Performance Evaluation Report

Senior Care Action Network (SCAN) Health Plan

July 1, 2008–June 30, 2009

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

December 2010

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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.

This report is unique to the MCMC Program's contracted plan, Senior Care Action Network Health Plan ("SCAN Health Plan," "SCAN," or "the plan"), for the review period July 1, 2008, to June 30, 2009. 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 of care. Actions taken by the plan subsequent to June 30, 2009, regarding findings identified within this report will be included in the next annual plan-specific evaluation report.

SCAN is contracted with the MCMC Program as a specialty plan that provides medical services to members who are eligible for both Medicare and Medi-Cal managed care ("dual eligibles").

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.

To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPLs indicate low performance, rates at or above the HPLs indicate high performance, and rates at the MPLs or between the MPLs and HPLs demonstrate average performance.

HSAG found that SCAN demonstrated average performance for the quality of care domain. This was based on the plan's 2009 performance measure rates (which reflect 2008 measurement data), QIP outcomes, and compliance review standards related to measurement and improvement.

Both of SCAN's performance measure rates fell between the established MPLs and HPLs. This is the first year in which the plan selected and reported rates that complied with the DHCS and federal requirements for reporting performance measures.

During the review period, SCAN had two QIPs in progress that were under the quality domain of care. The plan focused on improved management of chronic obstructive pulmonary disease and decreasing the incidence of stroke and ischemic attack. Both QIPs were in the baseline phase; therefore, HSAG could not assess QIP outcomes during this review period. HSAG noted that SCAN has an opportunity to improve its QIP documentation to meet the Centers for Medicare & Medicaid Services (CMS) requirements for conducting a QIP. Additionally, the plan should only report in its QIP those data that reflect its Medi-Cal managed care members and internally track an overall performance measure rate.

Medical performance audit findings related to quality management standards showed that the plan was fully compliant. The plan demonstrated adequate organizational capacity to support the delivery of quality care. Findings related to medical grievances revealed that not all grievances involving a quality-of-care concern were adequately evaluated and/or referred for peer review.

Access

The access domain of care relates to a plan's ability to meet 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.

SCAN demonstrated average performance for the access domain of care based on its performance measures and QIP outcomes that addressed access and compliance review standards related to the availability of and access to care.

The plan's rate for the *Glaucoma Screening in Older Adults (GSO)* performance measure fell between the MPL and HPL, suggesting adequate access for members to this service.

Medical performance audit findings related to the accessibility and availability of services showed that the plan had standards for routine, urgent, and emergency care, while it lacked a process for monitoring member wait times in provider offices, telephone wait and call-return times, and appointment wait times. The plan used a nurse advice line to provide 24-hour telephone access to assist members; however, the plan did not have procedures for the oversight of this advice line.

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, to minimize any disruptions to care, and to 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.

Based on the medical performance audit review findings, the plan demonstrated below-average performance in the timeliness domain of care. The audit revealed that the plan had challenges

meeting Medi-Cal managed care contractual requirements for members related to member grievances and prior-authorization notifications and timeliness.

Conclusions and Recommendations

Based on the information available for the review period, SCAN demonstrated average performance in providing quality and accessible health care services to its MCMC members and below average performance related to timeliness.

Based on the overall assessment of SCAN in the areas of quality and access to care, HSAG recommends that the plan does the following:

- Continue to produce valid and reportable performance measure rates for the Medi-Cal managed care membership to allow for tracking and trending of performance over time.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.
- Include only Medi-Cal managed care members when reporting QIP rates to allow the plan to identify its performance for this specific population.
- Establish criteria for evaluating quality-of-care grievances and a process for determining the need for peer review.
- Implement a mechanism to monitor office wait times, telephone wait and call-return times, and appointment wait times.
- Implement a formal process for oversight of the delegated 24-hour nurse advice line.
- Revise prior-authorization policies and procedures to reflect Medi-Cal managed care requirements for member notifications and timelines.
- Revise grievance policies and procedures to reflect Medi-Cal managed care requirements for member acknowledgment and resolution letters.
- Implement a process for monitoring the timeliness of member grievance acknowledgment and resolution letters and prior-authorization notifications.
- Implement a formal process for prior-authorization oversight of the pharmacy benefits manager.

