Medi-Cal Managed Care Division

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Medi-Cal Managed Care External Quality Review Organization

2007-2008 Annual Report of Performance for AHF Healthcare Centers

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DHCS
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Delmarva Foundation
Improving Health in the Communities We Serve

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Introduction

As of 2009, the Medi-Cal Managed Care Division (MMCD) of the California Department of Health Care Services (the DHCS or "the Department") contracts with health care plans to provide care to 3.6 million Medi-Cal beneficiaries enrolled in managed care plans in 25 counties throughout California. Healthcare providers within each plan's contracted network provide comprehensive healthcare services—primary and preventive care, as well as the full range of specialty care mandated by federal and state law.

Federal law pertaining to Medicaid managed care programs (42 CFR § 438.240) requires the DHCS to contract with an External Quality Review Organization (EQRO) to independently evaluate the quality of care provided to Medi-Cal beneficiaries enrolled in any of California's managed care plans. During the period covered by this report, the DHCS retained the services of the Delmarva Foundation for Medical Care (Delmarva) as the Department's EQRO. Among the services provided by the EQRO is an annual independent assessment of each contracted plan's "… quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract…" as stated in Title 42 of the U.S. Code.

Plan Background

Most Medi-Cal beneficiaries enrolled in managed care plans receive their health care through full-scope Managed Care Organizations, most of which are licensed Health Maintenance Organizations. Medi-Cal managed care plans provide their members' health care through one of three models of health care delivery[1]; however, the DHCS also contracts with a few other plan types, which are informally referred to as "specialty plans."

Specialty health plans are different from regular health plans in that they serve a special group of the Medi-Cal population. AHF Healthcare Centers ("AHF" or "the program" or "the plan") is a partially capitated

[1] Medi-Cal managed care's three models of health care delivery: County Organized Health Systems (COHS), Geographic Managed Care (GMC), and Two-Plan. COHS plans are county-operated managed care organizations. In the GMC model, enrollees choose from several commercially operated plans within a certain geographic area. The Two-Plan model consists of Commercial Plans (CPs)—which are commercially operated managed care plans—and Local Initiatives (LIs)—which are community-developed managed care plans that operate as quasi-governmental agencies.

Medi-Cal primary care case management (PCCM) program for adults (18 years and older) diagnosed with AIDS. AHF contracts with the DHCS in Los Angeles County under the name "Positive Healthcare."

Positive Healthcare is a non-profit health program that provides case management to members as a primary care provider for all outpatient services, including prescription drugs, long-term care, and hospice. Hospital services are authorized by AHF but paid for by the Medi-Cal Fee-For-Service program. Certain predesignated anti-retroviral drugs are carved out of AHF's contract with the DHCS. As of December 2008, AHF's total Medi-Cal enrollment was 826 members.

Federal Reporting Requirements

The Department amended AHF's contract, effective January 1, 2007, to include requirements that AHF must (1) report on two performance measures annually, (2) maintain two quality improvement projects, and (3) submit to the DHCS the results of a consumer satisfaction survey conducted by the AHF. Due to the small size of specialty plan populations, the DHCS modified the external quality review requirements applied to these plans as follows:

- Instead of the 12 Healthcare Effectiveness Data and Information Set (HEDIS®)[2] performance measures required of regular plans, the DHCS requires specialty plans to report on only two performance measures (HEDIS or other), selected to be appropriate to the plan's population. Plans must report performance measurement results that are specific to the plan's Medi-Cal managed care members and not the plan's entire population.
- Specialty plans are not required to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3] surveys, but instead are required to conduct some kind of plan-developed member satisfaction survey and periodically report results to the DHCS and the EQRO.

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[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA, 2008). HEDIS is a nationally recognized set of performance measures developed by the National Committee for Quality Assurance (NCQA). HEDIS measures are used by health care purchasers to assess the quality, access, and timeliness of care and service provided to members of managed care plans. For a more detailed explanation of HEDIS, see Appendix: HEDIS.

