# Performance Evaluation Report

# **Family Mosaic Project**

# July 1, 2008–June 30, 2009

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

December 2010

## 1. EXECUTIVE SUMMARY

### Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.6 million beneficiaries (as of June 2009) in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Plan-specific reports are issued in tandem with the technical report. The plan-specific reports include findings for each plan regarding its organizational assessment and structure, performance measures, and QIPs as they relate to the quality, access, and timeliness domains. This report is specific to the contract between the DHCS and the Family Mosaic Project ("FMP" or "the plan"), operated by the City and County of San Francisco Department of Public Health.

FMP is a specialty plan with intensive case management and wrap-around services for Medi-Cal managed care children and adolescents in San Francisco County who are at risk for out-of-home placement. As such, the plan has contractual requirements that have been modified from those specified for the full-scope contracted health plans.

# Overall Findings Regarding Health Care Quality, Access, and Timeliness

## Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for Medi-Cal managed care members through the provision of health care services and the plan's structural and operational characteristics.

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

FMP had few initiatives and data specific to its Medi-Cal managed care capitated population because this population represents a small segment of the plan's overall membership. This limited the ability of HSAG and the plan to assess quality of care provided to these members.

During the review period, the plan did not have performance measures in place; however, HSAG found that FMP took the necessary steps toward complying with DHCS requirements to report on two performance measures annually. The plan participated in bimonthly technical assistance calls with HSAG to develop two draft performance measures and working definitions. As part of this process, the plan underwent an on-site Information Systems Capabilities Assessment in June 2009. HSAG primarily focused on FMP's data systems, data collection, and systems integration to help identify data for objective measurement that were meaningful to the plan and had potential for performance improvement. As a result of this assessment, HSAG provided the plan with recommendations to improve its process for data accuracy and data completeness, both of which are necessary for producing valid rates. In June 2009, the plan submitted its draft performance measures to the DHCS with a target to report rates for the performance measures for the first time in 2010. Both performance measures address quality of care for its Medi-Cal managed care members by reporting, tracking, and analyzing inpatient hospitalizations and out-of-home placements, which will allow the plan to implement strategies to improve performance in these areas.

Despite FMP's efforts to comply with DHCS requirements, the plan was still deficient with performance measure requirements for the review period. Additionally, the plan did not have quality improvement projects in place to meet contract requirements during the review period.

Accordingly, HSAG found that FMP demonstrated below-average performance for the quality domain of care.

## Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess plans' compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

HSAG assessed the access domain of care for FMP based solely on State and federal standards since neither performance measure nor quality improvement project results were available during the review period. HSAG found that FMP demonstrated average performance for the access domain of care. The DHCS's Member Rights and Program Integrity Unit (MRPIU) review found the plan fully compliant with cultural and linguistic services requirements.

## Timeliness

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

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management.

FMP demonstrated average performance for the timeliness domain of care based on MRPIU review findings. The plan was fully compliant in the area of prior authorizations; however, FMP had deficiencies related to member grievances. The plan's grievance policy and procedure lacked the required time frames for resolving a member grievance. Additionally, the plan did not maintain grievance files for the required five-year time frame.

## Conclusions and Recommendations

While FMP continued to be out of compliance with MCMC Program requirements for a specialty plan during the review period, FMP has taken many steps toward achieving contractual compliance. The plan reported performance measures beginning in 2010 and is on target to meet QIP requirements by December 31, 2010.

Based on the overall assessment of FMP in the areas of quality and timeliness of and access to care, HSAG recommends the following:

- Explore tracking and trending internal quality improvement indicators for the Medi-Cal managed care capitated membership to better assess the quality and timeliness of and access to care provided to this specialty population.

- Finalize performance measures, resolve all outstanding action items provided by HSAG as part of the Information Systems Capabilities Assessment, and conduct test data pulls to ensure readiness for 2010 reporting.

- Continue QIP technical assistance calls with HSAG to assist in the development of a QIP proposal through the study design phase.

