87%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	84.37%	77.77%	81.92%	↑

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

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
L.A. Care—Los Angeles County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	10.99%	9.19%	13.55%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	27.42	32.50	31.16	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	169.83	294.71	284.50	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	72.80%	78.24%	85.50%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	75.57%	89.77%	40.65%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	71.64%	77.33%	83.81%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	91.20%	91.98%	92.33%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	82.97%	82.88%	84.21%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	87.12%	83.93%	86.47%	↑
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	85.96%	79.56%	82.42%	↑

* Member months are a member’s “contribution” to the total yearly membership.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total* measure improved significantly from RY 2014 to RY 2015, and the improvement resulted in the rate moving to above the HPL. The rates for the following measures also improved significantly from RY 2014 to RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*; however, the rate remained below the MPL for the fourth consecutive year.
- ◆ All four *Children and Adolescents' Access to Primary Care Practitioners* measures; however, the rates for all four measures remained below the MPLs for at least the third consecutive year.
- ◆ *Controlling High Blood Pressure*.
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*.

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total.*

The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rates for the following measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions.*
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*, resulting in the rate moving from above the HPL in RY 2014 to below the MPL in RY 2015.
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total.*

Seniors and Persons with Disabilities Findings

The SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures were significantly better than the non-SPD rates, and the SPD rates were significantly worse than the non-SPD rates for the following measures:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*

Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measure may be attributed to children and adolescents in the SPD population in this age group relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

For measures stratified for the SPD and non-SPD populations, all variations in the SPD and non-SPD rates from RY 2014 to RY 2015 are already reflected in the analyses above.

Assessment of Improvement Plans

Based on RY 2014 performance measure results, L.A. Care was required to submit improvement plans (IPs) and Plan-Do-Study-Act (PDSA) cycles for two measures. The following is a summary of the IPs and PDSA cycles.

Annual Monitoring for Patients on Persistent Medications

L.A. Care submitted three PDSA cycles related to the *Annual Monitoring for Patients on Persistent Medications* measures. The MCP identified the following barriers to the rates for the measures being above the MPLs:

- ◆ Missing and incorrect lab data
- ◆ Lack of participating provider groups' (PPGs') expertise on gap reports
- ◆ Providers having difficulty using the MCP's online portal which houses the gap reports
- ◆ Staff turnover at the PPGs

L.A. Care submitted two PDSA cycles. A summary of each cycle follows:

- ◆ The purpose of the test of change was to determine if missing or incorrect lab data were causing the low performance. The MCP contacted physicians with patients who had no record of the required labs being completed during a three-month time period. The results confirmed that missing or incorrect lab data could be the cause of low performance, and the MCP therefore decided to implement provider outreach in the next quarter.
- ◆ The purpose of the test of change was for 50 percent of the PPGs to achieve statistically significant improvement in at least one drug category by a specified date. L.A. Care conducted provider education and assisted providers with downloading the gap reports. Additionally, the MCP provided the PPGs with a summary of their performance to date and highlighted areas in need of improvement. The results of the test of change showed that the targets were met; therefore, L.A. Care decided to apply a similar strategy to physician offices. The MCP also decided to provide PPGs with a reminder letter template to serve as a laboratory order to facilitate completion of their patients' laboratory tests.

L.A. Care's efforts resulted in the rates improving significantly for the *Annual Monitoring for Patients on Persistent Medications*—*ACE or ARBs* and *Diuretics* measures and the rate for the *ACE or ARBs* measure moving to above the MPL; however, the rate for the *Diuretics* measure remained below the MPL. L.A. Care will be required to continue implementing PDSA cycles for this measure.

Prenatal and Postpartum Care—Postpartum Care

L.A. Care continued its IP from the previous year and indicated that no new barriers to the rate being above the MPL were identified. The MCP indicated that the previously recognized barriers of identifying and contacting eligible beneficiaries were still relevant. The MCP implemented a new intervention which included identifying deliveries by combining hospital discharge information with hospital preauthorization and adding information from the case management database. L.A. Care continued to implement the Healthy Mom Program which provides:

- ◆ Outreach and education.

- ◆ Transportation and appointment resources.
- ◆ Incentives.

The MCP also modified its outreach efforts for beneficiaries residing in Antelope Valley by adding health educator hospital visits and offering non-monetary promotional items.

L.A. Care submitted two PDSA cycles for the *Postpartum Care* measure. A summary of each cycle follows:

- ◆ The MCP identified deliveries and obtained accurate contact information for the eligible population by combining hospital discharge information and case management information. Additionally, health educators visited beneficiaries in the hospital. Analysis of the data suggested that telephone calls, paired with the incentive, resulted in more postpartum visits and that hospital visits by the health educator did not result in improvement in beneficiaries obtaining services. L.A. Care planned to adapt the intervention to explore methods for obtaining accurate telephone numbers for contacting eligible beneficiaries.
- ◆ L.A. Care increased call attempts from two to three in its Healthy Mom Program and worked with the MCP's beneficiary eligibility staff to identify alternate telephone numbers. The test of change resulted in an increased reach rate and improvement in the *Postpartum Care* rate. Since the improvement was not deemed to be significant, the MCP planned to work with targeted plan partners to improve rates.

While the improvement in the rate for the *Postpartum Care* measure was not statistically significant, the rate improved to above the MPL in RY 2015; and the MCP will not be required to continue the IP.

Required Improvement Plans for RY 2015

In addition to being required to continue PDSA cycles for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure, L.A. Care will be required to submit an IP for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure based on the rate for the measure being below the MPL in RY 2015.

Strengths

HSAG auditors determined that L.A. Care followed the appropriate specifications to produce valid rates. The rate for one measure was above the HPL, and the rates for 10 measures improved significantly. The rates for two measures improved from below the MPLs in RY 2014 to above the MPLs in RY 2015.

Opportunities for Improvement

L.A. Care has the opportunity to develop strategies to remedy the significant challenges experienced for the second consecutive year with its encounter data processing vendor.

The MCP has the opportunity to assess the factors leading to the rates for three measures declining significantly from RY 2014 to RY 2015. L.A. Care also has the opportunity to take steps to assess why the rates for six measures were below the MPLs and to implement strategies to prevent further decline in performance or to improve performance. Specifically, the MCP should address why the rate for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure declined significantly and moved from above the HPL in RY 2014 to below the MPL in RY 2015.

Finally, L.A. Care has the opportunity to assess whether or not planned strategies designed to ensure that the MCP is meeting the needs of the SPD population are successful (See Table 6.1), since the SPD rates for two measures continued to be significantly worse than the non-SPD rates.

Quality Improvement Project Objectives

L.A. Care participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists L.A. Care’s QIPs and indicates the QIP conducted; whether the QIP was clinical or nonclinical; and the domains of care (i.e., quality, access, and timeliness) the QIP addressed.

**Table 4.1—Quality Improvement Projects for L.A. Care
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Improving HbA1c and Diabetic Retinal Exam Screening Rates</i>	Clinical	Q, A

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

L.A. Care’s *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP attempted to increase HbA1c testing and retinal eye exams by implementing beneficiary and provider interventions. At the initiation of the QIP, L.A. Care identified 15,649 adult beneficiaries with diabetes. Blood glucose monitoring and retinopathy screening assist in developing appropriate treatment plans to decrease the risk of diabetes complications. Lack of appropriate testing in beneficiaries with diabetes may indicate suboptimal care and case management.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
L.A. Care—Los Angeles County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	92%	86%	<i>Partially Met</i>
Internal QIPs				
<i>Improving HbA1c and Diabetic Retinal Exam Screening Rates</i>	Annual Submission	83%	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, 2014, through June 30, 2015, showed that L.A. Care’s annual submission of its *All-Cause Readmissions* QIP received a *Partially Met* validation status. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, L.A. Care conducted a PDSA cycle for the *All-Cause Readmissions* QIP. The *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP annual submission achieved an overall validation status of *Met*, with 100 percent of the critical evaluation elements receiving a *Met* score.

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

Table 4.3—Quality Improvement Project Average Rates*
L.A. Care—Los Angeles County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

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	100%	0%	0%
Design Total		100%	0%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	76%	24%	0%
	VIII: Appropriate Improvement Strategies**	88%	13%	0%
Implementation Total		80%	20%	0%
Outcomes	IX: Real Improvement Achieved**	63%	0%	38%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total**		63%	0%	38%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for both L.A. Care’s *All-Cause Readmissions* and *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP annual submissions.

L.A. Care demonstrated an excellent application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP demonstrated an adequate application of the Implementation stage, meeting 80 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *All-Cause Readmissions* QIP, L.A. Care reported a Remeasurement 1 rate inconsistent with the audited rate reported to DHCS, resulting in a lowered score for Activity VII. For the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP, the MCP provided an inaccurate comparison between Remeasurement 4 and baseline, also resulting in a lowered score for Activity VII. Additionally, the MCP did not document evaluations for all provider interventions conducted for the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP, resulting in a lowered score for Activity VIII.

Both QIPs progressed to the Outcomes stage during the reporting period, and L.A. Care met 63 percent of the requirements for all applicable evaluation elements within the study stage for both

QIPs. While the *All-Cause Readmissions* QIP successfully achieved statistically significant improvement over baseline at Remeasurement 1, the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP still had not achieved statistically significant improvement over baseline at Remeasurement 4. Both study indicators for the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP declined between Remeasurement 3 and Remeasurement 4, resulting in a lowered score for Activity IX. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for L.A. Care—Los Angeles County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions					
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]					
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13		Sustained Improvement [‡]		
17.1%	15.5%*		‡		
QIP #2—Improving HbA1c and Diabetic Retinal Exam Screening Rates					
Study Indicator 1: The percentage of members 18–75 years of age with diabetes who received HbA1c testing as of December 31 of the measurement year					
Baseline Period 1/1/09–12/31/09	Remeasurement 1 1/1/10–12/31/10	Remeasurement 2 1/1/11–12/31/11	Remeasurement 3 1/1/12–12/31/12	Remeasurement 4 1/1/13–12/31/13	Sustained Improvement [‡]
82.1%	85.0%	83.8%	84.3%	83.5%	‡
Study Indicator 2: The percentage of members 18–75 years of age with diabetes who received a retinal eye exam in the measurement year or a negative retinal eye exam in the year prior to the measurement year					
Baseline Period 1/1/09–12/31/09	Remeasurement 1 1/1/10–12/31/10	Remeasurement 2 1/1/11–12/31/11	Remeasurement 3 1/1/12–12/31/12	Remeasurement 4 1/1/13–12/31/13	Sustained Improvement [‡]
52.8%	50.7%	50.7%	49.8%	46.3%	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement from the baseline period (p value < 0.05).

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

All-Cause Readmissions QIP

L.A. Care's goal for the *All-Cause Readmissions* QIP was to achieve statistically significant decline in readmissions rates from baseline to Remeasurement 1. The MCP met the project's goal by decreasing the readmission rate to 15.5 percent. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ L.A. Care identified the following new barriers during the Remeasurement 1 time period:
 - The transition of care (TOC) program data are difficult to capture in the MCP's existing software.
 - Beneficiaries are difficult to reach by phone after discharge.
 - Specialty referrals from the PPGs are not received in a timely manner.
- ◆ L.A. Care launched the new TOC program during the Remeasurement 1 time period. The MCP hired additional staff to make phone calls and evaluate beneficiaries for risk stratification prior to beneficiaries' discharge. High-risk beneficiaries received additional calls post discharge and were placed in case management after 30 days if they remained at a high risk for readmissions. Beneficiaries at moderate or low risk for readmissions were connected to internal L.A. Care resources and community services. The TOC program also notified the primary care providers (PCPs) that the beneficiaries had been in the hospital and assisted the beneficiaries in getting timely appointments or specialty referrals.

Improving HbA1c and Diabetic Retinal Exam Screening Rates QIP

L.A. Care's goals for the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP were to increase HbA1c screening rates to 84.1 percent and retinal eye exam rates to 55.8 percent. The MCP met its goal for Study Indicator 1 at Remeasurement 3, but the rate declined at Remeasurement 4. L.A. Care did not meet its goal for Study Indicator 2 at Remeasurement 4, and the retinal eye exam rate continued to decline year-over-year. Additionally, neither indicator achieved statistically significant improvement over baseline. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- ◆ L.A. Care reexamined the prior causal/barrier analysis and conducted a new causal/barrier analysis during the Remeasurement 4 time period. The MCP identified and prioritized the following barriers:
 - Beneficiaries are too busy, have conflicting priorities, or do not follow through with getting the exams.
 - Beneficiaries have difficulty scheduling appointments with qualified eye care providers or receiving appropriate referrals from PCPs.
 - Beneficiaries lack knowledge of appropriate diabetes management and needed screenings.

- An increase in the SPD population caused a sharp increase in the proportion of L.A. Care’s beneficiaries living with diabetes.
- ◆ Although the interventions were not successful at improving the QIP outcomes, following is a brief description of the interventions L.A. Care indicated it implemented during the Remeasurement 4 time period:
 - Launched the Diabetes Screening Member Incentive Program offering incentives to beneficiaries to complete their retinal eye exams and HbA1c and LDL screenings.
 - Continued the Physician Pay-for-Performance Program offering incentives to providers who provided quality services to beneficiaries related to 14 measures, including the *Comprehensive Diabetes Care—HbA1c Testing and Eye Exam (Retinal) Performed* measures.
 - Continued the L.A. Pay-for-Performance Program offering incentives to L.A. Care’s PPGs based on performances on clinical quality; medical cost management; and beneficiary satisfaction, including the *Comprehensive Diabetes Care—HbA1c Testing and Eye Exam (Retinal) Performed* measures.
 - Continued to provide *Provider Opportunity Reports* to high-volume providers containing beneficiary gap in care information for the *Comprehensive Diabetes Care—HbA1c Testing and Eye Exam (Retinal) Performed* measures.
 - Continued to provide *Participating Provider Group Summary Report* to L.A. Care’s PPGs containing performance on the *Comprehensive Diabetes Care—HbA1c Testing and Eye Exam (Retinal) Performed* measures.

Plan-Do-Study-Act Review

The *All-Cause Readmissions* QIP did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for the QIP topic.

L.A. Care set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By March 31, 2015, our goal is to increase the rate of medication reconciliation and scheduling of a PCP visit within seven days to 72 percent for those beneficiaries who agree to participate in the TOC program at moderate or high risk for a hospital readmission.

The purpose of the *All-Cause Readmissions* PDSA cycle was to test the timely completion of the new electronic reporting form that will capture medication reconciliation and PCP scheduling post hospital discharge.

L.A. Care completed the *All-Cause Readmissions* PDSA cycle as planned. However, the results showed that the medication reconciliation rate declined from 62 percent to 61 percent, and the PCP follow-up rate also declined from 62 percent to 38 percent. The MCP determined that the number of beneficiaries involved in this PDSA cycle was too low to draw conclusions. L.A. Care planned to adopt the change and continue to monitor the new electronic tool as it was successful in providing current and accurate data. The MCP indicated that it would also like to recruit more beneficiaries into the TOC program and address strategies to support the scheduling of follow-up PCP appointments.

Strengths

L.A. Care demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIPs. L.A. Care was one of six MCPs that achieved statistically significant improvement over baseline at Remeasurement 1 for the statewide collaborative *All-Cause Readmissions* QIP. The *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP achieved a *Met* validation status on the first submission.

Opportunities for Improvement

Although L.A. Care will not be continuing the formal QIPs, the MCP should continue to reassess the barriers to improvement since the rate for the *All-Cause Readmissions* measure was significantly worse in RY 2015 when compared to RY 2014. As indicated in the *All-Cause Readmissions* PDSA Cycle Worksheet, the MCP should continue to recruit more beneficiaries into the TOC program and monitor the new electronic tool for current and accurate data. In addition, L.A. Care should explore new strategies to address barriers identified through the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP since the interventions the MCP implemented did not impact the screening rates for four consecutive years.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

L.A. Care’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for L.A. Care. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for L.A. Care

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	25.6%	26.3%	25th–75th	11.5%	9.2%	25th–75th
Diagnosis Code	31.7%	31.6%	25th–75th	38.8%	34.6%	25th–75th
Procedure Code	59.2%	43.8%	10th–25th	27.7%	22.5%	25th–75th
Procedure Code Modifier	70.1%	58.5%	10th–25th	NA	46.0%	NA
Rendering Provider Name	16.8%	25.0%	75th–90th	31.6%	68.1%	75th–90th
Billing Provider Name	33.5%	35.0%	25th–75th	10.2%	8.6%	25th–75th

Note: HSAG displayed “NA” when the denominator was less than 30.

Overall, the medical record omission rates for L.A. Care ranged from 16.8 percent (*Rendering Provider Name*) to 70.1 percent (*Procedure Code Modifier*). Three of L.A. Care’s medical record omission rates were better than the respective statewide rates, with *Rendering Provider Name* better by 8.2 percentage points. The remaining three rates were worse than the statewide rates, with *Procedure Code* and *Procedure Code Modifier* worse by 15.4 and 11.6 percentage points, respectively. When compared to other MCPs’ performance, L.A. Care received a percentile ranking of “10th–25th” for two elements, a percentile ranking of “25th–75th” for three elements, and a percentile ranking of “75th–90th” for one element. These findings suggest a moderate level of completeness among key encounter data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for L.A. Care contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, L.A. Care's rates varied from 10.2 percent (*Billing Provider Name*) to 38.8 percent (*Diagnosis Code*). One of L.A. Care's encounter data omission rates was better than the respective statewide rate (*Rendering Provider Name*) by 36.5 percentage points. Of the four remaining reportable encounter data omissions rates, none were worse than the statewide rate by more than 5.2 percentage points. An opportunity exists for L.A. Care to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in L.A. Care's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to L.A. Care (and/or the data subsequently being submitted to DHCS).
- ◆ L.A. Care did not populate or populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files L.A. Care submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for L.A. Care. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for L.A. Care

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	81.7%	83.6%	10th–25th	NA
Procedure Code	73.7%	77.6%	25th–75th	Inaccurate Code (44.5%); Lower Level of Services in Medical Records (36.2%)
Procedure Code Modifier	NA	99.5%	NA	—
Rendering Provider Name	57.4%	63.0%	25th–75th	Incorrect Names (81.0%)
Billing Provider Name	59.9%	68.6%	10th–25th	Incorrect Names (97.4%)
All-Element Accuracy	9.3%	4.3%	75th–90th	—

Note: HSAG displayed "NA" when the denominator was less than 30. HSAG displayed "—" when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found below average for accuracy for L.A. Care, with all four reportable element accuracy rates lower than the respective statewide rates. When comparing the performance among the MCPs, two of the four key data elements received a percentile ranking of “10th–25th” and two elements received a percentile ranking of “25th–75th”. The *Procedure Code* data element showed that 44.5 percent of errors were associated with the use of inaccurate codes, wherein the reported codes were not supported by national coding standards; and 36.2 percent of errors were associated with higher-level procedure codes in the DHCS encounter data than were documented in the beneficiaries’ medical records (i.e., the procedure code was considered an error due to a lower level service documented in the medical record). The majority of rendering and billing provider name errors (81.0 percent and 97.4 percent, respectively) were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records.

Although L.A. Care’s all-element accuracy rate was higher than the statewide rate by 5.0 percentage points, only 9.3 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 90 percent of the dates of service reviewed in this study. While all five key data elements contributed to L.A. Care’s empirically low all-element accuracy rate, the *Procedure Code Modifier* data element contributed least.

Medical Record Review Recommendations

Based on the study findings for L.A. Care, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, L.A. Care should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.

- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. L.A. Care should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ L.A. Care should avoid using local procedure codes for the encounter data submitted to DHCS.
- ◆ L.A. Care should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code* and *Procedure Code Modifier* data elements and develop strategies to improve rates.
- ◆ L.A. Care should explore the reasons for the relatively high encounter data omission rate for the *Diagnosis Code* data element and take actions to improve rates.
- ◆ L.A. Care should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with L.A. Care.
- ◆ L.A. Care should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.

- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

L.A. Care's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to PACES. Based on review of L.A. Care's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist L.A. Care with improving its encounter data quality. DHCS followed up with L.A. Care regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of L.A. Care's performance in the three domains of care—quality, access, and timeliness.

Quality

As in previous years, L.A. Care's quality improvement program description included detailed documentation of processes the MCP uses to ensure that quality care is provided to beneficiaries.

The rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* measure, which falls into the quality domain of care, improved significantly from RY 2014 to RY 2015; and the improvement resulted in the rate moving to above the HPL. The rates for the following quality measures also improved significantly from RY 2014 to RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, resulting in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*; however, the rate remained below the MPL for the fourth consecutive year.
- ◆ *Controlling High Blood Pressure*.
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*.
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*.

The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the quality domain of care, improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rates for the following quality measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*.
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total*, resulting in the rate moving from above the HPL in RY 2014 to below the MPL in RY 2015.
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total*.

For quality measures stratified by the SPD and non-SPD populations, the SPD rates were significantly better than the non-SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures. The SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure, which is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of L.A. Care's QIPs fell into the quality domain of care. Although the *All-Cause Readmissions* QIP achieved statistically significant improvement over baseline at Remeasurement 1 (RY 2014), the rate for the measure declined significantly from RY 2014 to RY 2015, suggesting that the MCP needs to reassess its QIP and PDSA strategies for reducing readmissions, including referring beneficiaries to the TOC program and using an electronic tool to capture medication reconciliation and PCP appointment scheduling post hospital discharge.

The *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP was not successful at achieving statistically significant improvement over baseline for four consecutive years, suggesting that L.A. Care should reassess causes/barriers to improvement to ensure that quality care is being provided to beneficiaries with diabetes.

Overall, L.A. Care showed average performance related to the quality domain of care.

Access

As in previous years, L.A. Care's quality improvement program description included detailed documentation of processes the MCP uses to ensure access to care for beneficiaries. In L.A. Care's *Quality Improvement Program Annual Report and Evaluation 2014*, the MCP provided descriptions of access-related evaluations, noted many opportunities for improvement, and included action steps for improvement related to specific access-related priorities. Additionally, as in the previous year, the vendor contracted by the MCP to conduct an annual access to care assessment found many opportunities for improvement related to access goals.

The rates improved significantly from RY 2014 to RY 2015 for all four *Children and Adolescents' Access to Primary Care Practitioners* measures, which fall into the quality domain of care.

The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the access domain of care, improved from RY 2014 to RY 2015 and; as noted above, although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rate for the *All-Cause Readmissions* measure, which falls into the access domain of care, was significantly worse in RY 2015 when compared to RY 2014.

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The SPD rates were significantly worse than the non-SPD rates for the following measures:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*

As noted previously, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measure may be attributed to children and adolescents in the SPD population in this age group relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Both of L.A. Care's QIPs fell into the access domain of care. As noted above, the QIP and PDSA cycle results suggest that the MCP needs to reassess its strategies for reducing readmissions and barriers to HbA1c and diabetic retinal exam screenings to ensure access to needed care for the MCP's beneficiaries.

Overall, L.A. Care showed below-average performance related to the access domain of care.

Timeliness

As in previous years, L.A. Care’s quality improvement program description included information on the processes the MCP implements to ensure timeliness of care for beneficiaries.

The rates for the five measures falling into the timeliness domain of care were between the MPLs and HPLs. The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure improved from below the MPL in RY 2014 to above the MPL in 2015.

Overall, L.A. Care 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with L.A. Care’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—L.A. Care’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Demonstrate to the Department of Managed Health Care (DMHC) that the MCP’s actions in the areas of Grievances and Appeals and Utilization Management are sufficient to comply with DMHC requirements.</p>	<ul style="list-style-type: none"> • Improved fax template to request a response on each specific issue. <p>MCP has developed and utilizes the new grievance and new appeal fax cover sheets. The appeals and the grievance fax cover sheets are specific to each of the individual PPGs. The fax cover sheets include the PPG’s “To/Contact” name, department, and fax number as well as the MCP’s contact information. The appeals cover sheet has fields for due date and explanation of timelines for both standard and expedited appeals. The grievance and the appeals fax cover sheets include related DMHC, NCQA, and CMS regulatory elements.</p> <p>The templates are restricted documents with editable fields for specialist to number and enter detail for each specific issue raised by member in the grievance or appeal as well as a comment section to request specific materials or documentation from the PPGs and the due date.</p> <ul style="list-style-type: none"> • Developed a new resolution letter template with a numbering format that prompts the MCP to include all enrollees’ grievances. <p>The new letter templates are restricted documents that include NCQA and CMS standards and editable “Concern” and “Resolution” fields for</p>

2013–14 External Quality Review Recommendation Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>specialist to number and enter detail regarding each concern in the member grievance as well as number and detail for each resolution and action addressing the concern. Letter templates include related DMHC, NCQA, and CMS regulatory elements.</p> <ul style="list-style-type: none"> • Implemented a new monthly training and quarterly regulatory compliance refresher training for the A & G Department. Staff member completed trainings for 2015 include: <ul style="list-style-type: none"> February 2015 – Potential Quality Issue (PQI) Training February 2015 – Quarterly Refresher Training – Medi-Cal (MCAL) Resolution Letters March 2015 – Clinical Assurance Training March 2015 – Process Communication Tracking (PCT) System Training April 2015 – Cultural and Linguistics (C&L) Interpreter Training April 2015 – Employee Assistance Program (EAP) Change Management Training May 2015 – Collaborative Customer Service Training May 2015 – Member Portal Healthx Training June 2015 – Behavioral Health Training June 2015 – Business Writing Training June 2015 – Fraud and Abuse Training (Compliance) June 2015 – Human Resources Training June 2015 – Quarterly Refresher Training–Knox Keene July 2015 – Lesbian, Gay, Bisexual, Transgender/Questioning (LGBT/Q) Training July 2015 – Essette System Training • Implemented an independent internal audit program on July 15, 2015, to assess compliance and report to the Internal Compliance Committee. Audit program scope includes: <ul style="list-style-type: none"> ▪ Tools were developed to include all regulatory standards as well as additional quality elements related to letter quality, readability, and relevance to the members’ issues. ▪ Auditing of A&G cases, letters, and each specialist monthly and quarterly to ensure every issue in the grievance is appropriately investigated and addressed. ▪ Letters are audited monthly using the NCQA 8/30 rule and process. ▪ Results are shared with management in order to develop action plans for improvement as well as to track trends.

2013–14 External Quality Review Recommendation Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>2. Improve the HEDIS audit process by:</p> <ul style="list-style-type: none"> a. Developing long-term solutions to improve its medical services data quality. b. Consider documenting and keeping information related to its new database and the conversion process, including processes; issues; and resolution. c. Ensure that specialty clinics are accurately labeled in its database. 	<p>2. Improve the HEDIS audit process by:</p> <ul style="list-style-type: none"> a. Using long-term solutions that have been put in place to improve the medical services data quality. These are: <ul style="list-style-type: none"> 1. <u>Maintenance of best data sources</u>: L.A. Care has worked with provider groups to receive data directly. L.A. Care has increased its data sources to include lab, immunization, and pharmacy data delivered directly to L.A. Care. 2. <u>Data quality ensured from start to finish</u>: In order to verify that data are sent correctly from providers, groups, and service locations, L.A. Care has meticulously created and shared clear guidelines for technical and formatting specifications for the way data must be sent in order to be processed correctly, minimizing corruption and loss of data. Once data files are received at L.A. Care, notifications from the Data Import Team are sent; and then file is logged on a tracking list. The HEDIS Data Team then obtains the file for quality review. Using SQL Queries/SAS and other methods to check for lack of or incorrectly formatted data, the file is either approved for use or rejected; and a request is sent back to the source for revision with comments of how to correct errors. Once the file is approved for import into Inovalon, the data are again accepted or rejected based on correct formatting and semantics. 3. <u>Manageable schedule</u>: L.A. Care has established a manageable schedule for provider groups to send data so as not to overload the group with too many requests at certain times and to ensure that L.A. Care resources will be available to manage issues with the groups. 4. <u>Consolidated data package requests</u>: To reduce the number of files sent (thereby reducing possibility for errors) the technical and formatting guidelines (mentioned above) include all possible types of files in one package. 5. <u>Recognition of missing data</u>: <i>Provider Opportunity Reports (PORs)</i> have been created and shared with participating provider groups which identify members who are appropriate for interventions, but our data sources do not show that the interventions have been done. This could represent a gap in care but, if not, identifies a problem with data transfer from the group to L.A. Care. If this is the case, we can work with the provider or groups to identify and resolve the problem—which may be at the point of data entry, missing or misformatted data on the summary report

2013–14 External Quality Review Recommendation Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>from the group, corruption in transfer, or problems in receipt or import of data into L.A. Care data repositories or applications.</p> <p>6. <u>Consistent communication</u>: Regular and ad hoc meeting are held with provider groups to discuss any issues and to verify files sent and received. Clear messaging is sent via email only when necessary and with one contact for data issues, for ease of coordination.</p> <p>b. Considering documenting and keeping information related to its new database and the conversion process, including processes, issues, and resolution.</p> <p>L.A. Care transitioned its contracted HEDIS vendor from Verisk to Inovalon this year. In order to be certain of both delivering on time and ensuring the accuracy of reports, contracts remained open with both vendors. All data were processed through both systems in order to verify stability of the new system through the end of February, at which time on-site compliance audits could establish validity as well. Advantages noted with this change were greater flexibility in processing HEDIS data and greater accuracy in the resulting rates.</p> <p>During the transition, a system setup and L.A. Care specific issues were tracked and addressed with the Inovalon implementation staff. Inovalon specifications were then applied to L.A. Care data formats, which were implemented and tested with recurrent data loads. Once the implementation period was complete, an enhancement list was developed that will be tracked to further optimize L.A. Care’s use of Inovalon.</p> <p>For more detail regarding documentation of formatting, L.A. Care has created two standard data submission templates. One is Inovalon format; and another is a simplified version, because some provider groups cannot utilize the full formatting and L.A. Care allows only required fields to be submitted. Trainings and instructions to provider groups were provided to ensure they submit data in either standard format. For those provider groups who only submitted data files in the old Verisk format, we have a process to convert them into the Inovalon standard format. Received data files are checked against the standard quality control process described above. During this process, issues identified and resolved were data duplication, some provider groups being unable to convert their existing formatting programs to the new format, formatting differences between vendors for diagnoses and ICD9 Procedure Codes, limitations on the number of specialties for a provider, and limitations on the number of office locations for a single provider—a learning process for the new vendor’s processing requirements.</p>

2013–14 External Quality Review Recommendation Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>To address several complications in processing the data with two vendors, the group held several internal discussions and resolved as a group (L.A. Care and Inovalon) how best to deal with them. Standard code was developed that all the analysts used to edit and reformat the data, and resulting data validation procedures were implemented. The resulting HEDIS rates were compared between the two systems, and member records with or without compliance between the two systems were examined in detail. The net result was that an error was discovered in processing the new system, Inovalon; and the data were backed out of the system, reedited, and reprocessed. This meant that we began our medical record review later than planned, but we were then comfortable with the accuracy in Inovalon. With Inovalon, however, L.A. Care has greater visibility over the HEDIS data process and is satisfied with the move.</p> <p>c. Ensuring that specialty clinics are accurately labeled in its database.</p> <p>At L.A. Care, the Credentialing department works with Provider Network Operations to verify valid provider status, including legitimate medical license status and board certified specialty and subspecialty designations of all providers. This information is captured in the master provider database. Only specialties listed in that database are used to identify provider specialties within the HEDIS database. L.A. Care Plan Partners, who have delegated responsibility for credentialing, also document the license and specialty information of their own internal providers and have provided that information on their submitted data. Provider groups that work with L.A. Care tend to have a more varied process for documenting this information. Thus, provider information sent from these sources has been challenged historically. When the specialty and license information is missing, these records show “UNKNOWN” for these fields. L.A. Care has access to the Medical Board of California for provider license information, and this is used to populate missing fields with valid information. L.A. Care is developing procedures for license validation to add to our standard data processing for received data to ensure maximal capture of this information. If a discrepancy is noted between medical board and L.A. Care information, the HEDIS Data Team will communicate this to Credentialing and Provider Network Operations.</p> <p>Specialty clinics are designated by attributes in data tables that focus on specialty or location description.</p>
<p>3. Assess the factors leading to the rates for eight measures continuing to be below the MPLs and the rates for seven measures being significantly worse in 2014 when compared to 2013, and identify strategies that have the potential to result in improvement on the rates. For measures below the MPLs for consecutive</p>	<p>L.A. Care conducted a root cause analysis and segmented the results of these measures into three categories:</p> <ol style="list-style-type: none"> 1. Provider: <ol style="list-style-type: none"> a. Low physician awareness and understanding of measures. b. Lack of physician office triggers to identify members who need services at the time of their visit.