[3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ, 2008). The CAHPS program is funded and administered by the U.S. Agency of Healthcare Research and Quality (AHRQ), which works closely with a consortium of public and private organizations to develop and support a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their health care experiences. AHRQ developed the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 2007 4.0H Adult Medicaid and the 3.0H Child Medicaid surveys. Delmarva conducted these CAHPS surveys in 2007 for MMCD's regular contracted health care plans.

- While specialty plans must be engaged in two Quality Improvement Projects (QIPs) at all times just as regular plans, specialty plans are not required to participate in statewide collaborative QIPs.

This is MMCD's first annual review of AHF and covers performance results and quality improvement activities for reporting years 2007 and 2008. The following review and evaluation of plan performance is brief, in part, due to delays in the development and approval of the revised contract. Amending the contract to incorporate new standards for external quality review compliance ultimately resulted in postponement of the planned monitoring activities. The plan is in the early stages of implementing required activities.

Definitions

Federal and State regulations require that contracted Medi-Cal plans be assessed for the standards quality, access, and timeliness. The terms quality, access, and timeliness provide the framework for this plan-specific review of AHF. Consistency in meaning and use of these key terms are important for a thorough understanding of this report, so definitions follow:

- **Quality**, as it pertains to external quality review, is defined by the Centers for Medicare & Medicaid Service (CMS) as "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." (CMS, 2008)

- **Access** (or accessibility) to health care, according to the Agency for Healthcare Research and Quality (AHRQ), means having "the timely use of personal health services to achieve the best health outcomes. Attaining good access to care requires three discrete steps: gaining entry into the health care system; getting access to sites of care where patients can receive needed services; and, finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust." (AHRQ, 2007)

- **Timeliness,** according to AHRQ, is defined as "…the health care system's capacity to provide health care quickly after a need is recognized….Measures of timeliness include waiting time spent in doctors' offices and emergency departments (EDs) and the interval between identifying a need for specific tests and treatments and actually receiving those services." (AHRQ, 2007)

Data Sources Used to Assess AHF's Performance

Delmarva typically uses several types of standards or information sources to assess Medi-Cal managed care plan performance relative to a plan's ability to provide its members with care that meets Federal and State quality, access, and timeliness requirements. Because the contract requirements changed during the period

covered by this report, data sources available for Delmarva's assessment of AHF were limited. Comparable benchmarks for performance measurement (usually HEDIS) data are also limited due to AHF's unique member population.

The following data sources were used to assess AHF quality performance:

- **Performance Measures.** HEDIS scores for reporting year 2007 (results reflect data collected for the period January 1, 2006, through December 31, 2006) and reporting year 2008 (results reflect data collected for the period January 1, 2007, through December 31, 2007).
- **Quality Improvement Projects.** Summaries of plan-conducted Quality Improvement Projects conducted during the period January 1, 2006, through December 31, 2007.
- **Member Satisfaction Surveys.** Summaries of member satisfaction surveys conducted during the period of January 1, 2006, through December 31, 2007.
- **Medi-Cal Medical Audits.** The results and findings of any routine medical survey (audit) conducted to assess plan compliance with contract requirements and state regulations during calendar years 2007 and 2008.
- **Grievance and Appeal Data.** Grievance and appeal data submitted by plans to the DHCS and reports prepared by MMCD's Office of the Ombudsman. This report includes data for calendar years 2006 and 2007.

This report provides analysis of the data collected from these sources, as well as assessment of AHF's delivery of quality, access, and timeliness of care for the plan's members.

