Medi-Cal Managed Care Division

state of california

Medi-Cal Managed Care External Quality Review Organization

2007-2008 Annual Report of Performance for SCAN Health Plan

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DHCS
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Improving Health in the Communities We Serve

Table of Contents

2007 - 2008 Annual Report: SCAN Health Plan

Table of Contents i

Introduction 1
Plan Background 1
Federal Reporting Requirements 2
Definitions 3
Data Sources 4
Assessment of Performance 5
Conclusions 10
Recommendations 11

Appendix: HEDIS® ..... Appendix 1

References ..... References 1

2007 - 2008 Annual Report: SCAN Health Plan

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 its 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

In addition to contracting with traditional full-scope Managed Care Organizations (MCOs), most of which are licensed Health Maintenance Organizations (HMOs), the DHCS also contracts with specialty plans—health care plans that serve a special group of the Medi-Cal population. The Senior Care Action Care Network Health Plan (SCAN or "the plan") has contracted with the State of California as a Medi-Cal managed care specialty plan since 1985 in Los Angeles County and since 1997 in San Bernardino and Riverside counties.

Most Medi-Cal beneficiaries enrolled in managed care plans receive their health care through three models of health care delivery[1]. However, SCAN's Medi-Cal members are Medicare-Medi-Cal dually eligible

[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.

beneficiaries (also referred to as "Dual Eligibles" or "Medi-Medi members") who are entitled to Medicare Part A and/or Part B and also eligible for some form of Medi-Cal benefits.

SCAN is a not-for-profit health plan providing comprehensive medical coverage, prescription benefits and support services specifically designed for seniors, serving members in Los Angeles, Riverside, and San Bernardino counties. SCAN receives monthly pre-paid capitation from both Medicare and Medi-Cal and pools its financing to pay for all services as a full-risk HMO. As a Medicare Advantage Organization, SCAN operates as a Social HMO[2] under special waivers and has held a contract with the Federal Centers for Medicare and Medicaid Services (CMS) since 1985. The plan serves both Medicare and Medicaid beneficiaries of several counties in California and Arizona.

In California, SCAN has been licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act since November 30, 1984. As of December 2007, SCAN's total enrollment was approximately 105,000. Of those members, 6,349 were Medi-Cal members (Los Angeles – 4,355; Riverside 1,349; and San Bernardino – 645).

SCAN's goal is to enhance the ability of seniors to manage their health and remain independent. Through extended home care benefits, SCAN assigns a planner to work with members to assist them in remaining independent. Typical services include personal care coordination, transportation services, personal care, adult day care, home-delivered meals, etc. To be eligible for the plan, an individual must be 65 years of age, or older, live in the service area, have Medicare Part A and B, not have end-stage renal disease, and be certified as nursing home eligible in order to receive extended home care benefits. SCAN provides preventive, social services, acute and long-term care services.

Federal Reporting Requirements

In 2006, the Centers for Medicare and Medicaid Services (CMS) directed the DHCS to make specialty plans subject to the same external quality review requirements as other Medi-Cal managed care plans, as well as other appropriate contract requirements, in order for the Department to continue to receive Federal Financial Participation (FFP) for those plans.

[2] A Social HMO (or Social Managed Care Plan) is an organization that provides the full range of Medicare benefits offered by standard Managed Care Plan's plus additional services which include care coordination, prescription drug benefits, chronic care benefits covering short term nursing home care, a full range of home and community based services such as homemaker, personal care services, adult day care, respite care, and medical transportation. Membership offers other health benefits that are not provided through Medicare alone or most other senior health plans.

Federal regulations require that the quality of care, including access, and timeliness, be evaluated annually by an EQRO. 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 twelve Healthcare Effectiveness Data and Information Set (HEDIS®)[3] 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. Performance measurement results must be reported specifically for the plan's Medi-Cal managed care members, not for the plan's entire population.
- Specialty plans are not required to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[4] surveys, but instead are required to conduct some kind of member satisfaction survey and periodically report results to the DHCS and the EQRO.
- 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 for SCAN and covers reporting years (RYs) 2007 and 2008, focusing on performance measurement results and quality improvement activities conducted during calendar years 2006 and 2007.

