Performance Evaluation Report

Western Health Advantage

July 1, 2008–June 30, 2009

Medi-Cal Managed Care Division
California Department of
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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 3.4 million beneficiaries 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 MCMC Program's contracted plan, Western Health Advantage ("WHA" or "the plan").

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

The quality-of-care domain 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 MPL indicate low performance, rates at or above the HPL indicate high performance, and rates at the MPL or between the MPL and HPL demonstrate average performance.

HSAG found that WHA demonstrated average performance for the quality-of-care domain. This is 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.

Most of WHA's performance measures fell between the MCMC-established MPL and HPL. Overall, WHA's performance measure rates demonstrated either stable or improved performance from the prior measurement period, with four measures showing statistically significant increases and no statistically significant declines.

During the review period, WHA reported a fourth remeasurement period for its QIP aimed at improving prenatal and postpartum care. The plan achieved statistically significant and sustained improvement for both prenatal and postpartum care between 2004 and 2008.

The statewide collaborative emergency room (ER) QIP was in the baseline phase during the review period; therefore, HSAG could not assess for improvement. HSAG noted that the plan has an opportunity to improve its documentation of both QIPs to meet compliance with federal requirements for conducting a QIP.

WHA's strength in delivering quality care to members was related to appropriate treatment for acute bronchitis in adults and appropriate treatment of upper respiratory infection (URI) in children. Appropriate treatment for these conditions requires providers to avoid prescribing antibiotics for viral infections, which can lead to antibiotic resistance. WHA had the highest 2009 rate among all Medi-Cal managed care plans for the measure, *Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis (AAB).*[1] WHA also demonstrated statistically significant and sustained improvement for its prenatal and postpartum QIP. Finally, the plan demonstrated that it had the resources and operational structure to comply with State and federal requirements.

WHA can improve quality of care for its Medi-Cal managed care members by increasing its four performance measure rates that fell below the MCMC program's MPLs related to management of asthma, childhood immunizations, prenatal care, and breast cancer screening. Based on joint audit review findings, WHA also has the opportunity to implement a process to ensure that the medical director reviews member grievances related to quality-of-care issues in a timely manner.

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.

Many performance measures fall under more than one domain. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

WHA demonstrated average performance for the access domain of care based on its 2009 performance measure rates related to access, QIP outcomes that address access, and compliance review standards related to the availability of and access to care.

WHA's 2009 performance measures related to access fell primarily between the MPL and HPL, with four of these measures below the MPL. Despite the statistically significant and sustained improvement in WHA's prenatal and postpartum care QIP, timeliness of prenatal care remains below the MCMC MPL and continues to be an opportunity for improvement.

[1] California Department of Health Services. *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program*. July 2010.

Audit findings showed that WHA had good procedures in place for monitoring access to routine, urgent, and emergent care through geographic access reports, provider audits, member access complaints and grievances, and member satisfaction data. WHA also monitors standards for access to behavioral health services, which is unique since behavioral health services are carved-out for Medi-Cal managed care members in all other counties.

Audit findings noted deficiencies related to the continuity and coordination of care—specifically, WHA's inability to identify members receiving early intervention services and individuals with developmental disabilities. The plan has an opportunity to ensure that members referred to these programs are receiving all medically necessary services in coordination with their primary care provider.

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. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service after a need is identified within a recommended period of time.

WHA demonstrated average performance under the timeliness domain of care. The plan performed within the MCMC-established thresholds for well-child visits and postpartum visits, while the plan performed below the MPLs for childhood immunizations and timeliness of prenatal care.

DHCS audits showed that the plan made timely utilization management decisions and had a mechanism to monitor for under- and overutilization. The plan has an opportunity to ensure that it conducts ongoing monitoring of its delegated entities related to grievances and provides a feedback mechanism. Additionally, WHA's delegated entities need to log and report grievances for tracking and trending purposes. The plan is responsible for compliance in this area. WHA and its delegated entities cannot adequately trend and address grievance patterns if the delegated entities are not reporting all grievance-related data.