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

Plan Overview

Senior Care Action Network Health Plan ("SCAN Health Plan," "SCAN" or "the plan") is a not-for-profit health plan that contracts with the DHCS as a specialty plan. SCAN provides a full range of health care services for elderly members dually eligible under both the Medicare and Medi-Cal programs who reside in Los Angeles, Riverside, and San Bernardino counties. As of June 30, 2009, the plan had approximately 7,000 MCMC members in all three counties combined.[1]

SCAN has been licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act in California since November 30, 1984, and became operational in Los Angeles County with the MCMC Program in 1985. The plan expanded into Riverside and San Bernardino counties in 1997. In 2006 the DHCS, at the direction of CMS, designated SCAN as a managed care plan. SCAN functioned as a social health maintenance organization under a federal waiver, which expired at the end of 2007.

In 2008 SCAN entered into a comprehensive risk contract with the State. SCAN receives monthly pre-paid capitation from both Medicare and Medi-Cal, pooling its financing to pay for all services as a full-risk social managed care plan. The DHCS amended SCAN's contract in 2008 to include federal and State requirements for managed care plans. Among these requirements, the DHCS specifies that specialty plans participating in the MCMC Program report on two performance measures annually and maintain two internal QIPs.

SCAN provides preventive, social, acute, and long-term care services to members who are 65 years of age or older, live in the service area, have Medicare Part A and B as well as Medi-Cal eligibility, and are certified as eligible for a nursing home. The plan does not enroll individuals with end-stage renal disease. Comprehensive medical coverage and prescription benefits are offered by the plan in addition to support services specifically designed for seniors with a goal to enhance the ability of plan members to manage their health and remain independent. Support services include care coordination, chronic care benefits covering short-term nursing home care, medical transportation, and a full range of home- and community-based services, such as homemaker services, personal care services, adult day care, and respite care. SCAN members receive other health benefits that are not provided through Medicare or by most other senior health plans under special waivers.

[1] State of California. Department of Health Care Services. *HCO Monthly Plan Enrollment Status Report*, June 2009. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_EnrollDisenroll_Rpts/2009/200906/COPS25_0906.pdf

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 SCAN'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, while standards related to measurement and improvement fall under the quality domain. 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.

Medical Performance Audit Review

For full-scope contracted plans, the DHCS's Audits and Investigations Division (A&I) works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. A joint audit is conducted for each MCMC plan approximately once every three years to assess the plan's compliance with contract requirements and State and federal regulations. In some instances, A&I conducts non-joint medical audits of Medi-Cal managed care plans. For the purposes of this report, HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards.

A&I conducted a non-joint medical performance audit of SCAN in March 2009, covering the audit period of February 1, 2008, through January 31, 2009. The audit evaluated six areas of performance: utilization management, continuity of care, access and availability, member's rights,

quality management, and administrative and organizational capacity. The audit showed that the plan demonstrated both strengths and opportunities for improvement.

Audit results for utilization management standards showed that the plan's utilization management program met program requirements. SCAN demonstrated the use of sound clinical criteria as the basis for making authorization decisions and demonstrated adequate monitoring of under- and overutilization. Audit findings in this area related to timeliness of prior-authorization decisions and following Medi-Cal prior-authorization procedures for pharmacy requests. A file review of prior authorizations showed that while pharmacy denials were made within Medicare time frames, the plan did not meet the Medi-Cal contractual time frame for three of the five denials reviewed. The audit noted challenges with the plan implementing prior-authorization and concurrent review procedures to comply with Medi-Cal requirements in addition to Medicare requirements when appropriate. The plan followed Medicare requirements but did not meet Medi-Cal requirements for denied, deferred, or modified services. Denial letters lacked all required information, and Medi-Cal notice of action letters were not used. An additional finding was related to oversight of the plan's delegated pharmacy benefit manager (PBM). The plan had not required its PBM to comply with Medi-Cal prior-authorization requirements and use required notice of action letters.