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 SCAN. Consistency in meaning and use of these key terms are important for a thorough understanding of this report, so definitions follow:

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[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA, 2008). 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.

[4] 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 CAPHS surveys in 2007 for MMCD's regular contracted health care plans.

- **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, 2008)

- **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, 2008)

Data Sources

Delmarva used five types of standards or information sources to assess SCAN's performance relative to the plan's ability to provide its members with care that meets federal and state quality, access, and timeliness requirements:

- **Performance Measures**. Due to delays in the development and approval of contract requirements, SCAN had not yet selected two measures to fulfill DHCS's performance measure reporting requirement for reporting year 2007 (for measurement year 2006). However, by 2007, the DHCS, the EQRO, and SCAN had collaboratively chosen two HEDIS measures to fulfill the 2008 reporting year requirement. For that reason, this report addresses only the 2008 HEDIS results (measurement year 2007).

- **Member Satisfaction Surveys**. The report summarizes results of SCAN's plan-designed member satisfaction surveys conducted between January 1, 2006, and December 31, 2007. SCAN's administers its member satisfaction survey to all its members. Initially, the plan was not able to isolate survey results for its Medi-Cal population but has agreed to do this in the future.

- **Quality Improvement Projects (QIPs)**. This report contains summaries of the QIPs conducted by SCAN during the period January 1, 2006, and December 31, 2007.

- **Medi-Cal Medical Audits.** The DHCS's Audits and Investigations Division and the California Department of Managed Health Care (DMHC) conduct routine medical surveys (audits) to assess plan compliance with contract requirements and state regulations. The most recent *Routine Medical Survey Final Report* for SCAN was issued in July 2004. Since no audit was conducted during the period January 1, 2006, through December 31, 2007, no audit results are included in this report.

- **Grievance and Appeal Data.** All regular Medi-Cal managed care plans are required to submit quarterly grievance and appeal data to the DHCS. While some specialty plans are not subject to this requirement, SCAN's contract with the Department includes this requirement. In addition, MMCD's Office of the Ombudsman prepared reports summarizing member calls received by the Office of the Ombudsman and SCAN's call data for calendar years 2006 and 2007 is included in this report.

Assessment of Performance

Because information was not available in all five areas, Delmarva was limited in its ability to provide a complete assessment. The next annual performance review, covering 2008, may present a more complete assessment.

The following review and evaluation of plan performance is brief, due in part to delays in the development and approval of the revised contract requirements, which resulted in postponement of the planned monitoring activities. Additionally, SCAN had limited amounts of available data, as the plan is in the early stages of implementing the required external quality review activities. Lastly, benchmarks to measure SCAN's performance against are limited due to the plans' specialized population.

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 two performance measures. The measures are chosen collaboratively by the DHCS, the EQRO, and the plan with a focus on the measure's relevance to the plan's membership.

2007 HEDIS Performance Measures

In 2007, the DHCS made a preliminary recommendation that SCAN report the following HEDIS measures for Medi-Cal members only: *Comprehensive Diabetes Care* and *Breast Cancer Screening*. Due to contracting issues between SCAN and the DHCS and the inability to facilitate a joint audit between auditors for Delmarva and Medicare, SCAN did not report HEDIS scores for 2007 to the DHCS. However, after further consultation with Delmarva, the DHCS and SCAN later agreed on two different HEDIS measures to be reported:

- *Glaucoma Screening in Older Adults.* This measure is a Medicare-only designated HEDIS measure.
- *Persistence of Beta-Blocker Treatment After a Heart Attack.* This measure is a Medicare- and Medicaid-designated HEDIS measure.

2008 HEDIS Performance Measures

The 2008 HEDIS scores reflect data for the 2007 measurement year. Although SCAN's HEDIS system and procedures were not audited by Delmarva in 2008, the plan was audited by Medicare.

Both of the selected HEDIS measures reported by SCAN fall into the quality domain and are relevant to the plan's membership. However, the results displayed in Table 1 are for informational purposes only. The results related to SCAN's entire population, which include both Medicare-only members and Medi-Cal dual-eligible members; therefore, the rates did not meet Medi-Cal reporting requirement that rates isolate Medi-Cal managed care members from the plan's general membership.