Conclusions and Recommendations

Overall, WHA demonstrated average performance in providing quality, timely, and accessible health care services to its MCMC members.

WHA's 2009 performance measure rates fell primarily between the MCMC MPLs and HPLs, exceeding the HPL on two measures and falling below the MPL on four. The plan demonstrated stable and, in some cases, improved performance, with all rates showing either no statistically significant change or a statistically significant increase. The plan performed best in areas related to quality of care for appropriate treatment of acute bronchitis in adults and appropriate treatment of URIs in children.

Based on available compliance review information, the plan demonstrated compliance with most MCMC standards for enrollee rights and protections, structure and operations, and access and availability. WHA's opportunities for improvement relate to policies and procedures, tracking of all member grievances, coordination of care for early intervention services and developmentally disabled members. WHA's greatest opportunity for improvement related to compliance monitoring was to address areas of noncompliance as part of its quality improvement program and work plan. This step would help to ensure that the plan corrects deficiencies and eliminates repeat findings of noncompliance.

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

- Continue to target improvement activities for performance measures that remain below the MCMC MPLs.
- Analyze areas of high performance, such as avoidance of antibiotics for acute bronchitis in adults and appropriate treatment of URI in children to determine if modified intervention strategies can be applied to areas of low performance.
- Retire the prenatal and postpartum QIP, which has had four remeasurement periods, as a formal project in order to focus efforts or refine intervention strategies on other areas in need of improvement.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance for increasing compliance with the Centers for Medicare & Medicaid Services (CMS) protocol for conducting QIPs.
- Incorporate a process to address and monitor the resolution of audit findings to avoid repeat areas of noncompliance.

WHA terminated its MCMC contract with the DHCS as of December 31, 2009; therefore, HSAG will not assess the plan's success with these recommendations.

Plan Overview

Western Health Advantage (WHA) was a full-scope Medi-Cal managed care plan in Sacramento County. WHA became operational with the MCMC Program in Sacramento County in May 1997, and as of June 30, 2009, WHA had 16,076 MCMC members.[2] WHA terminated its contract with the DHCS as of December 31, 2009.

WHA served its Medi-Cal managed care members under a Geographic Managed Care (GMC) model. The GMC model allows enrollees in Sacramento County to choose from several commercial plans.

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

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 WHA'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-of-care 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.

Joint Audit Review

The DHCS's Audits and Investigations (A&I) Division works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A joint audit is conducted for each MCMC plan approximately once every three years. In addition, the DHCS's A&I Division periodically conducts non-joint medical audits of five MCMC plans; however, WHA was not among those plans designated for a non-joint medical audit.

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. The most recent joint audit for WHA was conducted in

September 2005, reflecting the review period of September 1, 2004, through August 31, 2005.[3] Subsequent audits were not conducted during the period covered by this report.

The scope of the 2005 audit covered six categories of performance: utilization management, continuity of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity. HSAG reviewed the results of this audit, which led to several corrective action plans.

Under the utilization management category, WHA demonstrated a process to monitor under- and overutilization. The plan demonstrated that it informs members of their right to appeal and has a process to monitor the accuracy, timeliness, and appropriateness of the plan in handling member appeals. The audit showed that prior-authorization letters did not include the required reason for the denial in clear and concise language. WHA corrected this deficiency. In addition, WHA did not ensure that drugs prescribed in emergency circumstances were provided in amounts sufficient to last until the member could reasonably be expected to have the prescription filled.