SCAN was compliant with many of the standards related to continuity of care. The audit showed that the plan delegated care management to its provider organizations and had good oversight and monitoring processes in place. Additionally, the plan used an integrated case management approach for geriatric health management, disease management, and complex case management. The audit noted that the plan lacked a policy and procedure for identifying and referring members who may be eligible for the HIV/AIDS Home and Community Based Services Waiver Program. While the plan required an initial health assessment for new members within 120 days of enrollment and reported 95 percent compliance with this standard based on medical record review, the plan was not compliant with ensuring that members received an initial health education behavioral assessment because the plan did not use the DHCS-approved tool.

The audit showed that SCAN had adequate accessibility standards in place for routine, urgent, and emergent care and monitored these standards through its quality management committee structure. The plan lacked monitoring of wait time in provider offices, telephone call answer and return times, and time to obtain appointments. While SCAN had a contracted vendor to provide members with 24-hour access to assistance by telephone, it did not have policies and procedures in place for oversight of the vendor. The plan also lacked procedures for monitoring member access to medications in emergency circumstances.

The review of plan compliance with standards related to members' rights showed that the plan implements and maintains a grievance system. A review of 19 grievances found that the plan exceeded time frames for sending acknowledgment and resolution letters to members, the plan lacked clinical review by a physician for potential quality-of-care issues, and letters lacked State fair

hearing process information. For grievances reviewed by a physician, the audit noted that not all medically related issues were fully resolved before the case was closed. SCAN had policies and procedures in place to adequately safeguard protected health information; however, the plan did not include procedures for reporting suspected breaches to the DHCS within contractual time frames.

SCAN was fully compliant with standards related to the quality management program. The plan demonstrated that it used a rapid cycle of improvement for identifying and resolving opportunities for improvement. The audit found that qualified providers were used and were appropriately monitored on an ongoing basis through the plan's credentialing committee.

Auditors also found that SCAN had adequate administrative and organizational capacity to support the quality management program. However, one finding showed that not all newly contracted plan providers received Medi-Cal managed care training within 10 days as required.

The DHCS *Medical Audit Close-Out Report* was released in December 2009 after the review period of this evaluation report. HSAG will include actions taken by the plan to correct these areas of deficiencies in the next evaluation report.

Member Rights and Program Integrity Monitoring Review

The Member Rights/Program Integrity Unit (MRPIU) in 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. This MCMC-contracted plan is unique in that the contract is managed by the Department of Long Term Care; therefore, MRPIU does not conduct reviews of this plan. Other than the information from the medical performance audit, no other member rights and program integrity information for SCAN was available at the time this report was prepared.

Strengths

SCAN was fully compliant with all standards reviewed in the quality management area and demonstrated the administrative and organizational capacity to support delivery of quality care. The plan had good procedures in place to coordinate care for members, including a case management program appropriate to the needs of its members who are dually eligible for Medicare and Medi-Cal managed care. SCAN achieved a 95 percent completion rate for initial health assessments.

Opportunities for Improvement

Medical performance audit findings for SCAN revealed the greatest opportunities for the plan related to the areas of prior authorization and grievances. The plan needs to implement policies and procedures for meeting both Medicare and Medi-Cal managed care requirements for prior authorizations and grievances. The plan also should ensure that member grievances related to quality of care are appropriately reviewed and resolved prior to closing the grievance. Additionally, the plan needs to implement a process to ensure oversight of its delegated pharmacy benefit manager for prior authorizations and its 24-hour nurse advice line.

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. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provides a standardized method for objectively evaluating plans' delivery of services.

For Medi-Cal managed care's contracted specialty plans, the DHCS has different performance measure requirements due to the small size and/or special needs of the plans' member populations. Instead of requiring these plans to annually report the full list of performance measures rates to the EQRO as required for full-scope plans, specialty plans report only two performance measures. These two measures are chosen in collaboration with the DHCS and may be Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures or other measures appropriate to the plan's population, such as the two HEDIS Medicare measures SCAN reports. Just as with full-scope plans, the specialty plan must report performance measurement results specifically for its Medi-Cal managed care members, not for the plan's entire population.

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 its selected performance measures when calculating rates.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about SCAN's performance in providing quality, accessible, and timely care and services to its MCMC members. 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.

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

Performance Measure Validation

HSAG performed a HEDIS Compliance Audit™[3] of SCAN in 2009. HSAG found both measures to be reportable and that SCAN's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

The audit report included recommendations that SCAN shift from manual and ad hoc processes toward automation in encounter data processing/reconciliation. The plan also should formalize the yearly on-site audit of the plan's data processing vendor.

