Performance Evaluation Report

Senior Care Action Network (SCAN) Health Plan

July 1, 2009–June 30, 2010

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

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] 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 the 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. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Senior Care Action Network Health Plan ("SCAN Health Plan," "SCAN," or "the plan"), which delivers care to Medi-Cal managed care members in Los Angeles, Riverside, and San Bernardino counties. This report covers the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

SCAN 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, 2010, the plan had approximately 7,762 MCMC members in all three counties combined.[2]

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 Parts 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.

[2] State of California. Department of Health Care Services, Medi-Cal Managed Care Division Available at: 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 that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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 fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

For most MCMC plans, medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division (MMCD) work in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. Although SCAN is not Knox-Keene licensed, A&I still conducts a non-joint medical audit approximately once every three years. These A&I audits assess plans' compliance with contract requirements and State and federal regulations.

HSAG reviewed the most current medical performance review reports available as of June 30, 2010, to assess plans' compliance with State-specified standards. A&I conducted an on-site medical audit of SCAN in March 2009, for the period of February 1, 2008, through January 31, 2009. On July 30, 2009, SCAN submitted to A&I its Corrective Action Plan (CAP) addressing each of the deficiencies cited during the audit's Exit Conference. On December 14, 2009, A&I issued its final audit report, which included approval or non-approval of each of the plan's CAP items. The results of that audit were detailed in the 2008-2009 evaluation report of SCAN.

The following is a brief summary of the March 2009 audit results. The plan was fully compliant with the Quality Management category; however, there were several findings noted in the report. Under *Utilization Management*, issues were identified with timeliness of denial decisions and denial notifications. For Continuity of Care, the plan does not have procedures to refer eligible members to the HIV/AIDS Home and Community Based Services Waiver Program. For *Access* and *Availability*, the plan lacked oversight of contracted providers. Under *Member Rights*, SCAN was documented for having issues with grievance resolution, proper documentation of clinical review, and the timeliness of resolution letters being sent to members. Finally, under *Administrative* and *Organizational Capacity*, the plan was noted as deficient in providing proper training to new providers. SCAN resubmitted its CAP to the DHCS's Long Term Care Division (LTCD) on April 13, 2010. On November 2, 2010, the LTCD issued a response to the plan's CAP resubmission. The plan's CAP and corresponding response to the plan's CAP will be included in the next evaluation report.

Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's 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. As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately once every two years and does follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. However, MRPIU monitoring extends only to those contracts managed by the Medi-Cal Managed Care Division.

As an MCMC-contracted plan, SCAN is unique in the MCMC program in that its contract is managed by LTCD. For that reason, MRPIU does not conduct reviews of SCAN.

LTCD conducts ongoing desk reviews of SCAN's policies and procedures, including quarterly grievance report submissions, marketing materials, and member rights materials. 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 the quality management category as evidenced in A&I's medical audit report. The plan was able to sufficiently address several issues outlined in the audit report in a CAP, focusing on utilization management, continuity of care, availability and accessibility, member rights, and administrative and organizational capacity.

Opportunities for Improvement

SCAN has an opportunity to fully address and resolve any issues that were identified in A&I's 2009 medical audit. Specifically, SCAN should address these items: the requirement to make pharmaceutical denials within twenty-four hours, provider organizations not maintaining an effective referral tracking system, the timeliness of adjudication of claims, the timeliness and content of grievance letters, and the proper review of grievances by a medical director.

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

Due to the small size of specialty plan populations, the DHCS modified the performance measure requirements applied to these plans. Instead of requiring a specialty plan to annually report the full list of performance measure rates as full-scope plans do, the DHCS required specialty plans to report only two performance measures. In collaboration with the DHCS, a specialty plan may select measures from the Healthcare Effectiveness Data and Information Set (HEDIS®)[3] or design a measure that is appropriate to the plan's population. Furthermore, the specialty plan must report performance measure results specific to the plan's 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 performance measures when calculating rates.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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 selected EAS measures fell under two domains of care—quality and access.