For continuity of care, WHA was compliant with standards related to coordinating care for members receiving emergency services from in-network and out-of-network providers. The audit noted that WHA needed to coordinate care for all out-of-network services. The plan had appropriate procedures in place to identify and refer children with conditions that make them eligible for the California Children's Service program. Findings from the audit noted some deficiencies related to continuity and coordination of care—specifically, WHA's inability to identify members receiving Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and individuals with developmental disabilities. The plan could not ensure that members referred to these programs were receiving all medically necessary services in coordination with their primary care provider. This finding was a repeat finding from the October 1999 and June 2002 medical audits. The audit findings noted several actions taken by the plan to address this area of noncompliance, but stated the need to monitor the plan after full implementation. Finally, the audit showed that while WHA had policies and procedures in place to require an initial health assessment and an individual health educational behavioral assessment for each new member within 120 days of enrollment, the plan did not have completion rate data to demonstrate compliance with this requirement.

WHA demonstrated that it had adequate procedures in place to provide routine, urgent, and emergency services. The plan had benchmarks for appointment wait times and monitored for compliance through provider audits, member complaints and grievances related to access and availability issues, and member satisfaction data. One audit finding noted that WHA's provider directory did not inform members of pharmacy hours of operation.

[3] *Department of Health Care Services. Audits and Investigations Medical Review.* Report issued March 9, 2006. Accessed at http://www.dmhc.ca.gov/healthplans/med/med_default.aspx.

The audit noted several areas of deficiency related to the plan's grievance system under the member rights category. Grievance files did not contain evidence that WHA obtained sufficient data to evaluate actions and follow-up on potential quality-of-care issues. Additionally, WHA had deficiencies related to oversight of delegated grievances. The plan did not consistently receive grievance reports to identify and assess grievance trends and did not follow up with the delegated entity when it failed to meet required time frames for resolving grievances.

For cultural and linguistic service requirements, the plan was compliant with all requirements except for those related to its contracted retail pharmacies, which did not have a process to assess the linguistic capabilities and performance of interpreters or bilingual staff.

Under the quality management category, the audit noted that WHA had an opportunity to include the reevaluation of deficient and corrective action areas within its work plan since many of the findings were repeat findings of noncompliance.

WHA was fully compliant with the requirements of the administrative and organizational capacity category. The audit report showed evidence that the plan had the adequate resources and operational structure to comply with State and federal requirements.

Member Rights and Program Integrity Monitoring Review

The Member Rights/Program Integrity Unit (MRPIU) 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 review of WHA in April 2008, which covered the review period of July 1, 2006, through June 30, 2007. The review showed that WHA had documented findings in the areas of member grievances and cultural and linguistic services. The plan was fully compliant with prior-authorization notifications and marketing requirements.

Under member grievances, not all resolution letters to members included a clear and concise explanation of the plan's decision. Two of the 15 files reviewed did not contain documentation indicating that the case had been elevated to the medical director for quality-of-care concerns. Finally, WHA is responsible for tracking grievance information received by the plan or from any delegated entity. The review found that 5 of the 10 provider offices interviewed indicated that they do not log or report member complaints for tracking and trending purposes.

MRPIU noted that 3 of the 10 provider offices reviewed indicated that they did not discourage the use of family, friends, or minors as translators. Additionally, one provider office indicated that it did not offer access to 24-hour oral interpreter services.

Strengths

Joint audit and MRPIU findings showed that WHA was compliant with many areas under the scope of the audit as they related to health care quality, access, and timeliness.

WHA demonstrated strength in ensuring member access to care and services by establishing timeliness standards for routine, urgent, and emergent care and by monitoring ongoing performance through geographic access reports, provider audits, member complaints and grievances related to access and availability issues, and member satisfaction data. In addition, the plan had standards for behavioral health services. WHA is unique among Medi-Cal managed care plans, where behavioral health is not a carved-out benefit. Furthermore, the plan made timely utilization management decisions and had a mechanism to monitor for under- and overutilization.

WHA demonstrated the adequate resources and operational structure to comply with State and federal requirements.

Opportunities for Improvement

WHA can improve its compliance by resolving deficiencies within its quality improvement program, including those identified in audit findings, to eliminate repeat areas of noncompliance.