2013–14 External Quality Review Recommendation Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>years, the MCP would benefit from evaluating current improvement strategies to determine if they should be modified or discontinued or if new strategies need to be developed.</p> <p>The measures are listed on page 14 and 15 of the 2013–14 report, under the Performance Measure Result Findings.</p>	<ul style="list-style-type: none"> c. Weak outreach strategies to engage the member to obtain services. <ul style="list-style-type: none"> 2. Member: <ul style="list-style-type: none"> a. Poor understanding of the importance of preventive care. b. Difficulty accessing care at times convenient for the member. c. Frequently changing member demographic information such as address and phone. 3. Systems: <ul style="list-style-type: none"> a. Fragmented data aggregation of certain sources, such as pharmacy and lab data. b. Difficulty integrating data from delegated provider systems. <p>Possible interventions addressing the above root causes include:</p> <ul style="list-style-type: none"> 1. Provider: <ul style="list-style-type: none"> a. Provider education was completed during on-site visits conducted by the HEDIS nurses. This involved the nurses reviewing a representative sample of charts and providers being educated regarding the measures and best practices. b. Providers and their staff were educated through the use and distribution of HEDIS Tip Sheets, which define the HEDIS measure, requirements to demonstrate compliance, and best practices. c. Quarterly <i>Provider Opportunity Reports (POR)</i> made available, which reflect the members’ gaps-in-care. These reports are intended to identify members requiring outreach efforts. 2. Member: <ul style="list-style-type: none"> a. Shared pertinent information regarding staying healthy through mailings and member newsletters. b. Implemented member incentive programs to encourage members to obtain specific health services. 3. Systems: <ul style="list-style-type: none"> a. Provided pharmacy data for medication monitoring. b. Developed protocol to reformat data submissions from delegates into L.A. Care system. <p>L.A. Care has mixed results from interventions taken and recognizes that some modifications and adjustments need to happen. We will continue to leverage development of protocols that allow better use of PPG systems and data. Also, will continue direct integration of data from not only pharmacy, but lab and certain vendors, such as VSP (vision service provider). We will modify our provider opportunity</p>

2013–14 External Quality Review Recommendation Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>reports and distribute more frequently rather than quarterly. Looking at the development of opportunity reports for specific low performing measures that give PCPs more concurrent information.</p> <p>Finally, developing strategies based on member relationship to the PCP. If member has been seen within the last 15 months, the strategy will be driven by the PPG and PCP. If member not seen within the last 15 months, the strategy will be driven by the health plan.</p>
<p>4. Since the SPD rates were significantly worse than the non-SPD rates for six measures, assess if improvement efforts are working or if L.A. Care needs to implement new strategies to ensure that the MCP is meeting the SPD population’s health care needs.</p>	<p>The SPD population tends to be sicker and more complex and managed often by a specialist. They also tend to have more interactions with multiple providers. They also will have a focus on chronic conditions versus preventive care. Therefore, SPD members versus non-SPDs:</p> <ul style="list-style-type: none"> • Take more medications for chronic conditions. • Have more admissions, which result in more readmissions. • Have more need for coordination of services. • Have more ambulatory visits for their chronic condition than for preventive services. <p>L.A. Care’s SPD strategies need to be redesigned with an emphasis on prevention and the member’s involvement with appropriate resources that can assist in care coordination. For example, for SPD children, the development of partnerships with regional centers and the California Children’s Services (CCS) program for coordination of care is essential.</p> <p>Additionally, our strategies will include working closely with pharmacy in coordination of medication management and development of stronger transition of care programs partnering with hospitals and PPGs.</p>
<p>5. Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.</p>	<p>We have implemented processes to ensure that all required information is included within the QIP Summary Form. Initially, we ensure that the team focusing on the QIP has an understanding of what is required in developing and submitting the QIP.</p> <p>Additionally, we double and triple check the information prior to submission to ensure all necessary documentation is complete and included.</p>
<p>6. Conduct a new causal/barrier analysis for the <i>Improving HbA1c and Diabetic Retinal Exam Screening Rates</i> QIP; and assess whether interventions should be revised, standardized, scaled up, or discontinued.</p>	<p>We conducted a new root cause analysis and determined:</p> <ul style="list-style-type: none"> • Members lack the awareness of the connection between diabetes and the development of complications, which could be decreased by appropriate monitoring and early detection. • Providers have poor alert systems to trigger when to order an exam during a non-diabetic-related visit.

2013–14 External Quality Review Recommendation Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<ul style="list-style-type: none"> • HbA1c and diabetic retinal exam may not be able to be performed in PCP office. • Services may require an additional visit. <p>Review of current interventions suggests the need for revision of the QIP to include:</p> <ul style="list-style-type: none"> • Development of member outreach strategy based on missing the diabetic eye exam as the trigger. • Initiation of live agent call campaign designed to educate and assist members with getting services. • Development of education materials and opportunity reports identifying members missing these services to be issued every other month. • Development of a partnership with the vision vendor to identify members missing services and leverage the vision vendor’s existing outreach strategies.

Recommendations

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

- ◆ Develop strategies to remedy the significant challenges experienced during the NCQA HEDIS Compliance Audit for the second consecutive year with the MCP’s encounter data processing vendor.
- ◆ Assess the factors leading to the rates for the following measures declining significantly from RY 2014 to RY 2015 or being below the MPL in RY 2015, and implement strategies to prevent further decline in performance or improve performance:
 - *All-Cause Readmissions*
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics*
 - All four *Children and Adolescents’ Access to Primary Care Practitioners* measures
 - *Medication Management for People with Asthma—Medication Compliance 50% Total*
 - *Medication Management for People with Asthma—Medication Compliance 75% Total*

For the *Children and Adolescents’ Access to Primary Care Practitioners* measures, the MCP should build on the improvement achieved from RY 2014 to RY 2015 and strive to improve performance to above the national Medicaid 25th percentiles (i.e., MPLs).

- ◆ Assess whether or not planned strategies designed to ensure that the MCP is meeting the needs of the SPD population were successful since the SPD rates for two measures, *All-Cause Readmissions* and *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, continued to be significantly worse than the non-SPD rates.
- ◆ Although L.A. Care will not be continuing the formal QIPs, the MCP should:
 - Continue to recruit more beneficiaries into the TOC program.
 - Monitor the new TOC program electronic tool for current and accurate data.
 - Consider developing new strategies to address barriers identified through the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix V:
Performance Evaluation Report
Molina Healthcare of California
Partner Plan, Inc.
July 1, 2014 – June 30, 2015**

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Appendix V: Performance Evaluation Report

Molina Healthcare of California Partner Plan, Inc.

July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Molina Healthcare of California Partner Plan, Inc. (“Molina” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

In Riverside and San Bernardino counties, Molina is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a commercial plan (CP) under the Two-Plan Model (TPM). Beneficiaries may enroll in Molina, the CP; or in Inland Empire Health Plan, the alternative “local initiative.”

In Sacramento and San Diego counties, Molina delivers services to its beneficiaries under a Geographic Managed Care (GMC) model. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within a specified geographic area (county).

For Sacramento County, beneficiaries may select from the following MCPs in addition to Molina:

- ◆ Anthem Blue Cross Partnership Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Kaiser NorCal

For San Diego County, beneficiaries may select from the following MCPs in addition to Molina:

- ◆ Care1st Partner Plan
- ◆ Community Health Group Partnership Plan
- ◆ Health Net Community Solutions, Inc.
- ◆ Kaiser SoCal

In Imperial County, Molina delivers services to its beneficiaries under the Imperial Model. Beneficiaries may enroll in Molina or in California Health & Wellness Plan, the alternative CP.

Molina became operational in Riverside and San Bernardino counties to provide MCMC services in December 1997. DHCS allows Molina to combine data for Riverside and San Bernardino counties for reporting purposes. For this report, Riverside and San Bernardino counties are a single reporting unit.

The MCP expanded to Sacramento County in 2000 and San Diego County in 2005. Molina began providing services in Imperial County effective November 1, 2013.

Table 1.1 shows the number of beneficiaries for Molina for each county, the percent of beneficiaries enrolled in the county, and the MCP's total number of beneficiaries as of June 30, 2015.¹

Table 1.1—Molina Enrollment as of June 30, 2015

County	Enrollment as of June 30, 2015	Percent of Beneficiaries Enrolled in the County
Imperial	16,400	24%
Riverside*	80,323	13%
Sacramento	55,506	14%
San Bernardino*	86,586	14%
San Diego	185,795	30%
Total	424,610	

* Note that DHCS allows Molina to report Riverside and San Bernardino counties as a combined rate (i.e., single reporting unit).

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: November 3, 2015.

1115 Waiver Seniors and Persons with Disabilities Enrollment Survey

The most recent Department of Managed Health Care (DMHC) 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey (hereafter referred to as “SPD medical survey”) for Molina was conducted September 16, 2013, through September 19, 2013, covering the review period of June 1, 2012, through May 31, 2013. DMHC assessed the following areas:

- ◆ Utilization Management
- ◆ Continuity of Care
- ◆ Availability and Accessibility of Services
- ◆ Member Rights
- ◆ Quality Management

In a report dated January 24, 2014, DMHC identified potential deficiencies in all areas assessed. DMHC also summarized Molina’s efforts to support SPD enrollees, including the following:

- ◆ Molina conducts comprehensive oversight of each Independent Practice Association that provides care for Molina’s beneficiaries.
- ◆ Molina takes appropriate measures to ensure that new SPD enrollees have an initial risk assessment and are provided with an opportunity to continue care with their existing providers when possible.
- ◆ The MCP dedicates significant effort to ensure that all educational and informational literature sent to enrollees is available in all threshold languages.
- ◆ Molina tracks several SPD-specific measures and reviews them through the MCP’s Quality Management Committee.

In a letter dated October 2, 2014, DHCS stated that on March 3, 2014, Molina provided DHCS with a response to its corrective action plan (CAP) originally issued on January 27, 2014. DHCS stated that it reviewed all remaining open items and found Molina to be in compliance. Therefore, DHCS closed the CAP.

Medical and State Supported Services Audit

DHCS conducted a medical and State Supported Services audit for Molina September 16, 2013, through September 27, 2013, covering the review period of June 1, 2012, through May 31, 2013. DHCS assessed the following areas:

- ◆ Compliance with State Supported Services contract and regulations
- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Availability and Accessibility
- ◆ Member's Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

On January 10, 2014, DHCS issued reports for both portions of the audit. Molina was found to be fully compliant with State Supported Services requirements; however, DHCS identified findings in all areas reviewed under the medical audit. In a letter dated February 2, 2015, DHCS stated that on March 11, 2014, Molina provided DHCS with a response to its CAP originally issued on January 24, 2014. DHCS stated that it reviewed all remaining open items and found Molina to be in compliance. Therefore, DHCS closed the CAP.

Strengths

Molina fully resolved all findings from the MCP's most recent SPD medical survey and medical and State Supported Services audit. During the SPD medical survey, DHCS identified several examples of Molina's efforts to support SPD enrollees.

Opportunities for Improvement

As the MCP fully resolved all findings identified during the most recent SPD medical survey and medical and State Supported Services audit, HSAG has no recommendations for Molina in the area of compliance reviews.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Molina Healthcare of California Partner Plan, Inc.* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that Molina followed the appropriate specifications to produce valid rates, and no issues of concern were identified. The auditor noted that Molina made significant improvements over last year regarding its oversight of vendor file submissions.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 through Table 3.4 for Molina's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1 through Table 3.4

The reader should note the following regarding Table 3.1 through Table 3.4:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
Molina—Imperial County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	S	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	56.81	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	446.79	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	90.05%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	91.03%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	NA	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	40.22%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	34.04%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	85.65%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	77.44%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	46.93%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	54.51%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	86.64%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	25.27%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	81.59%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	67.15%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	40.00%	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	40.00%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	51.89%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	76.22%	Not Comparable
Use of Imaging Studies for Low Back Pain	Q	—	—	—	59.18%	Not Comparable

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	—	80.57%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	—	56.51%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	—	44.37%	Not Comparable
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	—	58.94%	Not Comparable

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* (>9.0%) measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.2—Multi-Year Performance Measure Results*
Molina—Riverside/San Bernardino Counties**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	14.65%	14.03%	15.59%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	43.22	43.60	39.94	39.85	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	285.69	260.50	206.96	354.46	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	81.55%	86.05%	87.83%	85.10%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	92.11%	95.56%	59.38%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	81.41%	84.41%	86.60%	84.02%	↓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	20.13%	30.23%	27.64%	31.68%	↔
Cervical Cancer Screening	Q,A	—	—	60.81%	58.53%	↔
Childhood Immunization Status—Combination 3	Q,A,T	59.63%	63.86%	69.57%	68.21%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	94.88%	93.65%	92.67%	90.64%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	83.76%	83.03%	85.02%	81.86%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	82.68%	81.96%	85.15%	84.29%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	84.19%	84.51%	83.63%	83.18%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	59.33%	56.52%	59.60%	54.75%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	54.83%	46.68%	50.99%	43.93%	↓
Comprehensive Diabetes Care—HbA1c Testing	Q,A	78.65%	81.92%	82.56%	81.68%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	40.00%	43.48%	38.19%	37.75%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	81.80%	83.30%	81.90%	86.31%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	48.76%	43.71%	48.79%	51.43%	↔
Controlling High Blood Pressure	Q	—	53.83%	47.22%	39.82%	↓
Immunizations for Adolescents—Combination 1	Q,A,T	60.88%	69.10%	73.77%	70.83%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	31.87%	43.36%	44.71%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	14.51%	25.22%	22.82%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	43.84%	28.99%	47.46%	43.68%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	77.17%	64.27%	71.52%	68.96%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	76.40%	78.21%	77.08%	74.85%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	44.32%	42.00%	55.19%	76.51%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	64.97%	59.40%	66.00%	69.35%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	57.08%	49.42%	57.40%	52.13%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	74.77%	68.39%	72.73%	66.67%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.3—Multi-Year Performance Measure Results*
Molina—Sacramento County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	13.20%	13.71%	15.15%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	44.96	47.83	50.20	58.83	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	238.15	261.22	257.68	454.21	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	78.84%	73.99%	79.52%	83.95%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	NA	82.86%	50.00%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	74.23%	73.63%	79.48%	82.45%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	28.29%	23.08%	32.39%	27.23%	↔
Cervical Cancer Screening	Q,A	—	—	60.63%	57.27%	↔
Childhood Immunization Status—Combination 3	Q,A,T	50.12%	54.06%	59.42%	59.29%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	95.79%	94.81%	94.51%	89.13%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	84.21%	84.09%	83.89%	80.42%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	83.45%	83.80%	82.85%	80.44%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	83.38%	84.20%	80.58%	79.99%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	58.22%	54.65%	52.76%	53.64%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	56.22%	47.91%	48.79%	48.79%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	81.78%	78.60%	79.25%	77.04%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	46.89%	46.05%	45.25%	44.81%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	83.11%	80.47%	79.47%	80.57%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	40.89%	43.26%	46.36%	43.93%	↔
Controlling High Blood Pressure	Q	—	51.29%	47.23%	50.99%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	55.32%	66.04%	67.33%	68.73%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	31.72%	51.36%	43.43%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	17.24%	22.27%	19.70%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	51.36%	37.47%	43.93%	39.96%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	81.45%	69.62%	74.39%	69.54%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Use of Imaging Studies for Low Back Pain</i>	Q	84.03%	83.24%	81.50%	80.60%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	62.33%	54.61%	45.70%	84.67%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	64.65%	59.34%	56.51%	79.33%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	58.37%	49.65%	49.89%	55.11%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	76.10%	73.21%	67.31%	70.97%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Performance Measure Results*
Molina—San Diego County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	14.45%	14.93%	16.01%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	43.30	45.58	40.54	41.47	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	331.91	305.90	228.23	443.05	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	86.72%	85.15%	86.03%	84.41%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	94.74%	79.66%	56.94%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	85.85%	86.01%	87.07%	84.90%	↓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	18.21%	17.33%	28.29%	28.90%	↔
Cervical Cancer Screening	Q,A	—	—	68.11%	51.02%	↓
Childhood Immunization Status—Combination 3	Q,A,T	73.19%	75.00%	76.89%	74.61%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	94.76%	95.93%	95.73%	93.95%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	88.46%	88.02%	88.81%	86.38%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	87.55%	88.31%	89.06%	89.81%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	83.75%	85.26%	86.20%	87.03%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	62.00%	62.30%	60.71%	58.72%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	56.44%	58.55%	55.63%	60.93%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.44%	88.76%	87.64%	89.85%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	46.22%	57.85%	49.45%	55.19%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	80.22%	84.31%	84.99%	87.42%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	46.67%	32.55%	41.50%	34.44%	▲
Controlling High Blood Pressure	Q	—	52.76%	53.88%	46.44%	↓
Immunizations for Adolescents—Combination 1	Q,A,T	71.30%	80.83%	81.44%	73.78%	↓
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	35.33%	45.12%	46.73%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	18.63%	25.18%	26.42%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	61.40%	51.52%	64.68%	54.20%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	88.94%	79.72%	83.00%	83.21%	↔
Use of Imaging Studies for Low Back Pain	Q	71.98%	72.00%	68.64%	68.42%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	57.67%	64.79%	68.30%	86.31%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	61.86%	65.96%	62.28%	72.41%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	52.33%	55.16%	53.57%	56.51%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	78.89%	74.74%	74.29%	70.06%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.5 through Table 3.12 present a summary of the RY 2015 SPD measure results reported by Molina. Table 3.5 through Table 3.8 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.9 through Table 3.12 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

⁴ 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 3.5 through Table 3.8.

Table 3.5—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Molina—Imperial County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	S	NA	Not Comparable	S
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	90.37%	NA	Not Comparable	90.05%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.07%	NA	Not Comparable	91.03%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	85.65%	NA	Not Comparable	85.65%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	77.36%	NA	Not Comparable	77.44%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	NA	NA	Not Comparable	NA
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	NA	NA	Not Comparable	NA

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 3.6—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Molina—Riverside/San Bernardino Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	10.87%	19.55%	▼	15.59%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.73%	85.53%	↔	85.10%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	59.38%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.25%	84.93%	↔	84.02%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	90.92%	NA	Not Comparable	90.64%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	81.89%	80.74%	↔	81.86%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	84.31%	83.99%	↔	84.29%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	83.65%	75.52%	↓	83.18%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.7—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Molina—Sacramento County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	10.98%	16.14%	▼	15.15%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.15%	84.69%	↔	83.95%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	50.00%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.02%	85.01%	↑	82.45%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	89.21%	NA	Not Comparable	89.13%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	80.54%	75.00%	↔	80.42%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	80.57%	77.42%	↔	80.44%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	80.93%	70.32%	↓	79.99%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.8—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Molina—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	14.02%	18.01%	▼	16.01%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.18%	85.90%	↑	84.41%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	56.86%	Not Comparable	56.94%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	82.50%	88.06%	↑	84.90%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	93.94%	NA	Not Comparable	93.95%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.40%	85.64%	↔	86.38%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	89.86%	88.47%	↔	89.81%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	87.20%	83.53%	↓	87.03%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

**Table 3.9—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Molina—Imperial County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
440.92	55.82	899.94	132.65

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

**Table 3.10—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Molina—Riverside/San Bernardino Counties**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
335.56	37.13	571.37	71.10

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

**Table 3.11—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Molina—Sacramento County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
384.77	54.54	799.21	80.14

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

**Table 3.12—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
Molina—San Diego County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
398.66	38.26	913.25	75.48

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

Table 3.13 through Table 3.16 present the three-year trending information for the SPD population, and Table 3.17 through Table 3.20 present the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.13—RY 2015 (MY 2014) HEDIS SPD Trend Table
Molina—Imperial County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	NA	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	132.65	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	899.94	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	NA	Not Comparable

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.14—RY 2015 (MY 2014) HEDIS SPD Trend Table
Molina—Riverside/San Bernardino Counties**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	18.15%	16.27%	19.55%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	67.24	72.83	71.10	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	346.49	312.01	571.37	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.80%	89.83%	85.53%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	90.63%	95.00%	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.06%	89.26%	84.93%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	79.18%	78.45%	80.74%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	84.52%	83.40%	83.99%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	83.44%	76.02%	75.52%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.15—RY 2015 (MY 2014) HEDIS SPD Trend Table
Molina—Sacramento County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	14.68%	15.39%	16.14%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	65.28	68.46	80.14	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	415.9	423.73	799.21	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	74.59%	80.05%	84.69%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	83.87%	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	74.40%	80.25%	85.01%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	79.27%	80.95%	75.00%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	87.88%	79.07%	77.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	79.40%	74.85%	70.32%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.16—RY 2015 (MY 2014) HEDIS SPD Trend Table
Molina—San Diego County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	17.65%	17.07%	18.01%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	61.02	71.93	75.48	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	512.86	434.68	913.25	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.79%	87.49%	85.90%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	94.12%	80.36%	56.86%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.10%	88.57%	88.06%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	80.65%	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	84.13%	86.83%	85.64%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.63%	84.92%	88.47%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.01%	81.87%	83.53%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.17—RY 2015 (MY 2014) Non-SPD Trend Table
Molina—Imperial County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	S	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	55.82	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	440.92	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	90.37%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	90.07%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	85.65%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	77.36%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	NA	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.18—RY 2015 (MY 2014) Non-SPD Trend Table
Molina—Riverside/San Bernardino Counties**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.17%	8.46%	10.87%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	40.14	35.41	37.13	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	247.94	192.15	335.56	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.14%	83.84%	84.73%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.14%	81.00%	83.25%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	93.77%	92.80%	90.92%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.13%	85.22%	81.89%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	81.88%	85.22%	84.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.55%	84.03%	83.65%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.19—RY 2015 (MY 2014) Non-SPD Trend Table
Molina—Sacramento County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.02%	7.34%	10.98%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	42.97	44.36	54.54	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	218.18	204.58	384.77	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	71.60%	77.06%	83.15%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	70.51%	75.81%	80.02%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	94.90%	94.72%	89.21%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	84.18%	83.98%	80.54%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	83.64%	83.01%	80.57%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	84.55%	81.09%	80.93%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.20—RY 2015 (MY 2014) Non-SPD Trend Table
Molina—San Diego County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.37%	8.52%	14.02%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	43.19	35.84	38.26	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	273.91	197.22	398.66	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.63%	81.81%	83.18%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.40%	82.50%	82.50%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.16%	95.85%	93.94%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.11%	88.86%	86.40%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.25%	89.22%	89.86%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	85.32%	86.40%	87.20%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

RY 2015 was the first year Molina reported rates for Imperial County; therefore, DHCS did not hold the MCP accountable to meet the MPLs in this county. While DHCS did not hold the MCP accountable to meet the MPLs in Imperial County, HSAG includes the performance measure results in its analysis of Molina’s performance to assist DHCS and Molina in assessing the MCP’s overall performance related to established benchmarks.

The rates for the following measures were above the HPLs in RY 2015:

- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in San Diego County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total* in Sacramento County and San Diego County

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total* in Sacramento County

The rates for the following measures were significantly better in RY 2015 when compared to RY 2014:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Sacramento County; however, the rate remained below the MPL for the fourth consecutive year
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Sacramento County; however, the rate remained below the MPL for the fourth consecutive year
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* in San Diego County
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in San Diego County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total* in Riverside/San Bernardino counties, Sacramento County, and San Diego County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total* in Sacramento County and San Diego County

The rates for the following measures improved from RY 2014 to RY 2015. Although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Sacramento County
- ◆ *Controlling High Blood Pressure* in Sacramento County
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Sacramento County

As in previous years, Molina demonstrated many opportunities for improvement. Across all counties, 16 rates declined significantly from RY 2014 to RY 2015, and the decline resulted in the rates for eight measures moving from above the MPLs in RY 2014 to below the MPLs in RY 2015. In total, 46 rates were below the MPLs across all counties (including Imperial County), with 17 rates being below the MPLs for three or more consecutive years.

Seniors and Persons with Disabilities Findings

With the exception of the *Ambulatory Care* measures (for which no comparisons are made), Molina was not able to report any SPD rates for Imperial County due to the denominators for all measures being less than 30; therefore, no comparisons could be made between the SPD and non-SPD rates for this county.

The following is a summary of the SPD versus non-SPD rate comparisons across Riverside/San Bernardino, Sacramento, and San Diego counties:

- ◆ The SPD rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure in San Diego County was significantly better than the non-SPD rate.
- ◆ The SPD rates for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure in Sacramento County and San Diego County were significantly better than the non-SPD rates.
- ◆ The SPD rates for all counties for the following measures were significantly worse than the non-SPD rates:
 - *All-Cause Readmissions*
 - *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure may be attributed to beneficiaries in this age group in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

The following is a summary of the comparison between the RY 2015 and RY 2014 SPD rates across Riverside/San Bernardino, Sacramento, and San Diego counties:

- ◆ The SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE or ARBs* and *Diuretics* measures in Sacramento County were significantly better in RY 2015 when compared to RY 2014.
- ◆ The SPD rates for the following measures in Riverside/San Bernardino counties were significantly worse in RY 2015 when compared to RY 2014:
 - *All-Cause Readmissions*
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The following is a summary of the comparison between the RY 2015 and RY 2014 non-SPD rates across Riverside/San Bernardino, Sacramento, and San Diego counties:

- ◆ The non-SPD rate for the *Annual Monitoring for Patients on Persistent Medications—ACE or ARBs* measure in Sacramento County was significantly better in RY 2015 when compared to RY 2014.

- ◆ The non-SPD rates in all counties for the *Children and Adolescents' Access to Primary Care practitioners—12 to 24 Months* and *25 Months to 6 Years* measures declined significantly from RY 2014 to RY 2015.
- ◆ The non-SPD rate for the *7 to 11 Years* measure in Sacramento County declined significantly from RY 2014 to RY 2015.
- ◆ The non-SPD rate for the *All-Cause Readmissions* measure in San Diego County was significantly worse in RY 2015 when compared to RY 2014.

Assessment of Improvement Plans

Molina had five existing and four new improvement plans (IPs) in MY 2014. The following is a summary of each IP and HSAG's analysis of the progress the MCP made on improving performance on the measures.

Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics

Molina submitted a Plan-Do-Study-Act (PDSA) cycle to DHCS that encompassed both the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures for Sacramento County. The MCP targeted beneficiaries assigned to one clinic who required lab work. The MCP implemented the following interventions:

- ◆ Identified beneficiaries who needed a lab test.
- ◆ Conducted provider engagement and staff education.
- ◆ Conducted outreach calls to beneficiaries identified as noncompliant.

The results of the PDSA cycle will be used as the baseline for improvement. The MCP noted that periodic data refresh results in a change in the beneficiaries included in the noncompliant population, which changes the target population for the beneficiary outreach. The MCP also found that outreach conducted at the clinic has proven to be effective.

While the rates for both measures in Sacramento County improved significantly from RY 2014 to RY 2015, the rates remained below the MPLs; and Molina will be required to continue its PDSA cycles for these measures for Sacramento County. Additionally, the rates for these measures were below the MPLs in Riverside/San Bernardino counties and San Diego County; so the MCP will be required to conduct PDSA cycles for these counties based on the RY 2015 rates.

Childhood Immunization Status—Combination 3

Based on RY 2014 results, the MCP was required to continue its IP for the *Childhood Immunization Status—Combination 3* measure in Sacramento County. The MCP conducted three PDSA cycles to improve the rate on the measure. The MCP's plan was to obtain immunization data from the California Immunization Registry (CAIR) and Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM 160 form). Additionally, the MCP conducted beneficiary outreach.

To assist Molina with improving its rate in Sacramento County for the *Childhood Immunization Status—Combination 3* measure, DHCS facilitated two conference calls—one with CAIR and one with the San Diego Immunization Registry—to identify barriers to the MCP obtaining accurate registry information. CAIR also conducted a webinar for MCPs and providers in January 2015 on registry inputs, reports, and resources.

While the MCP reported an increase in the administrative rate as a result of its improvement efforts, the MCP's rate reported through the NCQA HEDIS Compliance Audit process was slightly lower than the RY 2014 rate; therefore, the MCP will be required to continue its IP/PDSA cycle process in Sacramento County to improve the rate to above the MPL.

Controlling High Blood Pressure

Molina submitted a combined IP for the following measures:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* for Sacramento County
- ◆ *Controlling High Blood Pressure* for Riverside/San Bernardino counties and Sacramento County

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

- ◆ Beneficiaries ages 56–65 having a higher rate of hypertension diagnoses and higher rate of noncompliance with the treatment regimen compared to beneficiaries ages 18–55
- ◆ Beneficiaries lacking knowledge regarding having uncontrolled blood pressure
- ◆ Providers' lack of knowledge of the current clinical practice guidelines for hypertension and implementing different treatment protocols
- ◆ Primary care providers (PCPs) lacking awareness of their assigned beneficiaries' hypertension diagnoses and need for annual visits and appropriate treatment
- ◆ Beneficiaries lacking understanding of the importance of controlling hypertension and taking prescribed medications

The MCP implemented the following interventions to address the barriers:

- ◆ Produced and sent a report to PCPs with a list of beneficiaries each in need of an annual visit for hypertension.
- ◆ Distributed to PCPs the clinical practice guidelines on treatment of hypertension.
- ◆ Conducted beneficiary outreach calls to increase medication compliance.
- ◆ Conducted beneficiary education and outreach through distribution of postcards.

Molina also submitted PDSA cycles related to controlling high blood pressure as part of the MCP's *Improving Hypertension Control* QIP. A summary of each PDSA cycle is included in the "Quality Improvement Projects" section of this report.

As a result of the MCP's improvement efforts, the rates in Sacramento County for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *Controlling High Blood Pressure* measures improved to above the MPLs in RY 2015. Unfortunately, the rate for the *Controlling High Blood Pressure* measure in Riverside/San Bernardino counties declined significantly from RY 2014 to RY 2015 and remained below the MPL. Molina will be required to continue the IP/PDSA cycle process in Riverside/San Bernardino counties. Additionally, the MCP will be required to add San Diego County to the IP/PDSA cycle for the *Controlling High Blood Pressure* measure since the rate for this measure declined significantly from RY 2014 to RY 2015, moving the rate to below the MPL.

Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)

Molina submitted a new IP for the *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* measure for Riverside/San Bernardino counties. The MCP identified the following barriers to the rate being above the MPL:

- ◆ Beneficiaries lacking knowledge about self-care
- ◆ Providers lacking awareness of beneficiaries with poor HbA1c control
- ◆ Providers lacking awareness of the need for HbA1c testing

Molina implemented the following beneficiary-level interventions to address the barriers:

- ◆ Conducted telephonic outreach to discuss needed services and coordinate care.
- ◆ Contracted with vendors to perform in-home lab tests.
- ◆ Sent postcards to beneficiaries reminding them to schedule their follow-up appointments with their provider. The postcard included a place for the beneficiary to log their appointments and test results.

Molina implemented the following provider-level interventions to address the barriers:

- ◆ Conducted outreach to provide PCPs and provider staff members with information on beneficiaries with missing or uncontrolled HbA1c results so that the PCPs/providers could follow up with the beneficiaries. Additionally, provided information on clinical practice guidelines for beneficiaries with diabetes.
- ◆ Produced a provider profile report to inform providers of goals relevant to quality performance and a scorecard on select HEDIS measures to present to providers.
- ◆ Conducted telephonic outreach to remind providers to schedule appointments for beneficiaries with uncontrolled HbA1c levels or in need of testing.
- ◆ Sent providers test results from the in-home lab tests.

The MCP's improvement efforts did not result in the rate for the measure moving to above the MPL, and Molina will be required to continue its IP for this measure in Riverside/San Bernardino counties.

Medication Management for People with Asthma—Medication Compliance 50% Total

Molina submitted a new IP for Riverside/San Bernardino counties for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure. The MCP identified the following barriers to the rate being above the MPL:

- ◆ Beneficiaries being noncompliant with asthma controller medication, especially beneficiaries in the child population
- ◆ Providers lacking awareness of beneficiary noncompliance with prescribed asthma controller medication
- ◆ Beneficiaries relying on emergency care for their rescue medication prescriptions

Molina implemented several interventions to address the barriers, including:

- ◆ Mailed postcards to beneficiaries who had filled three or more prescriptions for rescue medications within a three-month period and who had not filled a prescription for an asthma controller medication. The postcard encouraged beneficiaries to talk with their PCP.
- ◆ Mailed letters to providers listing beneficiaries who had filled three or more prescriptions for rescue medications within a three-month period and who had not filled a prescription for an asthma controller medication, to encourage the providers to conduct outreach to these beneficiaries to remind them to fill their prescriptions.

- ◆ Conducted on-site provider visits and meetings with providers to discuss the clinical guidelines for medication management for people with asthma and for identifying beneficiaries noncompliant with their asthma controller medication.
- ◆ Conducted telephonic outreach to parents of the children who had had an emergency room visit with an asthma or respiratory diagnosis.

Molina also submitted a PDSA cycle for the *Medication Management for People with Asthma—Medication Compliance 50% Total* measure. The MCP identified children ages 5 to 17 years old diagnosed with persistent asthma and who had not consistently filled their asthma controller medication and sent notification to the beneficiaries' providers to follow up with the beneficiaries. Molina reported that it experienced a delay in implementing the test of change, and the MCP identified changes that needed to be made to the data collection methodology. The MCP indicated that it planned to make improvements to the process and continue to test the intervention.

Molina's improvement efforts resulted in slight improvement in the rate; however, the rate remained below the MPL, and the MCP will be required to continue the IP/PDSA cycle process for Riverside/San Bernardino counties. Additionally, the MCP will be required to add Sacramento and San Diego counties to the IP/PDSA cycle for the measure since the rates for this measure in both counties moved to below the MPL in RY 2015.