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

Performance Measure Validation

SCAN reported two HEDIS measures; therefore, HSAG performed an NCQA HEDIS Compliance Audit™ in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[4] Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. Table 3.1 displays a HEDIS performance measure name key.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
GSO	*Glaucoma Screening in Older Adults*
PBH	*Persistence of Beta-Blocker Treatment After a Heart Attack*

Table 3.2 presents a summary of SCAN's HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan's HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

For the *Glaucoma Screening in Older Adults (GSO)* measure, the DHCS based the MPL and HPL on the 2009 Medicare 25th and 90th percentiles, respectively, since no Medicaid benchmark exists for this measure. For the *Persistence of Beta-Blocker Treatment After a Heart Attack* (*PBH*) measure, a rate of *NA* was assigned since the denominator was too small to report a valid rate (a denominator less than 30). Based on 2009 and 2010 performance measure results, HSAG recommends that the plan and the DHCS explore another measure that is meaningful and provides the sufficient number of MCMC members to report a valid rate.

[4] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Table 3.2—2009–2010 Performance Measure Results for SCAN Health Plan

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
Glaucoma Screening in Older Adults							
GSO	Q,A	72.7%	75.2%	★★	↑	50.6%	76.6%
Persistence of Beta-Blocker Treatment After a Heart Attack							
PBH	Q,A,T	72.4%	NA	NA	NA	67.7%	85.0%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[5] Performance comparisons are based on the Chi-square 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 GCO measure, the MPL is based on the national Medicare 25th percentile since no Medicaid benchmark exists for this measure.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the GCO measure, the HPL is based on the national Medicare 90th percentile since no Medicaid benchmark exists for this measure.
★ = Below-average performance relative to the national Medicaid/Commercial 25th percentile.
★★ = Average performance relative to national Medicaid/Commercial percentiles (between the 25th and 90th percentiles).
★★★ = Above-average performance relative to the national Medicaid/Commercial 90th percentile.
NA = Not applicable due to the plan's denominator being too small to report a valid rate (less than 30).
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

For the *GSO* measure, SCAN Health Plan performed above the established MPL but below the HPL in 2010. The DHCS based the MPL and HPL on the 2009 Medicare 25th and 90th percentiles, respectively, since no Medicaid benchmark exists for this measure. In addition, the plan showed statistically significant improvement from 2009 to 2010. For the *PBH* measure, a rate of *NA* was assigned in 2010, since the denominator was too small to report a valid rate (a denominator less than 30).

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline the steps it will take to improve care.

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was

successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans. SCAN did not have any 2009 performance measure rates that required an improvement plan.

Strengths

SCAN showed strong performance for the *GSO* measure, as it measured above the MPL and demonstrated statistically significant improvement.

Opportunities for Improvement

For the *PBH* measure, HSAG recommends that the plan and the DHCS explore another measure that is meaningful and provides the sufficient number of MCMC members to report a valid rate.

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 clinical and nonclinical areas.

HSAG reviews each QIP using the Centers for Medicare & Medicaid Services' (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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

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, 2009, through June 30, 2010. 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 access and quality domains of care.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for SCAN Health Plan July 1, 2009, through June 30, 2010

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Internal QIPs				
Chronic Obstructive Pulmonary Disease (COPD) Management	Annual Submission	68%	90%	*Not Met*
	Resubmission	81%	100%	*Met*
Prevention of Stroke and Transient Ischemic Attack	Annual Submission	81%	80%	*Not Met*
	Resubmission	94%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a new proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met, Partially Met,* or *Not Met*. In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that the annual submission by SCAN of its *COPD Management* QIP and *Prevention of Stroke and Transient Ischemic Attack* QIP both received an overall validation status of *Not Met.* As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted these QIPs; and upon subsequent validation, both QIPs achieved an overall *Met* validation status.

Table 4.2 summarizes the validation results for both of SCAN's QIPs across the CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for SCAN Health Plan
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2009, through June 30, 2010

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	69%	25%	6%
	IX: Real Improvement Achieved†	50%	13%	38%
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total†		**63%**	**21%**	**17%**

***** The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

‡ No QIPs were assessed for this activity/evaluation element.

†The sum of an activity or stage may not equal 100 percent due to rounding.