The plan may consider an internal process to review its compliance with member grievance resolution letters to ensure that they include a clear and concise explanation of the plan's decision. WHA needs to implement procedures to review and investigate all member grievances related to quality-of-care issues and document the timeliness of elevating the issues to the medical director for review.

The plan has an opportunity to provide a greater level of oversight of its delegated entities, specifically related to member grievances. Delegated entities need to log and report grievances for tracking and trending purposes, and WHA should ensure that it provides ongoing monitoring of compliance, including a feedback mechanism to its delegated providers.

Conducting the Review

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, allowing for a standardized method of objectively evaluating plans' delivery of services.

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 EAS-specific performance measures when calculating rates.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about WHA's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness. *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.

Performance Measure Validation

HSAG performed a HEDIS® Compliance Audit™[4] of WHA in 2009, covering the measurement period of January 1, 2008, through December 31, 2008. HSAG found all measures to be reportable and that WHA's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

Recommendations from the audit involved tracking and capturing relevant data from rejected or denied encounters. This effort would support WHA's process to ensure accurate and timely gathering of data for HEDIS reporting.

[4] 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.

Performance Measure Results

Table 4.1 presents a summary of WHA's county-level HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to its 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.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the NCQA's national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—a low rate indicates better performance and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the Medicaid 10th percentile. Due to significant methodology changes for the CDC–H7 measure for 2009, the MCMC Program was unable to compare 2008 and 2009 performance results for this measure.

Appendix A includes a performance measure name key with abbreviations contained in the following table.

Table 4.1—2008–2009 Performance Measure Results for Western Health Advantage—Sacramento County

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	31.1%	51.2%	★★★	↔	20.6%	35.4%
ASM	Q	84.0%	84.0%	★	↔	86.1%	91.9%
AWC	Q,A,T	32.4%	37.7%	★★	↔	35.9%	56.7%
BCS	Q,A	41.4%	43.1%	★	↔	44.4%	61.2%
CCS	Q,A	59.9%	65.0%	★★	↔	56.5%	77.5%
CDC–E	Q,A	60.8%	63.9%	★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	24.1%	35.1%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	51.6%	34.9%	★★	↑	52.5%	32.4%
CDC–HT	Q,A	78.8%	88.7%	★★	↑	74.2%	88.8%
CDC–LC (<100)	Q	37.0%	42.6%	★★	↔	25.1%	42.6%
CDC–LS	Q,A	67.2%	77.7%	★★	↑	66.7%	81.8%
CDC–N	Q,A	73.7%	84.3%	★★	↑	67.9%	85.4%
CIS–3	Q,A,T	57.9%	59.8%	★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	71.0%	72.5%	★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	53.3%	55.4%	★★	↔	54.0%	70.6%
URI	Q	95.5%	95.3%	★★★	↔	79.6%	94.1%
W15	Q,A,T	48.8%	60.8%	★★	↔	44.5%	73.7%
W34	Q,A,T	61.1%	68.1%	★★	↑	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for full name of each HEDIS measure.
[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] Performance comparisons are based on the *z* test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
†The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.
Not Comparable = Performance could not be compared due to significant changes between years, or rates were not reported for both years.

Performance Measure Result Findings

Overall, WHA demonstrated average performance, with 65 percent of its 2009 performance measures falling between the MPL and HPL. The plan exceeded the MCMC HPL for *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)* and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*. The plan performed below the MPL in four areas: *Use of Appropriate Medications for People With Asthma (ASM)*, *Breast Cancer Screening (BCS), Childhood Immunization Status—Combination 3 (CIS–3),* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)*.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPL. Plans that have rates below this minimum level must submit an improvement plan to the DHCS for each area of deficiency, outlining the steps they will take to improve care.