Table 1. 2008 HEDIS Measures: *Glaucoma Screening in Older Adults* and *Persistence of Beta-Blocker Treatment After a Heart Attack*.

SCAN Health Plan	Glaucoma Screening in Older Adults	Persistence of Beta-Blocker Treatment After a Heart Attack
HEDIS 2008 Rate	71.8%	77.1%
Minimum Performance Level* (25th percentile of national Medicare results)	50.7%	69.2%
High Performance Level* (90th percentile of national Medicare results)	77.3%	88.0%

* The Minimum Performance Levels (MPLs) and High Performance Levels (HPLs) included above are from the *2008 Audit, Means, Percentiles, and Rations for Medicare Plans*, available on the NCQA website at http://www.ncqa.org/tabid/334/Default.aspx.

The Minimum Performance Levels (MPLs) and High Performance Levels (HPLs) included in the table above are from the *2008 Audit, Means, Percentiles, and Rations for Medicare Plans*. These percentiles are provided for information only. SCAN did not report 2008 HEDIS rates for its Medi-Cal managed care population and therefore was not subject to the DHCS-designated MPLs and HPLs, which are based on national results for Medicaid plans.

For the *Glaucoma Screening in Older Adults* measure, in 2008, SCAN reported a rate of 71.8 percent—5.5 percentage points lower than the Medicare High Performance Level (HPL), which is the 90th percentile of the national results for Medicare plans.

SCAN reported a rate of 77.1 percent for the *Persistence of Beta-Blocker Treatment After a Heart Attack* measure, which was 10.9 percentage points *lower* than the Medicare HPL and 7.9 percentage points *higher* than the Medicare MPL. (See Appendix A for further information regarding HPLs and MPLs.)

SCAN's 2009 HEDIS results for its Medi-Cal managed care members will be audited by DHCS's EQRO, and the 2009 HEDIS aggregate report will include specific results for SCAN's Medi-Cal managed care population.

Quality Improvement Projects

Specialty plans are required to have two Quality Improvement Projects (QIPs) underway at all times, but are not required to participate in the statewide collaborative QIP. Specialty plans may conduct either two internal QIPs or conduct one internal QIP and participate in a small group collaborative QIP if approved by the DHCS.

In 2008, SCAN submitted two Quality Improvement Projects (QIPs) to DHCS for review and approval: *Chronic Obstructive Pulmonary Disease Management* and *Prevention of Stroke and Transient Ischemic Attack*. SCAN submitted these projects late in the 2008 calendar year, after Delmarva's contract with DHCS had ended; therefore, Delmarva did not validate these QIPs.

Prior to the release of SCAN's next plan-specific report, the DHCS and its EQRO will be working with the plan to ascertain whether QIP results can be reported specifically for their Medi-Cal enrollees rather than for all the Medicare enrollees. This report summarizes SCAN's proposed QIPs below. *Note:* Baseline measurements reflect SCAN's entire Medicare population, not only its Medi-Cal managed care members.

Chronic Obstructive Pulmonary Disease Management

The objective of SCAN's internal QIP, *Chronic Obstructive Pulmonary Disease Management*, is to increase the rate of spirometry testing for chronic obstructive pulmonary disease (COPD) diagnosis and increase the percentage of patients who receive a prescription for a bronchodilator. The data reported for the SCAN's *Chronic Obstructive Pulmonary Disease Management* QIP cover two geographical areas within California, identified as contracts H9104 and H5425. This QIP falls into the quality domain.

- ***Relevance:***
  - As of December 2007, 20.2 percent of SCAN members (age over 64) had a COPD diagnosis.
  - During the timeframe of September 1, 2006, through August 31, 2007, SCAN members with COPD experienced a total of 4,069 acute inpatient or emergency department visits.