Performance Measure Results

Table 4.1 presents a summary of SCAN's HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measure results (based on calendar year 2007 data). In addition, the table shows the plan's HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs. The MCMC Program based its MPLs and HPLs for these measures on the National Committee for Quality Assurance (NCQA)'s national Medicare 25th percentile and 90th percentile, respectively, since Medicaid benchmarks do not exist for these measures.

The DHCS approved SCAN to report performance measure rates consistent with its two existing special needs plan contracts, one that represents a small demonstration project and another that covers the remaining membership. Because the Medicare demonstration population is very small, HSAG publically reports a combined performance measure rate for SCAN that reflects all of its Medi-Cal managed care members across Los Angeles, Riverside, and San Bernardino counties. Appendix A includes a performance measure name key with abbreviations contained in Table 4.1.

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

Table 4.1—2008–2009 Performance Measure Results for SCAN Health Plan Los Angeles, Riverside, and San Bernardino Counties Combined

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	MMCD's Minimum Performance Level[5]	MMCD's High Performance Level (Goal)[6]
Glaucoma Screening in Older Adults (GSO)	Q, A	Not reported	72.4%	★★	50.0%	82.1%
Persistence of Beta-Blocker Treatment After a Heart Attack (BPH)	Q	Not reported	72.7%	★★	50.7%	77.3%

[1] DHCS-selected HEDIS performance measures developed by NCQA.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.
[4] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[5] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicare 25th percentile.
[6] The MMCD's high performance level (HPL) is based on NCQA's national Medicare 90th percentile.
★ = Below-average performance relative to the national Medicare 25th percentile.
★★ = Average performance relative to national Medicare percentiles (between the 25th and 90th percentiles).
★★★ = Above-average performance relative to the national Medicare 90th percentile.
Not Reported = The plan was not required to report rates in 2008.

Performance Measure Result Findings

Because performance measurement requirements were not added to SCAN's contract until 2008, the DHCS did not require reporting by SCAN until 2009. Overall, SCAN demonstrated average performance, falling between the 25th and 90th national Medicare percentiles for both reported performance measures in 2009. SCAN's selected performance measures fell under the quality and access domains of care. Neither of the measures related to the timeliness domain.

HEDIS Improvement Plans

Based on its 2009 performance, SCAN was not required to submit improvement plans for either measure.

Strengths

SCAN reported performance measure rates for two measures during the measurement year, which made the plan compliant with the DHCS and federal requirements. The plan's rates were above the MPLs for both measures.

Opportunities for Improvement

The plan will report rates again for these measures for the 2010 reporting year, which will allow initial tracking of plan performance over time.

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.

Findings

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

Quality Improvement Projects Conducted

Like full-scope plans, specialty plans must be engaged in two QIPs at all times. However, due to the small and unique populations served, the DHCS does not require specialty plans to participate in statewide collaborative QIPs. Instead, specialty plans are required to design and maintain two internal QIPs focused on improving health care quality, access, and/or timeliness for the plan's MCMC members.

SCAN had two internal clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted improved management of chronic obstructive pulmonary disease (COPD) among members 40 years of age and older. SCAN's second QIP aimed to decrease the incidence of stroke and transient ischemic attack (TIA). Both QIPs fell under the quality domain of care.

Quality Improvement Project Validation Findings

The DHCS contracted with HSAG as its new EQRO in the second half of 2008. HSAG began validation for QIPs submitted by the plans after July 1, 2008.

The table below summarizes the validation results for both of SCAN's QIPs across CMS protocol activities during the review period.

Table 5.1—QIP Validation Results for SCAN Health Plan
Los Angeles, Riverside, and San Bernardino Counties Combined (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	83%┼	8%┼	8%┼
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	67%	0%	33%
IV.	Correctly Identified Study Population	67%	0%	33%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	58%┼	8%┼	33%┼
VII.	Appropriate Improvement Strategies	25%	75%	0%
VIII.	Sufficient Data Analysis and Interpretation	13%┼	13%┼	75%┼
IX.	Real Improvement Achieved	‡		
X.	Sustained Improvement Achieved	‡		
Percentage Score of Applicable Evaluation Elements *Met*		**53%**		
Validation Status		***Not Applicable****		

‡ The QIP did not progress to this phase during the review period and could not be assessed.
* QIPs were not given an overall validation status during the review period.
┼ The sum may not equal 100 percent due to rounding.