HEDIS Performance Measures

While specialty plans are not required to report on the same HEDIS measures as regular Medi-Cal managed care plans, specialty plans are required to report annual results for a minimum of two performance measures. The measures are chosen collaboratively by the DHCS, the EQRO, and the plan with a focus on their relevance to the plan's membership. AHF chose two HEDIS measures that would measure plan performance specific to the needs of its membership:

- Effectiveness (Quality) of Care domain: *Colorectal Cancer Screening.*
- Access/Availability of Care domain: *Adults' Access to Preventive/Ambulatory Health Services, Ages 20-44 Years, Ages 45-64 Years, Ages 65 Years +.*

Neither of the HEDIS measures selected by AHF coincide with the twelve HEDIS measures required by the DHCS for reporting by its regular Medi-Cal managed care health plans; therefore Delmarva can offer no

performance comparisons with Medi-Cal managed care plans in the areas of *Colorectal Cancer Screening* or *Adults' Access to Preventive/ Ambulatory Health Services.*

2007 HEDIS Performance Measures

Table 1 provides AHF's 2007 HEDIS results for the measures, *Colorectal Cancer Screening* and *Adults' Access to Preventive/Ambulatory Health Services.*

Table 1. 2007 HEDIS Measure Results for AHF Healthcare Centers.

2007 HEDIS Measure	2007 AHF Healthcare Centers Rate*	Minimum Performance Level†	High Performance Level‡
Colorectal Cancer Screening	7.6%	§	§
Adults' Access to Preventive/Ambulatory Health Services, Ages 20-44 Years	95.2%	72.7%	87.0%
Adults' Access to Preventive/Ambulatory Health Services, Ages 45-64 Years	98.7%	79.1%	89.4%
Adults' Access to Preventive/Ambulatory Health Services, Ages 65+	100%	72.1%	93.0%

* Rates obtained from *The Report of the 2007 Performance Measures for Medi-Cal Managed Care Members.*
† High Performance Level is HEDIS 2006 national Medicaid 90th Percentile.
‡ Minimum Performance Level is HEDIS 2006 national Medicaid 25th Percentile.
§ No benchmarks, MPLs, or HPLs are available for comparison to this measure.

For 2007, no national Medicaid benchmarks for a Minimum Performance Level (MPL) or High Performance Level (HPL) were available for comparison with AHF's score for the *Colorectal Cancer Screening* measure. However, AHF's rate exceeded the HPL for the *Adults' Access to Preventive/Ambulatory Health Services* measure in all age categories. The plan's rate for that measure was 8.2 percentage points higher than the HPL in the in the 20 through 44-year age group, 9.3 percentage points higher in the 45 through 64-year age group, and 7.0 percentage points higher in the 65-year plus age group. Please refer to Appendix A for further information regarding HEDIS measures and HPLs and MPLs.

2008 HEDIS Performance Measures

Table 2 provides AHF's 2008 HEDIS results for the same measures reported in 2007—*Colorectal Cancer Screening* and *Adults' Access to Preventive/Ambulatory Health Services.*

Table 2. 2008 HEDIS Measure Results for AHF Healthcare Centers.

2008 HEDIS Measure	2008 AHF Healthcare Centers Rate*	Minimum Performance Level†	High Performance Level‡
Colorectal Cancer Screening	47.7%	§	§
Adults' Access to Preventive/Ambulatory Health Services, Ages 20-44 Years	97.3%	74.4%	88.0%
Adults' Access to Preventive/Ambulatory Health Services, Ages 45-64 Years	97.8%	80.3%	89.8%
Adults' Access to Preventive/Ambulatory Health Services, Ages 65+ Years	95.5%	71.1%	93.5%

* Rates obtained from *The Report of the 2008 Performance Measures for Medi-Cal Managed Care Members*.
† High Performance Level is HEDIS 2007 national Medicaid 90th Percentile.
‡ Minimum Performance Level is HEDIS 2007 national Medicaid 25th Percentile.
§ No benchmarks, MPLs, or HPLs are available for comparison to this measure.

For 2008, no national Medicaid benchmarks for the MPL or HPL were available for comparison with AHF's score for the *Colorectal Cancer Screening* measure. However, AHF again exceeded the HPL on the *Adults' Access to Preventive/Ambulatory Health Services* measure for all age categories. AHF's rate in the 20-year through 44-year age group was 9.3 percentage points higher than the HPL, 8 percentage points higher in the 45-year through 64-year age group, and 2 percentage points higher than the HPL in the 65-year plus age group.