In 2008, the DHCS required WHA to submit eight improvement plans for:

- *Adolescent Well-Care Visits (AWC)*
- *Appropriate Medication for People With Asthma (ASM)*
- *Breast Cancer Screening (BCS)*
- *Cervical Cancer Screening (CCS)*
- *Childhood Immunization Status—Combination 3 (CIS–3)*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)*
- *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*

Although WHA had statistically significant improvement in rates for only one of these measures—*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*—the plan's rates for *Adolescent Well-Care Visits (AWC), Cervical Cancer Screening (CCS),* and *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)* increased above the MPL for HEDIS 2009; therefore, no improvement plan for these measures was required for the plan's 2009 performance.

WHA's *Appropriate Medication for People With Asthma (ASM), Breast Cancer Screening (BCS), Childhood Immunization Status—Combination 3 (CIS–3),* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* rates remained below the MPL in 2009 despite an increase in all rates except for the *Appropriate Medication for People With Asthma (ASM)* measure, which remained the same.

Asthma Management

WHA implemented an asthma management program in 2008 as a means to reinforce asthma action plans and self-management as well as provide education to both members and providers. The *Appropriate Medication for People With Asthma (ASM)* measure evaluated members 5 to 56 years of age diagnosed with persistent asthma who were appropriately prescribed medications during the measurement year. WHA may consider examining members who did not receive appropriate asthma medication to determine if there was a provider prescribing barrier or a member compliance barrier to help focus future interventions. In addition, WHA may consider including members without evidence of appropriate medications for enrollment in its asthma medication program. This would allow WHA to follow up with providers and members to specifically address barriers to obtaining appropriate medication.

Cancer Screening

To improve the *Breast Cancer Screening (BCS)* rate the plan focused on both member and provider education. The health plan identified member barriers such as lack of awareness and fear of finding cancer as factors contributing to a low screening rate. The health plan identified provider oversight for recommending mammography as the primary provider barrier.

To address its low performance in *Breast Cancer Screening (BCS)*, WHA outlined planned member interventions, including newsletters, information on its Web site, and screening reminders. The plan continued many of the existing interventions implemented in prior years, repeating them quarterly. For providers, the plan continued quarterly newsletters and pay-for-performance incentives. In the last quarter of 2008, the plan implemented mail and telephone reminders to members who had not been screened. Additionally, the plan distributed and discussed the HEDIS 2008 rates with providers in July 2008. Although the plan had an increase in its 2009 rate compared to 2008, the new intervention activities may not have been in place long enough to fully impact its 2009 HEDIS rate (which was based on 2008 measurement data). The plan remained just below the MPL in 2009 and will need to continue to monitor its rate until it reaches the MPL.

To address cervical cancer screening, WHA implemented two new interventions late in 2008. The first was a women's wellness resource mailing to members that included information on the Pap test. The second was a monthly outreach reminder call/postcard campaign to encourage cervical cancer screening. The plan's 2009 rate of 65 percent exceeded the MCMC Program's MPL of 56.5 percent.

Prenatal and Postpartum Care

WHA performed below the MPL for both prenatal and postpartum care in 2008. The plan initiated only one new intervention in 2008, which targeted postpartum care. Members received telephone and postcard outreach in late 2008. The plan had a slight increase in its postpartum rate

in 2009 and achieved the MPL. The plan did not achieve the MPL in 2009 for prenatal care and should consider implementing new interventions targeting prenatal care to increase its rate.

Childhood Immunizations and Well-Child Visits

In July 2008, WHA implemented a new intervention involving telephone outreach and a postcard reminder to encourage well-child visits and immunizations for children younger than 2 years of age. The plan's 2009 childhood immunization rate of 59.8 percent improved over the 2008 rate and fell just below the MPL of 59.9 percent. The plan should continue its outreach intervention, which shows promise for improving this rate.

WHA had success with improving its rate for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* in 2009 over its 2008 rate. The plan implemented several new interventions in 2008, including provider education on preventive health recommendation guidelines and member outreach reminder calls. The plan had statistically significant improvement over its 2008 rate and exceeded the MPL in 2009.