Prenatal and Postpartum Care—Postpartum Care

Based on RY 2014 results, the MCP was required to continue its IP for the *Prenatal and Postpartum Care—Postpartum Care* measure in Riverside/San Bernardino counties and Sacramento County; however, the MCP included San Diego County in its improvement efforts. Molina indicated that the main barrier to the rate being above the MPL was identifying beneficiaries needing postpartum visits. The MCP continued to conduct beneficiary and provider outreach and modified its beneficiary incentive program. Additionally, the MCP began identifying beneficiaries who needed postpartum visits by using prior authorization requests for labor and delivery.

In addition to the interventions above, Molina submitted information on two PDSA cycles it tested. The following is a summary of each cycle:

- ◆ Molina identified beneficiaries hospitalized for births through prior authorization requests and conducted outreach with the identified beneficiaries to schedule a postpartum visit for each. The MCP reported that the number of beneficiaries reached in July 2014 and August 2014 was significantly higher than the number reached in September through December 2014 and indicated that the holiday season was a barrier to reaching beneficiaries for follow-up. When assessing interim rates, the MCP noted improvement in the rate for Sacramento County and a slight decline in the rate for Riverside/San Bernardino counties. The MCP planned to continue the outreach intervention, combined with aggressive promotion of the beneficiary incentive program, and to allocate additional staff members to conduct the outreach calls.

- ◆ Molina identified beneficiaries hospitalized for births through prior authorization requests to conduct outreach to increase participation in the beneficiary incentive program. The MCP noted that while fewer beneficiaries were identified through the prior authorization method than anticipated, the MCP was able to increase the number of beneficiaries successfully contacted and the number who opted in to the beneficiary incentive program from Quarter 4, 2014 to Quarter 1, 2015. The MCP planned to adapt the intervention to continue beneficiary and provider outreach to promote the beneficiary incentive program and allocate additional staff members to conduct the outreach calls.

Molina's efforts did not result in the rates for Riverside/San Bernardino counties and Sacramento County improving to above the MPLs. The MCP will be required to continue its IP/PDSA cycle process for these counties. Additionally, the MCP will be required to add San Diego County to the IP/PDSA cycle for the measure since the rate for this measure in San Diego County declined significantly from RY 2014 to RY 2015, resulting in the rate moving to below the MPL in RY 2015.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

Based on RY 2014 results, the MCP was required to continue its IP for the *Prenatal and Postpartum Care—Postpartum Care* measure in Riverside/San Bernardino counties and Sacramento County. The MCP identified the following new barriers to the rates being above the MPLs:

- ◆ Outreach staff members being temporarily reassigned to other duties
- ◆ Beneficiaries being difficult to reach during the holiday months

Molina also stated that identifying eligible beneficiaries continued to be a barrier.

The MCP continued to implement the following interventions to address the barriers:

- ◆ Identified eligible beneficiaries through provider pregnancy notification reports, notifications from Medi-Cal enrollment files, and pharmacy administrative data on prenatal vitamins.
- ◆ Conducted telephonic beneficiary outreach.
- ◆ Implemented the Motherhood Matters program, which provided education and resources to pregnant beneficiaries.

Additionally, Molina modified the Motherhood Matters program to include incentives.

In addition to the interventions above, Molina submitted information on two PDSA cycles it tested. For both cycles, the MCP tested whether or not identifying beneficiaries through provider pregnancy notification reports, notifications from Medi-Cal enrollment files, and pharmacy administrative data on prenatal vitamins would result in an increase in the number of beneficiaries contacted through outreach efforts. As with the outreach efforts related to the *Postpartum Care*

measure, Molina noted that fewer beneficiaries were reached during the September through December 2014 time frame. Additionally, the MCP indicated that the PDSA cycles were not able to be carried out as planned due to staff members being reallocated. Molina planned to adapt the test of change to increase the success of the outreach efforts. The MCP will continue to engage providers to promote the beneficiary incentive program and provide education on ways to improve the *Timeliness of Prenatal Care* rates.

Molina's efforts did not result in the rates for Riverside/San Bernardino counties and Sacramento County improving to above the MPLs. The MCP will be required to continue its IP/PDSA cycle process for these counties.

Use of Imaging Studies for Low Back Pain

Based on RY 2014 results, the MCP was required to continue its IP for the *Use of Imaging Studies for Low Back Pain* measure in San Diego County. The MCP tested interventions through a PDSA cycle process, which included facilitating discussions with hospital leadership about protocols for ordering imaging studies for beneficiaries with a new diagnosis of low back pain and current NCQA guidelines for imaging studies. Molina reported that, based on the timing of the MCP implementing the interventions, improvement was not seen until Quarter 3 of 2014. Molina noted that the MCP made improvements to its data collection methodology and that it planned to continue to test the interventions. Additionally, Molina stated that it planned to expand the intervention to the MCP's low-performing, highest-volume federally qualified health center.

Molina's improvement efforts did not result in the rate moving to above the MPL, and the MCP will be required to continue the IP/PDSA cycle process for this measure.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Molina submitted a new IP for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure for Sacramento County. The MCP indicated that the main barrier to the rate being above the MPL was incomplete medical record documentation. Molina noted that many providers were still in the process of converting paper records to electronic medical records (EMRs) and that EMRs are more complete than the paper records. The MCP implemented the following interventions to address the barriers:

- ◆ Assigned a quality improvement nurse to conduct focused medical record reviews.
- ◆ Conducted face-to-face visits with providers to address documentation deficiencies.
- ◆ Provided tools to providers to help improve documentation compliance.
- ◆ Provided performance feedback to providers.

The rate for the measure improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving to above the MPL in RY 2015. The MCP will not be required to continue the IP for this measure based on RY 2015 results.

Required Improvement Plans for RY 2015

In addition to the IPs/PDSA cycles noted above that Molina will need to continue or newly implement based on RY 2015 performance measure results, the MCP will be required to submit new IPs for the following measures. Note that DHCS may allow the MCP to implement improvement strategies for one or more of the measures through the performance improvement project (PIP) process (known as the QIP process for the current review period).

- ◆ *Cervical Cancer Screening* for San Diego County
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Riverside/San Bernardino counties
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* for Sacramento County
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total* for Riverside/San Bernardino counties and Sacramento County

Strengths

HSAG auditors determined that Molina followed the appropriate specifications to produce valid rates, and no issues of concern were identified. The auditor also noted that Molina made significant improvements from last year with its oversight of vendor file submissions.

Across all counties, the rates for four measures were above the HPLs, and the rates for nine measures were significantly better in RY 2015 when compared to RY 2014. Additionally, the rates for three measures improved from below the MPLs in RY 2014 to above the MPLs in RY 2015.

Opportunities for Improvement

As noted in previous years, Molina continues to have many opportunities for improvement related to performance measures. Across all counties, 16 rates declined significantly from RY 2014 to RY 2015, and the decline resulted in the rates for eight measures moving from above the MPLs in RY 2014 to below the MPLs in RY 2015. In total, 46 rates were below the MPLs across all counties (including Imperial County), with 17 rates being below the MPLs for three or more consecutive years. Of the most noteworthy county-specific changes, while in RY 2014 San Diego County had only one measure with a rate below the MPL (not counting the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure), in RY 2015 San Diego County had eight measures with rates below the MPLs. HSAG recommends that Molina work closely with DHCS to identify priority areas for improvement and that the MCP utilize DHCS and the EQRO for technical assistance to help increase the potential for improved outcomes.

Quality Improvement Project Objectives

Molina participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

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

**Table 4.1—Quality Improvement Projects for Molina
July 1, 2014, through June 30, 2015**

QIP	Counties	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Riverside/San Bernardino, Sacramento, and San Diego	Clinical	Q, A
<i>Improving Hypertension Control</i>	Riverside/San Bernardino, Sacramento, and San Diego	Clinical	Q, A

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

Molina’s *Improving Hypertension Control* QIP evaluated whether beneficiaries’ blood pressure was controlled. Controlled blood pressure in beneficiaries with hypertension is associated with reductions in stroke, myocardial infarction, and heart failure incidences. At the initiation of the QIP, the percentage of hypertensive beneficiaries with controlled blood pressure ranged between 56.6 to 66.4 percent for Molina’s counties. For this QIP, the rates for Riverside and San Bernardino counties are combined to be consistent with HEDIS reporting since the project outcome is a HEDIS measure; Sacramento and San Diego counties’ rates are reported separately.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
Molina—Riverside/San Bernardino, Sacramento, and San Diego Counties
July 1, 2014, through June 30, 2015**

Name of Project/Study	Counties	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>	Riverside/San Bernardino	Annual Submission	88%	100%	<i>Met</i>
	Sacramento and San Diego received the same score.	Annual Submission	85%	100%	<i>Met</i>
Internal QIPs					
<i>Improving Hypertension Control</i>	Riverside/San Bernardino and Sacramento received the same score.	Annual Submission	86%	90%	<i>Partially Met</i>
	San Diego	Annual Submission	80%	90%	<i>Partially 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, 2014, through June 30, 2015, showed that Molina’s annual submission of its *All-Cause Readmissions* QIP received a *Met* validation status, with 100 percent of the critical evaluation elements receiving a *Met* score in all counties. The *Improving Hypertension Control* QIP annual submission achieved an overall validation status of *Partially Met* in all counties. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a PDSA cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, Molina conducted a PDSA cycle for the *Improving Hypertension Control* QIP.

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

Table 4.3—Quality Improvement Project Average Rates*
Molina—Riverside/San Bernardino, Sacramento, and San Diego Counties
(Number = 6 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

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	100%	0%	0%
Design Total		100%	0%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	96%	4%	0%
	VIII: Appropriate Improvement Strategies**	63%	38%	0%
Implementation Total		85%	15%	0%
Outcomes	IX: Real Improvement Achieved	29%	0%	71%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		29%	0%	71%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for both Molina’s *All-Cause Readmissions* and *Improving Hypertension Control* QIP annual submissions.

Molina demonstrated a strong application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP demonstrated an adequate application of the Implementation stage, meeting 85 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *All-Cause Readmissions* QIP, Molina did not report the evaluation of all interventions implemented during Remeasurement 1, resulting in a lowered score for Activity VIII. For the *Improving Hypertension Control* QIP, the MCP did not accurately calculate the percentage point difference and statistical testing between baseline and Remeasurement 4 for San Diego County, resulting in a slightly lowered score for Activity VII. In addition, Molina provided incomplete causal/barrier analysis and evaluation of the interventions implemented during Remeasurement 4, which lowered the score for Activity VIII. Molina received a low score for Activity IX because

neither QIP achieved statistically significant improvement over baseline. Although the study indicator for the *All-Cause Readmissions* QIP in Riverside/San Bernardino County demonstrated decline over baseline, the improvement was not statistically significant. Activity X was not assessed since sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for Molina—Riverside/San Bernardino, Sacramento, and San Diego Counties
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions						
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]						
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13		Sustained Improvement [‡]		
Riverside/San Bernardino	14.7%	14.0%		‡		
Sacramento	13.2%	13.7%		‡		
San Diego	14.5%	14.9%		‡		
QIP #2—Improving Hypertension Control						
Study Indicator: Percentage of members 18 to 85 years of age who had both a systolic and diastolic blood pressure of <140/90						
County	Baseline Period 1/1/09–12/31/09	Remeasurement 1 1/1/10–12/31/10	Remeasurement 2 1/1/11–12/31/11	Remeasurement 3 1/1/12–12/31/12	Remeasurement 4 1/1/13–12/31/13	Sustained Improvement [‡]
Riverside/San Bernardino	59.6%	42.6%*	53.7%*	53.8%	47.2%*	‡
Sacramento	56.6%	50.8%	53.1%	51.3%	47.2%	‡
San Diego	66.4%	58.3%*	55.0%	52.8%	53.9%	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

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

All-Cause Readmissions QIP

Molina's goal for the *All-Cause Readmissions* QIP was to decrease the readmissions rate to 12.2 percent at Remeasurement 1 in each county. Unfortunately, the MCP did not meet the project's goal for all counties. Although the readmissions rate decreased in Riverside/San Bernardino County, the change was not statistically significant. Molina's readmissions rates in Sacramento and San Diego counties increased slightly at Remeasurement 1. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ The readmission rates for non-SPD beneficiaries declined for all counties.
- ◆ Molina identified the top five diagnoses for the readmissions that occurred during Remeasurement 1 to be infectious diseases, coronary heart failures, Type 2 diabetes, pulmonary diseases, and gastrointestinal diseases.
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions Molina indicated it implemented during the Remeasurement 1 time period:
 - Conducted inpatient review rounds with the MCP's medical director and utilization management staff to discuss beneficiaries currently hospitalized. (Beneficiaries were identified for case management prior to hospital discharge.)
 - Case managers made a "Welcome Home" call to the beneficiary within 24 hours of discharge. The purpose of the call was to both determine that the beneficiary understood the discharge instructions and confirm that the beneficiary scheduled the follow-up appointment with the PCP.
 - Conducted Interdisciplinary Care Team meetings with the MCP's medical directors and care/case managers to address all aspects of beneficiaries' health care, including medical, behavioral, and social health needs. Care transition clinicians communicated discharge plans to physicians and other community service providers to ensure appropriate follow-up care of beneficiaries after discharge.
 - Encouraged beneficiaries to be active participants in their own care.
 - Hired more case managers, community health workers, and support staff to assume more responsibility for beneficiaries' discharge planning.
 - Upon admission to the MCP case management program, provided timely verbal and written communication of beneficiary issues, interventions, and medication adjustments to the PCP.
 - Notified PCPs of beneficiary admission and discharge and provided discharge plans to the PCPs.
 - Facilitated safe discharges by making on-call discharge staff available after hours, on weekends, and on holidays.

- Care managers arranged for in-home support services so beneficiaries received required care in the community. Additionally, community health workers were assigned to beneficiaries to provide social support.
- Care managers, community connectors, or beneficiary services staff assisted beneficiaries in arranging all transportation related to health care.
- Care managers, community connectors, and beneficiary services staff continually educated beneficiaries regarding their plan benefits, health problems, treatment requirements and options, use of translator services, and use of other support services to optimize recovery and prevent health problems.

Improving Hypertension Control QIP

Molina submitted Remeasurement 4 results for the *Improving Hypertension Control QIP*. The rates for all counties remained below the baseline rate at Remeasurement 4. A review of the MCP's QIP Summary Form and QIP Validation Tools revealed the following:

- ◆ The study indicator rate decreased significantly from Remeasurement 3 to Remeasurement 4 in Riverside/San Bernardino counties.
- ◆ Based on Remeasurement 3 intervention evaluation, Molina discontinued the *Hypertension Pharmacy Profile* reports for Remeasurement 4.
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions Molina indicated it continued to implement during the Remeasurement 4 time period:
 - Sent postcards to beneficiaries.
 - Distributed *Needed Services* report to increase PCPs' awareness of beneficiaries' hypertension diagnosis and needed treatments.
 - Circulated newsletters and clinical practice guidelines to PCPs.
- ◆ Due to the continued decline in performance of the QIP's study indicator, the MCP indicated it planned to implement the following during 2014:
 - Conduct quality improvement redesign to standardize best practice tools and build quality function into the organizational structure across various departments.
 - Implement the Provide Engagement Project to provide expert resources that work with designated provider groups to improve provision and documentation of quality health care for beneficiaries.
 - Distribute monthly the Provider Profile & Scorecard to inform providers of the goals relevant to quality performance.

Plan-Do-Study-Act Review

The *Improving Hypertension Control* QIP did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for the QIP topic.

For the *Controlling Blood Pressure* PDSA cycle, Molina set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective for each county as follows:

By March 31, 2015, increase the rate of controlled blood pressure compliance for 30 percent of beneficiaries in an identified high-volume provider group [in each county] by conducting targeted provider engagement visits.

The purpose of the *Controlling Blood Pressure* PDSA cycle was to test if conducting provider engagement visits will increase the *Controlling Blood Pressure* compliance rate for 30 percent of beneficiaries assigned to a targeted high-volume provider in all counties.

Molina completed the *Controlling Blood Pressure* PDSA cycle as planned. The percentage of beneficiaries with controlled blood pressure increased for all four counties, as indicated in Table 4.5.

Table 4.5—Controlling Blood Pressure PDSA Cycle Results

County	Percentage of Beneficiaries with Controlled Blood Pressure during Date of Service from January 1, 2015, through January 31, 2015	Percentage of Beneficiaries with Controlled Blood Pressure during Date of Service from January 1, 2015, through March 31, 2015
Imperial	26.09%	47.83%
Riverside/San Bernardino	32.16%	51.46%
Sacramento	19.12%	38.82%
San Diego	29.19%	54.30%

The MCP indicated plans to adapt the change and to conduct an additional PDSA cycle to test the following:

- ◆ Allow the HEDIS Team to schedule and coordinate the office visits with the targeted high-volume providers.
- ◆ Have the Compliance Team gather and prepare pertinent materials and beneficiary noncompliance lists prior to the provider engagement visits.
- ◆ Conduct informational sessions with provider and office staff to review the *Controlling Blood Pressure* measure and the provider toolkit.
- ◆ Distribute the beneficiary noncompliance lists, pertinent materials, and provider toolkits to the respective providers at the time of the visit to increase the compliance rate.

Strengths

Molina demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Improving Hypertension Control* QIPs. The *All-Cause Readmissions* QIP achieved a *Met* validation status the first submission.

The *Controlling Blood Pressure* PDSA cycle results indicated that Molina's test of change was successful at increasing the number of beneficiaries with controlled blood pressure.

Opportunities for Improvement

Although Molina will not be continuing the formal QIPs, the MCP should continue to implement strategies to improve the *All-Cause Readmissions* rate. In addition, the MCP should conduct additional PDSA cycles to test the changes as indicated in the *Controlling Blood Pressure* PDSA Cycle Worksheet. Instead of testing all indicated changes at once, HSAG recommends that Molina conduct PDSA cycles for each test of change separately to identify which interventions truly impact the *Controlling Blood Pressure* rate.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

Molina’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for Molina. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for Molina

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	21.7%	26.3%	25th–75th	9.6%	9.2%	25th–75th
Diagnosis Code	28.8%	31.6%	25th–75th	30.0%	34.6%	25th–75th
Procedure Code	34.9%	43.8%	25th–75th	19.9%	22.5%	25th–75th
Procedure Code Modifier	44.5%	58.5%	75th–90th	39.4%	46.0%	25th–75th
Rendering Provider Name	18.9%	25.0%	75th–90th	25.3%	68.1%	75th–90th
Billing Provider Name	28.4%	35.0%	25th–75th	9.8%	8.6%	25th–75th

Overall, the medical record omission rates for Molina ranged from 18.9 percent (*Rendering Provider Name*) to 44.5 percent (*Procedure Code Modifier*). All six of Molina’s medical record omission rates were better than the respective statewide rates, and the medical record omission rate for *Procedure Code Modifier* was 14.0 percentage points better than the corresponding statewide rate. There were variations among the four counties for Molina, and cases associated with San Diego County had the best medical record omission rates for all key data elements except *Rendering Provider Name*.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for Molina contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, Molina’s rates varied from 9.6 percent (*Date of Service*) to 39.4 percent (*Procedure Code Modifier*). Four of Molina’s encounter data omission rates were better than the respective statewide rates with the *Rendering Provider Name* encounter omission rate being better

than the statewide rate by 42.8 percentage points. However, Molina performed worse than the statewide encounter data omission rate by 0.4 percentage points for the *Date of Service* and 1.2 percentage points for the *Billing Provider Name* data elements. An opportunity exists for Molina to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information. At the county level, there were some variations.

The most common reasons for encounter data omissions were:

- ◆ The provider’s billing office made a coding error.
- ◆ DHCS’s encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in Molina’s encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider’s performance of the service and submission of the encounter to Molina (and/or the data subsequently being submitted to DHCS).
- ◆ Molina populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files Molina submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for Molina. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for Molina

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	87.7%	83.6%	75th–90th	Inaccurate Code (98.8%)
Procedure Code	80.2%	77.6%	25th–75th	Lower Level of Services in Medical Records (40.4%); Higher Level of Services in Medical Records (35.0%)
Procedure Code Modifier	95.8%	99.5%	25th–75th	–

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Rendering Provider Name	72.3%	63.0%	25th–75th	Inaccurate Names (69.5%)
Billing Provider Name	90.9%	68.6%	≥90th	Incorrect Names (100.0%)
All-Element Accuracy	17.6%	4.3%	75th–90th	–

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “–” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be quite accurate for Molina—with four of the five element accuracy rates higher than the respective statewide rates. When compared to the performance among the assessed MCPs, three of the five key data elements ranked in the “25th–75th” percentile, and the remaining elements received a percentile ranking of “75th–90th” or “≥90th”. The *Diagnosis Code* data element received a percentile ranking of “75th–90th” with almost all diagnosis-related errors involving discrepancies in the use of inaccurate codes compared to national coding standards rather than specificity errors. For the *Procedure Code* data element, 40.4 percent of the errors involved providers submitting a higher-level service code than were documented in the beneficiary’s medical record and 24.6 percent of the identified errors being associated with the use of inaccurate codes not supported by national coding standards. All billing provider name errors were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records.

Although Molina’s all-element accuracy rate for encounter data was better than the statewide rate by 13.3 percentage points, only 17.6 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 82 percent of the dates of service reviewed in this study. While all five key data elements contributed to Molina’s relatively low all-element accuracy rate, *Rendering Provider Name*, *Procedure Code*, and *Diagnosis Code* contributed to the inaccuracy more than the other two data elements.

Medical Record Review Recommendations

Based on the study findings for Molina, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, Molina should consider the following actions:

- Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
- Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. Molina should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ Molina should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ Molina should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code Modifier* and *Procedure Code* data elements and develop strategies to improve rates.
- ◆ Molina should explore the reasons for the relatively high encounter data omission rates for the *Procedure Code Modifier* and *Diagnosis Code* data elements and take actions to improve rates.
- ◆ Molina should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with Molina.
- ◆ Molina should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).

- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

Molina's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to PACES. Based on review of Molina's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist Molina with improving its encounter data quality. DHCS followed up with Molina regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

6. OVERALL FINDINGS AND RECOMMENDATIONS

for Molina Healthcare of California Partner Plan, Inc.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of Molina's performance in the three domains of care—quality, access, and timeliness.

Quality

As in previous years, Molina's quality improvement program documents describe an organizational structure that supports the delivery of quality care to the MCP's beneficiaries.

The rates for the following quality measures were above the HPLs in RY 2015:

- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in San Diego County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in Sacramento County and San Diego County

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total* in Sacramento County

The rates for the following quality measures were significantly better in RY 2015 when compared to RY 2014:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Sacramento County; however, the rate remained below the MPL for the fourth consecutive year.
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Sacramento County; however, the rate remained below the MPL for the fourth consecutive year.
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in San Diego County.
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total* in Riverside/San Bernardino counties, Sacramento County, and San Diego County.
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total* in Sacramento County and San Diego County.

The rates for the following quality measures improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rates moving from below the MPLs in RY 2014 to above the MPLs in RY 2015:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Sacramento County
- ◆ *Controlling High Blood Pressure* in Sacramento County
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Sacramento County

Across all counties, the rates for nine quality measures declined significantly from RY 2014 to RY 2015, and the decline resulted in the rates for seven of these measures moving from above the MPLs in RY 2014 to below the MPLs in RY 2015. In total, the rates for 35 quality measures were below the MPLs across all counties, with eight being below the MPLs for three or more consecutive years.

For quality measures stratified by the SPD and non-SPD populations:

- ◆ The SPD rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure in San Diego County was significantly better than the non-SPD rate.
- ◆ The SPD rates for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure in Sacramento County and San Diego County were significantly better than the non-SPD rates.
- ◆ The SPD rates for Riverside/San Bernardino, Sacramento, and San Diego counties for the *All-Cause Readmissions* measure were significantly worse than the non-SPD rates; however, the

higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of Molina's QIPs fell into the quality domain of care and neither QIP achieved statistically significant improvement over baseline. The MCP was required to submit a PDSA cycle for its *Improving Hypertension Control* QIP, and the MCP found that conducting provider engagement visits resulted in an increase in the number of beneficiaries with controlled blood pressure at the targeted high-volume provider in San Diego County.

Overall, Molina showed below-average performance related to the quality domain of care.

Access

HSAG reviewed Molina's 2015 *Quality Improvement Program Description* document and found descriptions of activities and processes designed to ensure beneficiaries' access to care, including monitoring and evaluation. The MCP also included access-related goals in its quality improvement work plan.

Notable results for measures falling into the access domain of care were:

- ◆ The rate in San Diego County for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure was above the HPL in RY 2015.
- ◆ The rate in San Diego County for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure was significantly better in RY 2015 when compared to RY 2014.
- ◆ The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Sacramento County improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.
- ◆ Across all counties, the rates for 11 access measures declined significantly from RY 2014 to RY 2015, and the decline resulted in the rates for four of these measures moving from above the MPLs in RY 2014 to below the MPLs in RY 2015.
- ◆ In total, the rates for 26 access measures were below the MPLs across all counties, with 13 being below the MPLs for three or more consecutive years.

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The SPD rates for Riverside/San Bernardino, Sacramento, and San Diego counties for the *All-Cause Readmissions* and *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measures were significantly worse than the non-SPD rates. As noted above, the higher rate of hospital readmissions for the SPD population is expected. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure may be attributed to beneficiaries in this age group in the SPD population relying on specialty

providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Both of Molina's QIPs fell into the access domain of care and, as noted above, neither QIP achieved statistically significant improvement over baseline. Also as noted above, through testing a PDSA cycle, the MCP found that conducting provider engagement visits resulted in an increase in the number of beneficiaries with controlled blood pressure at the targeted high-volume provider in San Diego County.

Overall, Molina showed below-average performance related to the access domain of care.

Timeliness

As in previous years, HSAG's review of Molina's quality documents found documentation of monitoring processes and goals designed to ensure timeliness of care for the MCP's beneficiaries.

The rate in Sacramento County for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which falls into the timeliness domain of care, improved from RY 2014 to RY 2015; and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in RY 2014 to above the MPL in RY 2015.

The rates in San Diego County for the following timeliness measures declined significantly from RY 2014 to RY 2015:

- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015

The rates for the following timeliness measures were below the MPLs for three or more consecutive years:

- ◆ *Childhood Immunization Status—Combination 3* in Sacramento County
- ◆ *Prenatal and Postpartum Care—Postpartum Care* in Riverside/San Bernardino counties and Sacramento County
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Riverside/San Bernardino counties and Sacramento County

Additionally, the rates for all five timeliness measures in Imperial County were below the MPLs.

Overall, Molina showed below-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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with Molina’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—Molina’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Continue to use technical assistance calls with DHCS and the EQRO to discuss how Molina can modify its strategies to improve the likelihood of positive outcomes. Specifically, focus efforts on the following measures, for which the MCP is required to submit IPs in 2014:</p> <ul style="list-style-type: none"> a. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i> for Sacramento County b. <i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i> for Sacramento County c. <i>Childhood Immunization Status—Combination 3</i> for Sacramento County d. <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> for Sacramento County e. <i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i> for Riverside/San Bernardino counties f. <i>Controlling High Blood Pressure</i> for Riverside/San Bernardino and Sacramento counties g. <i>Medication Monitoring for People with Asthma—</i> 	<p>Implementation of effective processes and interventions is the key driver in achieving high quality performance. In order to improve our measure rates, Molina focused on several priority areas during July 2014–June 2015:</p> <p><u>Molina participated in a technical assistance call with a DHCS nurse consultant and DHCS medical director to review 2014 HEDIS outcomes and define 2014–15 IP submission requirements on August 7, 2014.</u></p> <p>During this call, Molina established the following IP/PDSA submission plan:</p> <ul style="list-style-type: none"> a. <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i> for Sacramento County <ul style="list-style-type: none"> • New PDSA monitoring members’ compliance with ACE/ARB annual lab testing. • Submitted October 17, 2014. b. <i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i> for Sacramento County <ul style="list-style-type: none"> • New PDSA monitoring members’ compliance with diuretic annual lab testing. • Submitted October 17, 2014. c. <i>Childhood Immunization Status—Combination 3</i> for Sacramento County <ul style="list-style-type: none"> • Ongoing PDSA monitoring receipt of Immunization Registry data. • Submitted January 15, 2015, and April 15, 2015. d. <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> for Sacramento County <ul style="list-style-type: none"> • Decision was made to combine this with the Hypertension IP submitted October 17, 2014. • No separate submission was required. e. <i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i> for Riverside/San Bernardino counties <ul style="list-style-type: none"> • New IP monitoring members’ compliance with Diabetes Management.

2013–14 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p><i>Medication Compliance 50% Total for Riverside/San Bernardino counties</i></p> <p>h. <i>Prenatal and Postpartum Care—Postpartum Care for Riverside/San Bernardino and Sacramento counties</i></p> <p>i. <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care for Riverside/San Bernardino and Sacramento counties</i></p> <p>j. <i>Use of Imaging Studies for Low Back Pain for San Diego County</i></p> <p>k. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life in Sacramento County</i></p>	<ul style="list-style-type: none"> • Submitted October 17, 2014. <p>f. <i>Controlling High Blood Pressure for Riverside/San Bernardino and Sacramento counties</i></p> <ul style="list-style-type: none"> • Ongoing IP monitoring members’ compliance with Hypertension Management. • Submitted annual internal QIP August 29, 2014, and new IP October 17, 2014. • New PDSA plan implemented December 12, 2014, for all counties. <ul style="list-style-type: none"> ▪ Riverside/San Bernardino, San Diego, Imperial, and Sacramento. ▪ First Do/Study/Act reports submitted April 30, 2015. <p>g. <i>Medication Monitoring for People with Asthma—Medication Compliance 50% Total for Riverside/San Bernardino counties</i></p> <ul style="list-style-type: none"> • New IP monitoring members’ compliance with Asthma management. • Submitted September 2, 2014. • New PDSA report submitted January 15, 2015. <p>h. <i>Prenatal and Postpartum Care—Postpartum Care for Riverside/San Bernardino and Sacramento counties</i></p> <ul style="list-style-type: none"> • New PDSA process to monitor receipt of Pregnancy Notification Forms to facilitate member contact and education about attending prenatal visits. • PDSA submitted January 15, 2015, and April 15, 2015. <p>i. <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care for Riverside/San Bernardino and Sacramento counties</i></p> <ul style="list-style-type: none"> • New PDSA process to monitor member contact and education about receiving postpartum visits. • PDSA submitted January 15, 2015, and April 15, 2015. <p>j. <i>Use of Imaging Studies for Low Back Pain (LBP) for San Diego County</i></p> <ul style="list-style-type: none"> • New PDSA process to monitor clinic compliance with LBP guidelines. • New PDSA submitted January 15, 2015. <p>k. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life in Sacramento County</i></p> <ul style="list-style-type: none"> • New IP monitoring members’ compliance with annual well child visits. • Submitted September 2, 2014. <ul style="list-style-type: none"> • Based on DHCS recommendations, Molina volunteered to participate in collaborative work group calls. The work group calls were scheduled to discuss Molina PDSA improvement strategies. <ul style="list-style-type: none"> a. <i>Comprehensive Diabetes Care</i>: February 19, 2015, March 5, 2015, and April 14, 2015. During these calls Molina collaborated with

2013–14 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>peer health plans to share best practices for improving diabetes care outcomes. Molina is currently working on implementing quality improvement initiatives based on information obtained during these work groups.</p> <p>b. <i>Controlling High Blood Pressure</i>: January 6, 2015, March 10, 2015, and June 9, 2015. During these calls, Molina collaborated with peer health plans to share best practices for improving hypertension rates.</p> <p>c. <i>Prenatal and Postpartum Care</i>: June 24, 2015. During this call Molina collaborated with peer health plans to share best practice and study outcomes based on improving postpartum care outcomes.</p> <p>d. <i>All-Cause Readmissions</i>: November 19, 2014, February 18, 2015, and April 20, 2015. During these calls, Molina collaborated with peer health plans to share best practices and present PDSA results. Molina is currently in the process of tracking readmission rates and implementing programs such as the Transition of Care (ToC) program to reduce the rate of member readmissions.</p> <ul style="list-style-type: none"> • Molina Quality Improvement Leadership attended a DHCS-HSAG sponsored Annual Quality Conference on September 11, 2014. The conference included discussions on: <ul style="list-style-type: none"> ▪ PDSA Improvement Strategies (HSAG) ▪ Successful Evidence-based Strategies for Improving Care of Diabetes, Prenatal/Postpartum Care, and Improving Medication Monitoring (Health Plans, HSAG) ▪ Successful Strategies for Meeting the Needs of the Seniors and Persons with Disabilities Population (DHCS) • Molina participated in a technical assistance call with a DHCS nurse consultant to review IP/PDSA submissions and 2015 submission scheduled on December 1, 2014. During this call the following PDSAs were reviewed: CDC-CPM, CDC-HbA1C <8, MPM, ACE-ARB, and Diuretic. • Molina participated in a technical assistance call to review final 2014–15 PDSA submissions on April 24, 2015. During this call the following PDSAs were reviewed: PPC-Prenatal, PPC-Postpartum, and CIS.
<p>2. Since San Diego County is performing better than the other counties, consider implementing strategies in the other counties that are resulting in positive outcomes in San Diego County.</p>	<p>Due to the success Molina has achieved in San Diego County, Molina has begun coordinating a more robust provider engagement initiative in the other service counties similar to activities performed in San Diego County. Molina is working in all contracted counties to collaboratively engage independent physician associations (IPAs), clinics, and Federally Qualified Health Centers (FQHCs) by conducting face-to-face visits to provide HEDIS measure education, tools, and support and performance feedback.</p>

2013–14 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>3. For measures with SPD rates significantly worse than the non-SPD rates, assess factors leading to the significantly worse rates to ensure that the MCP is meeting the needs of the SPD population.</p>	<p>After review of the All-Cause Readmissions (ACR) rates, a factor that led to the significantly higher rates of readmission for the SPD population was comorbidity.</p> <ol style="list-style-type: none"> 1. Members with cognitive and sensory impairment are less likely to adhere to discharge instructions. <ul style="list-style-type: none"> • Interventions: Transition of Care program, “Welcome Home” calls, and complex case management. 2. Members with multiple comorbidities are often on complex medication regimes which may increase the risk of non-adherence, drug-to-drug interaction, and serious adverse effects. <ul style="list-style-type: none"> • Interventions: Transition of Care program, welcome home calls, complex case management, Interdisciplinary Care Team meetings, and in-home support services 3. Multiple comorbidities may pose independent management challenges. <ul style="list-style-type: none"> • Interventions: Transition of Care program, in home support services, and complex case management 4. Members with comorbidities were more likely to be readmitted. <ul style="list-style-type: none"> • Interventions: Transition of Care program, welcome home calls, complex case management, Interdisciplinary Care Team meetings, and in-home support services <p>Data analysis of the SPD members with readmission identified that this group had high comorbidities, more chronic conditions, and a higher risk for readmission than their non-SPD counterparts. Readmission rates were particularly high among members with septicemia, chronic obstructive pulmonary disease (COPD), and kidney failure. Additionally, SPD members who had a diagnosis of heart failure, diabetes, and co-morbid cardiovascular and pulmonary diseases were found to have a higher incidence of readmission.</p> <p>Another factor identified as a potential cause of higher rates of readmission for the SPD population was a tendency for these members to refuse participation in the ToC intervention when they were contacted by the ToC staff. Below are reasons why members refuse the ToC program:</p> <ol style="list-style-type: none"> 1. Member is homeless and we are unable to contact them once they leave the hospital. 2. No telephone or limited minutes to communicate with the ToC Coach. 3. Have family member at home caring for the member. 4. Member states, “I don’t have the time.” 5. Member feels he or she is independent. 6. Member is noncompliant with care and does not want our help.