- Revise the grievance policy and procedure to include the required time frames to resolve member grievances and maintain grievance files.

- Review the Department of Mental Health's audit report to identify any findings that may apply to FMP and Medi-Cal managed care, and address those issues.

In the next annual review, HSAG will evaluate FMP's progress with these recommendations along with its continued successes. It should be noted that FMP has already acted on some of the above recommendations during 2010.

## Plan Overview

The Family Mosaic Project (FMP), operated by the City and County of San Francisco Department of Public Health, is a specialty managed care plan in San Francisco County. FMP became operational with the Medi-Cal managed care program in February 1993. As of June 30, 2009, FMP had 152 MCMC members.[1]

FMP is part of the Child, Youth, and Family System of Care operated by the City and County of San Francisco Department of Public Health, Community Behavioral Health Services. The plan provides Medi-Cal managed care children and adolescents at risk for out-of-home placement with intensive case management and wraparound services through a capitation agreement. To receive services from FMP, a member 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 out-of-home placement or already in an out-of-home placement. The plan submits appropriate clients to the DHCS for approval to be enrolled in FMP's Medi-Cal managed care program. Once a client is approved and included under FMP's contract with the DHCS, the plan receives a per-member, per-month capitated rate to provide mental health and related wraparound services to these members.

In 2006, the DHCS, at the direction of the Centers for Medicare & Medicaid Services (CMS), designated FMP as a managed care plan that must comply with external quality review requirements and other contract requirements in order for the DHCS to receive federal financial participation for this plan. The DHCS amended FMP's contract in early 2007 to include federal and State requirements for managed care plans, modified as appropriate to this specialty plan. Among these requirements, the DHCS requires that specialty plans participating in the Medi-Cal Managed Care Program report on two performance measures annually and maintain two internal QIPs.

During the review period, FMP was unable to collect or report any performance measures. After extensive review, HSAG determined that FMP did not have standardized data available to support accurate performance measure reporting. HSAG also found that FMP needed a considerable amount of technical assistance to develop performance measures due to the unique nature of the services provided by the plan. Existing performance measures relevant to the unique services FMP

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[1] *Medi-Cal Managed Care Enrollment Report, June 2009.* Available at:
http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

provides did not exist; therefore, the plan could not easily adopt standardized measures. Additionally, FMP has only 150 to 200 members enrolled at a given time, which presents challenges for developing meaningful measures for an extremely small population. FMP also needed technical assistance with constructing valid QIPs, as the plan had not yet initiated formal QIPs.

In lieu of conducting performance measure validation and QIPs validation for FMP during the period of July 1, 2008, through June 30, 2009, the DHCS gave its approval for HSAG to provide technical assistance to the plan to help the plan increase its compliance with the DHCS requirements for performance measure reporting and QIPs.

## Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. The DHCS conducts this review activity through an extensive monitoring process to assess plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

## Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about FMP's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards primarily fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

### Physical and Mental Health Care Audit Review

For full-scope contracted plans, the DHCS's Audits and Investigations Division works in conjunction with the California Department of Managed Health Care (DMHC) to conduct medical performance audits and routine medical surveys (joint audits) of MCMC plans. These joint audits assess plans' compliance with contract requirements and State and federal regulations. However, due to the unique nature of FMP's membership and the plan's emphasis on the mental health component of the services it delivers, FMP is not subject to joint audits by the DHCS and DMHC. FMP, as part of San Francisco County's Mental Health Plan, is subject to review by the Division of Program Compliance—Medi-Cal Oversight, California Department of Mental Health (DMH).

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. A DMH audit was performed in February 2008. The scope of the audit covered the following areas of review: access, authorization, beneficiary protection, funding and reporting requirements, target populations and array of services, interface with physical health care, provider relations, the quality improvement program, implementation of the Conlan decision, the Mental Health Services Act, and chart review. Since the scope of the

audit included the larger San Francisco County Mental Health Plan, HSAG could not determine if any of the audit findings related specifically to FMP and the Medi-Cal managed care program. HSAG recommends that the plan review the audit report to identify any findings that may apply to FMP and Medi-Cal managed care and address those issues.