SCAN submitted Remeasurement 1 data for both QIPs; therefore, HSAG validated Activity I through Activity IX. SCAN applied the documentation requirements for the activities of the Design and Implementation stages, scoring 100 percent on all evaluation elements for each activity. Conversely, for the Outcomes stage, SCAN was scored lower in Activity VIII for the plan's incomplete interpretation of results, not including documentation identifying if there were factors that affected the ability to compare results between measurement periods, and not discussing follow-up activities for its *COPD Management* QIP. For both the *COPD Management* QIP and the *Prevention of Stroke and Transient Ischemic Attack* QIP, the plan reported that there were potential factors affecting the validity of the results; however, the plan did not discuss the impact or resolution of these factors. Two of the three study indicators for the *Prevention of Stroke and Transient Ischemic Attack* QIP demonstrated statistically significant improvement. The *COPD Management* QIP did not demonstrate statistically significant improvement; therefore, SCAN received a score of 50 percent for Activity IX.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3—Quality Improvement Project Outcomes for SCAN Health Plan
July 1, 2009, through June 30, 2010

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 7/1/08–12/31/09**	**Sustained Improvement**
1) Incidence rate of new stroke/TIA for SCAN H5425 members with no prior history of stroke	10.7%	7.8%*	¥	‡
2) Incidence rate of new stroke/TIA for SCAN H9014 members with no prior history of stroke	8.2%	7.2%*	¥	‡
2) Incidence rate of new stroke/TIA for SCAN H9014 Medi-Medi members with no prior history of stroke	8.3%	7.3%	¥	‡
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%	13.3%	‡	‡
2) Percentage of members 40 years of age and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) who were dispensed appropriate medications for inpatient discharge or emergency department encounter related to COPD exacerbations	65.7%	^	^	^

‡ The QIP did not progress to this phase during the review period and could not be assessed.

¥ Only six months of the 12-month measurement year were reported at the time of submission, so the results were not included.

*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05)

^ Study Indicator 2 was discontinued for this year's submission.

SCAN's two contract populations are H5245 and H9014. H5425 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 represents the remainder of SCAN's dually eligible managed care population.

For the *Prevention of Stroke and Transient Ischemic Attack* QIP, all three study indicators improved; and for Study Indicators 1 and 2, the improvement was statistically significant. The plan's interventions were letters to providers listing members with stroke risk and an article to members discussing co-management of chronic disease.

For the *COPD Management* QIP, the study indicator did not improve. SCAN's improvement strategy consisted of letters to providers identifying members with COPD and an article in the member newsletter discussing the management of COPD.

Strengths

SCAN's QIP topics were appropriate for the health plan's population. SCAN applied the documentation requirements for the activities of the Design and Implementation stages, scoring 100 percent on all evaluation elements for each activity.

The plan demonstrated statistically significant improvement for two of the three study indicators for its *Prevention of Stroke and Transient Ischemic Attack* QIP.

Opportunities for Improvement

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. The plan should incorporate a method of determining the efficacy of the interventions that it implements to facilitate the decision of which interventions should be continued and which ones should be revised.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. Specialty plans are required to administer an annual consumer satisfaction survey to their members to evaluate member satisfaction with care and services.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

SCAN reported the survey results within its internal quality evaluation for fiscal year 2009; the member satisfaction survey took place in August of 2009. HSAG reviewed the survey description, survey results, and SCAN analysis. The goals of the survey were to analyze doctor-patient communication, linguistic capabilities, and member satisfaction.

Overall, both English- speaking and Spanish-speaking members expressed high satisfaction with SCAN. Eighty-five percent of members were "very satisfied" with SCAN compared to 70 percent in 2006. Sixty-eight percent of Spanish-speaking members were speaking Spanish with their providers. The plan had realized a significant improvement in the utilization of interpreters since the last member satisfaction survey was administered.

Since the last survey, SCAN has increased efforts to improve the quality and quantity of Spanish translated materials and letters. Seventy-five percent of respondents in 2009 preferred written language to be in Spanish and reported the Spanish mailings as "very easy to read" compared to 53 percent in 2007. Very similar results were reported for reading materials provided by providers.

Strengths

SCAN exhibited average performance in the consumer satisfaction survey results. A majority of members found the SCAN Club newsletter to be "very useful."