2013–14 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation																
	<ul style="list-style-type: none"> Interventions: Transition of Care program, welcome home calls, complex case management, Interdisciplinary Care Team meetings, and in-home support services. <p>ToC is a program that offers pre- and post-discharge follow-up to ensure a smooth transition from hospital to home. The purpose of the program is to determine that discharge instructions are understood and follow-up appointment with PCP has been made.</p> <p>To better serve the SPD population, Molina revisited the ToC staff’s approach for engaging the member. Staff trainings focused on strategies to engage members who may be resistant to partnering with staff to address their health care challenges. Training also included motivational interview techniques. Ongoing, the ToC team will focus on the hospitalized SPD population in each county to reduce the probability of readmission.</p> <p>ACR Rates: 30 Day Readmissions / Index Stays</p> <table border="1" data-bbox="678 877 1256 1171"> <thead> <tr> <th>County</th> <th>Non-SPD</th> <th>SPD</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Riverside/San Bernardino</td> <td>21/248 (8.47%)</td> <td>105/456 (23.03%)</td> <td>126/704 (17.90%)</td> </tr> <tr> <td>Sacramento</td> <td>4/101 (3.96%)</td> <td>57/396 (14.39%)</td> <td>61/497 (12.27%)</td> </tr> <tr> <td>San Diego</td> <td>22/295 (7.46%)</td> <td>113/709 (15.94%)</td> <td>135/1004 (13.45%)</td> </tr> </tbody> </table> <p>Full description of interventions implemented by Molina to reduce ACR rates.</p> <ul style="list-style-type: none"> Conduct inpatient review rounds with the MCP’s medical director and utilization management staff to discuss members currently hospitalized. (Members are identified for case management prior to hospital discharge.) Case managers make a “Welcome Home” call to the member within 24 hours of discharge. The purpose of the call is to both determine that the member understood the discharge instructions and confirm that the member scheduled the follow-up appointment with the PCP. Conduct Interdisciplinary Care Team meetings with the MCP’s medical directors and care/case managers to address all aspects of members’ health care, including medical, behavioral, and social health needs. Care transition clinicians communicate discharge plans to physicians and other community service providers to ensure appropriate follow-up care of members after discharge. Care managers arrange for in-home support services so members receive required care in the community. Additionally, community health workers are assigned to members to provide social support. Care managers, community connectors, and member services staff continually educate members regarding their plan benefits, health 	County	Non-SPD	SPD	Total	Riverside/San Bernardino	21/248 (8.47%)	105/456 (23.03%)	126/704 (17.90%)	Sacramento	4/101 (3.96%)	57/396 (14.39%)	61/497 (12.27%)	San Diego	22/295 (7.46%)	113/709 (15.94%)	135/1004 (13.45%)
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2013–14 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>problems, treatment requirements and options, use of translator services, and use of other support services to optimize recovery and prevent health problems.</p> <ul style="list-style-type: none"> • Molina has an established Complex Case Management ToC Model. The model is a patient-centered program designed to improve quality, reduce readmissions, and address complex care needs as the member transitions across settings. The program has a “high-touch,” patient-centered focus, with the ToC team conducting face-to-face visits during inpatient hospitalization and telephonic outreach within 30 days of discharge. The four critical elements that provide the foundation to help prepare members, including the SPD population, to navigate their transition are: <ol style="list-style-type: none"> 1. Medication management—Coordination of member medication authorizations as appropriate, medication therapy management, and member education. 2. Personal Health Record (PHR)—Molina staff assist members with completion of a portable document with pertinent medical history, practitioner information, discharge checklist, and medication record. The PHR ensures continuity across practitioners and settings. 3. Follow up with practitioner and/or specialist appointments—Molina staff educate members on the importance of keeping follow-up appointments and sharing their personal health and medication record with their physician by facilitating appointment scheduling and transportation. 4. Knowledge of ‘Red Flags’—Molina staff educate members about signs and symptoms that may indicate that their condition is worsening and how to respond.
<p>4. Ensure that all required documentation is included in the QIP Summary Form. The MCP should reference the QIP Completion Instructions and previous QIP validation tools to ensure that all documentation requirements for each activity have been addressed prior to submission.</p>	<p>From July 1, 2014, through June 30, 2015, Molina has ensured that all required documentation was included within all of the submitted QIPs. Molina received validation from DHCS/HSAG that the requirements within all areas were met for each submission.</p>
<p>5. For its <i>Improving Hypertension Control</i> QIP, both to assess if the MCP should discontinue or modify existing interventions or identify new interventions to better address the large influx of SPD members. Additionally, perform county-specific causal/barrier analyses to determine whether or</p>	<p>In calendar year 2013 the eligible HEDIS population included a mixture of traditional Temporary Assistance for Needy Families (TANF) Medi-Cal members and Seniors and Persons with Disabilities (SPD) Medi-Cal members. The number of Medi-Cal SPDs in the HEDIS population almost doubled in each county between 2012 and 2013. Data analysis indicated that SPDs have a higher incidence of comorbidities and medical complications that may increase the challenge of controlling blood pressure. Other medical conditions may take priority over management of blood pressure.</p>

2013–14 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>not different barriers exist in each county and to then implement appropriate county-specific interventions as needed.</p>	<p>After conducting causal/barrier analyses, some barriers are identified in all counties. Barriers specific to individual counties are listed below. Barriers were prioritized based on the level of impact and the likelihood of achieving positive results, if targeted.</p> <p>Barriers and interventions listed below apply to Riverside/San Bernardino County and Sacramento County. For details on interventions please see the “Controlling Blood Pressure Interventions” section below.</p> <ol style="list-style-type: none"> 1. Insufficient medical record documentation of a hypertension diagnosis in members’ medical records, resulting in a lack of patient education <ul style="list-style-type: none"> • Interventions: Provider Engagement Program and Provider Hypertension Toolkit 2. Lack of PCP awareness of their assigned members’ hypertension diagnosis and their need for an annual visit and appropriate treatment <ul style="list-style-type: none"> • Interventions: Provider Engagement Program and Provider Hypertension Toolkit 3. Lack of adherence to established practice guidelines <ul style="list-style-type: none"> • Interventions: Provider Engagement Program and Provider Hypertension Toolkit 4. Lack of patient/member understanding of the importance of controlling hypertension and taking prescribed medications and patient/member noncompliance with therapy <ul style="list-style-type: none"> • Interventions: Provider Engagement Program, member education, and Provider Hypertension Toolkit <p>Barriers listed below apply to San Diego County:</p> <ol style="list-style-type: none"> 1. Lack of PCP awareness of their assigned members’ hypertension diagnosis and their need for an annual visit and appropriate treatments <ul style="list-style-type: none"> • Interventions: Provider Engagement Program and Provider Hypertension Toolkit 2. Lack of adherence to established practice guidelines <ul style="list-style-type: none"> • Interventions: Provider Engagement Program and Provider Hypertension Toolkit 3. Lack of patient/member understanding of the importance of controlling hypertension and taking prescribed medications and patient/member noncompliance with therapy <ul style="list-style-type: none"> • Interventions: Provider Engagement Program, member education, and Provider Hypertension Toolkit <p>Unlike Riverside/San Bernardino county and Sacramento County, performance rates have increased in San Diego largely due to the clinics’ and FQHCs’ proactive model of care for the San Diego members. San Diego’s</p>

2013–14 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>clinics and FQHCs are directly contracted with Molina, making collaborative efforts with Molina easily attainable. San Diego clinics and FQHCs have worked closely with key subject matter experts including but not limited to medical directors, a facility site review nurse, Provider Services, and the HEDIS Interventions Team in an effort to continuously improve care.</p> <p>CBP Interventions</p> <p>In mid-2014, several interventions were conducted to increase the rate for the CBP measure.</p> <ol style="list-style-type: none"> 1. Provider engagement: Molina continued to work in all contracted counties to collaboratively engage IPAs, clinics, and FQHCs by conducting face-to-face visits to provide HEDIS measure education, tools, and support and performance feedback. 2. Member education: Hypertension education postcards were mailed to increase member knowledge, target member empowerment, and improve patient compliance with hypertension medication management. 3. Provider Hypertension Toolkit: Provided educational materials to engage provider offices to improve specific clinical, coding, and quality metrics for hypertension. <p>During the December 2014 technical assistance call with DHCS, it was determined that, to reduce the difficulty of assessing which intervention was making the most impact on improvement, Molina would convert to a PDSA rapid-cycle measurement tool for the CBP measure. Rather than targeting every member in each county, Molina focused one intervention on a smaller cohort in each county.</p> <p>Molina is now monitoring a cohort of members monthly by obtaining blood pressure results through an EMR system in selected high- volume provider offices in each of the following counties: Imperial, San Diego, Riverside/San Bernardino, and Sacramento. The PDSA process will allow more accurate measurement of the members’ compliance or noncompliance and further evaluate the effectiveness of the provider engagement intervention.</p>

Recommendations

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

- ◆ Continue to work closely with DHCS to identify priority areas for improvement and utilize DHCS and the EQRO for technical assistance to help increase the potential for improved outcomes. Specifically, focus efforts on the following measures for which the MCP is required to submit IPs in 2015:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics* for Riverside/San Bernardino counties, Sacramento County, and San Diego County
- *Cervical Cancer Screening* for San Diego County
- *Childhood Immunization Status—Combination 3* for Sacramento County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Riverside/San Bernardino counties
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* for Riverside/San Bernardino counties
- *Comprehensive Diabetes Care—HbA1c Testing* for Sacramento County
- *Controlling High Blood Pressure* for Riverside/San Bernardino counties and San Diego County
- *Medication Management for People with Asthma—Medication Compliance 50% Total* for Riverside/San Bernardino Counties, Sacramento County, and San Diego County
- *Medication Management for People with Asthma—Medication Compliance 75% Total* for Riverside/San Bernardino counties and Sacramento County
- *Prenatal and Postpartum Care—Postpartum Care* for Riverside/San Bernardino counties, Sacramento County, and San Diego County
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Riverside/San Bernardino counties and Sacramento County
- *Use of Imaging Studies for Low Back Pain* for San Diego County
- ◆ Since the majority of the reportable rates in Imperial County were below the MPLs in RY 2015 and the MCP will be held accountable to meet the MPLs in this county in RY 2016, the MCP should, for applicable measures, duplicate the successful improvement strategies being implemented in the MCP’s other counties.
- ◆ Although Molina will not be continuing the formal QIPs, the MCP should:
 - Continue to implement strategies to improve the *All-Cause Readmissions* rate.
 - Conduct additional PDSA cycles to test the changes indicated in the *Controlling Blood Pressure PDSA Cycle Worksheet*.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix W:
Performance Evaluation Report
Partnership HealthPlan of California
July 1, 2014 – June 30, 2015**

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Appendix W: Performance Evaluation Report

Partnership HealthPlan of California

July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Partnership HealthPlan of California (“Partnership” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

Partnership is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a County Organized Health System (COHS).

Partnership became operational to provide MCMC services in Solano County in May 1994, in Napa County in March 1998, in Yolo County in March 2001, in Sonoma County in October 2009, and in Marin and Mendocino counties in July 2011. As part of the expansion authority under Section 1115 of the Social Security Act, MCMC expanded into several rural northern counties of California in 2013. Under the expansion, Partnership contracted with DHCS to provide MCMC services in Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties beginning November 1, 2013.

Table 1.1 shows the number of beneficiaries for Partnership for each county and the MCP's total number of beneficiaries as of June 30, 2015.¹

Table 1.1—Partnership Enrollment as of June 30, 2015

County	Enrollment as of June 30, 2015
Del Norte	10,852
Humboldt	47,249
Lake	27,996
Lassen	7,035
Marin	35,236
Mendocino	35,776
Modoc	2,951
Napa	27,520
Shasta	60,835
Siskiyou	15,973
Solano	107,741
Sonoma	108,692
Trinity	4,550
Yolo	50,503
Total	542,909

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: November 6, 2015.

2. MANAGED CARE HEALTH PLAN COMPLIANCE

for Partnership HealthPlan of California

Follow-up on Previous Medical Audit

DHCS conducted a medical audit of Partnership on December 2, 2013, through December 13, 2013, covering the review period of September 1, 2012, through August 31, 2012. HSAG summarized the findings from the audit in Partnership's 2013–14 MCP-specific evaluation report. DHCS identified findings in the following areas:

- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Member's Rights
- ◆ Quality Management

In a letter dated September 11, 2014, DHCS stated that on September 3, 2014, Partnership provided DHCS with a response to its corrective action plan (CAP) originally issued on August 14, 2014. DHCS stated that it had reviewed all remaining open items and found the MCP to be in compliance. Therefore, DHCS closed the CAP.

Medical and State Supported Services Audit

DHCS conducted a medical and State Supported Services audit for Partnership February 23, 2015, through March 6, 2015, covering the review period of December 1, 2013, through November 30, 2014. DHCS assessed the following areas:

- ◆ Compliance with State Supported Services contract and regulations
- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Member's Rights
- ◆ Administrative and Organizational Capacity

Reports were issued by DHCS August 19, 2015, for each audit type. DHCS found Partnership to be in compliance with the State Supported Services contractual requirements; however, DHCS identified findings in all areas reviewed under the medical audit. In a letter dated December 22, 2015, DHCS stated that on December 21, 2015, Partnership provided DHCS with the MCP's most

recent response to the corrective action plan (CAP) originally issued by DHCS on August 24, 2015. The letter stated that DHCS had reviewed all deficiencies and had closed the CAP. DHCS noted that one deficiency in the area of Utilization Management was provisionally closed and that DHCS would continue to monitor and follow up with Partnership on the deficiency. Note that while DHCS issued the referenced reports and letter outside the review dates for this MCP-specific evaluation report, HSAG included the information because it was in reference to audits that occurred within the review dates for this report and because DHCS closed the CAP that was issued related to the medical audit.

1115 Waiver Seniors and Persons with Disabilities Enrollment Survey

The Department of Managed Health Care (DMHC) conducted an 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey (hereafter referred to as “SPD medical survey”) for Partnership February 23, 2015, through February 27, 2015, covering the review period of December 1, 2013, through November 30, 2014. DMHC issued the report to DHCS on December 7, 2015, which is outside the review dates for this MCP-specific evaluation report. HSAG will include the results of the SPD medical survey in Partnership’s 2015–16 MCP-specific evaluation report, along with a summary of Partnership’s CAP for deficiencies identified in the report.

Strengths

DHCS found Partnership to be fully compliant with State Supported Services contractual requirements during the February–March 2015 State Supported Services audit. Partnership fully resolved all findings from the December 2013 and February–March 2015 medical audits.

Opportunities for Improvement

Since Partnership fully resolved all findings from the MCP’s previous medical audits, HSAG has no recommendations for improvement related to compliance reviews.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Partnership HealthPlan of California* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that Partnership followed the appropriate specifications to produce valid rates. Although the auditor identified issues with one of the MCP's supplemental data sources, there was minimal impact on measure reporting. A brief summary of notable findings and opportunities for improvement is included below.

- ◆ Partnership processed its medical services data at two sites during the measurement year. Although the MCP experienced large increases in the number of beneficiaries during 2014, one site experienced no backlogs or delays in medical services data processing. Initially, Partnership experienced backlogs at the other site; however, the MCP remedied the issues, which resulted in claims being processed within the MCP's timeliness standards.
- ◆ Although Partnership experienced an increase in the number of providers (including primary care providers) during the measurement year, the MCP processed all provider information in a timely manner.
- ◆ The auditor determined that Partnership could not use one of its proposed supplemental data sources based on the MCP having extremely low validation of data entered manually and errors identified by the auditor during the audit process. The auditor determined minimal, if any, impact on the rates since the same data could be obtained through hybrid review. The auditor recommended that, if Partnership plans to use this data source in the future, the MCP should implement a vigorous validation process to ensure that all data are accurate.
- ◆ Kaiser (KP Cal, LLC) is a delegated service partner for some of Partnership's beneficiaries. Kaiser implemented several changes in its data submission to Partnership, which impacted Partnership's ability to ensure that the data were complete and accurate. The auditor recommended that Partnership strengthen its oversight of Kaiser's data extraction and submission activities to ensure that complete data are received for HEDIS reporting in a timely manner.

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 through Table 3.4 for Partnership's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Partnership's regions are as follows:

- ◆ **Northeast**—Lassen, Modoc, Shasta, Siskiyou, and Trinity counties
- ◆ **Northwest**—Del Norte and Humboldt counties
- ◆ **Southeast**—Napa, Solano, and Yolo counties
- ◆ **Southwest**—Marin, Mendocino, Sonoma, and Lake counties

Note: RY 2015 is the first year Partnership reported rates for three of its regions. DHCS did not hold the MCP accountable to meet the minimum performance levels (MPLs) for the Northeast and Northwest regions. While DHCS did not hold the MCP accountable to meet the MPLs in the Northeast and Northwest regions, HSAG includes the performance measure results in its analysis of Partnership's performance to assist DHCS and Partnership in assessing the MCP's overall performance related to established benchmarks. Since Partnership has previously reported measures for most counties included in the Southwest Region, DHCS held the MCP accountable to meet the MPLs in this region for RY 2015; however, since the MCP did not previously report the combined rate for all the counties included in the Southwest Region, HSAG makes no comparison to previous years' rates for this region.

Understanding Table 3.1 through Table 3.4

The reader should note the following regarding Table 3.1 through Table 3.4:

- ◆ The MCP's performance compared to the DHCS-established MPLs and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	14.55%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	68.85	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	248.98	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	82.11%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	60.42%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	83.23%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	22.31%	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	45.99%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	58.64%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	94.08%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	80.79%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	56.69%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	34.79%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	87.35%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	48.91%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	76.16%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	42.58%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	48.42%	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	39.17%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	52.80%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	78.83%	Not Comparable
Use of Imaging Studies for Low Back Pain	Q	—	—	—	80.46%	Not Comparable

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	—	86.13%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	—	55.96%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	—	40.39%	Not Comparable
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	—	62.04%	Not Comparable

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.2—Multi-Year Performance Measure Results*
Partnership—Northwest (Del Norte and Humboldt Counties)**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	13.22%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	55.74	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	251.63	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	80.41%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	83.65%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	29.35%	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	49.64%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	56.13%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	96.54%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	87.40%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	58.39%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	39.17%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	92.21%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	56.20%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	85.89%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	31.14%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	47.45%	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	57.98%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	50.36%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	82.97%	Not Comparable
Use of Imaging Studies for Low Back Pain	Q	—	—	—	84.26%	Not Comparable

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	—	66.91%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	—	46.47%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	—	36.25%	Not Comparable
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	—	62.53%	Not Comparable

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.3—Multi-Year Performance Measure Results*
Partnership—Southeast (Napa, Solano, and Yolo Counties)**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	13.25%	15.60%	15.07%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	47.82	52.33	53.57	58.01	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	256.88	312.13	311.38	331.00	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	82.13%	84.46%	89.71%	88.26%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	80.88%	90.48%	94.44%	58.64%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	82.38%	82.35%	89.42%	88.88%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	42.76%	33.18%	34.31%	34.83%	↔
Cervical Cancer Screening	Q,A	—	—	69.59%	58.19%	↓
Childhood Immunization Status—Combination 3	Q,A,T	71.93%	68.87%	72.32%	68.66%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	94.91%	96.49%	96.81%	94.46%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	82.91%	86.42%	87.79%	86.65%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	80.35%	83.67%	85.84%	85.98%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	77.25%	84.94%	83.80%	84.19%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	69.27%	66.67%	65.21%	61.95%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	56.79%	53.42%	60.34%	54.15%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	86.64%	85.65%	82.48%	88.05%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	60.58%	53.64%	52.31%	53.66%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	83.74%	84.33%	86.86%	84.88%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	28.73%	35.76%	37.47%	35.37%	↔
Controlling High Blood Pressure	Q	—	53.86%	56.72%	58.52%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	56.81%	65.33%	64.10%	71.05%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	59.90%	61.68%	58.96%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	39.41%	40.23%	40.13%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	70.29%	75.92%	68.85%	69.17%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	87.27%	81.41%	80.00%	87.50%	↑
Use of Imaging Studies for Low Back Pain	Q	88.52%	88.95%	89.17%	87.12%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	74.77%	77.44%	69.76%	77.02%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	65.05%	67.91%	65.12%	73.11%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	53.70%	52.79%	54.15%	67.97%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	74.34%	74.26%	73.83%	75.30%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.4—Multi-Year Performance Measure Results*
Partnership—Southwest (Marin, Mendocino, Sonoma, and Lake Counties)**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	14.24%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	50.01	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	333.19	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	83.20%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	56.38%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	83.30%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	40.97%	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	56.20%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	73.72%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	95.78%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	88.92%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	89.77%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	87.86%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	64.48%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	49.15%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	87.10%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	46.72%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	76.64%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	43.31%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	54.01%	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	68.86%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	59.39%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	37.94%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	68.37%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	86.13%	Not Comparable
Use of Imaging Studies for Low Back Pain	Q	—	—	—	88.00%	Not Comparable

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	—	—	—	86.62%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	—	—	—	62.77%	Not Comparable
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	—	—	—	53.77%	Not Comparable
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	—	—	—	72.02%	Not Comparable

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.5 through Table 3.12 present a summary of the RY 2015 SPD measure results reported by Partnership. Table 3.5 through Table 3.8 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.9 through Table 3.12 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.5—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	11.25%	16.60%	▼	14.55%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	78.60%	85.14%	↑	82.11%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	60.42%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.40%	85.41%	↑	83.23%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	94.10%	NA	Not Comparable	94.08%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	80.61%	88.41%	↑	80.79%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	NA	NA	Not Comparable	NA
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	NA	NA	Not Comparable	NA

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

⁴ 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 3.5 through Table 3.8.

Table 3.6—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Partnership—Northwest (Del Norte and Humboldt Counties)

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	10.44%	14.92%	▼	13.22%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	76.35%	83.83%	↑	80.41%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable	NA
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.86%	87.36%	↑	83.65%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.54%	NA	Not Comparable	96.54%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	87.34%	90.63%	↔	87.40%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	NA	NA	Not Comparable	NA
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	NA	NA	Not Comparable	NA

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.7—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Partnership—Southeast (Napa, Solano, and Yolo Counties)

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	10.71%	16.32%	▼	15.07%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.52%	89.41%	↑	88.26%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	59.42%	Not Comparable	58.64%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.59%	90.76%	↑	88.88%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	94.45%	95.35%	↔	94.46%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.73%	84.08%	↔	86.65%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	86.02%	85.40%	↔	85.98%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	84.52%	81.39%	↓	84.19%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.8—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Partnership—Southwest (Marin, Mendocino, Sonoma, and Lake Counties)

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	11.99%	16.07%	▼	14.24%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.82%	84.83%	↑	83.20%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	63.33%	53.13%	↔	56.38%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.31%	86.29%	↑	83.30%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	95.76%	NA	Not Comparable	95.78%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	88.89%	91.02%	↔	88.92%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	89.87%	87.14%	↔	89.77%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	88.03%	84.88%	↓	87.86%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.9—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
221.32	62.01	413.55	109.59

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

Table 3.10—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures Partnership—Northwest (Del Norte and Humboldt Counties)

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
224.69	48.98	420.22	98.05

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

Table 3.11—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures Partnership—Southeast (Napa, Solano, and Yolo Counties)

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
276.89	51.68	602.57	89.77

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

Table 3.12—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures Partnership—Southwest (Marin, Mendocino, Sonoma, and Lake Counties)

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
306.70	45.75	590.09	91.33

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

Table 3.13 through Table 3.16 present the three-year trending information for the SPD population, and Table 3.17 through Table 3.20 present the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.13—RY 2015 (MY 2014) HEDIS SPD Trend Table
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	—	—	16.60%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	109.59	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	413.55	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	85.14%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	85.41%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	—	—	88.41%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	—	—	NA	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.14—RY 2015 (MY 2014) HEDIS SPD Trend Table
Partnership—Northwest (Del Norte and Humboldt Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	—	—	14.92%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	98.05	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	420.22	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	83.83%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	87.36%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	—	—	90.63%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	—	—	NA	Not Comparable

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.15—RY 2015 (MY 2014) HEDIS SPD Trend Table
Partnership—Southeast (Napa, Solano, and Yolo Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	15.67%	16.98%	16.32%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	79.44	81.68	89.77	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	503.87	565.93	602.57	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.70%	90.49%	89.41%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	91.07%	94.90%	59.42%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.26%	90.39%	90.76%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	86.79%	92.31%	95.35%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	82.56%	85.68%	84.08%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	84.64%	85.27%	85.40%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	81.91%	81.25%	81.39%	↔

* Member months are a member’s “contribution” to the total yearly membership.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.16—RY 2015 (MY 2014) HEDIS SPD Trend Table
Partnership—Southwest (Marin, Mendocino, Sonoma, and Lake Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	—	—	16.07%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	91.33	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	590.09	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	84.83%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	53.13%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	86.29%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	—	—	91.02%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	—	—	87.14%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	—	—	84.88%	Not Comparable

* Member months are a member’s “contribution” to the total yearly membership.

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.17—RY 2015 (MY 2014) Non-SPD Trend Table
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	11.25%	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	62.01	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	221.32	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	78.60%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	80.40%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	94.10%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	80.61%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	NA	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.18—RY 2015 (MY 2014) Non-SPD Trend Table
Partnership—Northwest (Del Norte and Humboldt Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	10.44%	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	48.98	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	224.69	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	76.35%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	78.86%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	96.54%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	87.34%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	NA	Not Comparable

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

— = A year for which data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.19—RY 2015 (MY 2014) Non-SPD Trend Table
Partnership—Southeast (Napa, Solano, and Yolo Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	6.84%	7.48%	10.71%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	47.01	45.79	51.68	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	274.50	240.94	276.89	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	78.93%	84.91%	85.52%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	74.90%	83.24%	84.59%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.69%	96.88%	94.45%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.57%	87.88%	86.73%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	83.59%	85.88%	86.02%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	85.36%	84.15%	84.52%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.20—RY 2015 (MY 2014) Non-SPD Trend Table
Partnership—Southwest (Marin, Mendocino, Sonoma, and Lake Counties)**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	—	—	11.99%	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	—	45.75	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	—	306.70	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	—	81.82%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	—	63.33%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	—	80.31%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	—	—	95.76%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	—	—	88.89%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	—	—	89.87%	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	—	—	88.03%	Not Comparable

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

— = A year for which data were not collected.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rates for the following measures were above the HPLs in RY 2015:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in the Southwest Region
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* in the Northwest Region
- ◆ *Use of Imaging Studies for Low Back Pain* in the Northwest Region, Southeast Region (fifth consecutive year), and Southwest Region
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in the Northeast Region and Southwest Region

The rates for the following measures in the Southeast Region improved significantly from RY 2014 to RY 2015:

- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- ◆ All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

Across all regions, the rates for 29 measures were below the MPLs and the rates for the following measures in the Southeast Region declined significantly from RY 2014 to RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Cervical Cancer Screening*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*

Seniors and Persons with Disabilities Findings

Comparison of the SPD rates to the non-SPD rates showed the following:

- ◆ In all regions, the SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures were significantly better than the non-SPD rates.
- ◆ The SPD rate for the Northeast Region for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure was significantly better than the non-SPD rate.
- ◆ In all regions, the SPD rates for the *All-Cause Readmissions* measure were significantly worse than the non-SPD rates; however, the higher rate of readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.
- ◆ In the Southeast and Southwest regions, the SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure was significantly worse than the non-SPD rate, which may be attributed to children and adolescents in this age group in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than on accessing care from primary care practitioners.

For the Southeast Region, no notable differences occurred in the SPD rates from RY 2014 to RY 2015, and the non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* and *25 Months to 6 Years* measures declined significantly from RY 2014 to RY 2015.

Assessment of Improvement Plans

Based on RY 2014 rates, Partnership was required to submit improvement plans (IPs) or Plan-Do-Study-Act (PDSA) cycles for the following measures:

- ◆ *Childhood Immunization Status—Combination 3* for Mendocino County
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Mendocino County
- ◆ *Immunizations for Adolescents—Combination 1* for Mendocino County
- ◆ *Medication Management for People with Asthma—Medication Compliance 50% Total* for Marin County

Partnership's improvement efforts related to the immunization measures were conducted as part of the QIP process and are summarized in the "Quality Improvement Projects" section of this report.

Partnership's IPs and PDSA cycles were originally designed to bring the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* rate above the MPL for Mendocino County and to bring the *Medication Management for People with Asthma—Medication Compliance 50% Total* rate to above the MPL for Marin County. Since for RY 2015 Partnership reported a combined rate for Marin, Mendocino, Sonoma, and Lake counties (i.e., Southwest Region), it is not possible to determine if the implemented interventions achieved the goal of improving the rates in the individual counties to above the MPLs. It is important to note that the rates for both measures for the Southwest Region were above the MPLs in RY 2015.

Required Improvement Plans for RY 2015

Partnership will be required to submit IPs/PDSA cycles for the following measures for the Southwest Region based on RY 2015 performance measure results:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*

Strengths

HSAG auditors determined that Partnership followed the appropriate specifications to produce valid rates. Although Partnership experienced an increase in the number of providers during the measurement year, including primary care providers, the MCP processed all provider information in a timely manner.

Across all regions, the rates for seven measures were above the HPLs and the rates for six measures in the Southeast Region improved significantly from RY 2014 to RY 2015.

Opportunities for Improvement

As was recommended by HSAG previously, the MCP has the opportunity to implement vigorous validation processes to ensure that all supplemental data used for reporting rates are accurate. Additionally, the MCP has the opportunity to strengthen its oversight of one of its delegated service partners, Kaiser, to ensure that complete data are received for HEDIS reporting in a timely manner.

Partnership has the opportunity to assess the factors leading to many rates being below the MPLs and implement strategies to improve performance. Additionally, while the MCP documented reasons for SPD beneficiaries to have a significantly higher rate of readmissions than non-SPD beneficiaries (See Table 6.1), the MCP did not provide the requested documentation to HSAG and DHCS on what Partnership is doing to address the higher needs of this population.

Quality Improvement Project Objectives

Partnership participated in the statewide collaborative QIP and had three internal QIPs in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists Partnership’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, and timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for Partnership
July 1, 2014, through June 30, 2015**

QIP	Counties	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Marin, Mendocino, Napa/Solano/Yolo, and Sonoma	Clinical	Q, A
<i>Childhood Immunization Status—Combo 3</i>	Mendocino	Clinical	Q, A, T
<i>Improving Access to Primary Care for Children and Adolescents</i>	Napa/Solano/Yolo and Sonoma	Clinical	A
<i>Improving the Timeliness of Prenatal and Postpartum Care</i>	Marin	Clinical	Q, A, T

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

The *Childhood Immunization Status* QIP targeted beneficiaries who will turn 2 years of age during the measurement year. The administration of immunizations has dramatically decreased the occurrence of many diseases including diphtheria, tetanus, pertussis, and small pox. However, due to either misconceptions about immunizations’ side effects or lack of access, the number of children who have not received immunizations has increased. By understanding why children are not receiving life-saving vaccines, Partnership hopes to increase the number of children who receive the recommended immunizations.