### Member Rights and Program Integrity Monitoring Review

The Member Rights and Program Integrity Unit (MRPIU) of DHCS's Medi-Cal Managed Care Division is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These reviews are done before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2009.

MRPIU conducted a routine monitoring review of FMP from March 3, 2009, through March 8, 2009, covering the review period of January 1, 2008, through December 31, 2008.

The plan was fully compliant with all requirements reviewed for prior-authorization notifications, marketing, and cultural and linguistic services; however, MRPIU noted two findings in the member grievances area. FMP's grievance policy and procedures lacked timeline requirements for resolving member grievances. Additionally, the DHCS requires that plans maintain grievance information for five years. The plan, however, noted that it maintains grievance files for two years.

## Strengths

MRPIU audit results showed that FMP was fully compliant with prior-authorization notifications, marketing, and cultural and linguistic services.

## Opportunities for Improvement

FMP has opportunities to address the MRPIU review findings related to member grievances. Additionally, FMP should review the DMH audit report of San Francisco County's Mental Health Plan and address any areas of deficiency relevant to FMP.

## Conducting the Review

For its full-scope contracted Medi-Cal managed care plans, the DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. Under its original contract with the DHCS, FMP—as with other specialty plans—was not held to the same performance measurement requirements as full-scope plans. In response to CMS' direction that the DHCS make specialty plans subject to the same external quality review requirements as other Medi-Cal managed care plans, FMP's contract was changed effective 2007 to include new performance measurement requirements.

Due to the small size of specialty plan populations, the DHCS modified the performance measurement requirements applied to these plans. The DHCS required that a specialty plan report on only two performance measures rather than the larger number of measures required of full-scope plans. With approval from the DHCS and its EQRO, a specialty plan may select its measures from the Healthcare Effectiveness Data and Information Set (HEDIS®)[2] or develop measures appropriate to the plan's population. Just as with full-scope plans, a specialty plan must report performance measurement results that are specific to the plan's Medi-Cal managed care members and not the plan's entire population.

As with all MCMC plans—full scope and specialty—HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for performance measures when calculating rates.

### Performance Measure Validation

During the review period—July 1, 2008, through June 30, 2009—FMP was unable to report any performance measures. Beginning in April 2009, HSAG began providing intensive technical assistance to the plan, with the goal of assisting FMP with the development of written specifications for two performance measures that the plan would begin reporting in 2010.

HSAG conducted an Information Systems Capabilities Assessment of FMP on June 24, 2009, covering the review period of January 1, 2008, through December 31, 2008. The assessment

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

included a review of FMP's information systems, enrollment process, inpatient hospitalization process, data form completion process, and clinical assessment data to determine the feasibility of FMP reporting performance measure data related to inpatient hospitalizations and out-of-home placements.

Based on the review, HSAG provided recommendations to FMP to streamline its use of "other" and "unknown" codes on its *Episode Opening* and *Episode Closing* forms by providing staff training in consistent coding. HSAG also recommended that FMP train data entry staff and implement procedures to be followed when a form is missing a code. Additionally, HSAG identified some inconsistency and ambiguity in FMP's application of the available *Reason for Discharge* codes. The plan acknowledged this as an area for improvement and shared with HSAG a draft *Reason for Discharge—Decision Tree* to define, standardize, and train staff on use of appropriate discharge codes.

## Performance Measure Results

Although FMP did not collect or report any performance measures during the review period, the plan was able to finalize two measures that it began reporting in 2010: inpatient hospitalizations and out-of-home placements.