Comparison of AHF' 2007 and 2008 HEDIS Scores

Table 3 provides a comparison of AHF's 2007 and 2008 HEDIS rates for the *Colorectal Cancer Screening* and *Adults' Access to Preventive/Ambulatory Health Services* measures.

Table 3. Comparison of AHF's 2007 and 2008 HEDIS Performance Rates.

HEDIS Performance Measure	2007 AHF Healthcare Centers Rate*	2008 AHF Healthcare Centers Rate*
Colorectal Cancer Screening	7.6%	47.73%
Adults' Access to Preventive/Ambulatory Health Services, Ages 20-44 Years	95.2%	97.3%
Adults' Access to Preventive/Ambulatory Health Services, Ages 45-64 Years	98.7%	97.8%
Adults' Access to Preventive/Ambulatory Health Services, Ages 65+ Years	100.0%	95.5%

* Rates obtained from the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members.*

Between 2007 and 2008, AHF improved its rates for the *Colorectal Cancer Screening* measure by over 40 percentage points. During the same period, the plan improved its rates for the *Adults' Access to Preventive/Ambulatory Health Services* measure for the 20-year through 44-year age group, but its rates decreased in the 45-year through 64-year and 65-year+ age groups. Nevertheless, the plan's rates exceeded the HPL on the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS measure for all age categories both years. This performance raises the question whether the plan would better use its resources by focusing on another performance indicator where there is greater need for improvement.

Quality Improvement Projects

In 2008, AHF submitted two Quality Improvement Projects (QIPs) to the DHCS for approval: *Controlling High Blood Pressure* and *Warfarin Sodium (Coumadin) Quality Improvement Project.* Because the plan submitted these projects late in 2008, the QIPs were not validated by Delmarva. Instead, the newly contracted EQRO completed validation of the two QIPs in 2009. The projects are described below, but no validation results are included.

Controlling High Blood Pressure

- ***Relevance:***
  - According to recent research in the field, the HIV/AIDS population is at risk for high blood pressure and/or higher relative risk for coronary artery disease.
  - Hypertension affects all populations, and controlling high blood pressure has become a significant quality improvement indicator.
- ***Goals:***
  - Reduce to less than 10 percent the number of members with systolic blood pressure greater than 140 mmHg.
  - Reduce to less than 10 percent the number of members with diastolic blood pressure greater than 90 mmHg.
- ***Outcomes:***
  - Proportion of patients with last systolic blood pressure less than 140 mmHg:
    - 2007 (Baseline): 70.5%
  - Proportion of patients with last diastolic blood pressure less than 90 mmHg:
    - 2007 (Baseline): 73.5%

Warfarin Sodium (Coumadin) Quality Improvement Project

- ***Relevance:***
  - Coumadin has adverse drug-drug and drug-disease interactions, particularly in the HIV/AIDS population.
  - Adverse event: An AHF member was hospitalized in the intensive care unit due to a bleeding episode related to a Coumadin drug-drug interaction, prompting an extensive case review.
  - Currently, AHF has no plan-wide review of hospital admissions related to adverse events due to Coumadin usage.
- ***Goals:***
  - To increase the proportion of continuous Coumadin patients with seven or more International Normalized Ratio (INR)[4] results in a given measurement year to at least 70 percent.
  - To increase the proportion of INR values that are less than 4.0 to at least 95 percent.
  - To reduce hospitalizations related to chronic anticoagulation therapy to two or less per year (28.1/1,000 patients).
- ***Outcomes:***
  - Proportion of patients with seven or more INR results on Coumadin in a given measurement year:
    - 2007 (Baseline): 40.1%
    - 2008 (Remeasurement 1): 47.4%
  - Proportion of INR values less than 4.0:
    - 2007 (Baseline): 86.4%
    - 2008 (Remeasurement 1): 95.1%
  - Hospital admission rate/1,000 patients on Coumadin:
    - 2007 (Baseline): 85.7/1,000 (3 hospitalizations)
    - 2008 (Remeasurement 1): 0/1,000 (0 hospitalizations)

Both QIPs, *Controlling High Blood Pressure* and *Warfarin Sodium (Coumadin) Quality Improvement Project*, appear to be relevant to AHF's population based on the provided rationales.