Having a primary care provider (PCP) may improve a child’s health by providing the opportunity for him/her to receive immunizations and preventive care. Partnership’s *Improving Access to Primary Care for Children and Adolescents* QIP aims to increase the rate at which children and adolescents access their PCP, since increasing access to PCPs may positively affect health. Partnership is focusing on four different age groups for this QIP: 12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12 to 18 years.

Partnership’s *Improving the Timeliness of Prenatal and Postpartum Care* QIP focused on improving the care women receive during and post pregnancy. Being able to maintain regular prenatal care visits throughout a pregnancy may help identify and treat any problems that may arise. Providing postpartum care is also an essential factor that may lead to successful health outcomes for the mother and child.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
Partnership—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties
July 1, 2014, through June 30, 2015**

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>	Marin, Mendocino, and Napa/Solano/Yolo	Annual Submission	85%	100%	<i>Met</i>
	Sonoma	Annual Submission	88%	100%	<i>Met</i>
Internal QIPs					
<i>Childhood Immunization Status—Combo 3</i>	Mendocino	Annual Submission	91%	100%	<i>Met</i>
<i>Improving Access to Primary Care for Children and Adolescents</i>	Napa/Solano/Yolo and Sonoma	Annual Submission	89%	100%	<i>Met</i>
<i>Improving the Timeliness of Prenatal and Postpartum Care</i>	Marin	Annual Submission	93%	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, 2014, through June 30, 2015, showed that Partnership’s annual submissions of its *All-Cause Readmissions*, *Childhood Immunization Status—Combo 3*, *Improving Access to Primary Care for Children and Adolescents*, and *Improving the Timeliness of Prenatal and Postpartum Care* QIPs all received an overall validation status of *Met* for all counties, with 100 percent of critical evaluation elements receiving a *Met* score.

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

Table 4.3—Quality Improvement Project Average Rates*
Partnership— Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties
(Number = 8 QIP Submissions, 4 QIP Topics)
July 1, 2014, through June 30, 2015

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	100%	0%	0%
Design Total		100%	0%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	97%	3%	0%
	VIII: Appropriate Improvement Strategies**	88%	13%	0%
Implementation Total		94%	6%	0%
Outcomes	IX: Real Improvement Achieved**	38%	13%	50%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		41%	12%	47%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for Partnership’s *All-Cause Readmissions*, *Childhood Immunization Status—Combo 3*, and *Improving the Timeliness of Prenatal and Postpartum Care* QIP annual submissions and Activities I through X for the MCP’s *Improving Access to Primary Care for Children and Adolescents* QIP annual submission.

Partnership demonstrated an excellent application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for all four QIPs. The MCP also demonstrated a strong application of the Implementation stage, meeting 94 percent of the requirements for all applicable evaluation elements within the study stage for all QIPs. The

MCP did not compare the Remeasurement 2 rates to the goals for the *Improving Access to Primary Care for Children and Adolescents* QIP, leading to a slightly lowered score for Activity VII. For the *All-Cause Readmissions* QIP, Partnership did not include a complete description of the evaluation method used for all interventions, resulting in a lowered score for Activity VIII.

All four QIPs progressed to the Outcomes stage during the reporting period. The score for Activity IX was lowered because the study indicators for three QIPs did not achieve statistically significant improvement over baseline. Only the *Improving Access to Primary Care for Children and Adolescents* QIP achieved statistically significant improvement over baseline. Although the study indicators for *All-Cause Readmissions* QIP (in Sonoma County) and *Improving the Timeliness of Prenatal and Postpartum Care* QIP demonstrated improvement, the improvement was not statistically significant. Therefore, only the *Improving Access to Primary Care for Children and Adolescents* QIP was assessed for Activity X since sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

Table 4.4—Quality Improvement Project Outcomes for Partnership—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties July 1, 2014, through June 30, 2015

QIP #1—All-Cause Readmissions				
Study Indicator 1: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]				
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Remeasurement 2 1/1/14–12/31/14	Sustained Improvement*
Marin	16.0%	16.5%	‡	‡
Mendocino	9.8%	11.5%	‡	‡
Napa/Solano/Yolo	13.3%	15.6%**	‡	‡
Sonoma	13.1%	12.8%	‡	‡
QIP #2—Childhood Immunizations Status—Combo 3				
Study Indicator 1: Improve the rate of children 2 years of age who had the DTap, IPV, MMR, Hib, HepB, VZV and PCV vaccinations.				
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Remeasurement 2 1/1/14–12/31/14	Sustained Improvement*
Mendocino	61.9%	61.1%	‡	‡

QIP #3—Improving Access to Primary Care for Children and Adolescents				
Study Indicator 1: Percentage of 12-to-24-month-old members with one or more visits with a PCP during the measurement year				
County	Baseline Period 1/1/11–12/31/11	Remeasurement 1 1/1/12–12/31/12	Remeasurement 2 1/1/13–12/31/13	Sustained Improvement [‡]
Napa/Solano/Yolo	94.9%	96.5%*	96.8%	Yes
Sonoma	95.2%	96.3%	98.2%*	‡
Study Indicator 2: Percentage of 25-month-to-6-year-old members with one or more visits with a PCP during the measurement year				
County	Baseline Period 1/1/11–12/31/11	Remeasurement 1 1/1/12–12/31/12	Remeasurement 2 1/1/13–12/31/13	Sustained Improvement [‡]
Napa/Solano/Yolo	82.9%	86.4%*	87.8%	Yes
Sonoma	86.5%	88.6%*	90.3%	Yes
Study Indicator 3: Percentage of 7-to-11-year-old members with one or more visits with a PCP during the measurement year or the year prior to the measurement year				
County	Baseline Period 1/1/11–12/31/11	Remeasurement 1 1/1/12–12/31/12	Remeasurement 2 1/1/13–12/31/13	Sustained Improvement [‡]
Napa/Solano/Yolo	80.4%	83.7%*	85.8%	Yes
Sonoma	83.3%	85.7%*	87.3%	Yes
Study Indicator 4: Percentage of 12-to-19-year-old members with one or more visits with a PCP during the measurement year or the year prior to the measurement year				
County	Baseline Period 1/1/11–12/31/11	Remeasurement 1 1/1/12–12/31/12	Remeasurement 2 1/1/13–12/31/13	Sustained Improvement [‡]
Napa/Solano/Yolo	77.3%	84.9%*	83.8%	Yes
Sonoma	84.4%	88.2%*	86.7%**	Yes
QIP #4—Improving the Timeliness of Prenatal and Postpartum Care				
Study Indicator 1: Improve the rate of women who receive timely prenatal care visits within the first trimester or within 42 days of enrollment into the organization.				
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Remeasurement 2 1/1/14–12/31/14	Sustained Improvement [‡]
Marin	78.2%	84.9%	‡	‡
Study Indicator 2: Improve the rate of women who receive timely postpartum care visits on or between 21 and 56 days after delivery.				
County	Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Remeasurement 2 1/1/14–12/31/14	Sustained Improvement [‡]
Marin	57.8%	67.6%	‡	‡

[^]A lower percentage indicates better performance.

[¥] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement from the baseline period (p value < 0.05).

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

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

All-Cause Readmissions QIP

Partnership's goal for the *All-Cause Readmissions* QIP was to decrease readmissions rates to 10.7 percent at Remeasurement 1 in each county. Unfortunately, the MCP did not meet the project's goal for all counties. Although the readmissions rate declined for Sonoma County, the change was not statistically significant. Partnership's readmissions rates in Marin, Mendocino, and Napa/Solano/Yolo counties increased at Remeasurement 1, with the readmissions rate for Napa/Solano/Yolo counties increasing significantly when compared to the baseline rate. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ Partnership conducted a causal/barrier analysis during Remeasurement 1 to reassess interventions related to the most current barriers. As a result, the MCP terminated the utilization management to care coordination referral initiative.
- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions Partnership indicated it implemented during the Remeasurement 1 time period:
 - Provided quarterly reports to 124 PCPs showing their readmission rates and, when requested, a drill down at the beneficiary level.
 - Tested at three primary care sites an email notification system that provided timely alert of beneficiary hospitalizations.
 - Hired a care transition nurse to work in Sonoma County to expand the care transition program previously implemented in Napa/Solano/Yolo counties.
 - Invited hospitals in Marin and Mendocino counties to participate in the Hospital Pay-for-Performance Program.

Childhood Immunization Status—Combo 3 QIP

The goal of the *Childhood Immunization Status—Combo 3* QIP was to meet the national Medicaid 25th percentile for the study indicator in Mendocino County. Unfortunately, the MCP did not meet the project's goal as the immunization rate declined at Remeasurement 1. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ Data analysis revealed a statistically significant improvement in the Hepatitis B immunization rate compared to baseline.
- ◆ Partnership conducted a causal/barrier analysis during Remeasurement 1 and identified two priority barriers:
 - Providers are confused about the childhood immunization guidelines.
 - Providers have challenges receiving documentation of the first Hepatitis B injection from hospitals.

- ◆ Although the interventions were not successful at improving the QIP outcomes, the following is a brief description of the interventions Partnership indicated it implemented during the Remeasurement 1 time period:
 - Continued to implement the MCP's primary care Pay-for-Performance Quality Improvement Program (P4P QIP), which provides financial incentives to providers appropriately injecting Hepatitis B and DTap antigens and using the California Immunization Registry (CAIR).
 - Continued to conduct provider-focused education about the fourth DTap injection and the importance of using CAIR.

Improving Access to Primary Care for Children and Adolescents QIP

Partnership's goal for the *Improving Access to Primary Care for Children and Adolescents* QIP was to meet the national Medicaid 25th percentile for the study indicators in Napa/Solano/Yolo and Sonoma counties. The MCP met the project's goals for more than half of the study indicators. Additionally, for Sonoma County, Study Indicator 1 (the only study indicator that did not demonstrate statistically significant improvement at Remeasurement 1) achieved statistically significant improvement over baseline at Remeasurement 2. All study indicators that achieved statistically significant improvement over baseline at Remeasurement 1 demonstrated sustained improvement at Remeasurement 2. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ Partnership conducted a causal/barrier analysis during Remeasurement 2 and determined to continue its quality improvement focus on appointment reminders.
- ◆ Partnership continued to implement its Robo Calls, an appointment reminder intervention, during the Remeasurement 2 time period. The MCP made recommended changes from Remeasurement 1 to prevent duplication of calls to households with more than one child between the ages of 24 months and 19 years. The MCP standardized this intervention and will monitor ongoing performance to ensure sustainability.

Improving the Timeliness of Prenatal and Postpartum Care QIP

Partnership achieved the goal for the *Improving the Timeliness of Prenatal and Postpartum Care* QIP and met the MPL for both study indicators in Marin County. Although the QIP achieved its goal, the improvement from baseline to Remeasurement 1 was not statistically significant. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ Partnership explained that the small eligible population in Marin County may be the reason for not achieving statistically significant improvement over baseline.

- ◆ The following is a brief description of the interventions that Partnership indicated it implemented during the Remeasurement 1 time period:
 - Continued to conduct the MCP's Growing Together Prenatal Program, a prenatal case management program offered to all pregnant beneficiaries in an effort to facilitate better health outcomes for the mother and baby.
 - Increased provider and community awareness of the Growing Together Prenatal Program by conducting targeted in-person trainings with clinic managers, providers, and community resource administrators.

Plan-Do-Study-Act Review

Due to reconfiguration of Partnership's reporting units from counties to regions and expansion into new counties, the MCP was required to conduct a PDSA cycle for the expansion counties. DHCS allowed the MCP to focus efforts on one or more counties and target the entire population or a subset of the population. Additionally, the MCP could target one high-volume provider rather than all providers to test the identified change. Partnership received permission to target Shasta County for the PDSA cycle and chose *Immunizations* for the topic. The MCP set the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Objective as follows:

By March 31, 2015, [Partnership] aims to partner with Shasta Community Health Center to increase the number of children under two years old immunized in their family practice department by 20 percent.

The purpose of the *Immunizations* PDSA cycle was to test if sharing best practices used by pediatric departments will increase the number of children under two years of age being immunized in their family practice departments.

Partnership completed the *Immunizations* PDSA cycle as planned. The MCP reported that the immunization rate increased by 46 percent, from 57.1 percent (during February 1 to March 31, 2014) to 83.3 percent (during February 1 to March 31, 2015). The MCP exceeded the SMART Objective goal of a 3 percent increase. Partnership indicated that the new workflow was successful, and no changes were suggested by staff. Partnership planned to adopt the change and share the revised workflow with other sites.

Strengths

Partnership demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for the *All-Cause Readmissions, Childhood Immunization Status—Combo 3, Improving Access to Primary Care for Children and Adolescents*, and *Improving the Timeliness of Prenatal and Postpartum Care* QIPs. The MCP also

demonstrated a strong application of the Implementation stage, meeting 94 percent of the requirements for all applicable evaluation elements within the study stage for all four QIPs. As a result, all four QIPs achieved a *Met* validation status on the first submission.

At Remeasurement 2, the MCP's *Improving Access to Primary Care for Children and Adolescents* QIP sustained improvement for all study indicators that achieved statistically significant improvement over baseline at Remeasurement 1. In addition, although the improvement was not statistically significant, the rates for both the *Improving the Timeliness of Prenatal and Postpartum Care* QIP study indicators moved to above the MPL.

The *Immunizations* PDSA cycle results indicated that Partnership's test of change was successful at increasing the number of children under two years old immunized at the targeted health center.

Opportunities for Improvement

Although Partnership will not be continuing the formal QIPs, the MCP should continue to monitor and implement improvement strategies initiated for all four QIPs. Specifically, since the *Improving Access to Primary Care for Children and Adolescents* and *Improving the Timeliness of Prenatal and Postpartum Care* QIPs achieved positive outcomes, the MCP should consider adopting the interventions in other regions. Also, the MCP should adopt the change tested through the *Immunizations* PDSA cycle and share the revised workflow with other provider sites.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

Partnership’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for Partnership. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for Partnership

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	14.4%	26.3%	75th–90th	6.8%	9.2%	75th–90th
Diagnosis Code	18.8%	31.6%	75th–90th	27.0%	34.6%	75th–90th
Procedure Code	25.8%	43.8%	75th–90th	31.5%	22.5%	10th–25th
Procedure Code Modifier	47.3%	58.5%	75th–90th	49.6%	46.0%	25th–75th
Rendering Provider Name	NA	25.0%	NA	100.0%	68.1%	0–≤25th
Billing Provider Name	20.1%	35.0%	75th–90th	7.2%	8.6%	25th–75th

Note: HSAG displayed “NA” when the denominator was less than 30.

Overall, the medical record omission rates for Partnership ranged from 14.4 percent (*Date of Service*) to 47.3 percent (*Procedure Code Modifier*). All five of Partnership’s reportable medical record omission rates were slightly better than the respective statewide rates. When compared to other MCPs’ performance, Partnership received a percentile ranking of “75th–90th” for all five reported medical record omission rates. These findings suggest a good level of completeness among key encounter data elements when compared to beneficiaries’ medical records, with moderate variation among results in Partnership’s six counties. The medical record omissions for Sonoma County were generally higher than for the other counties, except for the *Procedure Code* data element.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for Partnership contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, Partnership's rates varied from 6.8 percent (*Date of Service*) to 100 percent (*Rendering Provider Name*). Three of Partnership's encounter data omission rates were better than the respective statewide rates, with the *Diagnosis Code* encounter omission rate being better than the statewide rates by 7.6 percentage points (75th–90th percentile ranking). However, Partnership performed worse than the statewide encounter data omission rate by 31.9 percentage points for the *Rendering Provider Name* data element. An opportunity exists for Partnership to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information. At the county level, there were some variations.

The most common reasons for encounter data omissions were:

- ◆ Absence of *Rendering Provider Name* data in DHCS's encounter data system resulted in disagreement between data sources.
- ◆ The provider's billing office made a coding error.
- ◆ DHCS's encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in Partnership's encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider's performance of the service and submission of the encounter to Partnership (and/or the data subsequently being submitted to DHCS).
- ◆ Partnership populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files Partnership submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for Partnership. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for Partnership

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	88.3%	83.6%	75th–90th	Inaccurate Code (92.7%)
Procedure Code	68.9%	77.6%	10th–25th	Lower Level of Services in Medical Records (42.5%); Higher Level of Services in Medical Records (31.5%); Inaccurate Code (25.9%)
Procedure Code Modifier	100.0%	99.5%	≥75th	—
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	79.7%	68.6%	75th–90th	Incorrect Names (100%)
All-Element Accuracy	0.0%	4.3%	0–≤25th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, three of the key data elements were found to be quite accurate for Partnership. When compared to the other MCPs, two of the five reported key data elements received a percentile ranking of “75th–90th”, one received a percentile ranking of “≥75th”, and one received a percentile ranking of “10th–25th”. For the *Procedure Code* data element, 42.5 percent of the errors involved providers submitting a higher-level service code than that supported in the beneficiaries’ medical records. All billing provider name errors were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records.

Partnership’s all-element accuracy rate was lower than the statewide rate by 4.3 percentage points. None of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. These overall accuracy findings indicated the presence of at least one inaccurate data element for all dates of service present in both data sources. While all five key data elements contributed to Partnership’s relatively low all-element accuracy rate, the *Rendering Provider Name* data element contributed the most.

Medical Record Review Recommendations

Based on the study findings for Partnership, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, Partnership should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS. For example, Partnership should investigate why rendering provider identification numbers were not populated in the 2012 DHCS encounter data.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields. Partnership should ensure that the additional diagnosis codes are submitted to DHCS after the system transition.
- ◆ Partnership should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ Partnership should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code Modifier* data element and develop strategies to improve rates.
- ◆ Partnership should explore the reasons for the relatively high encounter data omission rates for the *Procedure Code Modifier* and *Procedure Code* data elements and take actions to improve rates.
- ◆ Partnership should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with Partnership.
- ◆ Partnership should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

Partnership's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to PACES. Based on review of Partnership's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist Partnership with improving its encounter data quality. DHCS followed up with Partnership regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of Partnership's performance in the three domains of care—quality, access, and timeliness.

Quality

HSAG reviewed Partnership's Quality and Performance Improvement Program Description and found a description of an organizational structure that supports delivery and monitoring of quality care to the MCP's beneficiaries.

The rates for the following quality measures were above the HPLs in RY 2015:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in the Southwest Region
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* in the Northwest Region

- ◆ *Use of Imaging Studies for Low Back Pain* in the Northwest Region, Southeast Region (fifth consecutive year), and Southwest Region
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in the Northeast Region and Southwest Region

The rates for the following quality measures in the Southeast Region improved significantly from RY 2014 to RY 2015:

- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- ◆ All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

Across all regions, the rates for 23 quality measures were below the MPLs, and the rates for the following quality measures in the Southeast Region declined significantly from RY 2014 to RY 2015:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Cervical Cancer Screening*

For quality measures stratified by the SPD and non-SPD populations, the SPD rates in all regions for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures were significantly better than the non-SPD rates. Additionally, in all regions the SPD rates for the *All-Cause Readmissions* measure were significantly worse than the non-SPD rates; however, this is expected based on the greater and often more complicated health care needs of these beneficiaries.

Three of Partnership’s QIPs fell into the quality domain of care (*All-Cause Readmissions*, *Childhood Immunization Status—Combo 3*, and *Improving the Timeliness of Prenatal and Postpartum Care*). All three progressed to the Outcomes stage; however, none of the QIPs achieved statistically significant improvement over baseline. Although the *Improving the Timeliness of Prenatal and Postpartum Care* QIP did not achieve statistically significant improvement over baseline, the QIP was successful at bringing the rates for both study indicators to above the MPL in Marin County, suggesting that the QIP was successful at improving the quality of prenatal and postpartum care for beneficiaries.

Partnership implemented an *Immunizations* PDSA cycle for one of its expansion counties (Shasta), which fell into the quality domain of care. The MCP found that sharing workflow best practices within a family practice department of a community health center resulted in an increase in the number of children under two years of age being immunized.

Overall, Partnership showed below-average performance related to the quality domain of care.

Access

As in previous years, Partnership's quality improvement documents include information on the MCP's processes to monitor beneficiary access to care. Partnership's Quality and Performance Improvement Program Description also includes descriptions of activities designed to assess access to care for the SPD population.

The rate in the Northwest Region for the *Comprehensive Diabetes Care—HbA1c Testing* measure, which falls into the access domain of care, was above the HPL in RY 2015.

The rates for the following access measures in the Southeast Region improved significantly from RY 2014 to RY 2015:

- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Across all regions, the rates for 18 access measures were below the MPLs, and the rates for the following access measures in the Southeast Region declined significantly from RY 2014 to RY 2015:

- ◆ *Cervical Cancer Screening*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. Comparison of the SPD rates to the non-SPD rates for access measures showed the following:

- ◆ The SPD rate for the Northeast Region for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure was significantly better than the non-SPD rate.
- ◆ In all regions, the SPD rates for the *All-Cause Readmissions* measure were significantly worse than the non-SPD rates; however, as noted above, the higher rate of readmissions for the SPD population is expected.
- ◆ In the Southeast and Southwest regions, the SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure was significantly worse than the non-SPD rate, which may be attributed to children and adolescents in this age group in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than on accessing care from primary care practitioners.

All four of Partnerships QIPs fell into the access domain of care, and all four progressed to the Outcomes stage. Only the *Improving Access to Primary Care for Children and Adolescents* QIP achieved statistically significant improvement over baseline for all indicators in all counties. Additionally, in instances where sustained improvement could be assessed, all indicators achieved sustained improvement. The results of this QIP show that Partnership's improvement efforts are increasing access to primary care for children and adolescents in the specified age groups. As noted above, although the *Improving the Timeliness of Prenatal and Postpartum Care* QIP did not achieve statistically significant improvement over baseline, the QIP was successful at bringing the rates for both study indicators to above the MPL in Marin County. The improvement achieved suggests that the strategies were successful at improving access to prenatal and postpartum care for beneficiaries.

Partnership's *Immunizations* PDSA cycle for Shasta County fell into the access domain of care and, as noted above, the MCP found that sharing workflow best practices within a family practice department of a community health center resulted in an increase in the number of children under two years of age being immunized.

Overall, Partnership showed below-average performance related to the access domain of care.

Timeliness

As in previous years, Partnership's Quality and Performance Improvement Program Description includes information on the MCP's processes for assessing timeliness of care delivered to beneficiaries.

The rates for the following timeliness measures in the Southeast Region improved significantly from RY 2014 to RY 2015:

- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Across all regions, the rates for the following timeliness measures were below the MPLs:

- ◆ *Childhood Immunization Status—Combination 3* in the Northeast Region and Northwest Region
- ◆ *Immunizations for Adolescents—Combination 1* in the Northeast Region and Northwest Region
- ◆ *Prenatal and Postpartum Care—Postpartum Care* in the Northeast Region and Northwest Region
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in the Northeast Region and Northwest Region

Two of Partnership's QIPs fell into the timeliness domain of care (*Childhood Immunization Status—Combo 3* and *Improving the Timeliness of Prenatal and Postpartum Care*). As noted above, neither QIP achieved statistically significant improvement over baseline; however, the *Improving the Timeliness of*

Prenatal and Postpartum Care QIP was successful at bringing the rates for both study indicators to above the national Medicaid 25th percentile in Marin County. The improvement achieved suggests that the strategies were successful at improving timeliness of care to beneficiaries in need of prenatal and postpartum care. Additionally, Partnership’s *Immunizations* PDSA cycle for Shasta County fell into the timeliness domain of care and, as noted above, the MCP found that sharing workflow best practices within a family practice department of a community health center resulted in an increase in the number of children under two years of age being immunized.

Overall, Partnership showed below-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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with Partnership’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—Partnership’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendations Directed to Partnership HealthPlan of California	Self-Reported Actions Taken by Partnership HealthPlan of California during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendations
1. Ensure that all findings from the December 2013 medical audit are fully resolved. The areas with findings are Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member’s Rights, and Quality Management.	PHC received a letter from the Department of Health Care Services on September 11, 2014, confirming that the CAPs the MCP provided DHCS were accepted. All remaining open items were reviewed and found to be in compliance. See attached.
2. Regarding the use of supplemental data: <ul style="list-style-type: none"> a. Implement an ongoing and formal validation process for supplemental datasets. b. Validate a large percentage of records to ensure that these data are reliable for future reporting. c. Require all providers to upload into the supplemental database proof-of-service documentation for all services they provided. 	Partnership HealthPlan has leveraged our Internal Quality Improvement Program Technical Workgroup and Internal Quality Data Workgroup to develop an ongoing and formal validation process for supplemental data. Our first priority was to focus on improving our validation process for data collected through our Quality Improvement Program using eReports. The Internal Quality Improvement Program Technical Workgroup has agreed on the following proposed recommendations to audit data entered into eReports. Audit annually: Start with an annual audit in early April. (Justification: Providers tend to wait to enter data toward the end of the reporting window of eReports. This time frame will

2013–14 External Quality Review Recommendations Directed to Partnership HealthPlan of California	Self-Reported Actions Taken by Partnership HealthPlan of California during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendations
	<p>also be in parallel with HEDIS Medical Record Collection to decrease the burden on providers. This will allow critical and noncritical errors to be addressed prior to payment.) Re-evaluate the need for a biannual audit post 2015-16 auditing results/findings.</p> <p>Auditing Sampling: Exact sample size and sampling methodology TBD.</p> <p>Auditing Criteria: Using HEDIS specifications for determining critical vs. noncritical errors.</p> <p>Target Rate of Compliance: 98 percent.</p> <p>Critical Errors: Notify the site of findings and remove the data from the site’s score for 2015-16 QIP year.</p> <p>Noncritical Errors: Numerator compliance remains, and an email notification of non-critical error finding is sent to the provider. Data entry is corrected in eReports.</p> <p>Corrective Action Plan: For continuous critical error findings the following intervention would be applied:</p> <ul style="list-style-type: none"> • Individual counseling and education on the PCP QIP and data reporting requirements, in addition to the above steps.
<p>3. Assess the factors leading to several measures having rates below the MPLs. Specifically, work with DHCS to prioritize quality improvement activities and interventions and, based on DHCS’s requirements, submit an IP and/or use a rapid cycle approach (including Plan-Do-Study-Act cycle) to address the MCP’s poor performance related to the following measures:</p> <ol style="list-style-type: none"> <i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs (MPM) for Mendocino and Sonoma counties</i> <i>Annual Monitoring for Patients on Persistent Medications—Diuretics (MPM) for Mendocino County</i> <i>Childhood Immunization Status—Combination 3 (CIS) for Mendocino County</i> <i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC-Eye Exam) for Mendocino County</i> <i>Immunizations for Adolescents—</i> 	<p>Partnership HealthPlan of CA (PHC) identified several measures falling below the MPLs with the majority falling in Mendocino County. PHC worked closely with DHCS to prioritize improvement activities and interventions and completed improvement plans and/or PDSA cycles that addressed poor performance. Please see below a summary of the IPs and PDSAs completed.</p> <p><u>MPM—Mendocino and Sonoma County</u> For HEDIS 2014, we identified additional data sources through the following:</p> <ul style="list-style-type: none"> • Quest’s online lab portal. • Labs performed by providers but not available through the portal: Santa Rosa Community Health Clinic, Kaiser Permanente and Mendocino Community Health Clinic. <p>The supplemental data source significantly improved the performance across multiple measures and regions for HEDIS 2014. Alongside our long-range work to improve our lab data quality, PHC has continued its efforts to ensure data completeness and accurate reflection of measure performance in monitoring patients on persistent medications.</p> <p><u>CDC-Eye Exam</u> PHC tested the administrative data file provided by VSP to evaluate whether VSP is sending us data on PHC members that</p>

<p>2013–14 External Quality Review Recommendations Directed to Partnership HealthPlan of California</p>	<p>Self-Reported Actions Taken by Partnership HealthPlan of California during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendations</p>
<p><i>Combination 1 (IMA) for Mendocino County</i></p> <p>f. <i>Medication Management for People with Asthma—Medication Compliance 50% Total (MMA) for Marin County</i></p> <p>g. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) for Mendocino County</i></p>	<p>have had an eye exam with VSP for diabetic retinal disease, by using 2013 measurement year data. This built off of the test implemented in October where PHC identified using a sample of 20 members that we collected data from VSP on 19 of our MY 2013 numerator negatives, suggesting that we now look at whether data are complete for our positive hits in MY 2013.</p> <p>During the course of our PDSA, PHC identified the following:</p> <ul style="list-style-type: none"> • 12 out of the 20 had the service and a claim present in VSP claims system (60 percent). • It is clear that PHC is missing service data from VSP. • VSP acknowledged that there is a gap. <p>The results suggest that there is a data gap in the VSP data file. Long term, PHC will work with our IT department and VSP to identify root causes for the gap and implement solutions accordingly. The ultimate goal would be to receive all data through monthly data files to PHC and have a system to check the completeness on a routine basis.</p> <p>In the short-term and to better understand the issues, the QI Analyst and IT team are working with VSP on a separate file layout which will be used as supplemental data for HEDIS MY 2014. During the week of January 23, 2015, VSP shared a file layout which we have sent to our auditor for review and approval.</p> <p>On February 2, 2015, our HEDIS auditor approved the use of VSP as supplemental data for MY 2014.</p> <p><u>MMA</u></p> <p>PHC partnered with our largest federally qualified health center (FQHC) in Marin County, Marin Community Clinic, to address members’ low compliance rate with taking their asthma medications. PHC’s focus was to identify members assigned to Marin Community Clinic who have received an asthma controller medication but not yet remained on asthma controller medication for at least 50 percent of their treatment periods. Once this population was identified, the Senior Health Educator worked closely with Marin to understand its current process for managing patients with asthma. During the course of our PDSA, PHC learned that Marin Community Clinic has done previous work focused on asthma care and that Marin staff members believed mechanisms for managing these patients were in place. PHC learned that there may be a disconnect between the number of non-compliant PHC HEDIS records versus the quality of care and management being delivered to asthma patients.</p> <p>PHC determined to maintain open communication with Marin Community Clinic and to continue to monitor its process for</p>

2013–14 External Quality Review Recommendations Directed to Partnership HealthPlan of California	Self-Reported Actions Taken by Partnership HealthPlan of California during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendations														
	<p>managing asthma patients. PHC will re-evaluate performance based on HEDIS 2015. If performance continues to fall below the MPL, we will stratify the data, evaluate Marin Community Clinic’s performance, and determine appropriate interventions.</p> <p>CIS/IMA</p> <p>Alongside our long-range work to improve immunization rates for both childhood and adolescents in Mendocino County (i.e., incentivizing DTap and the utilization of the CAIR registry through PHC’s Pay-for-Performance program and provider-focused education on the importance of immunization), PHC tested whether an educational webinar would be an effective tool to increase provider knowledge of best practices and confidence in leveraging evidence-based tools to improve provider-parent communication, and consequently, childhood immunization rates. The individual supporting this test is a board-certified pediatrician at Kaiser Permanente in Vacaville, CA, with 19 years practice experience.</p> <p>Webinar Participant Evaluation Summary</p> <table border="1" data-bbox="719 951 1336 1228"> <tr> <td>Registrants</td> <td>73</td> </tr> <tr> <td>Number of attendees</td> <td>38</td> </tr> <tr> <td>Percentage of registrants that attended</td> <td>52%</td> </tr> <tr> <td>Number of counties represented</td> <td>9</td> </tr> <tr> <td>Number of health centers represented</td> <td>11</td> </tr> <tr> <td>Survey responses</td> <td>23</td> </tr> <tr> <td>Survey response rate</td> <td>61%</td> </tr> </table> <p>Reflecting on our predictions</p> <ol style="list-style-type: none"> 1. PHC predicts we will be able to identify what content provided by Dr. Gaborko was most helpful in guiding provider sites through conversations with parents who are resistant to vaccinating their children. <ol style="list-style-type: none"> a. FINDING: True. Provider sites indicated that the following content was most helpful: <ol style="list-style-type: none"> i. Techniques to use with parents resistant to vaccinating ii. Diagram of how to communicate with the three different types of parents (unsure of, want to delay, and resistant to vaccinating) iii. Guidance regarding building relationships with parent(s) and/or guardians (Emphasis on using the words “Safety” and “Protection”) 2. PHC predicts we will be able to identify provider sites in Mendocino County (and across PHC’s network) that feel confident applying some of the lessons learned from Dr. Gaborko. 	Registrants	73	Number of attendees	38	Percentage of registrants that attended	52%	Number of counties represented	9	Number of health centers represented	11	Survey responses	23	Survey response rate	61%
Registrants	73														
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2013–14 External Quality Review Recommendations Directed to Partnership HealthPlan of California	Self-Reported Actions Taken by Partnership HealthPlan of California during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendations
	<p>a. FINDING: True. 52 percent of survey respondents reported feeling very confident applying some of the lessons learned by Dr. Gaborko. No respondents indicated that they “did not feel confident” applying lessons learned from Dr. Gaborko’s webinar.</p> <p>3. PHC will identify provider sites (using the webinar evaluation) to support with further training and will obtain guidance regarding what training is needed.</p> <p>a. FINDING: True. 48 percent of respondents reported feeling “somewhat confident” in applying some of the lessons learned during the webinar. PHC identified Mendocino Community Health Clinics, a large site in Mendocino County, with whom it will further explore next steps.</p> <p>In addition to PHC’s three predictions, we identified opportunities for improvement. Based on qualitative feedback PHC received in the webinar evaluation, we identified the need to better promote physician attendance and explore offering continuing education credits (CEs) to motivate physician attendance among providers in our more rural counties (where CE opportunities are scarce).</p> <p>W34 Based on the number of measures that had fallen below the MPL in MY 2013, PHC worked closely with DHCS to prioritize measures based on the resource</p>
<p>4. Continue to assess the factors leading to five SPD rates being significantly worse than the non-SPD rates to ensure that the MCP is meeting the needs of the SPD population.</p>	<p>PHC saw lower performance among SPDs for the following measures:</p> <ul style="list-style-type: none"> a. Napa/Solano/Yolo: ACR, CAP-1219, CDC- BP b. Sonoma: CDC-BP c. Marin: CAP-1219 d. Mendocino: None <p>In response to the Readmissions measure, PHC believes the higher rate is due to the higher complexity and acuity of patients in the SPD population compared to those in the non-SPD population. This complexity is not controlled for in the readmission rate analysis.</p> <p>For the CAP age 12 to 19 years measure, we do not believe the differences are significant due to a smaller population of SPDs in this measure. In Napa/Solano/Yolo, for example, there were only 1216 members in the SPD denominator, compared to 8895 members in the non-SPD denominator. In Marin, there were 123 members in the SPD denominator, compared to 1400 members in the non-SPD denominator. The differences were not statistically significant and therefore no additional investigation was involved.</p>

2013–14 External Quality Review Recommendations Directed to Partnership HealthPlan of California	Self-Reported Actions Taken by Partnership HealthPlan of California during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendations
	<p>CDC-BP performance is lower among our SPDs in Napa/Solano/Yolo and Sonoma counties compared to our non-SPDs. This is the only CDC sub measure in the areas where non-SPD performance is statistically significantly higher than SPD performance. Blood pressure control may be more difficult to achieve in the SPD population given the higher complexity of this patient population. Since all other CDC sub measures revealed higher performance among SPDs than non-SPDs, PHC is confident that our SPD population is getting comparable diabetes care, compared to our non-SPD population.</p>
<p>5. Ensure all required documentation is included in the QIP Summary Form. The MCP should reference the QIP Completion Instructions and QIP Validation Tools to ensure that all documentation requirements for each activity have been addressed prior to QIP submission.</p>	<p>Partnership HealthPlan ensured documentation on the QIP summary form was complete, accurate and the QIP completion instructions were referenced. Partnership HealthPlan submitted three QIPs in 2014 that cover Eastern, Sonoma, Marin and Mendocino and received a “Met” status on all three on initial submission.</p>
<p>6. For the <i>Improving Access to Primary Care for Children and Adolescents</i> QIP, determine the factors that resulted in Study Indicator 1 for Sonoma County not achieving statistically significant improvement. HSAG recommends that Partnership assess whether existing interventions should be modified or new interventions with the potential to result in positive outcomes should be identified.</p>	<p>Partnership HealthPlan determined that the factors that resulted in Study Indicator 1 for Sonoma County not achieving statistically significant improvement were the following:</p> <ul style="list-style-type: none"> • Low supply of primary care clinicians • Operational inefficiency <p>PHC’s quality improvement team will continue to meet and evaluate existing interventions and reference our fishbone diagram to assist in identifying potential targeted interventions that both providers and member may benefit from.</p>

Recommendations

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

- ◆ Implement vigorous validation processes to ensure that all supplemental data used for reporting rates are accurate.
- ◆ Strengthen oversight of Kaiser to ensure that complete data are received for HEDIS reporting in a timely manner.
- ◆ Assess the factors leading to many rates being below the MPLs (mostly in the Northeast and Northwest regions) and implement strategies to improve performance to ensure meeting or exceeding the MPLs for all measures in RY 2016.