SCAN submitted baseline data for both projects during the review period; therefore, the QIPs had not progressed to the point of remeasurement and HSAG could not assess for real and sustained improvement.

During the period covered by this report, HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the MCMC plans. As a result, many plans had difficulty complying fully with these requirements during the first cycle of QIP validations by HSAG. This was the case with SCAN's QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided SCAN, as well as other plans, with an overall validation status of "Not Applicable" for both QIPs. This allowed time for plans to receive technical assistance and training with HSAG's validation requirements without holding up the ongoing progress of QIPs that were already underway.

Quality Improvement Project Outcomes

Table 5.2 shows SCAN's baseline data for its QIPs. The plan's first remeasurement year data will be submitted in time to be included in the next performance evaluation report (July 1, 2009, through June 30, 2010), at which time HSAG will assess for real improvement.

For the *Chronic Obstructive Pulmonary Disease (COPD) Management* QIP, SCAN set a baseline goal to reach the NCQA national Medicare 50th percentile for both study indicators. The rates for the COPD QIP were calculated by adding the numerators and denominators from both of SCAN's contract populations: H5425, which represents dual-eligible Medicare and Medi-Cal managed care members and was originally set up under the Medicare contract as a demonstration project, and H9014, which represents the remainder of SCAN's dually eligible managed care population.

For the *Prevention of Stroke and Transient Ischemic Attack* QIP, SCAN set baseline goals to reduce the incidence rates of new stroke among all three cohorts by five percent. The first cohort, which is assessed in Study Indicator 1, represents members who were considered high-risk and had no prior history of stroke. High-risk was defined by SCAN as members who were diagnosed with diabetes, hypertension, and dyslipidemia. The second cohort, which is assessed in Study Indicator 2, represents members who were diagnosed with atrial fibrillation and had no prior history of stroke. Finally, the third cohort, assessed in Study Indicator 3, represents members who were considered high-risk and were diagnosed with atrial fibrillation. Data for Study Indicators 2 and 3 were not yet reported in the 2008–2009 QIP submission.

The rates for the COPD QIP were calculated by adding the numerators and denominators from both of SCAN's contract populations: H5425, which represents dual-eligible Medicare and Medi-Cal managed care members and was originally set up under the Medicare contract as a demonstration project, and H9014, which represents the remainder of SCAN's Medi-Cal managed care population.

Table 5.2—QIP Outcomes for SCAN Health Plan
Los Angeles, Riverside, and San Bernardino Counties Combined

QIP #1 — Chronic Obstructive Pulmonary Disease Management				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement**
1) Percentage of members 40 years of age and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) who received appropriate Spirometry testing to confirm the diagnosis.	17.2%	‡	‡	‡
2) Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter and who were dispensed a bronchodilator within 30 days of the event.	65.7%	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2 — Prevention of Stroke and Transient Ischemic Attack				
QIP Study Indicator	**Baseline Period 7/1/07–6/30/08**	**Remeasurement 1 7/1/08–6/30/09**	**Remeasurement 2 7/1/09–6/30/10**	**Sustained Improvement**
1) Incidence rate of new stroke for SCAN members who were considered "high-risk" and had no prior history of stroke.	6.1%	‡	‡	‡
2) Incidence rate of new stroke for SCAN members who have been diagnosed with atrial fibrillation and had no prior history of stroke.	NR	‡	‡	‡
3) Incidence rate of new stroke for SCAN members who are considered "high-risk" and were diagnosed with atrial fibrillation.	NR	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

Strengths

SCAN demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data. Additionally, the QIP topics were appropriate for the health plan's population.

Opportunities for Improvement

SCAN has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with the DHCS requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

For both QIPS, SCAN should include only its Medi-Cal managed care members, while the full plan rates may be monitored internally. The plan should provide a detailed barrier analysis narrative or diagram in the QIP documentation, including the type of analysis and the resulting barriers.