Based on its 2009 performance, WHA had to submit improvement plans for the following measures with rates that remained below the MPL:

- *Use of Appropriate Medications for People With Asthma (ASM)*
- *Breast Cancer Screening (BCS)*
- *Childhood Immunization Status—Combination 3 (CIS–3)*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)*

Strengths

WHA performed above the MCMC-established HPL on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)* and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* measures, although changes were not statistically significant over the prior year. WHA had the highest rate of all Medi-Cal managed care plans in 2009 for *Avoidance of Antibiotic Treatment in Adults With Bronchitis (AAB)*.[5] Both measures fell under the quality domain of care.

In addition, four comprehensive diabetes care measures showed statistically significant improvement: monitoring for nephropathy, testing for HbA1c, reducing poor HbA1c control, and screening for LDL-C. Improvement in these measures demonstrated an effort to provide quality care in controlling diabetes.

[5] The California Department of Health Care Services. *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program.* June 2010.

For the 17 comparable measures, WHA performed at or above the MCMC 2009 weighted average rates for 11 of the measures.[6]

Opportunities for Improvement

WHA had the second-lowest rate of all MCMC plans for its *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* measure, which continued to present a significant opportunity for improvement.[7] WHA's performance in this area may point to issues with health care quality, access, and/or timeliness. WHA had additional opportunities for improvement with *Appropriate Medication for People With Asthma (ASM), Breast Cancer Screening (BCS)*, and *Childhood Immunization Status—Combination 3 (CIS–3)*. These rates all fell below the MCMC-established MPL.

[6] Ibid.
[7] Ibid.

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 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 the QIP.

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about WHA'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

WHA had two clinical QIPs in progress during the review period of July 1, 2008–June 30, 2009. The first QIP targeted the reduction of avoidable ER visits among members 12 months of age and older as part of the DHCS's statewide collaborative QIP. WHA's second project, an internal QIP, aimed to improve timeliness of prenatal and postpartum care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider in an office or clinic setting. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease. This QIP fell under both the quality and access domains of care.

WHA second project, *Improving Timeliness of Prenatal and Postpartum Care*, targeted improvement in both prenatal and postpartum care since both were below the MPL and more than half of WHA's female members were of childbearing age. Prenatal and postpartum care is important to achieving healthy outcomes for mothers and infants. WHA's project attempted to improve the quality of

and access to care for all pregnant members. Prenatal and postpartum care spans across quality, access, and timeliness domains 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 of QIPs submitted by the plans after July 1, 2008.

Table 5-1 summarizes the validation results for both of WHA's QIPs across CMS protocol activities during the review period.

Table 5-1—QIP Validation Results for Western Health Advantage (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	100%	0%	0%
II.	Clearly Defined, Answerable Study Question(s)	50%	0%	50%
III.	Clearly Defined Study Indicator(s)	77%	15%	8%
IV.	Correctly Identified Study Population	50%	17%	33%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	75%	6%	19%
VII.	Appropriate Improvement Strategies	100%	0%	0%
VIII.	Sufficient Data Analysis and Interpretation	56%	25%	19%
IX.	Real Improvement Achieved	75%┼	13%┼	13%┼
X.	Sustained Improvement Achieved	100%	0%	0%
Percentage Score of Applicable Evaluation Elements *Met*		**75%**		
Validation Status		***Not Applicable****		

* QIPs were not given an overall validation status during the review period.
┼ The sum may not equal 100 percent due to rounding.

WHA submitted baseline data for the ER QIP during the review period; therefore, the QIP had not progressed to the point of remeasurement and HSAG could not assess for real improvement. For the second QIP, WHA submitted Remeasurement 4 data, and HSAG was able to assess for both 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 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 WHA's QIPs, neither of which fully met the new validation criteria. As directed by DHCS, HSAG provided WHA, 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.

Quality Improvement Project Outcomes

Table 5-2 displays WHA's measurement period data for its QIPs. WHA's goal was a reduction of 10 percent in its avoidable ER visits rate. The plan submitted its first remeasurement year data in 2009, after this review period; however, those results will not be reported since the plan is no longer an MCMC plan. The prenatal and postpartum care QIP goal for each measurement period was the national Medicaid 25th percentile.