- ◆ For measures in the Southwest Region for which the MCP was held accountable to meet the MPLs in RY 2015, implement strategies to improve performance to above the MPLs in RY 2016:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
 - *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ While it is expected that the SPD population would have a higher rate of readmissions than the non-SPD population, the MCP should provide documentation of how the MCP assesses for the specific needs of the SPD population and ensures more intensive services are provided (as appropriate) to reduce the readmissions rate as much as possible.
- ◆ Although Partnership will not be continuing the formal QIPs, the MCP should continue to monitor and implement improvement strategies initiated for all four QIPs. Specifically, the MCP should:
 - Consider adopting the interventions that demonstrated positive impacts on the *Improving Access to Primary Care for Children and Adolescents* and *Improving the Timeliness of Prenatal and Postpartum Care* QIPs
 - Consider adopting the change tested through the *Immunizations* PDSA cycle, and share the revised workflow with other provider sites.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix X:
Performance Evaluation Report
San Francisco Health Plan
July 1, 2014 – June 30, 2015**

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Appendix X: Performance Evaluation Report – San Francisco Health Plan July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), was contracted by the California Department of Health Care Service (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), San Francisco Health Plan (“SFHP” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

SFHP is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries in San Francisco County may enroll in SFHP, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan.

SFHP became operational in San Francisco County to provide MCMC services effective January 1997. As of June 30, 2015, SFHP had 122,457 beneficiaries.¹ This represents 85 percent of the beneficiaries enrolled in San Francisco County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: October 1, 2015.

Medical Audit

The most recent medical audit for SFHP was conducted by DHCS March 3, 2014, through March 14, 2014, covering the review period of December 1, 2012, through November 30, 2013. The report was issued August 7, 2014. DHCS reviewed the following areas:

- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Members' Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

DHCS identified findings in all review areas. The following findings are repeat findings from previous reviews:

- ◆ Utilization Management—SFHP had not implemented a system to track prior authorization referrals to completion.
- ◆ Access and Availability of Care—The MCP's monitoring did not determine and ensure whether or not existing 24-hour network pharmacies were accessible and met beneficiaries' after-hours pharmacy needs.
- ◆ Quality Management—SFHP's Quality Improvement Committee was not accountable for delegation oversight activities conducted by the MCP.
- ◆ Administrative and Organizational Capacity—SFHP did not implement a more proactive fraud and abuse program as stated in its prior audit corrective action plan (CAP).

DHCS required SFHP to submit a CAP related to all findings identified during the medical audit. A letter from DHCS dated December 31, 2014, indicated that on October 15, 2014, SFHP provided DHCS with a response to its CAP, which was originally issued on August 29, 2014. The letter stated that all open items were reviewed and found to be in compliance or were provisionally closed. DHCS tracked provisionally closed deficiencies until they were ameliorated. The letter indicated that the CAP was closed.

Strengths

SFHP resolved all findings identified during the most recent medical audit.

Opportunities for Improvement

Since SFHP resolved all findings identified during the most recent medical audit, HSAG has no recommendations for opportunities for improvement related to compliance reviews.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for San Francisco Health Plan* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance Audit.³ HSAG auditors determined that SFHP followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the notable findings is included below.

- ◆ Although SFHP experienced significant membership growth during the measurement year, the MCP experienced no claims processing backlogs and no enrollment processing delays.
- ◆ SFHP continued its robust beneficiary and provider incentive programs to help encourage timely services that may impact HEDIS reporting and general quality of care.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. (See Table 3.1 for SFHP’s performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP’s performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA’s national percentiles. MPLs and HPLs align with NCQA’s national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

² Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit™ is a trademark of NCQA.

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement, as part of routine monitoring, is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
SFHP—San Francisco County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	15.81%	13.86%	19.71%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	26.68	35.34	33.03	34.32	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	354.39	348.95	383.10	369.40	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	73.20%	76.81%	87.32%	86.47%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	NA	81.82%	95.92%	51.02%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	71.43%	78.74%	86.31%	86.94%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	45.45%	53.75%	44.01%	45.34%	↔
Cervical Cancer Screening	Q,A	—	—	74.47%	74.00%	↔
Childhood Immunization Status—Combination 3	Q,A,T	87.04%	85.81%	85.42%	82.87%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	92.98%	95.95%	97.01%	93.66%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	87.90%	89.57%	92.55%	90.01%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	90.08%	93.16%	94.70%	94.11%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	86.78%	91.13%	91.04%	91.05%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	78.64%	74.77%	76.57%	75.41%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	69.72%	67.59%	62.41%	68.91%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	91.08%	90.97%	89.33%	91.42%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	63.38%	62.27%	63.57%	62.41%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	83.57%	87.73%	86.77%	87.94%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	26.53%	26.39%	24.36%	25.06%	↔
Controlling High Blood Pressure	Q	—	66.46%	63.42%	72.19%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	64.35%	81.02%	81.71%	79.40%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	42.82%	52.10%	55.69%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	21.55%	32.87%	32.43%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	75.64%	71.76%	70.40%	70.59%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	93.44%	87.96%	93.24%	90.12%	↔
Use of Imaging Studies for Low Back Pain	Q	82.98%	86.53%	84.86%	86.16%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	76.16%	85.19%	86.81%	85.19%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	80.56%	85.19%	82.41%	81.48%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	72.69%	83.80%	79.17%	77.78%	↔
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	84.95%	84.26%	86.81%	85.42%	↔

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

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

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 Seniors and Persons with Disabilities (SPD) measure results reported by SFHP. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for SFHP—San Francisco County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.81%	25.15%	▼	19.71%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.37%	87.32%	↔	86.47%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	48.65%	Not Comparable	51.02%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.24%	88.21%	↑	86.94%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	93.78%	NA	Not Comparable	93.66%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	90.09%	84.00%	↓	90.01%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	94.27%	88.38%	↓	94.11%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	91.33%	82.37%	↓	91.05%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the *All-Cause Readmissions* measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly *higher* SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly *lower* SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

⁴ 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 3.2.

**Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures
SFHP—San Francisco County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
331.26	27.68	621.71	78.27

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
SFHP—San Francisco County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014– 15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	18.08%	17.88%	25.15%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	74.89	75.73	78.27	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	527.95	615.01	621.71	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	77.85%	87.62%	87.32%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	80.56%	95.12%	48.65%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	79.97%	86.98%	88.21%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	NA	NA	NA	Not Comparable
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	83.67%	83.33%	84.00%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	90.85%	89.41%	88.38%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	87.06%	86.96%	82.37%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
SFHP—San Francisco County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.59%	5.69%	9.81%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	24.57	23.26	27.68	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	300.16	330.07	331.26	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	73.62%	86.25%	85.37%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	74.36%	83.72%	85.24%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.91%	97.04%	93.78%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.65%	92.69%	90.09%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	93.25%	94.85%	94.27%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	91.27%	91.16%	91.33%	↔

* Member months are a member’s “contribution” to the total yearly membership.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

SFHP had 13 measures with rates above the HPLs in RY 2015. The following measures had rates above the HPLs for the fifth consecutive year:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The following measures had rates above the HPLs for four consecutive years:

- ◆ *Use of Imaging Studies for Low Back Pain*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*

The rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure was above the HPL for the third consecutive year.

The rates for the following measures improved significantly from RY 2014 to RY 2015:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Controlling High Blood Pressure*

The rates for the following measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*

Seniors and Persons with Disabilities Findings

The SPD rate for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measures was significantly better than the non-SPD rate, and the SPD rates for the following measures were significantly worse than the non-SPD rates:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health needs of these beneficiaries. Additionally, the significantly lower SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population relying on specialist providers as their care source, based on complicated health care needs, rather than accessing care from a primary care practitioner.

Most SPD and non-SPD rates showed no statistically significant change from RY 2014 to RY 2015.

Assessment of Improvement Plans

SFHP had no rates below the MPLs in RY 2014, so the MCP was not required to submit any improvement plans (IPs). Although the rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measure was below the MPL in RY 2015, the MCP will not be required to submit an IP for this measure because DHCS did not require MCPs to meet the MPL due to the small range of variation between the MPL and HPL threshold for this measure.

Strengths

HSAG auditors determined that SFHP followed the appropriate specifications to produce valid rates, and identified no issues of concern. Although the MCP experienced significant membership growth during the measurement year, the MCP experienced no claims processing backlogs and no enrollment processing delays. Additionally, SFHP continued its robust beneficiary and provider incentive programs to help encourage timely services that may impact HEDIS reporting and general quality of care.

The rates for 13 measures exceeded the HPLs. The rates for seven measures exceeded the HPLs for the fifth consecutive year, the rates for two measures were above the HPLs for the fourth consecutive year, and the rate for one measure was above the HPL for the third consecutive year. The rates for two measures improved significantly from RY 2014 to RY 2015.

SFHP provided documentation of actions the MCP took to ensure that the MCP is meeting the needs of the SPD population (See Table 6.1).

Opportunities for Improvement

SFHP has the opportunity to assess the factors leading to the rates for the following measures being significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*

While there is no established MPL for the *All-Cause Readmissions* measure and DHCS does not hold MCPs accountable to meet the MPLs for the *Children and Adolescents' Access to Primary Care* measures, it is important for the MCP to assess the reasons for the rates declining significantly and implement improvement strategies, as applicable, to ensure that the decline does not continue.

Quality Improvement Project Objectives

SFHP participated in the statewide collaborative quality improvement project (QIP) and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 lists SFHP’s QIPs and indicates the QIP conducted; whether the QIP was clinical or nonclinical; and the domains of care (i.e., quality, access, and timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for SFHP
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Improving the Patient Experience</i>	Clinical	Q, A

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

SFHP selected two global measures from the *Consumer Assessment of Healthcare Providers and Systems (CAHPS®)*⁵ Survey to evaluate and improve the patient experience. The measures chosen were (1) *Rating of Personal Doctor*, and (2) *Rating of All Health Care*. By improving doctor-patient communication, SFHP aimed to improve beneficiaries’ satisfaction both with their personal doctors and their overall health care. Improved doctor-patient communication is associated with improved adherence to physician recommendations and improved self-management skills. Note: The CAHPS survey is not conducted annually; therefore, SFHP does not have the ability to annually determine if the MCP’s improvement efforts are resulting in an improvement in patient experience.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

⁵ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

**Table 4.2—Quality Improvement Project Validation Activity
SFHP—San Francisco County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	88%	100%	<i>Met</i>
Internal QIPs				
<i>Improving the Patient Experience</i>	Annual Submission	88%	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, 2014, through June 30, 2015, showed that SFHP’s submissions of its *All-Cause Readmissions* and *Improving the Patient Experience* QIPs each achieved an overall validation status of *Met*, with 100 percent of critical elements and 88 percent of evaluation elements met.

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

**Table 4.3—Quality Improvement Project Average Rates*
SFHP—San Francisco County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015**

QIP Study Stages	Activity	<i>Met</i> Elements	<i>Partially Met</i> Elements	<i>Not Met</i> 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	100%	0%	0%
Design Total		100%	0%	0%

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Implementation	VII: Sufficient Data Analysis and Interpretation**	71%	6%	24%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		80%	4%	16%
Outcomes	IX: Real Improvement Achieved	75%	0%	25%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		75%	0%	25%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for both SFHP’s *All-Cause Readmissions* and *Improving the Patient Experience* QIP annual submissions.

SFHP demonstrated a strong application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP demonstrated an adequate application of the Implementation stage, meeting 80 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For both *All-Cause Readmissions* and *Improving the Patient Experience* QIP annual submissions, SFHP did not document the factors that affected the ability to compare baseline data with Remeasurement 1 results. In addition, for the annual submission of the *Improving the Patient Experience* QIP, SFHP did not document the factors that threatened the internal or external validity of the Remeasurement 1 results and an interpretation of the extent to which the study was successful. Lastly, HSAG was unable to replicate the statistical testing for both study indicators for the *Improving the Patient Experience* QIP. Thus, both QIPs received lower scores for Activity VII.

Both QIPs progressed to the Outcomes stage during the reporting period, meeting 75 percent of the requirements for all applicable evaluation elements for both QIPs. The *Improving the Patient Experience* QIP met all applicable evaluation elements. However, the *All-Cause Readmissions* QIP did not achieve statistically significant improvement over baseline at Remeasurement 1, resulting in a lower score for Activity IX. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

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

**Table 4.4—Quality Improvement Project Outcomes for SFHP—San Francisco County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions		
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
15.8%	13.9%	‡
QIP #2—Improving the Patient Experience		
Study Indicator 1: Rating of overall health care		
Baseline Period 1/1/10–12/31/10	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
43.6%	52.9%*	‡
Study Indicator 2: Rating of personal doctor		
Baseline Period 1/1/10–12/31/10	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
54.7%	64.1%*	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement from the baseline period (*p* value < 0.05).

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

All-Cause Readmissions QIP

SFHP’s goal for the *All-Cause Readmissions* QIP was to decrease the readmission rate from 15.81 percent (baseline) to 15 percent (Remeasurement 1). The MCP surpassed the goal by decreasing the readmission rate to 13.86 percent. However, although the readmissions rate declined, the change was not statistically significant. A review of the MCP’s QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ SFHP revisited the major barriers identified at baseline and found no changes. The MCP continued to focus on the lack of follow-up with beneficiaries from clinics and medical groups in SFHP’s network.

- ◆ SFHP recategorized the *All-Cause Readmissions* measure in the Pay for Performance program as a required measure to be reported by program participants.

Improving the Patient Experience QIP

The *Improving the Patient Experience* QIP achieved statistically significant improvement over baseline for both study indicators. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ SFHP continued the Rapid Dramatic Performance Improvement (DPI) program, which assisted clinics to track real time “No Show Rate” and “Cycle Time” data and, ultimately, decrease the rates for both measures. The formal exit interview with participating clinics revealed a positive perception of the Rapid DPI program.
- ◆ SFHP worked with the Institute for Healthcare Communication to lead three all-day training sessions for providers on how to improve communication and patient centeredness while effectively using an electronic health record during the beneficiary visit.

Strengths

SFHP demonstrated an excellent application of the QIP Design stage, meeting all requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Improving the Patient Experience* QIPs. Both QIPs achieved a *Met* validation status on the first submission. Additionally, the *Improving the Patient Experience* QIP achieved statistically significant improvement over baseline for both study indicators.

Opportunities for Improvement

Although SFHP will not be continuing the formal QIPs, the MCP should continue to monitor whether or not the recategorization of the Pay for Performance program impacts the *All-Cause Readmissions* rates. In addition, as the *Improving the Patient Experience* QIP achieved statistically significant outcomes, the MCP should consider adopting the Rapid DPI program and/or the all-day provider training session and reassess to determine whether or not conducting these activities results in sustained improvement.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

SFHP’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for SFHP. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for SFHP

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	17.8%	26.3%	75th–90th	16.9%	9.2%	10th–25th
Diagnosis Code	26.4%	31.6%	25th–75th	42.8%	34.6%	10th–25th
Procedure Code	30.5%	43.8%	75th–90th	35.0%	22.5%	<10th
Procedure Code Modifier	71.9%	58.5%	10th–25th	77.6%	46.0%	<10th
Rendering Provider Name	7.2%	25.0%	≥90th	56.5%	68.1%	>25th–<75th
Billing Provider Name	32.3%	35.0%	25th–75th	18.7%	8.6%	<10th

Overall, the medical record omission rates for SFHP ranged from 7.2 percent (*Rendering Provider Name*) to 71.9 percent (*Procedure Code Modifier*). While five of SFHP’s medical record omission rates were better than the respective statewide rates, the medical record omission rate for the *Procedure Code Modifier* was worse than the statewide rate by 13.4 percentage points. When compared to other MCPs’ performance, SFHP’s performance varied depending on the specific data element (i.e., ranging from a percentile ranking of “10th–25th” for *Procedure Code Modifier* to “≥90th” for *Rendering Provider Name*).

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for SFHP contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For the encounter data omissions, SFHP’s rates varied from 16.9 percent (*Date of Service*) to 77.6 percent (*Procedure Code Modifier*). While SFHP performed better than the statewide encounter data omission rate by 11.6 percentage points for the *Rendering Provider Name* data element, the remaining five rates were worse than the respective statewide rates by at least 7.7 percentage points. SFHP

performed worse than 75 percent of the MCPs, with reportable encounter data omission rates with a percentile ranking of “<10th” or “10th–25th” for all key data elements except the *Rendering Provider Name*. These findings suggest that SFHP should take actions to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider’s billing office made a coding error.
- ◆ DHCS’s encounter data systems contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in SFHP’s encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider’s performance of the service and submission of the encounter to SFHP and/or DHCS.
- ◆ SFHP populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files SFHP submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for SFHP. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for SFHP

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	88.9%	83.6%	75th–90th	NA
Procedure Code	78.6%	77.6%	25th–75th	Inaccurate Code (52.2%); Higher Level of Services in Medical Records (26.7%)
Procedure Code Modifier	NA	99.5%	NA	—
Rendering Provider Name	86.9%	63.0%	75th–90th	NA
Billing Provider Name	73.7%	68.6%	25th–75th	NA
All-Element Accuracy	8.6%	4.3%	75th–90th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

When key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be generally accurate for SFHP, with all four reportable element accuracy rates being higher than the respective statewide rates. When compared to the MCPs, two data elements each received a ranking of “75th–90th”. For the *Procedure Code* data element, 52.2 percent of the identified errors in DHCS’s encounter data were associated with the use of inaccurate codes, where the reported codes were not supported by national coding standards; and 26.7 percent of the errors involved providers submitting lower-level service codes than were supported in the beneficiaries’ medical records.

Although SFHP’s all-element accuracy rate was better than the statewide rate, only 8.6 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 90 percent of the dates of service reviewed in this study. While the inaccuracy from each of the five key data elements contributed to SFHP’s all-element accuracy rate, the *Procedure Code Modifier* data element contributed the least to the all-element inaccuracies.

Medical Record Review Recommendations

Based on the study findings for SFHP, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, SFHP should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounter System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. SFHP should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.

- ◆ SFHP should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ SFHP should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code Modifier* data element and develop strategies to improve rates.
- ◆ SFHP should explore the reasons for the relatively high encounter data omission rates for all key data elements and take actions to improve rates.
- ◆ SFHP should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with SFHP.
- ◆ SFHP should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.

- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

SFHP's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to the Post Adjudicated Claims and Encounters System (PACES). Based on review of SFHP's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist SFHP with improving its encounter data quality. DHCS followed up with SFHP regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁶ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁶ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of SFHP's performance in the three domains of care—quality, access, and timeliness.

Quality

HSAG reviewed SFHP's 2015 Quality Improvement Program description and found detailed documentation of processes the MCP uses to ensure that quality care is provided to its beneficiaries. SFHP's *2014 Quality Improvement and Utilization Management Program Evaluation* document provided a summary of the MCP's progress toward meeting established goals. The MCP reported meeting most quality-related goals; and, for goals not met, the MCP provided details of interventions it would be implementing moving forward to meet the established goals.

The rates for 13 quality measures exceeded the HPLs in RY 2015, and the following quality measures had rates above the HPLs for at least the third consecutive year:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* (fifth consecutive year)
- ◆ *Childhood Immunization Status—Combination 3* (fifth consecutive year)
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* (fifth consecutive year)
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* (fifth consecutive year)
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* (third consecutive year)
- ◆ *Use of Imaging Studies for Low Back Pain* (fourth consecutive year)
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* (fourth consecutive year)
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* (fifth consecutive year)
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* (fifth consecutive year)
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (fifth consecutive year)

The rates for the following quality measures improved significantly from RY 2014 to RY 2015, resulting in the rates moving to above the HPLs:

- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Controlling High Blood Pressure*

The rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care, was significantly worse in RY 2015 when compared to RY 2014. Additionally, the SPD rate for the measure was significantly worse than the non-SPD rate; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health needs of these beneficiaries.

The SPD rate for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure was significantly higher than the non-SPD rate.

Both of SFHP's QIPs fell into the quality domain of care. Both QIPs progressed to the Outcomes stage. The *Improving the Patient Experience* QIP achieved statistically significant improvement over baseline for both study indicators; however, the *All-Cause Readmissions* QIP did not achieve statistically significant improvement from baseline to Remeasurement 1. Additionally, as noted previously, the rate for the *All-Cause Readmissions* measure was significantly worse in RY 2015 when compared to RY 2014.

Overall, SFHP showed above-average performance related to the quality domain of care.

Access

HSAG reviewed SFHP's 2015 Quality Improvement Program description and found that the MCP has a Member Access to Care Committee that meets at least quarterly to review access data, discuss ways to expand monitoring efforts, and evaluate the success of access-related initiatives.

The *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure falls into the access domain of care. As indicated above, the rate for the measure improved significantly from RY 2014 to RY 2015, resulting in the rate moving to above the HPL. Other access measures with rates above the HPLs in RY 2015 were:

- ◆ *Childhood Immunization Status—Combination 3* (fifth consecutive year).
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* (third consecutive year).
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (fifth consecutive year).

The rates for the following access measures were significantly worse in RY 2015 when compared to RY 2014:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*

Five of the measures stratified for the SPD and non-SPD populations fall into the access domain of care. The *All-Cause Readmissions* measure is one of the measures and, as stated above, the SPD rate was significantly worse than the non-SPD rate, which is to be expected. The SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years, 7 to 11 Years, and 12 to 19 Years* measures were significantly worse than the non-SPD rates. The significantly lower SPD rates for these measures may be attributed to children and adolescents in the SPD population relying on specialist providers as their care sources, based on complicated health care needs, rather than accessing care from primary care practitioners.

Both of SFHP's QIPs fell into the access domain of care. As stated above, both QIPs progressed to the Outcomes stage. As noted, the *Improving the Patient Experience* QIP achieved statistically significant improvement over baseline for both study indicators; however, the *All-Cause Readmissions* QIP did not achieve positive results, and the rate for the measure was significantly worse in RY 2015 when compared to RY 2014.

Overall, SFHP showed above-average performance related to the access domain of care.

Timeliness

SFHP’s 2015 Quality Improvement Program description includes information on the MCP’s monitoring activities to ensure timeliness of care to beneficiaries. SFHP’s 2014 Quality Improvement and Utilization Management Program Evaluation document indicated that the MCP experienced challenges meeting utilization management goals in the final two months of calendar year 2014. To address the barriers to meeting the goals, the MCP planned to increase staffing and provide additional training to the utilization management staff members.

The rates for the following timeliness measures were above the HPLs in RY 2015:

- ◆ *Childhood Immunization Status—Combination 3* (fifth consecutive year)
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (fifth consecutive year)

Overall, SFHP showed average performance related to the timeliness domain of care. SFHP’s timeliness score is average because the score is based on five measures. The rates for three timeliness measures were between the MPLs and HPLs (i.e., average performance) and two timeliness measures had rates above the HPLs, which results in a score of average performance based on the standardized scoring process.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with SFHP’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—SFHP’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. Assess the factors leading to the SPD rates for six measures being significantly worse than the non-SPD rates to ensure that the needs of the SPD population are being met.</p>	<p>In 2013–2014, SPDs represented a newer demographic for SFHP. As a result, our program interventions listed below had not adequately impacted our SPD rates. Moving forward, SFHP will maintain the programs listed below. In addition, SFHP has recently developed a rolling HEDIS database that will allow for more frequent monitoring of stratification on those rates required by DHCS.</p> <p>For the <i>All-Cause Readmissions</i> measure, SFHP achieved a <i>Met</i> validation status with the <i>All-Cause Readmissions</i> QIP in 2014 through submission and evaluation of its quality improvement plan. In</p>

2013–14 External Quality Review Recommendation Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
	<p>addition, SFHP integrated an <i>All-Cause Readmissions</i> measure into its Pay for Performance program (P4P) measure set in 2014. The goal of the program is to improve performance for both SPD and non-SPD members.</p> <p>For the <i>CDC BP Control</i> and <i>Eye Exam</i> measures, SFHP plans to expand its member interventions related to diabetes as part of its new disease management program in 2015. The program will now include a new \$25 eye exam incentive in addition to the \$25 gift card for BP control and A1c testing. SFHP’s CareSupport program also promoted these incentives throughout the time period above to the SPD members to whom they provide case management support.</p> <p>To improve performance in the <i>Children and Adolescents’ Access to Primary Care Practitioners</i> measure, SFHP implemented an iPad raffle incentive (promoted via mail) to encourage members (both SPD and non-SPD) to get their annual primary care visit. SFHP has not taken additional actions to improve compliance for the CAP measure for the following reasons: DHCS is no longer holding MCPs to a minimum performance level because there is insufficient evidence to support the CAP measure as an adequate measure of access for the target population; SFHP has very low denominators for the SPD CAP stratification.</p>
<p>2. Continue to reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to the QIP submission and, if needed, request to have a technical assistance call with HSAG to ensure that the MCP fully understands all QIP documentation requirements.</p>	<p>To meet the QIP Completion Instruction requirements, SFHP attended all technical assistance calls offered by HSAG. Additionally, SFHP has kept in close contact with HSAG representatives to clarify QIP requirements. During this review period, both of SFHP’s QIPs were accepted on the first submission, receiving an overall status of “Met.”</p>
<p>3. Perform an annual barrier analysis for the <i>Improving Patient Experience</i> QIP, and assess whether interventions should be revised, standardized, scaled up, or discontinued.</p>	<p>SFHP completed a causal/barrier analysis for the <i>Improving Patient Experience</i> QIP during the review period. Each intervention was evaluated for possible changes, sustainability, and spreading to other environments. Evaluation findings and next steps were articulated in each of the QIP submissions.</p>

Recommendations

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

- ◆ While DHCS does not hold MCPs accountable to meet the MPLs for the *Children and Adolescents’ Access to Primary Care* measures, the MCP should assess the reasons for the rates for the *12 to 24 Months* and *25 Months to 6 Years* measures declining significantly and implement improvement strategies, as applicable, to ensure that the decline does not continue.

- ◆ Although SFHP will not be continuing the formal QIPs, the MCP should:
 - Continue to monitor whether or not the recategorization of the Pay for Performance program impacts the *All-Cause Readmissions* rates. Additionally, since the rate for the *All-Cause Readmissions* measure was significantly worse in RY 2015 when compared to RY 2014, the MCP should reassess the barriers to improvement and implement strategies to address the significant increase in the number of readmissions.
 - Consider adopting the Rapid DPI program and/or the all-day provider training session and reassess to determine if conducting these activities results in sustained improvement related to beneficiary experience.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix Y:
Performance Evaluation Report
Santa Clara Family Health Plan
July 1, 2014 – June 30, 2015**

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Appendix Y: Performance Evaluation Report – Santa Clara Family Health Plan July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), Santa Clara Family Health Plan (“SCFHP” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

SCFHP is a full-scope MCP delivering services to its Medi-Cal Managed Care (MCMC) beneficiaries (referred to as “beneficiaries” in this report) as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). Beneficiaries may enroll in SCFHP, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan (CP).

SCFHP became operational in Santa Clara County to provide MCMC services effective February 1997. As of June 30, 2015, SCFHP had 234,845 beneficiaries in Santa Clara County.¹ This represents 78 percent of the beneficiaries enrolled in Santa Clara County.

¹ *Medi-Cal Managed Care Enrollment Report—June 2015*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: December 21, 2015.

2. **MANAGED CARE HEALTH PLAN COMPLIANCE** *for Santa Clara Family Health Plan*

Medical and State Supported Services Audit

DHCS conducted two audits in tandem—a medical audit and State Supported Services audit—of SCFHP March 3, 2014, through March 14, 2014, covering the period of January 1, 2013, through December 31, 2013. DHCS assessed the following areas:

- ◆ Compliance with State Supported Services contract and regulations
- ◆ Utilization Management
- ◆ Case Management and Coordination of Care
- ◆ Access and Availability of Care
- ◆ Member’s Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

DHCS issued two reports on September 11, 2014—one for the medical audit and one for the State Supported Services audit. DHCS indicated that SCFHP was in compliance with the State Supported Services contractual requirements; however, DHCS identified findings in all areas it assessed during the medical audit portion of the March 2014 on-site visit.

In a letter dated June 18, 2015, DHCS stated that on October 24, 2014, SCFHP provided DHCS with a response to the corrective action plan (CAP) originally issued on September 23, 2014. Additionally, DHCS stated that on January 26, 2015, SCFHP provided a response to an email from DHCS regarding provisionally-closed deficiencies. DHCS indicated that it provisionally closed all open deficiencies and that the MCP could either provide evidence of the implementation of the policies or the items could remain provisionally closed until the next audit, tentatively scheduled for the first quarter of 2016. The letter indicated that the accompanying report would serve as DHCS’s final response to the MCP’s CAP.