- ***Goals:***
  - Increase the rate of spirometry testing for COPD patients.
  - Increase the percentage of patients who receive a prescription for bronchodilator.
- ***Outcomes:***
  - Use of spirometry testing for assessment and diagnosis of COPD:
    - Baseline (1/01/07 -12/31/07):
      - Contract H9104: 16.9 percent
      - Contract H5425: 25.4 percent
  - Pharmacotherapy management of COPD exacerbations:
    - Baseline (1/01/07 through 12/31/07)
      - Contract H9104: 62.6 percent
      - Contract H5425: 65.5 percent

Prevention of Stroke and Transient Ischemic Attack

The objective of SCAN's internal QIP, *Prevention of Stroke and Transient Ischemic Attack*, is to prevent new incidence of stroke or transient ischemic attack (TIA) by implementing interventions to target risk factors. This QIP falls into the quality domain.

- ***Relevance:***
  - As of December 2007, 19,439 of SCAN's total membership had a stroke or TIA diagnosis. Of these members, 4,663 were newly diagnosed in 2006, and 4,690 were diagnosed in 2007.
  - According to a 2007 health questionnaire, 9.2 percent of SCAN members had a stroke at some point in their lifetime.
- ***Goals:***
  - Prevent risk of stroke or TIA (primary prevention).
  - Reduce recurrence of stroke and TIA (secondary prevention).
- ***Outcomes:***

  Not applicable as this project was in its proposal stage at the time this report was prepared. The proposal did not include existing baseline data.

Based on the rationales provided, both of SCAN's QIPs, *Chronic Obstructive Pulmonary Disease Management* and *Prevention of Stroke and Transient Ischemic Attack*, appear to be relevant to the plan's population. SCAN reported baseline data for the *Chronic Obstructive Pulmonary Disease Management* project, but did not include baseline data in it proposal for the *Prevention of Stroke and Transient Ischemic Attack* QIP.

Member Satisfaction Survey

Because of its small number of members and specialized focus, DHCS does not require SCAN to participate in the CAHPS surveys. The plan instead must submit information about its plan-administered member satisfaction survey (both the survey tool and the methodology) and then provide an annual summary of survey results, preferably specifically for SCAN's Medi-Cal managed care members.

In 2007, SCAN provided the survey tool used for its member satisfaction survey, the *SCAN Medi-Medi Group Needs Assessment,* the sampling methodology, and a summary of the most recent results to Delmarva and the DHCS for review. SCAN designed this survey as a telephone-based member survey, which is administered to its members[5] in Los Angeles, Riverside and San Bernardino counties. The survey's goals were to solicit member input regarding doctor-patient communication, written communication, access to care, linguistic capabilities (*e.g.*, language preference and availability of interpreters, and satisfaction with both plan service and provider care). SCAN uses survey results to modify and develop its service delivery systems to better meet the needs of the Medi-Cal membership.

SCAN's Diversity and Member Education Department developed the survey, which consisted of 22 close-ended questions and one open-ended question. Several questions allowed the respondent to select more than one response; in those areas, the results could exceed 100 percent. From June to November 2007, bilingual staff from SCAN's Member Education area, PAL unit (Medi-Medi call center), and Member Services area, as well as Senior Advocates, conducted the 23-question phone survey. Staff completed 843 surveys, sampling 12.5 percent of SCAN's membership. As noted previously, results for SCAN's Medi-Cal managed care members could not be isolated.

The 2007 results of the survey were not available to Delmarva at the time this report was prepared.

Grievance and Ombudsman Reports

MMCD requires contracted health plans to maintain grievance systems in accordance with the California Code of Regulations, Title 28, Section 1300.68. Plans must track all grievances received —in writing or verbally—in a grievance log. Plans submit quarterly reports to MMCD, as well as to the Department of Managed Health Care (DMHC), with detailed information about pending grievances and those that were not resolved within 30 days (MMCD All Plan Letter No. 03-008).

[5] SCAN's Medi-Cal members are Medicare-Medicaid dually eligible beneficiaries (also referred to as Dual Eligibles or Medi-Medi members). These are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

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 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 many or few grievances, calls, or requests for State Fair Hearings over time. The Department holds discussions with plans regarding unusual patterns in grievances, calls, or hearing requests when appropriate. The Department 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.