The plan reported Baseline results for the *Controlling High Blood Pressure* project and Remeasurement 1 results for the *Warfarin Sodium (Coumadin)* project. The *Warfarin Sodium (Coumadin)* project submission showed improvement in all three measures. Most notably, hospital admissions were reduced to zero. Please note, however, that the plan did not submit documentation for these two QIPs in time for Delmarva to validate the projects and include validation results in this report.

[4] A laboratory test that measures the time it takes for blood to coagulate (clot) and compares it to an average.

Member Satisfaction Survey

In 2007, AHF administered a member satisfaction survey to its members and was able to isolate survey results for its Medi-Cal population.

Survey results indicated positive feedback by AHF members. Sixty-eight percent of members rated the plan's care excellent and 23 percent rated the care very good. AHF members rated the overall care excellent at 59 percent and very good at 25 percent. Other highly rated areas of the survey included:

- Cleanliness of the healthcare center
- Feeling welcome at the healthcare center
- Courtesy and respect from office staff
- Helpfulness of office staff
- Courtesy and respect from provider
- Attentiveness and listening from provider
- Provider speaking in a way member can understand
- Provider's response to concerns and/or complaints
- Medication purpose and dose explained clearly
- Whether the member would recommend AHF Healthcare Centers to a friend

Additionally, members responded with high ratings to questions about pharmacy and medication services. Very few negative responses were noted in the survey results.

Medi-Cal Medical Audits

The DHCS's Audits and Investigations Division (A&I) and the California Department of Managed Health Care (DMHC) conduct routine medical surveys (audits) to assess plan compliance with contract requirements and state regulations for MMCD's contracted Knox-Keene-licensed[5] plans. AHF is Knox-Keene licensed for its Medicare line of business, but not for Medi-Cal. Therefore, AHF does not fall under the auditing

[5] The Knox-Keene Health Care Service Plan Act of 1975 provides for the regulation and licensing of health care service plans by the Department of Managed Health Care for the purpose of promoting "the delivery of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan by …[e]nsuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional."

jurisdiction of DMHC. Instead, the plan is audited by A&I with the assistance of MMCD's Medical Monitoring Unit (MMU). The last audit conducted by A&I was in April of 2006. Since no medical audits were conducted in 2007 and 2008 (the period covered by this report), no audit results are included. A&I had scheduled AHF's next audit for April 2009, but that audit was postponed pending the plan's decision to renew its contract with MMCD for 2010.

Grievance and Ombudsman Reports

The Medi-Cal Managed Care Division (MMCD) requires that contracted health plans maintain grievance systems as required by state law (California Code of Regulation Title 28, Section 1300.68). All grievances received by a plan—in writing or verbally—must be tracked in a grievance log. Plans submit quarterly reports to MMCD, as well as to the Department of Managed Health Care, with detailed information about pending grievances and those that were not resolved within 30 days (MMCD All Plan Letter No. 03-008).

MMCD's Office of the Ombudsman also provides assistance to members who have questions or problems related to provider and plan services, as well as other areas, such as Medi-Cal eligibility. The Office of the Ombudsman functions, in part, to help solve problems from a neutral standpoint to ensure that its members receive all medically necessary covered services for which plans are contractually responsible. Complaints or issues that are not resolved immediately by the Office of the Ombudsman are entered into the Ombudsman Case Management System (OCMS) for tracking and follow-up. The Office of the Ombudsman also assists members who wish to request a formal hearing with the State Fair Hearings Board.