For inpatient hospitalizations, the plan will report the percentage of capitated Medi-Cal managed care members enrolled in FMP with a mental health admission to an inpatient hospital facility during the measurement period. The program provides wrap-around services to children and adolescents at risk for out-of-home placement to keep them in a home-like setting. FMP's goal is to keep these members out of an acute inpatient facility for mental health. This measure falls under the quality of care domain.

For out-of-home placements, FMP will report the percentage of Medi-Cal capitated managed care members enrolled in FMP who were discharged to an out-of-home placement during the measurement period. The plan's goal is to keep members in a home-like setting; therefore, FMP wants the rate of out-of-home placements to be minimal. This measure falls under both the quality and access domains of care.

## Strengths

FMP participated in intensive bimonthly technical assistance sessions and underwent an Information Systems Capabilities Assessment with HSAG to take necessary steps toward complying with DHCS requirements. As of July 2009, FMP had developed draft working definitions for two performance measures with the goal of reporting rates for each measure beginning in 2010.

## Opportunities for Improvement

FMP has the opportunity to finalize its performance measures, conduct test data pulls, and resolve any outstanding action items from the Information Systems Capabilities Assessment recommendations to ensure its readiness to report rates beginning in 2010.

## Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas.

HSAG reviews each QIP using CMS' validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

### *Quality Improvement Projects Conducted*

For full-scope Medi-Cal managed care plans, each plan must be engaged in two QIPs at all times. One QIP is the statewide collaborative QIP, and the second QIP can be either a small-group collaborative QIP or an internal QIP. Due to the unique and small populations served by specialty plans, the DHCS does not require these plans to participate in the statewide collaborative QIP. Instead, specialty plans are required to design and maintain two internal QIPs that will support activities designed to improve the quality and timeliness of, and/or access to, services for the plan's MCMC members.

FMP's earlier efforts to develop two plan-specific QIPs were unsuccessful. The plan was not reporting rates for appropriate performance measures or collecting data in a manner that could produce meaningful data for QIPs.

Since FMP did not have any quality improvement projects in place during the review period, the DHCS agreed to have FMP receive technical assistance training from HSAG instead with the goal of developing and submitting two acceptable QIP proposals through the study design phase by June 30, 2009.

Given the significant challenges identifying FMP data sources that could produce accurate, complete, and meaningful data for a QIP, HSAG made the development of performance measures a priority over QIP development since accurate and complete data are essential to a valid QIP.

As of June 30, 2009, FMP had not completed either QIP through the study design phase. As part of the systems capabilities assessment, HSAG began exploring a QIP topic with FMP related to

improving the accuracy and completeness of performance measure data since opportunities existed in this area. However, HSAG found that this topic would not meet the requirements of a QIP.

In July 2009, HSAG recommended to the DHCS that FMP continue efforts to identify an appropriate QIP topic and initiate one QIP by May 31, 2010, with HSAG providing technical assistance to the plan through the study design phase. Additionally, HSAG recommended that the DHCS allow the plan to delay meeting its second QIP requirement until December 31, 2010. This delay would give FMP time to assess data results from both 2010 performance measures and to assess 2009 Child and Adolescent Needs and Strengths (CANS) data to identify opportunities for improvement as well as have data systems in place to support a second QIP. CANS is an outcome/assessment tool designed to identify which of a child's needs and strengths require action. The tool also provides clinicians and supervisors a structured way to determine whether children/youth are being served at the right intensity of care and whether that care leads to positive outcomes.

## Strengths

FMP participated in QIP technical assistance sessions with HSAG, including a "QIP 101" training session. The plan took action to implement electronic data collection of CANS assessment data on all members, which increased the likelihood of FMP being able to use this data for a QIP.

## Opportunities for Improvement

As of June 30, 2009, FMP remained out of compliance with DHCS contract requirements for the plan to maintain two active QIPs. The plan has an opportunity to prioritize efforts to support the development of QIPs to meet contractual requirements. FMP has since submitted one QIP proposal that was approved by the DHCS and validated by HSAG and is moving through the design phase for a second QIP.