Opportunities for Improvement

Fifty-one percent of English-speaking respondents and 65 percent of Spanish-speaking respondents reported having problems getting health care. SCAN should continue to monitor survey results and trends to proactively address any areas of concern as they are identified.

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 the results of performance measures and quality improvement project (QIP) 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. Finally, some member satisfaction measures relate to quality of care.

The plan showed average performance based on SCAN's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, member satisfaction survey results, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

SCAN had average performance relating to the quality aspect of the plan's compliance findings. As reflected in the medical performance review report, the plan was fully compliant with the quality management category, however, the plan had several issues that were documented and that required a corrective action plan. The plan was able to address some but not all of the issues related to quality that were documented in the report.

The plan exceeded the MPL on both of its HEDIS measures and was not required to conduct an improvement plan for either of its measures from the previous year, which shows a focus on HEDIS performance.

SCAN demonstrated average performance with its QIPs. SCAN's QIP topics were appropriate for the health plan's population and SCAN scored 100 percent on all evaluation elements for the Design and Implementation stages. For the *Prevention of Stroke and Transient Ischemic Attack* QIP, all three

study indicators improved; and for Study Indicators 1 and 2, the improvement was statistically significant. For the *COPD Management* QIP, however, the study indicators did not improve.

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 a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, cultural and linguistic services, and coverage of services.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as *Adults' Access to Preventive/Ambulatory Health Service* fall under the domains of quality and access because members rely on access to services and their availability to receive care according to generally accepted clinical guidelines.

The plan demonstrated average to below-average performance based on a review of 2010 performance measure rates that related to access, results of the medical performance and member rights reviews regarding availability and accessibility of care, and member satisfaction results.

For access-related compliance standards, in the medical performance review report the plan had issues with oversight of providers and with ensuring that members were receiving enough prescription medications in emergency situations to last until the member could reasonably be expected to have a prescription filled.

Regarding the plan's COPD QIP, the 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 dropped from 17.2 percent to 13.3 percent from the baseline period to remeasurement period one. This shows that the plan will need to improve the level of access for members in need of this line of testing.

Member satisfaction results showed that 83 percent of Spanish-speaking members were always connected to a Spanish speaker right away when they called, and 0 percent of members reported being "not satisfied" with how long it takes to connect with someone on the telephone who speaks their language.

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. 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 within a recommended period of time after a need is identified.

SCAN exhibited average performance in the timeliness domain of care based on medical performance review standards related to timeliness and member satisfaction survey results related to timeliness.

The plan has opportunities to improve its timeliness of utilization management decisions and notification. Additionally, the plan can improve grievance resolution timeliness.

Conclusions and Recommendations

Overall, SCAN achieved average performance in providing quality health care services to its MCMC members.

Based on the overall assessment of SCAN in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following:

- Address any remaining open CAP issues that were identified in A&I's 2009 medical audit report.
- Conduct periodic, internal grievance file audits to ensure compliance with the DHCS standards.
- Continue efforts to educate providers on cultural and linguistic services and conduct routine monitoring to ensure compliance with policies and procedures.
- Identify an alternative performance measure that assesses quality, access, and/or timeliness of care provided to SCAN members.
- Target QIP development around areas that need performance improvement.