1115 Waiver Seniors and Persons with Disabilities Enrollment Survey

The most recent Department of Managed Health Care (DMHC) 1115 Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey (hereafter referred to as “SPD medical survey”) for SCFHP was conducted March 3, 2014 through March 6, 2014, covering the period of January 1, 2013, through December 31, 2013. DMHC assessed the following areas related to SCFHP’s delivery of care to the SPD population:

- ◆ Utilization Management
- ◆ Continuity of Care
- ◆ Availability and Accessibility
- ◆ Member Rights
- ◆ Quality Management

DMHC issued a report to DHCS March 26, 2015. In the report, DMHC indicated that it identified findings in all areas reviewed under the scope of the SPD medical survey. In a letter dated October 19, 2015, DHCS stated that on October 19, 2015, SCFHP provided DHCS with its most recent response to its CAP, originally issued on July 7, 2015. The letter stated that DHCS had reviewed all remaining open items and found SCFHP to be in compliance. DHCS therefore closed the CAP.

Note that while DHCS issued the referenced letter outside the review dates for this MCP-specific evaluation report, HSAG included the information because the MCP resolved all findings identified in the DMHC report that was submitted to DHCS during the review period for this MCP-specific evaluation report.

Strengths

DHCS identified no findings during the March 2014 State Supported Services audit for SCFHP. The MCP provided the required documentation to DHCS regarding findings from the March 2014 medical audit, resulting in DHCS sending to SCFHP its final response to the MCP's CAP related to the medical audit. Additionally, SCFHP resolved all findings from the March 2014 SPD medical survey.

Opportunities for Improvement

Since SCFHP appears to have provided the required documentation to DHCS regarding the March 2014 medical audit and March 2014 SPD medical survey findings, HSAG has no recommendations for SCFHP related to compliance audits.

Performance Measure Validation—Findings

The *HEDIS² 2015 Compliance Audit Final Report of Findings for Santa Clara Family Health Plan* contains the detailed findings and recommendations from HSAG's NCQA HEDIS Compliance Audit.³ HSAG auditors determined that SCFHP followed the appropriate specifications to produce valid rates, and no issues of concern were identified. The auditor noted that although SCFHP's membership increased by 47 percent from the prior measurement year, the MCP was able to absorb this significant increase without any major issues or disruption to services. Additionally, data integrity and processing were not impacted by the increase in membership.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. (See Table 3.1 for SCFHP's performance measure results for reporting years [RYs] 2012 through 2015. Note that data may not be available for all four years.) The RY is the year in which the MCP reported the rates. The RY rates reflect measurement year (MY) data from the previous calendar year.

Understanding Table 3.1

The reader should note the following regarding Table 3.1:

- ◆ The MCP's performance compared to the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs) is shown for each year.
 - DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, for which a low rate indicates better performance, and a high rate indicates worse performance. For this measure, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.
- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure originally developed for DHCS's *All-Cause Readmissions* collaborative quality improvement project (QIP); therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).

² Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

- ◆ The *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures, which measure the volume of services used. DHCS does not establish MPLs or HPLs for utilization measures. Additionally, HSAG did not compare performance for these measures since high and low rates do not necessarily indicate better or worse performance.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for RY 2015:
 - *Annual Monitoring for Patients on Persistent Medications—Digoxin*—Denominators are small for this indicator, and each individual counted toward the denominator would be expected to be counted toward the *ACE Inhibitors or ARBs* and *Diuretics* denominators since these patients generally receive all three medications. Furthermore, serum digoxin concentration measurement as part of routine monitoring is not evidence-based and is not recommended by the American College of Cardiology or American Heart Association (see <http://circ.ahajournals.org/content/113/21/2556.full.pdf+html>).
 - Note: NCQA made several changes to the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure specifications for HEDIS 2015. The specifications no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring. In addition, the specifications added monitoring of serum digoxin level to meet the numerator criteria. The additional requirement is more restrictive, and may be directly related to all MCPs with rates that could be compared to the previous year's rates experiencing statistically significant decline in their rates. Despite the specification changes, NCQA did not consider the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure to be a first-year measure in RY 2015; however, based on the potential negative impact the specification changes had on the rates for this measure, HSAG draws no conclusions from the comparative analysis on this measure for RY 2015 and does not include this measure in its assessment of MCP performance.
 - All four *Children and Adolescents' Access to Primary Care* measures—Due to the small range of variation between the MPL and HPL threshold for each measure, DHCS did not hold MCPs accountable to meet the MPLs for these four measures.

**Table 3.1—Multi-Year Performance Measure Results*
SCFHP—Santa Clara County**

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	13.77%	15.20%	16.92%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	35.89	34.79	32.64	34.98	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	292.77	267.45	260.02	233.52	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	86.05%	87.60%	87.39%	87.74%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	87.18%	88.10%	89.01%	58.16%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	84.85%	88.08%	87.91%	86.65%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	25.81%	26.43%	29.40%	30.94%	↔
Cervical Cancer Screening	Q,A	—	—	67.40%	57.18%	↓
Childhood Immunization Status—Combination 3	Q,A,T	80.05%	73.72%	75.43%	71.53%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	96.22%	96.87%	97.15%	94.65%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	88.63%	88.90%	88.94%	87.69%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	89.69%	88.92%	90.46%	90.15%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	86.78%	87.81%	87.46%	86.77%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	45.01%	53.53%	56.69%	60.58%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	47.69%	41.85%	46.72%	48.66%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	86.62%	86.62%	86.86%	91.48%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	51.09%	55.47%	54.01%	58.15%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	80.05%	79.81%	83.45%	90.51%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	40.88%	34.79%	33.82%	29.68%	↔
Controlling High Blood Pressure	Q	—	52.80%	52.55%	54.99%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	69.34%	75.67%	75.43%	81.27%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	58.61%	61.13%	59.94%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	35.95%	41.98%	37.01%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	58.39%	67.40%	59.61%	61.07%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	82.73%	82.97%	86.13%	82.24%	↔
Use of Imaging Studies for Low Back Pain	Q	80.37%	82.42%	86.37%	85.52%	↔

Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	Q	64.23%	66.91%	71.53%	76.64%	↔
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	Q	63.99%	67.88%	67.40%	74.94%	↑
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	Q	45.74%	41.85%	49.15%	61.80%	↑
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Q,A,T	75.67%	72.75%	69.59%	78.35%	↑

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

² HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* For most measures, the reported rate is **bolded** if the rate is below the national Medicaid 25th percentile (i.e., the MPL), and is shaded if the rate is above the 90th percentile (i.e., the HPL) for that year. For the *Comprehensive Diabetes Care—HbA1c Poor Control* measure, the reported rate is **bolded** if the rate is above the 75th percentile (i.e., MPL) and shaded if the rate is below the 10th percentile (i.e., the HPL), since a lower rate indicates better performance.

** Member months are a member’s “contribution” to the total yearly membership.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant decline in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant improvement in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.2 and Table 3.3 present a summary of the RY 2015 Seniors and Persons with Disabilities (SPD) measure results reported by SCFHP. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁴ and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures.

⁴ 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 3.2.

Table 3.2—RY 2015 (MY 2014) Performance Measure Comparison and Results for Measures Stratified by the SPD Population for SCFHP—Santa Clara County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	11.91%	21.25%	▼	16.92%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.90%	88.66%	↑	87.74%
Annual Monitoring for Patients on Persistent Medications—Digoxin	53.33%	60.29%	↔	58.16%
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.22%	88.35%	↑	86.65%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.97%	67.31%	↓	94.65%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.77%	84.40%	↓	87.69%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.30%	86.37%	↓	90.15%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.02%	81.33%	↓	86.77%

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

↑ = SPD rates in RY 2015 were significantly higher than the non-SPD rates.

↓ = SPD rates in RY 2015 were significantly lower than the non-SPD rates.

↔ = SPD rates in RY 2015 were not significantly different than the non-SPD rates.

▲ ▼ are used to indicate the performance difference for the All-Cause Readmissions measure, where a lower rate indicates better performance. A downward triangle (▼) denotes a significantly higher SPD rate than the non-SPD rate in RY 2015 (i.e., lower performance). An upward triangle (▲) denotes a significantly lower SPD rate than the non-SPD rate in RY 2015 (i.e., higher performance).

Table 3.3—RY 2015 (MY 2014) Non-SPD and SPD Rates for Ambulatory Care Measures SCFHP—Santa Clara County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
216.50	33.98	399.37	44.71

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

Table 3.4 presents the three-year trending information for the SPD population, and Table 3.5 presents the three-year trending information for the non-SPD population across the measures that DHCS required the MCPs to stratify for the SPD and non-SPD populations for all three years.

**Table 3.4—RY 2015 (MY 2014) HEDIS SPD Trend Table
SCFHP—Santa Clara County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	16.54%	18.25%	21.25%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	42.92	45.66	44.71	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	403.89	411.17	399.37	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.79%	89.10%	88.66%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	89.33%	88.61%	60.29%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.07%	90.26%	88.35%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.30%	80.95%	67.31%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	88.74%	88.93%	84.40%	↓
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	89.16%	88.55%	86.37%	↔
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	89.55%	86.53%	81.33%	↓

* Member months are a member’s “contribution” to the total yearly membership.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table 3.5—RY 2015 (MY 2014) Non-SPD Trend Table
SCFHP—Santa Clara County**

Measure	RY 2013	RY 2014	RY 2015	RYs 2014–15 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.26%	8.29%	11.91%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	33.44	30.95	33.98	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	244.89	240.37	216.50	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.67%	82.83%	86.90%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	53.33%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.20%	81.68%	85.22%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.87%	97.31%	94.97%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.91%	88.94%	87.77%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.91%	90.52%	90.30%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.74%	87.49%	87.02%	↔

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

↑ = Rates in RY 2015 were significantly higher than they were in RY 2014.

↓ = Rates in RY 2015 were significantly lower than they were in RY 2014.

↔ = Rates in RY 2015 were not significantly different than they were in RY 2014.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* measure, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the RY 2015 rate from the RY 2014 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the RY 2015 rate from the RY 2014 rate.

Not Comparable = A RY 2014–15 rate difference could not be calculated because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Performance Measure Findings

The rates exceeded the HPLs for the following measures in RY 2015:

- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Use of Imaging Studies for Low Back Pain*

The rates improved significantly from RY 2014 to RY 2015 for the following measures:

- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- ◆ *Immunizations for Adolescents—Combination 1*

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates declined significantly from RY 2014 to RY 2015 for the following measures:

- ◆ *Cervical Cancer Screening*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total*

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures. The SPD rates were significantly worse than the non-SPD rates for the following measures:

- ◆ *All-Cause Readmissions*
- ◆ All four *Children and Adolescents' Access to Primary Care Practitioners* measures

Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries. Additionally, the significantly lower SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care providers.

When comparing the RY 2015 SPD rates to the RY 2014 SPD rates and the RY 2015 non-SPD rates to the RY 2014 non-SPD rates, HSAG noted the following variations:

- ◆ The non-SPD rates were significantly better in RY 2015 when compared to RY 2014 for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures.

- ◆ Both the SPD and non-SPD rates were significantly worse in RY 2015 when compared to RY 2014 for the *All-Cause Readmissions* measure; however, the MCP's total rate for this measure remained stable from RY 2014 to RY 2015.
- ◆ The non-SPD rate declined significantly in RY 2015 when compared to RY 2014 for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measure.
- ◆ The SPD and non-SPD rates declined significantly in RY 2015 when compared to RY 2014 for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure.
- ◆ The SPD rate declined significantly in RY 2015 when compared to RY 2014 for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure.

Assessment of Improvement Plans

SCFHP had no rates below the MPLs in RY 2014 and therefore was not required to submit any improvement plans (IPs). Although the rate was below the MPL for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measure in RY 2015, DHCS requires no IP for this measure due to the small range of variation between the MPL and HPL for the measure.

Strengths

SCFHP followed the appropriate specifications to produce valid performance measure rates, and the auditor identified no issues of concern. The auditor noted that although SCFHP's membership increased by 47 percent from the prior measurement year, the MCP was able to absorb this significant increase without any major issues or disruption to services. Additionally, data integrity and processing were not impacted by the increase in membership.

The MCP had three measures that exceeded the HPLs in RY 2015, and the rates improved significantly from RY 2014 to RY 2015 for six measures.

Opportunities for Improvement

SCFHP has the opportunity to identify the factors leading to the decline in performance for five measures and to implement strategies to improve these measures' rates. The MCP documented rationale for the SPD rates being significantly worse than the non-SPD rates for the *All-Cause Readmissions* and *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measures (See Table 6.1); however, since the SPD rates were significantly worse than the non-SPD rates in RY 2015 for the *All-Cause Readmissions* and all four *Children and Adolescents' Access to Primary Care Practitioners* measures, the MCP has the opportunity to ensure that processes are in place to meet the complex needs of the SPD population.

Quality Improvement Project Objectives

SCFHP participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014–June 30, 2015.

Table 4.1 below lists SCFHP’s QIPs and indicates the QIP conducted; whether the QIP was clinical or nonclinical; and the domains of care (i.e., quality, access, and timeliness) the QIP addressed.

**Table 4.1—Quality Improvement Projects for SCFHP
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Diabetic Retinopathy Improvement and Prevention by Screening</i>	Clinical	Q, A

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

The *Diabetic Retinopathy Improvement and Prevention by Screening* QIP targeted beneficiaries with diabetes and focused on increasing the rate of completed retinal eye exams. Ongoing management of beneficiaries with diabetes is critical both to preventing complications and to ensuring optimal health for those beneficiaries.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across Centers for Medicare & Medicaid Services (CMS) protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity
SCFHP—Santa Clara County
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	73%	100%	<i>Partially Met</i>
Internal QIPs				
<i>Diabetic Retinopathy Improvement and Prevention by Screening</i>	Annual Submission	96%	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, 2014, through June 30, 2015, showed that SCFHP’s annual submission of its *All-Cause Readmissions* QIP received a *Partially Met* validation status. Starting July 1, 2014, DHCS required that each MCP with a QIP that did not achieve a *Met* validation status on the annual submission submit a Plan-Do-Study-Act (PDSA) cycle related to that QIP topic rather than resubmitting the QIP for validation. As a result, SCFHP conducted a PDSA cycle for the *All-Cause Readmissions* QIP. The *Diabetic Retinopathy Improvement and Prevention by Screening* QIP annual submission achieved an overall validation status of *Met*, with 100 percent of the critical evaluation elements receiving a *Met* score.

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

Table 4.3—Quality Improvement Project Average Rates*
SCFHP—Santa Clara County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

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)	83%	17%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		96%	4%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation**	69%	15%	15%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total**		79%	11%	11%
Outcomes	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		25%	0%	75%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for SCFHP’s *All-Cause Readmissions* annual submission and Activities I through VIII for the MCP’s *Diabetic Retinopathy Improvement and Prevention by Screening* QIP annual submission.

SCFHP demonstrated a strong application of the Design stage, meeting 96 percent of the requirements for all applicable evaluation elements within the study stage. For the *Diabetic Retinopathy Improvement and Prevention by Screening* QIP, the MCP did not provide an accurate population size, resulting in a lowered score for Activity V. SCFHP demonstrated an adequate application of the Implementation stage for these QIPs, meeting 79 percent of the requirements for all applicable evaluation elements within the study stage. For the *All-Cause Readmissions* QIP, the MCP did not identify the factors that threatened the internal or external validity of the Remeasurement 1 findings. In addition, SCFHP did not compare the Remeasurement 1 rate and the goal or document factors that affected the ability to compare the baseline rate to the Remeasurement 1 rate, resulting in a lowered score for Activity VII. The MCP met all requirements for the applicable evaluation elements for the *Diabetic Retinopathy Improvement and Prevention by Screening* QIP.

Only the *All-Cause Readmissions* QIP progressed to the Outcomes stage during the reporting period. However, SCFHP’s *All-Cause Readmissions* QIP did not achieve statistically significant improvement over baseline at Remeasurement 1, resulting in a low score for Activity IX. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

Diabetic Retinopathy Improvement and Prevention by Screening QIP

The *Diabetic Retinopathy Improvement and Prevention by Screening* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the interventions that SCFHP indicated it planned to implement during the Remeasurement 1 time period:

- ◆ Set up a dashboard reporting on the volume and timing of encounter data for specific indicator codes.
- ◆ Promote beneficiary incentive program by proactively outreaching and encouraging targeted beneficiaries to complete their retinal eye exams.
- ◆ Implement an annual member satisfaction survey for all beneficiaries with diabetes enrolled in the MCP’s disease management program.

All-Cause Readmissions QIP

The *All-Cause Readmissions* QIP progressed to the Outcomes stage during the review period. Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

**Table 4.4—Quality Improvement Project Outcomes for SCFHP—Santa Clara County
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions		
Study Indicator: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement [‡]
13.8%	15.2%	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

SCFHP's goal for the *All-Cause Readmissions* QIP was to achieve a statistically significant reduction in the readmissions rate from baseline to Remeasurement 1. Unfortunately, the MCP did not meet the project's goal. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ SCFHP conducted a detailed causal/barrier analysis through reviewing claims data, diagnoses, case management files, and medical records of all readmissions for beneficiaries served by non-delegated networks. These beneficiaries account for 18 percent of the total beneficiaries readmitted during the measurement period.
- ◆ The MCP identified and prioritized the following barriers:
 - The MCP is not notified immediately or at all of outpatient observation stays, which are considered readmissions.
 - The MCP continues to have an insufficient number of case managers to complete post-discharge calls to SPD beneficiaries.
 - The MCP cannot reach beneficiaries in order to complete post-discharge calls.
- ◆ Although the interventions were not successful at improving QIP outcomes, following is a brief description of the interventions SCFHP indicated it implemented during the Remeasurement 1 time period:
 - Added additional case management staff to increase the number of SPD beneficiaries engaged in case management services.
 - Implemented a post-discharge call policy and procedure.
 - Implemented a discharge plan documentation pilot program with Stanford Hospital wherein, upon a beneficiary being discharged, the MCP's concurrent review team becomes responsible for downloading the electronic discharge plans from Stanford's online system. The discharge plan information was used in the care planning and care coordination processes.

Plan-Do-Study-Act Review

The *All-Cause Readmissions* QIP did not achieve a *Met* validation status; therefore, the MCP was required to conduct a PDSA cycle for the QIP topic.

SCFHP set the SMART (Specific, Measureable, Achievable, Relevant, Time-bound) Objective as follows:

To prevent 30 day readmissions by increasing the percentage of post-discharge calls by case management team to Network 10 and Network 40 beneficiaries from 28 percent to 30 percent by March 30, 2015.

The purpose of the *All-Cause Readmissions* PDSA cycle was to test if conducting post-discharge calls following primary admissions would prevent readmissions within 30 days.

SCFHP completed the *All-Cause Readmissions* PDSA cycle; however, the MCP learned that the percentage of completed post-discharge calls was minimal. During first quarter of 2015, of the 132 beneficiaries eligible for the call, case management nurses attempted to reach 26 beneficiaries and only completed eight calls. The main factors contributing to the low rate of completed calls were inability to reach beneficiaries due to incorrect phone numbers, beneficiaries not responding after three attempts, and beneficiaries declining the call. Additionally, the MCP did not have a sufficient number of case management nurses to reach all eligible beneficiaries since each post-discharge call took 30 to 45 minutes to complete.

SCFHP concluded that this intervention is likely to be successful in reducing readmissions and will adopt the change as an ongoing project for the MCP's case management team. The MCP indicated that it will work with its information technology department to develop a tracking tool and with the hospital discharge staff to obtain current contact information for beneficiaries. Although SCFHP identified that it did not have sufficient staff to outreach all eligible beneficiaries, the MCP indicated that it is unable to add new staff at this time. As an alternative, the MCP approved having a senior case coordinator conduct post-discharge calls for acute cases and escalate complex issues to case management nurses for further follow-up.

Strengths

SCFHP demonstrated a strong application of the QIP Design stage, meeting 96 percent of the requirements for all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Diabetic Retinopathy Improvement and Prevention by Screening* QIPs. In addition, the *Diabetic Retinopathy Improvement and Prevention by Screening* QIP achieved a *Met* validation status on the first submission.

Opportunities for Improvement

Although SCFHP will not be continuing the formal QIPs, the MCP should continue to adopt the post-discharge outreach calls as documented in the *All-Cause Readmissions* PDSA Cycle Worksheet. In addition, the MCP should evaluate the interventions initiated in Remeasurement 1 of the *Diabetic Retinopathy Improvement and Prevention by Screening* QIP and continue efforts to improve performance on the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

SCFHP’s state fiscal year (SFY) 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for SCFHP. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for SCFHP

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	25.0%	26.3%	25th–75th	3.8%	9.2%	75th–90th
Diagnosis Code	34.5%	31.6%	10th–25th	30.7%	34.6%	25th–75th
Procedure Code	40.8%	43.8%	25th–75th	44.7%	22.5%	<10th
Procedure Code Modifier	66.6%	58.5%	25th–75th	59.8%	46.0%	10th–25th
Rendering Provider Name	23.5%	25.0%	25th–75th	17.5%	68.1%	≥90th
Billing Provider Name	30.1%	35.0%	25th–75th	4.1%	8.6%	75th–90th

Overall, the medical record omission rates for SCFHP ranged from 23.5 percent (*Rendering Provider Name*) to 66.6 percent (*Procedure Code Modifier*). Four SCFHP’s medical record omission rates were slightly better than the respective statewide rates, and the remaining two rates were worse than the statewide rates by 2.9 and 8.1 percentage points for the *Diagnosis Code* and *Procedure Code Modifier*, respectively. When compared to other MCPs’ performance, SCFHP received a percentile ranking of “25th–75th” for five of the medical record omission rates and a percentile ranking of “10th–25th” for one rate. These findings suggest an average level of completeness among key encounter data elements when compared to beneficiaries’ medical records.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located for the sampled dates of services.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for SCFHP contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, SCFHP’s rates varied from 3.8 percent (*Date of Service*) to 59.8 percent (*Procedure Code Modifier*). Four of SCFHP’s encounter data omission rates were better than the respective statewide rates with the *Rendering Provider Name* encounter omission rate better than the statewide rate by 50.6 percentage points (i.e., received a percentile ranking of “≥90th”). However, SCFHP performed worse than the statewide encounter data omission rates by 22.2 percentage points and by 13.8 percentage points for the *Procedure Code* and *Procedure Code Modifier*

data elements, respectively. An opportunity exists for SCFHP to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information.

The most common reasons for encounter data omissions were:

- ◆ The provider’s billing office made a coding error.
- ◆ DHCS’s encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields, DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in SCFHP’s encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ The provider submitted the non-standard codes instead of the standard procedure codes or procedure code modifiers.
- ◆ A lag occurred between the provider’s performance of the service and submission of the encounter to SCFHP (and/or the data subsequently being submitted to DHCS).
- ◆ SCFHP populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files SCFHP submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for SCFHP. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for SCFHP

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	85.0%	83.6%	25th–75th	NA
Procedure Code	85.1%	77.6%	25th–75th	NA
Procedure Code Modifier	NA	99.5%	NA	—
Rendering Provider Name	72.7%	63.0%	25th–75th	NA
Billing Provider Name	69.2%	68.6%	25th–75th	NA
All-Element Accuracy	7.8%	4.3%	75th–90th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be relatively accurate for SCFHP with all four reportable element accuracy rates higher than the respective statewide rates. When comparing the performance among MCPs, all four key data elements with reportable rates received a percentile ranking of “25th–75th”. In addition, low denominators prevented the display of error type results for these four key data elements.

Although SCFHP’s all-element accuracy rate was better than the statewide rate, only 7.8 percent of the dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated at least one inaccurate data element for more than 92 percent of the dates of service reviewed in this study. While all five key data elements contributed to SCFHP’s empirically low all-element accuracy rate, the *Procedure Code* data element contributed most and *Procedure Code Modifier* contributed least.

Medical Record Review Recommendations

Based on the study findings for SCFHP, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, SCFHP should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. SCFHP should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.
- ◆ SCFHP should avoid using local procedure codes or local procedure code modifiers for the encounter data submitted to DHCS.
- ◆ SCFHP should investigate the reasons for the relatively high medical record omission rate for the *Procedure Code Modifier* data element and develop strategies to improve the rate.

- ◆ SCFHP should explore the reasons for the relatively high encounter data omission rates for the *Procedure Code* and *Procedure Code Modifier* data elements and take actions to improve rates.
- ◆ SCFHP should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with SCFHP.
- ◆ SCFHP should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.
- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP’s Operational and Infrastructure Changes in Support of DHCS’s Transition to PACES

SCFHP’s SFY 2014–15 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the EDV study, which assessed the MCP’s operational and infrastructure changes in support of DHCS’s transition to PACES. Based on review of SCFHP’s Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist SCFHP with improving its encounter data quality. DHCS followed up with SCFHP regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

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.⁵ The scale for each level of performance is shown below:

- ◆ 2.5–3.0 = Above Average
- ◆ 1.5–2.4 = Average
- ◆ 1.0–1.4 = Below Average

The detailed scoring process is outlined below. (Note: When a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care).

Performance Measure Rates

Quality Domain

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

⁵ The CMS protocols specify that the EQRO must include in its detailed technical report 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. The report must also document procedures used by the EQRO to analyze the data collected, and describe how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

Access and Timeliness Domains

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

Quality Improvement Projects

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care. (Note: HSAG did not include the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure when calculating the Q, A, T scores because of the specification changes NCQA made to this measure for HEDIS 2015.)

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to beneficiaries; therefore, EDV study results are not included in the overall Q, A, and T scores.

Below, HSAG provides its assessment of SCFHP's performance in the three domains of care—quality, access, and timeliness.

Quality

As in previous years, SCFHP's quality improvement program description included details of the MCP's organizational structure and processes, which support the provision of quality care to beneficiaries. The MCP's work plan included goals and activities for improving quality of care, including an annual evaluation of the quality improvement program.

The rates exceeded the HPLs for the following quality measures in RY 2015:

- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Use of Imaging Studies for Low Back Pain*

The rates improved significantly from RY 2014 to RY 2015 for the following quality measures:

- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates declined significantly from RY 2014 to RY 2015 for the following quality measures:

- ◆ *Cervical Cancer Screening*
- ◆ *Medication Management for People with Asthma—Medication Compliance 75% Total*

For quality measures stratified by the SPD and non-SPD populations, the SPD rates were significantly better than the non-SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures. Additionally, the SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure; however, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Both of SCFHP's QIPs fell into the quality domain of care. Only the *All-Cause Readmissions* QIP progressed to the Outcomes stage, and the QIP did not achieve statistically significant improvement over baseline at Remeasurement 1. The MCP also conducted a PDSA cycle for the *All-Cause Readmissions* topic to test if conducting post-discharge calls following primary admissions would prevent readmissions within 30 days. While SCFHP had a low completion rate for the calls, the MCP determined that the intervention could be successful in reducing readmissions and therefore decided to adopt the change as an ongoing project for the MCP's case management team.

Overall, SCFHP showed above-average performance related to the quality domain of care.

Access

HSAG reviewed SCFHP's quality program documents and found that the MCP has processes in place to monitor beneficiary access to care.

SCFHP performance related to access measures was as follows:

- ◆ The rate improved significantly from RY 2014 to RY 2015 for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure, resulting in the rate moving to above the HPL in RY 2015.
- ◆ The rates improved significantly from RY 2014 to RY 2015 for the following measures:
 - *Comprehensive Diabetes Care—HbA1c Testing*
 - *Immunizations for Adolescents—Combination 1*
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- ◆ The rates declined significantly from RY 2014 to RY 2015 for the following measures:
 - *Cervical Cancer Screening*
 - *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*, resulting in the rate moving from above the MPL in RY 2014 to below the MPL in RY 2015
 - *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
 - *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Five of the measures stratified for the SPD and non-SPD populations fell into the access domain of care. The *All-Cause Readmissions* measure is one of these measures and, as stated above, the SPD rates were significantly worse than the non-SPD rates, which is to be expected. Additionally, the SPD rates were significantly worse than the non-SPD rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures. The significantly lower SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to children and adolescents in the SPD population relying on specialty providers as their care sources, based on complicated health care needs, rather than accessing care from primary care providers.

Both of SCFHP's QIPs fell into the access domain of care. As indicated above, only the *All-Cause Readmissions* QIP progressed to the Outcomes stage, and the QIP did not achieve statistically significant improvement over baseline at Remeasurement 1. Additionally, while SCFHP had a low completion rate for making post-discharge calls following primary admissions, the MCP determined that the intervention tested through the PDSA cycle could be successful in reducing readmissions and therefore decided to adopt the change as an ongoing project for the MCP's case management team.

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

Timeliness

HSAG reviewed SCFHP’s quality improvement program document and found that the MCP’s organizational structure included some processes designed to ensure that timely care is delivered to beneficiaries.

Five of the required performance measures fall into the timeliness domain of care. SCFHP performance related to these measures follows:

- ◆ The rates improved significantly from RY 2014 to RY 2015 for the following measures:
 - *Immunizations for Adolescents—Combination 1*
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- ◆ The rates for all five measures were between the MPLs and HPLs.

Overall, SCFHP 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with SCFHP’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—SCFHP’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
1. Assess the factors leading to the rate declining significantly from 2013 to 2014 for the <i>Prenatal and Postpartum Care—Postpartum Care</i> measure, and identify strategies to prevent the rate from declining to below the MPL.	Quality Improvement (QI) collaborated with Utilization Management to get census data for delivery-related admissions. QI staff outreached to mothers to educate them on the importance of getting postpartum care and offered gift cards to mothers who received postpartum care during the 21 to 56 days after delivery. HEDIS 2015 rates have increased to be above the MPL.

2013–14 External Quality Review Recommendation Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>2. For the following measures with SPD rates significantly worse than the non-SPD rates, assess the factors leading to the significantly worse SPD rates to ensure that the MCP is meeting the SPD population’s health care needs:</p> <ul style="list-style-type: none"> a. <i>All-Cause Readmissions</i> b. <i>Children and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months</i> c. <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i> 	<p>The MCP investigated the reasons for the disparity between SPD and non-SPD rates between 2013 and 2014 for the <i>All-Cause Readmissions (ACR)</i>, <i>CAP 12–24 months</i>, and <i>Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)</i>.</p> <p>The <i>ACR</i> measure is the best indication of how medically fragile the MCP SPD population is. While in 2014 the SPD population was 12 percent of the total population, the denominator for the <i>ACR</i> measure was more than double that of the non-SPD population. The MCP participates in the Coordinated Care Initiative (CCI) which has numerous metrics around case management. The refinement of the case management process will improve the <i>ACR</i> rates in subsequent years. While the rates may improve, the SPD population rates will probably continue to be statistically significantly different due to the medical fragility of the population.</p> <p>The <i>Children and Adolescents’ Access to Primary Care Practitioners (CAP) 12–24 months</i> SPD rate has significant differences from the non-SPD population rate mainly due to the small population size. The denominator for the last three years has averaged about 49 members, with the largest denominator being 54 members in 2013. A change of even one visit to a PCP can result in a change of 2 percent. Eighteen fewer visits in 2014 than there were in 2013 resulted in a decrease of 15 percent in the year for the SPD population. On the non-SPD side, an increase of 327 visits between 2013 and 2014 resulted in an increase of less than .5 percent for the non-SPD population. This is the best demonstration of the impact of small populations when measuring outcomes year to year.</p> <p>The <i>CDC</i> sub measures are a perfect indication of how medically frail the SPD population is. Most sub measures are comparable across the two populations, and in certain cases the SPD population outperforms their non-SPD counterparts in areas such as testing and control (with the exception of blood pressure control). This indicates that there is no barrier to receiving care (HbA1c testing and LDL-C screening) and that the care being received is having a positive impact on member health on a larger scale for the SPD population than for the non-SPD population (SPD population have better HbA1c control and better LDL-C levels than their non-SPD counterparts), but having worse BP control numbers indicates how medically frail the SPD population is.</p> <p>SPD Frailty</p> <p>Other HEDIS measures such as the <i>Ambulatory Care (AMB)</i> measure and <i>Inpatient Utilization (IPU)</i> measure are good indications of how the SPD population is getting in for preventive/primary care (high outpatient, low emergency department visits) but the population is also frail (higher inpatient average length of stays). This supports the disparities we see in the <i>ACR</i> and <i>CDC-BP</i> measures between the SPD and non-SPD measures.</p>

2013–14 External Quality Review Recommendation Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
3. Reference the QIP Completion Instructions and the feedback in the QIP Validation Tool to ensure that all documentation requirements for each activity have been addressed prior to QIP submissions.	The QI Department has revamped the QIP review process prior to submission to ensure that all documentation for each activity is attached prior to submission.

Recommendations

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

- ◆ Identify the factors leading to the declining or poor performance for the following measures, and implement strategies to prevent further decline in performance or improve performance:
 - *Cervical Cancer Screening*
 - *Children and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months*
 - *Children and Adolescents’ Access to Primary Care Practitioners—25 Months to 6 Years*
 - *Children and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years*
 - *Medication Management for People with Asthma—Medication Compliance 75% Total*

Although DHCS does not hold MCPs accountable to meet the MPLs for the *Children and Adolescents’ Access to Primary Care Practitioners* measures due to the small range of difference between the MPLs and HPLs, the MCP should assess the factors contributing to the decline in the measures’ rates to ensure that beneficiaries in the applicable age groups are receiving needed health care services.