Table 5-2—QIP Outcomes for Western Health Advantage

QIP #1—Reducing Avoidable Emergency Room Visits				
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**
Percentage of ER visits that were avoidable	13.8%	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Improving Timeliness of Prenatal and Postpartum Care						
		Remeasurement Period				
QIP Study Indicator	**Baseline Period 1/1/04–12/31/04**	**1 1/1/05–12/31/05**	**2 1/1/06–12/31/06**	**3 1/1/07–12/31/07**	**4 1/1/08–12/31/08**	**Sustained Improvement**
1) Percentage of eligible members who received a prenatal care visit in the first trimester	67.7%	66.7%	56.4%¥	71.0%*	72.5%	Yes
2) Percentage of eligible members who received a postpartum visit on or between 21 and 56 days after delivery	44.1%	50.0%	36.0%¥	53.3%*	55.4%	Yes
* Designates statistically significant improvement over the prior measurement period. ¥ Designates statistically significant decline in performance over the prior measurement period.						

For the prenatal and postpartum QIP, initially, between 2004 and 2006, the plan did not report improvement for timeliness of prenatal care or postpartum care. In 2006, the plan concentrated improvement efforts on its highest-volume providers. To improve timeliness of prenatal care, the plan added nurse practitioners and provided priority scheduling to late-entry prenatal members. Providers began scheduling postpartum appointments at 36 weeks gestation. Additionally, the plan

created a database to identify members after delivery and contacted all members failing to attend their scheduled appointment. By 2007, both study indicators had achieved statistically significant improvement. Between 2007 and 2008, the plan implemented educational improvement strategies targeting both measures and documented continued improvement in both prenatal and postpartum care.

For the statewide ER collaborative QIP, WHA implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits. The plan distributed newsletters quarterly to members and providers. WHA focused on an expanded analysis of data to help identify utilization patterns and characteristics of its MCMC members who use the ER. The highest users of the ER were members 1 to 8 years of age; therefore, the plan sent targeted mailings to the parents of members in this age group. In addition, the plan partnered with one of its provider groups to test the data quality and completeness of a software tool to identify members who have used the ER multiple times. Once the necessary criteria have been met, a process will be developed to identity, refer, and monitor outcomes for these members.

Strengths

WHA demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data. In addition, WHA's interventions to address identified causes/barriers and its system interventions were likely to induce permanent change.

WHA's *Improving Timeliness of Prenatal and Postpartum Care* QIP demonstrated statistically significant and sustained improvement for both study indicators between 2004 and 2008. The plan increased the percentage of its MCMC members receiving prenatal care within the first trimester. Additionally, the plan improved its rate of postpartum care. The plan was effective in revising and modifying its early intervention strategies that did not result in improvement.

Opportunities for Improvement

WHA 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 DHCS's requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

While the prenatal and postpartum care QIP demonstrated real and sustained improvement, WHA's 2009 rate for the timeliness of prenatal care measure remained below the MCMC-established MPL. The plan should continue to conduct annual barrier analyses to better focus its efforts in this area. The plan may need to implement new targeted interventions that address specific barriers from the annual barrier analysis.

The statewide collaborative member health education campaign aims to educate members about contacting their provider before going to the ER for many common, non-urgent conditions. WHA will need to gain provider support and participation to meet the collaborative campaign goal of treating patients in an outpatient setting rather than referring them to the ER.

The table below provides abbreviations of HEDIS performance measures used throughout this report.

Table A-1—HEDIS® Performance Measures Name Key

Abbreviation	Full Name of HEDIS® Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ASM	*Use of Appropriate Medications for People With Asthma*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–E	*Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed*
CDC–H7	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)*
CDC–H9	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC	*Comprehensive Diabetes Care—LDL-C Control*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W15	*Well-Child Visits in the First 15 Months of Life (Six or More Visits)*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*