It should be noted that the DHCS monitors plans' quarterly grievance reports and MMCD Office of the Ombudsman monthly statistics in order to understand what aspects of provider and plan performance generate more or less grievances, calls or requests for State Fair Hearings over time. Unusual patterns in grievances, calls or hearing requests are discussed with plans when appropriate. The DHCS does not generally perceive any particular number of grievances, calls or hearing requests as indicators of poor plan performance. Rather, these statistics are an ongoing indication of the degree to which plan members are using the various avenues available to them to ask questions or raise concerns about healthcare quality and plan service.

AHF's Grievance and Ombudsman Reports

AHF reported 20 grievances in 2006 (for quarters 1-3) and 53 grievances in 2007 (for quarters 2-4). Grievance issue types were categorized as follows: Administration and Delivery of Medical Services, Access to Specialists, and Waiting Time. The majority of grievances reported for AHF were related to administrative and service delivery issues.

No Office of the Ombudsman's Reports were received by Delmarva for AHF.

Conclusions

AHF reported two HEDIS measures for 2007 and 2008: *Colorectal Cancer Screening* and *Adults' Access to Preventive/Ambulatory Health Services*. The plan's scores were higher than the High Performance Level for all three age categories for the *Adults' Access to Preventive/Ambulatory Health Services* measure.

Delmarva was limited in its ability to assess the 2007 and 2008 HEDIS scores for the *Colorectal Cancer Screening* measure because no national Medicaid benchmark rates were available for comparison. However, the plan improved its rates for the *Colorectal Cancer Screening* measure by over 40 percentage points from 2007 to 2008.

For QIPs, the plan has two projects in progress—*Controlling High Blood Pressure* and *Warfarin Sodium (Coumadin) Quality Improvement*. The plan reported baseline data for the *Controlling High Blood Pressure* QIP. The *Warfarin Sodium (Coumadin) Quality Improvement Project* was further along with the plan reporting both baseline and Remeasurement 1 data. The plan's *Warfarin Sodium (Coumadin) Project* submission showed improvement in all three measures and hospital admissions were reduced to zero; however, the plan did not submit documentation for these two QIPs in time for Delmarva to include validation results in this report.

AHF administered a member satisfaction survey in 2007 and reported positive results for all areas, including high scores related to overall care received at the centers.

Recommendations

This is the first annual review for this specialty plan. Delmarva acknowledges that the plan is continuing to implement quality improvement initiatives and recommends that the plan focus on some areas:

- In the performance measurement area, the plan scored higher than the HPL for all three age categories for the *Adults' Access to Preventive/Ambulatory Health Services* measures for both 2007 and 2008. Because AHF is performing well on this measure, Delmarva recommends that the plan identify another HEDIS measure that needs improvement and begin reporting on a new measure once approved by the DHCS.

- AHF should continue to work collaboratively with DHCS and the EQRO to meet contract requirements and federal standards. Annual reporting of performance measures, QIPs, and administration of a member satisfaction survey are required.

- DHCS should ensure that the AHF is compliant with contract requirements and facilitate a working relationship that assists the plan in its quality improvement initiatives and timely implementation of contractual and federal requirements.

Appendix A: HEDIS®

HEDIS Background

The Healthcare Effectiveness Data and Information Set (HEDIS®)[6] is a nationally recognized, standardized set of performance indicators developed by the National Committee for Quality Assurance (NCQA). NCQA's Committee on Performance Measurement annually evaluates and makes collective decisions about the content of the measures and the entire HEDIS process. State governments, employer and business groups, payers, and consumers use the results of these measures. More than 90 percent of all national health plans use HEDIS to measure their performance on established dimensions of health care and plan services.

HEDIS data collection and validation are standardized across all plans. HEDIS methodology makes it possible to compare the performance of health plans to each other and to national benchmarks. Results are used to identify performance variances to help plans focus their quality improvement activities.