- ◆ Since the SPD rates were significantly worse than the non-SPD rates in RY 2015 for the *All-Cause Readmissions* and all four *Children and Adolescents’ Access to Primary Care Practitioners* measures, ensure that processes are in place to meet the complex needs of the SPD population.
- ◆ Although SCFHP will not be continuing the formal QIPs, the MCP should:
 - Continue to adopt the post-discharge outreach calls as documented in the *All-Cause Readmissions* PDSA Cycle Worksheet.
 - Evaluate the interventions initiated in Remeasurement 1 of the *Diabetic Retinopathy Improvement and Prevention by Screening* QIP.
- ◆ Review the *2013–14 Encounter Data Validation Study Report*, and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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

Medi-Cal Managed Care Technical Report

**Appendix Z:
Performance Evaluation Report
SCAN Health Plan
July 1, 2014 – June 30, 2015**

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Appendix Z: Performance Evaluation Report – SCAN Health Plan July 1, 2014 – June 30, 2015

1. INTRODUCTION

Health Services Advisory Group, Inc. (HSAG), external quality review organization (EQRO), was contracted by the California Department of Health Care Services (DHCS) to prepare the federally required *Medi-Cal Managed Care Technical Report, July 1, 2014–June 30, 2015*. The technical report provides an overview of the objectives and methodology for conducting the external quality review. Additionally, the technical report provides detailed information about each activity, including DHCS’s requirements related to each activity.

This appendix is specific to DHCS’s contracted Medi-Cal managed care health plan (MCP), SCAN Health Plan (“SCAN” or “the MCP”), for the review period July 1, 2014, through June 30, 2015. Actions taken by the MCP subsequent to June 30, 2015, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies that are described in greater detail in the main section of this technical report.

Managed Care Health Plan Overview

SCAN is a Medicare Advantage Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) that contracts with DHCS as a specialty health plan to provide services for the dual-eligible Medicare/Medi-Cal population subset residing in Los Angeles, Riverside, and San Bernardino counties.

SCAN provides all services in the Medi-Cal State Plan, including home- and community-based services to SCAN beneficiaries who are assessed at the nursing facility level of care and in nursing home custodial care. SCAN beneficiaries must be at least 65 years of age, live in the service area, have Medicare Parts A and B, and have full scope Medi-Cal with no share of cost. SCAN does not enroll individuals with end-stage renal disease.

SCAN has been licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act in California since November 30, 1984, and became operational to provide Medi-Cal Managed Care (MCMC) services in Los Angeles County in 1985. The MCP expanded into Riverside and San Bernardino counties in 1997. In 2006, DHCS, at the direction of the Centers for Medicare & Medicaid Services (CMS), designated SCAN as an MCP. SCAN then functioned as a social health maintenance organization under a federal waiver which expired at the end of 2007.

In 2008, SCAN entered into a comprehensive risk contract with the State. SCAN receives monthly capitation from both Medicare and Medi-Cal, pooling its financing to pay for all services as a full-risk social MCP.

DHCS amended SCAN's contract in 2008 to include federal and State requirements for MCPs. Among these requirements, DHCS specifies that specialty plans participating in MCMC both report on two performance measures annually and maintain two internal quality improvement projects (QIPs).

According to DHCS, as of June 30, 2015, SCAN had 7,279 MCMC beneficiaries (referred to as "beneficiaries" in this report) in Los Angeles County, 2,053 beneficiaries in Riverside County, and 1,374 beneficiaries in San Bernardino County—for a total of 10,706 beneficiaries in the three counties combined.

Compliance Reviews

On April 7, 2015, through April 9, 2015, DHCS conducted an evaluation of Nursing Facility (NF) Level of Care (LOC) certifications completed by SCAN during the audit period of July 1, 2014, through December 31, 2014. The scope of this audit included review of the policies, procedures, and tools SCAN used to conduct NF LOC certifications; a statistically valid sample of completed NF LOC certifications for appropriateness of NF LOC determination; and a statistically valid sample of completed NF LOC certifications for completeness/correctness per SCAN policies and procedures.

A letter dated April 23, 2015, indicated that DHCS found SCAN to be in significant compliance with NF LOC criteria required for enrollment in SCAN's Independent Living Power (ILP) program. The letter also stated that DHCS found SCAN to be fully compliant with the MCP's internal policies and procedures defining the assessment process and required elements.

SCAN will be added to the State Fiscal Year (SFY) 2016–17 annual audit schedule.

Strengths

SCAN was found to be in significant compliance with the assessed criteria for enrollment in the ILP program and fully compliant with the MCP's internal policies and procedures.

Opportunities for Improvement

DHCS identified no deficiencies during the April 2015 evaluation of SCAN's NF LOC certifications; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

Performance Measure Validation—Findings

For reporting year (RY) 2015, SCAN was required to report two HEDIS¹ measures—*Breast Cancer Screening* and *Osteoporosis Management in Women Who Had a Fracture*.

The *HEDIS 2015 Compliance Audit Final Report of Findings for SCAN Health Plan* contains the detailed findings and recommendations from HSAG’s NCQA HEDIS Compliance Audit.^{TM2} HSAG auditors determined that SCAN followed the appropriate specifications to produce valid rates, and no issues of concern were identified.

Performance Measure Results

After validating the MCP’s performance measure rates, HSAG assessed the results. (See Table 3.1 for SCAN’s performance measure results for RYs 2012 through 2015.) The RY rates reflect measurement year (MY) data from the previous calendar year.

**Table 3.1—Multi-Year Performance Measure Results*
SCAN—Los Angeles/Riverside/San Bernardino Counties**

Performance Measure ¹	Domain of Care ²	RY 2012 ³	RY 2013 ⁴	RY 2014 ⁵	RY 2015 ⁶	RYs 2014–15 Rate Difference ⁷
<i>Breast Cancer Screening*</i>	Q,A	79.9%	81.42%	74.90%	80.30%	↑
<i>Osteoporosis Management in Women Who Had a Fracture**</i>	Q,T	27.7%	28.40%	41.14%	51.95%	↔

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 RY 2012 rates reflect MY data from January 1, 2011, through December 31, 2011. Rates in RY 2012 were reported to one decimal place. To be consistent with NCQA, rates starting in RY 2013 are reported to two decimal places.

⁴ RY 2013 rates reflect MY data from January 1, 2012, through December 31, 2012.

⁵ RY 2014 rates reflect MY data from January 1, 2013, through December 31, 2013.

⁶ RY 2015 rates reflect MY data from January 1, 2014, through December 31, 2014.

⁷ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

* If the rate is **bolded**, it was below the minimum performance level (MPL) for that year, which is based on the national Medicaid 25th percentile; and if the rate is shaded, it was above the high performance level (HPL) for that year, which is based on the 90th percentile for that year.

** If the rate is **bolded**, it was below the MPL for that year, which is based on the national Medicare 25th percentile; and if the rate is shaded, it was above the HPL for that year, which is based on the national Medicare 90th percentile. Medicare benchmarks are used because there are no Medicaid benchmarks for this measure.

↑ = Statistically significant improvement.

↓ = Statistically significant decline.

↔ = No statistically significant change.

¹ Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

² NCQA HEDIS Compliance AuditTM is a trademark of the NCQA.

Performance Measure Findings

The rate for the *Breast Cancer Screening* measure improved significantly from RY 2014 to RY 2015 and remained above the high performance level (HPL) for the third consecutive year. The rate for the *Osteoporosis Management in Women Who Had a Fracture* measure showed no statistically significant change from RY 2014 to RY 2015.

Assessment of Improvement Plans

The rates were above the minimum performance levels (MPLs) for both of SCAN's required measures for RY 2014; therefore, the MCP was not required to submit any improvement plans (IPs). The rates in RY 2015 also were above the MPLs, so SCAN will not be required to submit any IPs based on RY 2015 performance measure results.

Strengths

SCAN followed the appropriate specifications to produce valid performance measure rates. In response to the rate for the *Breast Cancer Screening* measure declining significantly from RY 2013 to RY 2014, the MCP implemented several initiatives (see Table 6.1). The rate for the measure improved significantly from RY 2014 to RY 2015 and was above the HPL for the third consecutive year.

Opportunities for Improvement

In SCAN's 2013–14 MCP-specific report, HSAG made the recommendation, based on the MCP's consistently high performance on the *Breast Cancer Screening* measure, that the MCP report the measure for one more year (RY 2015) and in collaboration with DHCS identify a new measure for RY 2016. Based on information in All Plan Letter 15-024,³ DHCS is requiring SCAN to report the *Breast Cancer Screening* measure for in RY 2016. HSAG encourages SCAN to work with DHCS to identify a new measure to report on for RY 2017.

³ The All Plan Letter can be found at: <http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>. Accessed on: January 10, 2016.

Quality Improvement Project Objectives

Specialty MCPs must be engaged in two QIPs at all times. However, because specialty MCPs serve unique populations limited in size, DHCS does not require them to participate in the statewide collaborative QIP. Instead, specialty MCPs are required to design and maintain two internal QIPs with the goal of improving health care quality, access, and/or timeliness for the specialty MCP's beneficiaries. SCAN opted to participate in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2014, through June 30, 2015.

Table 4.1 below lists SCAN's QIPs conducted; whether the QIP was clinical or nonclinical; and the domains of care (i.e., quality, access, and timeliness) the QIP addressed.

**Table 4.1—Quality Improvement Projects for SCAN
July 1, 2014, through June 30, 2015**

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Patient Safety Analysis—Use of High-Risk Medication in the Elderly</i>	Clinical	Q, A

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

The *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIP sought to reduce the use of high-risk medications among its elderly beneficiaries. At the initiation of the QIP, approximately 16.45 percent of the targeted population were prescribed at least one high-risk medication and 1.99 percent were prescribed two high-risk medications. SCAN aimed to achieve a statistically significant reduction in the use of high-risk medications.

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
SCAN—Los Angeles/Riverside/San Bernardino Counties
July 1, 2014, through June 30, 2015**

Name of Project/Study	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>	Annual Submission	77%	86%	<i>Partially Met</i>
	Annual Resubmission 1	92%	100%	<i>Met</i>
Internal QIPs				
<i>Patient Safety Analysis—Use of High-Risk Medication in the Elderly</i>	Annual Submission	88%	86%	<i>Not Met</i>
	Annual Resubmission 1	88%	86%	<i>Partially Met</i>
	Annual Resubmission 2	100%	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, 2014, through June 30, 2015, showed that SCAN’s annual submissions of its *All-Cause Readmissions* and *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIPs initially received overall validation statuses of *Partially Met* and *Not Met*, respectively. DHCS required the MCP to resubmit the QIPs until they achieved an overall *Met* validation status. Based on HSAG’s validation feedback, SCAN resubmitted the QIPs; and each achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a *Met* score.

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

Table 4.3—Quality Improvement Project Average Rates*
SCAN—Los Angeles/ Riverside/San Bernardino Counties
(Number = 5 QIP Submissions, 2 QIP Topics)
July 1, 2014, through June 30, 2015

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		100%	0%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	86%	7%	7%
	VIII: Appropriate Improvement Strategies**	71%	14%	14%
Implementation Total**		81%	10%	10%
Outcomes	IX: Real Improvement Achieved	50%	0%	50%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		50%	0%	50%

* The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

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

HSAG validated Activities I through IX for SCAN’s *All-Cause Readmissions* annual submission and Activities I through VIII for the MCP’s *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIP annual submission.

SCAN demonstrated an excellent application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP demonstrated an adequate application of the Implementation stage, meeting 81 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *All-Cause Readmissions* QIP, the MCP provided a Remeasurement 1 rate inconsistent with the audited rate reported to DHCS and identified neither the factors that threatened the internal or external validity of Remeasurement 1 nor the factors that affected the ability to compare the baseline with Remeasurement 1 rates, resulting in a lowered score for Activity VII. SCAN omitted Activity VIII in its initial annual submission of the *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIP, resulting in the QIP receiving a zero score for the activity. The MCP corrected all deficiencies in its subsequent resubmissions, resulting in each QIP achieving an overall *Met* validation status.

Only the *All-Cause Readmissions* QIP progressed to the Outcomes stage during the reporting period. SCAN’s *All-Cause Readmissions* QIP did not achieve statistically significant improvement over baseline at Remeasurement 1, resulting in a lowered score for Activity IX. For both QIPs, Activity X was not assessed because sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved and sustained for a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

Patient Safety Analysis—Use of High-Risk Medication in the Elderly QIP

The *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcomes information is included in the report. Following is a summary of the interventions that SCAN indicated it planned to implement during the Remeasurement 1 time period:

- ◆ Call or fax prescribers of high-risk medications to encourage prescribing geriatric-safe, alternate prescriptions.
- ◆ Call beneficiaries upon their first fill of an estrogen product to inform of risks associated with using estrogens and safer alternatives.

All-Cause Readmissions QIP

The *All-Cause Readmissions* QIP progressed to the Outcomes stage during the review period. Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

**Table 4.4—Quality Improvement Project Outcomes for SCAN—Los Angeles/Riverside/San Bernardino Counties
July 1, 2014, through June 30, 2015**

QIP #1—All-Cause Readmissions		
Study Indicator 1: The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 21 years of age and older [^]		
Baseline Period 1/1/12–12/31/12	Remeasurement 1 1/1/13–12/31/13	Sustained Improvement[‡]
14.1%	12.4%	‡

[^]A lower percentage indicates better performance.

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

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

SCAN's goal for the *All-Cause Readmissions* QIP was to achieve a statistically significant decline in the readmissions rate from baseline to Remeasurement 1. Unfortunately, the MCP did not meet the project's goal. Although SCAN's readmissions rate declined at Remeasurement 1, the change was not statistically significant. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- ◆ SCAN revisited the barriers identified at baseline and reprioritized the top barrier as being the lack of a support system.
- ◆ The MCP piloted a care transitions program that included a multimedia sharing and messaging component wherein care transition coaches developed and recorded individualized video messages sent electronically to the beneficiary and/or the beneficiary's caregivers.
 - The beneficiaries not participating in the pilot had the same or better readmissions rates than those beneficiaries participating in the pilot. Thus, SCAN terminated this intervention.
- ◆ The MCP implemented a home-visit pilot to remove barriers related to readmissions. The home visits helped improve beneficiaries' understanding of their discharge plans and ensured that they received needed support services.
 - The readmissions rate improved by 60 percent for the pilot target population. SCAN concluded that the pilot was a success and plans to continue the intervention.

Strengths

SCAN demonstrated an excellent application of the Design stage, meeting all applicable evaluation elements within the study stage for both the *All-Cause Readmissions* and *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIPs.

Opportunities for Improvement

Although SCAN will not be continuing the formal QIPs, the MCP should continue to reassess the barriers to reducing readmissions. The MCP should test the home-visit intervention in additional settings since the MCP identified the pilot to be successful during Remeasurement 1. In addition, SCAN should evaluate the interventions initiated in Remeasurement 1 of the *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIP.

SFY 2013–14 Encounter Data Validation Study—Medical Record Review

SCAN’s SFY 2013–14 MCP-specific encounter data validation report contains HSAG’s detailed findings and recommendations from the encounter data validation (EDV) study, which consisted of medical record review. A brief summary of HSAG’s findings and recommendations is included below. Additionally, HSAG provides a list of limitations associated with the EDV study.

For each study indicator, HSAG used the following schema to assign a percentile ranking to show the performance among all MCPs with reportable rates. The 10th, 25th, 75th, and 90th percentiles were calculated based on MCPs’ rates using the UNIVARIATE procedure in SAS. Although 24 MCPs were evaluated in the EDV study, the number of rates used to derive the percentiles may be less than 24 because MCPs with a rate of “NA” were not included in the percentile calculation (refer to Table 5.1 for the number of rates included for each study indicator).

Table 5.1—Criteria for Percentile Ranking

Percentile Ranking	Study Indicator	Criteria
<10th	Medical record procurement, element accuracy, or all-element accuracy	Rate below the 10th percentile among all MCPs with reportable rates
10th–25th		Rate at or above the 10th percentile but below the 25th percentile among all MCPs with reportable rates
25th–75th		Rate at or above the 25th percentile but below the 75th percentile among all MCPs with reportable rates
75th–90th		Rate at or above the 75th percentile but below the 90th percentile among all MCPs with reportable rates
≥90th		Rate at or above the 90th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)
<10th	Medical record omission or encounter data omission	Rate above the 90th percentile among all MCPs with reportable rates
10th–25th		Rate at or below the 90th percentile but above the 75th percentile among all MCPs with reportable rates
25th–75th		Rate at or below the 75th percentile but above the 25th percentile among all MCPs with reportable rates
75th–90th		Rate at or below the 25th percentile but above the 10th percentile among all MCPs with reportable rates
≥90th		Rate at or below the 10th percentile among all MCPs with reportable rates
NA		No percentile ranking due to small denominator (i.e., <30)

For the medical record omission and encounter data omission rates, lower rates represent better performance. Therefore, the percentile ranking criteria are different from those for the element accuracy and all-element accuracy rates (i.e., the percentiles were reversed when assigning percentile ranking so that “≥90th” always represents the top 10 percent performance among the MCPs with reportable rates). Table 5.2 contains the values for the 10th, 25th, 75th, and 90th percentiles for each study indicator listed in this report. Due to the skewed distribution of results for certain indicators, the percentile ranking notation may differ slightly from the percentile rankings noted in Table 5.1; i.e., 0–≤25th, >25th–<75th, and ≥75th.

Table 5.2—Percentiles for Study Indicators

Study Indicator	Data Element	Number of MCPs with Reportable Rates	P10	P25	P75	P90
Medical record submission	–	24	67.9%	72.6%	87.2%	95.9%
Medical record omission	Date of Service	24	11.8%	17.9%	26.6%	33.0%
	Diagnosis Code	24	16.3%	25.9%	32.9%	40.7%
	Procedure Code	24	21.0%	31.2%	43.8%	61.3%
	Procedure Code Modifier	21	29.1%	47.6%	69.4%	71.9%
	Rendering Provider Name	13	11.0%	19.2%	32.9%	62.5%
	Billing Provider Name	24	19.6%	27.8%	34.2%	46.8%
Encounter data omission	Date of Service	24	1.9%	6.9%	12.0%	17.1%
	Diagnosis Code	24	25.1%	28.9%	39.7%	44.4%
	Procedure Code	24	12.0%	16.3%	27.7%	33.5%
	Procedure Code Modifier	17	24.0%	28.3%	52.4%	74.7%
	Rendering Provider Name	24	22.6%	38.0%	100.0%	100.0%
	Billing Provider Name	24	2.1%	5.1%	12.1%	18.2%
Element accuracy	Diagnosis Code	24	74.6%	81.8%	87.6%	90.7%
	Procedure Code	24	61.3%	70.9%	85.6%	90.8%
	Procedure Code Modifier	11	94.4%	95.8%	100.0%	100.0%
	Rendering Provider Name	11	49.3%	57.4%	86.9%	95.6%
	Billing Provider Name	24	52.6%	65.1%	79.2%	88.1%
All-element accuracy	–	24	0.0%	0.0%	7.5%	18.3%

Note: For the medical record omission and encounter data omission rates, lower rates represent higher performance. In addition, HSAG displayed “–” when the data element was not applicable to a study indicator.

Medical Record Review Findings

Encounter Data Completeness

Table 5.3 displays the medical record and encounter data omission rates for each key data element for SCAN. For both indicators, lower rates indicate better performance.

Table 5.3—Encounter Data Completeness Summary for SCAN

Key Data Elements	Medical Record Omission Rate			Encounter Data Omission Rate		
	MCP	Statewide	Percentile Ranking	MCP	Statewide	Percentile Ranking
Date of Service	18.9%	26.3%	25th–75th	10.9%	9.2%	25th–75th
Diagnosis Code	23.9%	31.6%	75th–90th	44.4%	34.6%	10th–25th
Procedure Code	43.8%	43.8%	25th–75th	11.5%	22.5%	≥90th
Procedure Code Modifier	65.3%	58.5%	25th–75th	29.9%	46.0%	25th–75th
Rendering Provider Name	NA	25.0%	NA	100.0%	68.1%	0–≤25th
Billing Provider Name	32.5%	35.0%	25th–75th	11.3%	8.6%	25th–75th

Note: HSAG displayed “NA” when the denominator was less than 30.

Overall, the medical record omission rates for SCAN ranged from 18.9 percent (*Date of Service*) to 65.3 percent (*Procedure Code Modifier*). Four of SCAN’s five reportable medical record omission rates were equal to or slightly better than the respective statewide rates. The remaining rate was worse than the statewide rate by 6.8 percentage points for the *Procedure Code Modifier*. When compared to other MCPs’ performance, SCAN received a percentile ranking of “25th–75th” for four of the five reportable medical record omission rates and a percentile ranking of “75th–90th” for the remaining rate. These findings suggest a moderate level of completeness among key encounter data elements when compared to beneficiaries’ medical records. Within the three counties where SCAN operates, some rate variations exist, though none is substantively large for a single data element.

As determined during this review, the most common reasons for medical record omissions were:

- ◆ The medical record could not be located.
- ◆ The provider did not document the services performed in the medical record despite submitting a claim/encounter.
- ◆ A data entry error occurred for one or more elements (e.g., *Date of Service*).
- ◆ The provider did not perform the service.
- ◆ Due to inclusion of the adjudication history, the DHCS encounter data for SCAN contained additional services which should not have been included for comparison with the medical records.
- ◆ Billing provider names are generally not part of the information included in medical records.

For encounter data omissions, SCAN’s rates varied from 10.9 percent (*Date of Service*) to 100 percent (*Rendering Provider Name*). Only two of SCAN’s six reportable encounter data omission rates were better than the respective statewide rates (i.e., the *Procedure Code* and *Procedure Code Modifier* encounter omission rates were better than the statewide rates by 11.0 percentage points

and 16.1 percentage points, respectively). However, SCAN performed worse than the statewide encounter data omission rate by 31.9 percentage points for the *Rendering Provider Name* data element. An opportunity exists for SCAN to improve the electronic encounter data completeness by increasing the percentage of key data elements aligning with medical record information. At the county level, there were some variations. The encounter data omission rates for Riverside County were generally the worst among the three counties.

The most common reasons for encounter data omissions were:

- ◆ The provider’s billing office made a coding error.
- ◆ DHCS’s encounter data system contained certain restrictions related to encounter submission requirements that affected the processing of some encounters (e.g., number of diagnosis or procedure code modifier fields. DHCS only kept the most current year of provider data from the MCPs).
- ◆ A deficiency occurred in SCAN’s encounter data submission processes, or a deficiency occurred in the resubmission of denied or rejected encounters to DHCS.
- ◆ A lag occurred between the provider’s performance of the service and submission of the encounter to SCAN (and/or the data subsequently being submitted to DHCS).
- ◆ SCAN populated an invalid rendering provider identification number when submitting encounter data to DHCS; or the provider files SCAN submitted to DHCS were not complete or accurate.

Encounter Data Accuracy

Table 5.4 displays the element accuracy rates for each key data element and the all-element accuracy rate for SCAN. For both indicators, higher rates indicate better performance.

Table 5.4—Encounter Data Accuracy Summary for SCAN

Key Data Elements	MCP	Statewide	Percentile Ranking	Main Error Type
Diagnosis Code	82.2%	83.6%	25th–75th	Inaccurate Code (83.4%)
Procedure Code	78.1%	77.6%	25th–75th	Lower Level of Services in Medical Records (73.1%)
Procedure Code Modifier	100.0%	99.5%	≥75th	—
Rendering Provider Name	NA	63.0%	NA	NA
Billing Provider Name	85.9%	68.6%	75th–90th	Incorrect Names (89.5%)
All-Element Accuracy	0.0%	4.3%	0–≤25th	—

Note: HSAG displayed “NA” when the denominator was less than 30. HSAG displayed “—” when the error type analysis was not applicable to a data element.

In general, when key data elements were present in the DHCS data system and the medical records, and evaluated separately for the individual data elements, the key data elements were found to be of average accuracy for SCAN, except for the *Billing Provider Name* data element, which exceeded the statewide rate by 17.3 percentage points. When comparing the performance among the MCPs, two of the four key data elements with reportable rates received a percentile ranking of “75th–90th” or “≥75th” and two received a percentile ranking of “25th–75th”. For the *Diagnosis Code* data element, 83.4 percent of errors involved discrepancies in the use of inaccurate codes compared to national coding standards rather than specificity errors. For the *Procedure Code* data element, 73.1 percent of errors were associated with higher-level procedure codes in the DHCS encounter data than were documented in the medical records (i.e., the procedure code was considered an error due to a lower level service documented in the medical record). The majority of the *Billing Provider Name* errors (89.5 percent) were associated with name discrepancies between the medical record and the DHCS data system rather than illegible names in medical records.

SCAN’s all-element accuracy rate was lower than the statewide rate by 4.3 percentage points. No dates of service present in both data sources accurately represented all five data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Rendering Provider Name*, and *Billing Provider Name*) when compared to beneficiaries’ medical records. The overall accuracy findings indicated the presence of at least one inaccurate data element for all dates of service present in both data sources. While all five key data elements contributed to SCAN’s relatively low all-element accuracy rate, the *Rendering Provider Name* data element contributed most, and the *Procedure Code Modifier* contributed least.

Medical Record Review Recommendations

Based on the study findings for SCAN, HSAG recommends the following:

- ◆ Accurate rendering provider information in the DHCS data system is crucial to locating medical records for future medical record review activities. Therefore, SCAN should consider the following actions:
 - Submit complete and accurate rendering provider identification numbers in the encounter data to DHCS.
 - Submit complete and accurate provider data to DHCS so that DHCS can find the correct rendering provider names and contact information by linking the rendering provider identification numbers between the encounter data and provider data. For example, all rendering provider identification numbers in the encounter data should exist in the provider data submitted to DHCS and should represent the rendering providers, not the billing providers.
- ◆ Currently, DHCS is transitioning from its current encounter data system to a new Post Adjudicated Claims and Encounters System (PACES), and the new PACES will have the

capacity to accept more than two diagnosis code fields and more than one procedure code modifier field. SCAN should ensure that the additional diagnosis codes and procedure code modifiers are submitted to DHCS after the system transition.

- ◆ Of the 418 dates of service identified in the DHCS encounter data, no visits had rendering provider names identifiable from the DHCS data system. SCAN should work with DHCS to investigate the reasons why no rendering provider names could be identified using DHCS encounter and provider data.
- ◆ SCAN should investigate the reasons for the relatively high medical record omission rates for the *Procedure Code Modifier* data element and develop strategies to improve rates.
- ◆ SCAN should explore the reasons for the relatively high encounter data omission rates for the *Rendering Provider Name* and *Diagnosis Code* data elements and take actions to improve rates.
- ◆ SCAN should consider developing periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with SCAN.
- ◆ SCAN should perform periodic reviews of claims/encounters submitted by the providers to verify appropriate coding and completeness to ensure encounter data quality.

Medical Record Review Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- ◆ Successful evaluation of beneficiaries' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that could not be located (e.g., missing or wrong provider information resulted in failing to procure the medical records) and medical records that were incomplete (e.g., missing pages).
- ◆ Since the study findings relied solely on the documentation contained in beneficiaries' medical records, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but did not document it in the beneficiary's medical record. As such, HSAG would have counted this scenario as a negative finding. This study was unable to distinguish cases in which a service was not performed versus a service that was performed but not documented in the medical record.
- ◆ The findings for the data elements *Billing Provider Name* and *Rendering Provider Name* should be reviewed with caution since rendering provider names and billing provider names are not generally included or legible in beneficiaries' medical records.

- ◆ Certain limitations in the DHCS data warehouse also affected the results. For example, the DHCS data warehouse only stores two data fields for the diagnosis codes while the medical records may indicate more than two codes. In addition, the DHCS data warehouse only contains the most recent provider data, which may lead to missing rendering provider names even though the rendering provider identification numbers were submitted in the encounter data.
- ◆ The findings from this study are associated with encounters from calendar year 2012 for the non-SPD population and encounters from the last seven months of calendar year 2012 for the SPD population; as such, the results may not reflect the current quality of DHCS's encounter data.
- ◆ The findings from this study are associated with physician visits and may not be applicable to the other claim types.

SFY 2014–15 Encounter Data Validation Study—Assessing the MCP's Operational and Infrastructure Changes in Support of DHCS's Transition to PACES

SCAN's SFY 2014–15 MCP-specific encounter data validation report contains HSAG's detailed findings and recommendations from the EDV study, which assessed the MCP's operational and infrastructure changes in support of DHCS's transition to PACES. Based on review of SCAN's Roadmap and questionnaire responses and supporting documentation, HSAG provided recommendations to DHCS to assist SCAN with improving its encounter data quality. DHCS followed up with SCAN regarding the recommendations and will continue to provide ongoing technical assistance to the MCP to support continued improvement in encounter data quality.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Although HSAG uses a standardized scoring process to evaluate each full-scope Medi-Cal MCP's performance measure rates and QIP performance in the areas of quality, access, and timeliness domains of care, HSAG does not use this scoring process for specialty MCPs due to the small size of the specialty MCPs' populations.

Quality

HSAG reviewed SCAN's quality improvement program description and found that the MCP designed its quality improvement program structure to ensure that high-quality care is provided to all beneficiaries.

Both of the MCP's required performance measures fall into the quality domain of care. The rate improved significantly for the *Breast Cancer Screening* measure and remained above the HPL for the third consecutive year. The rate remained above the MPL for the *Osteoporosis Management in Women Who Had a Fracture* measure.

Both of SCAN's QIPs fell into the quality domain of care; however, only the *All-Cause Readmissions* QIP progressed to the Outcomes stage. While the QIP did not achieve a statistically significant reduction in readmissions from baseline to Remeasurement 1, the MCP piloted a successful home-visit intervention that can be tested in additional settings with the intention of reducing the MCP's readmissions rate.

Access

SCAN's quality improvement program description included descriptions of processes the MCP implements to monitor and evaluate beneficiary access to needed health care services.

The *Breast Cancer Screening* measure falls into the access domain of care; and, as indicated above, the rate improved significantly and remained above the HPL for the third consecutive year.

Both of SCAN's QIPs fell into the access domain of care; and, as stated above, only the *All-Cause Readmissions* QIP progressed to the Outcomes stage. While the QIP did not achieve a statistically significant reduction in readmissions from baseline to Remeasurement 1, the MCP piloted a successful home-visit intervention that can be tested in additional settings with the intention of reducing the MCP's readmissions rate.

Timeliness

SCAN’s quality improvement program description provided a summary of the MCP’s processes related to grievances, care coordination, and utilization management, which can all affect the timeliness of care delivered to beneficiaries.

As indicated above, the rate remained above the MPL for the *Osteoporosis Management in Women Who Had a Fracture* measure, which falls into 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 2013–14 MCP-specific evaluation report. Table 6.1 provides external quality review recommendations from the July 1, 2013, through June 30, 2014, Performance Evaluation Report, along with SCAN’s self-reported actions taken through June 30, 2015, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of the MCP’s self-reported actions.

Table 6.1—SCAN’s Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2013–June 30, 2014, Performance Evaluation Report

2013–14 External Quality Review Recommendation Directed to SCAN	Self-Reported Actions Taken by SCAN during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>1. To ensure that the rate for the <i>Breast Cancer Screening</i> measure does not continue to decline, report the measure one more year (2015) and, in collaboration with DHCS, identify a new measure for 2016.</p> <p>a. To ensure the MCP’s continued high performance for the Breast Cancer Screening measure beyond reporting year 2015, HSAG recommends that SCAN develop an internal process for monitoring breast cancer screenings for eligible women.</p>	<p>SCAN has put processes in place to continue to address and encourage breast cancer screening for our members and to monitor screenings for eligible women. SCAN will continue to work collaboratively with our provider partners to ensure timely identification and member outreach as well as reviewing initiatives based on measure outcomes. The following initiatives have been implemented for 2014–2015:</p> <ol style="list-style-type: none"> 1. Identify all women between the ages of 59–74 years of age that have not had a breast cancer screening done in the last two years. 2. Live call by a SCAN nurse reminding members to get a mammogram done (August–September 2014). 3. Mailed out mammogram reminder cards to all female members that are coming due for a mammogram this year (February 2015). 4. Mailed out a health check record to all SCAN members, and there was a “Mammogram due” section on the Preventive Screenings page (June 2015). 5. Ongoing live calls by a SCAN buddy/care navigator reminding members to get a mammogram done as well as providing assistance scheduling an appointment and/or getting a referral for the mammogram.

2013–14 External Quality Review Recommendation Directed to SCAN	Self-Reported Actions Taken by SCAN during the Period July 1, 2014–June 30, 2015, that Address the External Quality Review Recommendation
<p>2. Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.</p>	<p>SCAN continues to work collaboratively with our internal team to ensure that all required documentation is included for submission of QIP activities, including integration of all of the provided instruction and guidance as well as a final quality control review prior to submission by a member of the QIP/California Child Care Initiative Project (CCIP) Work Group.</p>

Recommendations

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

- ◆ Work with DHCS to identify for RY 2017 a new performance measure to replace the *Breast Cancer Screening* measure.
- ◆ Although SCAN will not be continuing the formal QIPs, the MCP should:
 - Continue to reassess the barriers to reducing readmissions. Specifically, the MCP should test the home-visit intervention in additional settings since the MCP determined the pilot to be successful at Remeasurement 1.
 - Evaluate the interventions initiated in Remeasurement 1 of the *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIP.
- ◆ Review the *2013–14 Encounter Data Validation Study Report* and identify strategies to address the medical record review recommendations to ensure accurate and complete encounter data.

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