SCAN's Grievance Reports

SCAN's contract with the DHCS requires the plan to submit quarterly grievance reports. The DHCS's Office of Long-Term Care, which administers SCAN's contract, reviews these reports. Delmarva did not have access to these quarterly reports when this report was prepared.

Office of the Ombudsman's Reports

- 2006: 1 Ombudsman Case Management System case
- 2006: 0 State Fair Hearings
- 2007: 2 Ombudsman Case Management System cases
- 2007: 0 State Fair Hearings

Conclusions

SCAN did not report 2007 HEDIS results. For 2008 HEDIS, SCAN reported its Medicare performance results for two measures, *Glaucoma Screening in Older Adults* and *Persistence of Beta-Blocker Treatment After a Heart Attack*. Results are for SCAN's entire Medicare population and do not isolate results for the plan's Medi-Cal managed care members.

During the period covered by this report, SCAN submitted two internal QIPs to the DHCS for review and approval: *Chronic Obstructive Pulmonary Disease Management* and *Prevention of Stroke and Transient Ischemic Attack*. The plan submitted these projects late in 2008—too late for validation results to be included in this report.

In 2007, SCAN provided the sampling methodology for its member satisfaction survey to the DHCS and the EQRO for review. However, survey results were not provided in time to be included in this report.

This is the first annual review for SCAN, and it should be noted that the plan is continuing to improve its reporting of HEDIS, QIPs, and member satisfaction survey results to the DHCS and its EQRO.

Both HEDIS performance measures selected by SCAN (*Glaucoma Screening in Older Adults* and *Persistence of Beta-Blocker Treatment After a Heart Attack*) were relevant to its membership. Likewise, the QIPs topics *Chronic Obstructive Pulmonary Disease Management* and *Prevention of Stroke and Transient Ischemic Attack* selected by SCAN appear to be relevant to the plan's population, including its Medi-Cal members.

Recommendations

SCAN's performance measures all focus on the quality domain. SCAN should consider incorporating performance measures and QIPs from the access and timeliness domains to comply with federal mandates that plans incorporate quality initiatives for all three performance areas—quality, access, and timeliness. Whenever possible, SCAN should identify demographic differences of its Medi-Cal managed care membership in its quality assurance activities.

Delmarva recommends that the plan take steps to be able to isolate data and results for its Medi-Cal managed care members for the required performance measures, QIPs, and member satisfaction survey. This would allow the plan to determine more precisely performance improvement needed for this population. To support this goal, SCAN has asked that the EQRO coordinate the 2009 HEDIS audit with the plan's Medicare auditor to avoid undue burden on the plan for duplicative audit activities.

SCAN must work collaboratively with the DHCS and its EQRO to assure timely submission of HEDIS results, QIP reports, and member satisfaction survey results. Because the DHCS's Office of Long-Term Care (OLTC) manages the SCAN contract, rather than the Medi-Cal Managed Care Division, MMCD staff must coordinate with both the EQRO and OLTC staff to assure timely communication and follow-up with plan.

Appendix: 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 is 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, the DHCS required its regular contracted plans to report on 12 selected HEDIS measures—including multiple indicators for *Comprehensive Diabetes Care* and *Prenatal and Postpartum*

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

Care—for a total of 16 measurement indicators.[7] Because SCAN Health Plan is a specialty plan focused on seniors, MMCD did not require the plan to report on any of these 16 indicators. Instead, SCAN was required to choose two performance measures for approval by the DHCS—HEDIS measures or plan-designed measures. Due to contract issues, SCAN did not report performance measure scores in 2007.

2008 DHCS-Required HEDIS Measures

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*—for a total of 23 measurement indicators.[8] SCAN was required to report on the two performance measures that had been selected and approved by the DHCS as appropriate to the plan's Medi-Cal managed care members who are also enrolled in Medicare: *Glaucoma Screening in Older Adults* and *Persistence of Beta-Blocker Treatment After a Heart Attack*.

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*. SCAN's rates included in this report were taken from the *Annual Performance Measures reports*.

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)

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[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."

* MPLs/HPLs were not applied to these measures in 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."

* MPLs/HPLs were not applied to these measures in 2008.

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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