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

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions Which Address Recommendation
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.	HEDIS metrics and QIPs are reviewed, evaluated, and audited by HSAG. From 2008 (Delmarva) throughout 2010, SCAN has been in compliance with HEDIS and QIP submission requirements.
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.	QIP 2009 and 2010 submitted using HSAG's QIP Summary Form (QIP Summary Form was not available in 2008).
Include only Medi-Cal managed care members when reporting QIP rates to allow the plan to identify its performance for this specific population.	Performance and rates were presented specifically for Medi-Cal managed care members for all QIPs (stroke prevention and COPD starting with initial submission in 2008).
Establish criteria for evaluating quality-of-care grievances and a process for determining the need for peer review.	SCAN Health Plan created and implemented Policy and Procedure Number GA-0030, Medi-Cal Grievance and Appeal in April 2010. GA-0030 includes a process for the identification of potential quality of care grievances (pg. 4). SCAN Health Plan does have a process for identifying cases that require Peer Review (QM-0023, Quality Identified/Referred Issue Process [p.3, #3f, and p.6, #8a]).
Implement a mechanism to monitor office wait times, telephone wait and call-return times, and appointment wait times.	SCAN Health Plan revised the Delegation Oversight policy and process to include the monitoring of standard wait times for health care services provided. SCAN Health Plan Policy and Procedure Number QM-0008, Accessibility of Services Standards, was revised in April 2010 to include (p. 6 Accessibility Standards Grid): Urgent care appointment standards. Specialty appointment standards. Provider office wait time. Sensitive services. The Delegation Oversight Tool, which is used to monitor provider organizations according to regulatory guidelines, was revised September 30, 2009. The revision consisted of including the following standards: Waiting times in providers' offices. Telephone calls (answer and return). Time to obtain various types of appointments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions Which Address Recommendation
	In October 2009, the revised Delegation Oversight Tool was disseminated to the provider organizations through the Provider Update. The revised audit tool began being used in Provider Organization Audits in October 2009.
Implement a formal process for oversight of the delegated 24-hour nurse advice line.	SCAN Health Plan developed and implemented a formal process for oversight of the delegated 24-hour nurse advice line in April 2010. The process is documented in Policy and Procedure Number QM-0039, SCAN On Call Vendor Oversight. The oversight process includes: A review of valid licensing by clinical staff. Ensure vendor compliance with Utilization Review Accreditation Commission (URAC) accreditation for Health Call Center standards. Baseline set through conducting a random sample of actual calls will be reviewed to confirm the use of established clinical guidelines during the calls.
Revise prior-authorization policies and procedures to reflect Medi-Cal managed care requirements for member notifications and timelines.	In October 2009, SCAN Health Plan updated the following policies and procedures to reflect the Medi-Cal managed care timeliness requirements: UM-0013, Authorization Process. UM-0009, Timeliness of Utilization Management Decision Making. In April 2010, SCAN Health Plan Implemented the following policy and procedure to reflect the Medi-Cal managed care member notification requirements: UM-0074, Authorizations and Notice of Action Process for Medi- Cal Only Benefits.
Revise grievance policies and procedures to reflect Medi-Cal managed care requirements for member acknowledgment and resolution letters.	In April 2010, SCAN Health Plan created and implemented Policy and Procedure Number GA 0030, Medi-Cal Grievance and Appeal to reflect the Medi-Cal managed care requirements for member acknowledgement and resolution letters.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions Which Address Recommendation
Implement a process for monitoring the timeliness of member grievance acknowledgment and resolution letters and prior-authorization notifications.	In April 2010, SCAN Health Plan created and implemented Policy and Procedure Number GA 0030, Medi-Cal Grievance and Appeal to reflect the Medi-Cal managed care requirements for member acknowledgement and resolution letters. The plan prepares a quarterly grievance log that contains: Tracking the timeliness of responding to members. Tracking timeliness of grievance completion. The grievance log is submitted to the DHCS quarterly.
Implement a formal process for prior-authorization oversight of the pharmacy benefits manager.	SCAN Health Plan has a formal process of prior authorization oversight of the pharmacy benefits manager. The Pharmacy Department oversees that prior authorization criteria approved by SCAN's Pharmacy & Therapeutics (P&T) Committee is accurately set up in the Pharmacy Benefit Management (PBM) system(PH-0096 Formulary Management: Maintenance & Standard Operating Procedures PBM Oversight on Annual Formulary and Benefits Implementation by PBM). The Pharmacy Department oversees both the timeliness of reviews and trends on approvals and denials for prior authorizations conducted by the pharmacy benefits manager. The timeliness of reviews is conducted monthly (PH-0073 PBM Oversight: Coverage Determination). Approvals/denials are currently reviewed monthly by a clinical pharmacist. Based on noted trends, the clinical pharmacist may provide recommendations on how to improve the reviews being conducted by the PBM by either altering the criteria or refining how the question is presented. Beginning in July 2011, the performed trending and recommendations will be reported to the P & T Sub-Committee quarterly.