HEDIS Domains of Care

NCQA assigns each of the technically-defined HEDIS measures (71 measures in 2007 and 70 measures in 2008) to one of eight domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care (Adult and Child CAHPS)
- Use of Services
- Cost of Care
- Health Plan Descriptive Information
- Health Plan Stability
- Informed Health Care Choices

DHCS-Required Measures

2007 DHCS-Required HEDIS Measures

For the 2007 reporting year (2006 measurement year) , the DHCS required its regular contracted plans to report on 12 selected HEDIS measures—including multiple indicators for *Comprehensive Diabetes Care* and

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

Prenatal and Postpartum Care—for a total of 16 measurement indicators.[7] Because AHF is a specialty plan, MMCD did not require the plan to report on any of these 16 indicators. Instead, DHCS specified that each specialty plan would report two performance measures (HEDIS or other), selected as appropriate to the plan's members and approved by MMCD.

2008 DHCS-Required HEDIS Measures

For the 2008 reporting year (2007 measurement year), the DHCS required its regular contacted plans to report on 12 selected HEDIS measures— including multiple indicators for *Ambulatory Care, Childhood Immunization Status, Comprehensive Diabetes Care*, and Prenatal and Postpartum Care—for a total of 23 measurement indicators.[8] For the 2008 Reporting Year, the DHCS required its regular contacted plans to report on 12 selected HEDIS measures— including multiple indicators for *Ambulatory Care, Childhood Immunization Status, Comprehensive Diabetes Care*, and *Prenatal and Postpartum Care*—a total of 23 measurement indicators. Again, as a specialty plan, MMCD exempted AHF from the HEDIS reporting requirements of regular plans; instead, Instead, AHF was required to choose two performance measures for approval by the DHCS—HEDIS measures or plan-designed measures. AHF chose two HEDIS measures appropriate to the plan's population: *Colorectal Cancer Screening* and *Adults' Access to Preventive/Ambulatory Health Services* (three age groups: *Ages 20-44 Years, Ages 45-64 Years*, and *Ages 65 Years +*). As noted in the report, the two HEDIS measures reported by AHF were selected to be appropriate for the plan's unique population.

The DHCS strives to select measures that gauge the quality of care provided to and access to care experienced by the largest segments of the Medi-Cal managed care population. The EQRO compiles and validates the measurement results from all the plans and communicates the results to the DHCS in an annual *Performance Measures for Medi-Cal Managed Care Plans* report.

The *Report of the 2007 Performance Measures for Medi-Cal Managed Care Plans* and the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Plans* ("*Annual Performance Measures reports*") provide the Medi-Cal managed care weighted average for each measure. The Medi-Cal managed care weighted average accounts for variation in membership across plans. The plans' HEDIS data processes are audited according to the protocols described in the *Annual Performance Measures reports*. AHF's HEDIS rates were listed in the *Annual Performance Measures reports* but no weighted comparisons could be offered as the plan's HEDIS measures were not part of the DHCS's list of required measures.

[7] The measures are set forth annually in All Plan Letters issued by the DHCS and available on its website. See All Plan Letter No. 06-010, entitled "Quality and Performance Improvement Program Requirements for 2007."

[8] The measures are set forth annually in All Plan Letters issued by the DHCS and available on its website. See All Plan Letter No. 07-013, entitled "Quality and Performance Improvement Program Requirements for 2008."

Performance Level Criteria

The *Annual Performance Measures reports* utilize the following established benchmarks in assessing plans' performance on measures:

- Medi-Cal Managed Care Weighted Average (Same Year)
- National Medicaid Average (Prior Year)
- National Commercial Average (Prior Year)

The DHCS compares plan rates to Minimum Performance Levels (MPLs) and High Performance Levels (HPLs) for each measure to assess further program-wide quality of care and to identify specific health plan improvement needs. MPLs and HPLs are equal to the 25th and the 90th percentiles, respectively, of the 2006 and 2007 national Medicaid results. The performance benchmarks (MPLs and HPLs) were taken from NCQA's *Quality Compass* for the previous year.

The HPL rates help identify plans that outperform the national Medicaid 90th percentile from the previous year. The DHCS does not apply the MPL and HPL to the first-year scores reported for any measure since that rate establishes a "baseline". Similarly, the MPL and HPL are not applied in years when there were substantive changes to a measure's technical specifications, since making a comparison to the previous rate would be inappropriate.

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