Performance Evaluation Report

SCAN Health Plan

July 1, 2013–June 30, 2014

Managed Care Quality and Monitoring Division
California Department of Health Care Services

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TABLE OF CONTENTS

Performance Evaluation Report – SCAN Health Plan
July 1, 2013 – June 30, 2014

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)[1] in the State of California through a combination of contracted full-scope and specialty managed care health plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] 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 provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and operations,

[1] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2013–June 30, 2014). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, SCAN Health Plan ("SCAN" or "the MCP") for the review period July 1, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Health Plan Overview

SCAN is a Medicare Advantage Special Needs Plan that contracts with DHCS as a specialty plan to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los Angeles, Riverside, and San Bernardino counties.

SCAN provides all services in the Medi-Cal State Plan, including home and community based services to SCAN members who are assessed at the nursing facility level of care and nursing home custodial care. SCAN members must be at least 65 years of age, live in the service area, have Medicare Parts A and B, and have full scope Medi-Cal with no share of cost. SCAN does not enroll individuals with end-stage renal disease.

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 to provide MCMC services in Los Angeles County in 1985. The MCP expanded into Riverside and San Bernardino counties in 1997. In 2006, DHCS, at the direction of the Centers for Medicare & Medicaid Services (CMS), designated SCAN as an MCP. SCAN then 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 capitation from both Medicare and Medi-Cal, pooling its financing to pay for all services as a full-risk social MCP. DHCS amended SCAN's contract in 2008 to include federal and State requirements for MCPs. Among these requirements, DHCS specifies that specialty plans participating in MCMC both report on two performance measures annually and maintain two internal QIPs.

According to DHCS, as of June 30, 2014, SCAN had 8,176 MCMC members in the three counties combined.

Due to the MCP's unique membership, some of SCAN's contract requirements have been modified from the MCMC's full-scope MCP contracts.

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP'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. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to evaluate key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

Medical Audits and SPD Medical Surveys

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were

conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

DHCS received authorization "1115 Waiver" from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-County Organized Health System (COHS) counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

Reviews for SCAN

SCAN is unique in that its contract is managed by DHCS's Long-Term Care Division (LTCD). As part of the process for producing this MCP-specific evaluation report, HSAG received documentation from DHCS's LTCD regarding the status of SCAN's medical performance reviews.

SCAN was due to undergo a medical audit in 2012; however, DHCS did not schedule the audit because, at the time, it was working to end the existing contractual relationship with SCAN, which would allow SCAN the opportunity to set up a subcontracting relationship with Coordinated Care Initiative (CCI) health plans in Los Angeles, Riverside, and San Bernardino counties. This relationship would have allowed the beneficiaries served by SCAN to shift into the CCI where they would have the option to continue receiving services through SCAN as a sub-plan of a CCI health plan. As a result of the delayed implementation of CCI and a shift during 2014 in DHCS's policy regarding dual eligible special needs plans, DHCS is no longer pursuing this option and informed SCAN that its current contractual relationship will continue at minimum through the

course of the duals demonstration. The LTCD is working with A&I to schedule a medical audit of SCAN during State Fiscal Year 2015–16.

Strengths

SCAN has no outstanding findings or deficiencies from previously-conducted reviews.

Opportunities for Improvement

As no new reviews were conducted with SCAN during the reporting period, HSAG has no recommendations in the area of compliance.

Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal Managed Care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

Due to the small size of specialty MCP populations, DHCS modified the performance measure requirements applied to these MCPs. Instead of requiring a specialty MCP to annually report the full list of performance measure rates as full-scope MCPs do, DHCS requires specialty MCPs to report only two performance measures. In collaboration with DHCS, a specialty MCP may select measures from the Healthcare Effectiveness Data and Information Set (HEDIS®)[3] or design a measure appropriate to the MCP's population. The measures put forth by the specialty MCPs are subject to approval by DHCS. Furthermore, specialty MCPs must report performance measure results specific to MCMC members.

HSAG conducts validation of the External Accountability Set performance measures as required by DHCS to evaluate the accuracy of the MCPs' reported results. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of

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

performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[4] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

For 2014, SCAN was required to report two HEDIS measures—*Breast Cancer Screening* and *Osteoporosis Management in Women Who Had a Fracture*.

HSAG performed NCQA HEDIS Compliance Audits™[5] of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid. Note that SCAN participated in the statewide collaborative QIP, and that SCAN's rate information for the *All-Cause Readmissions* measure is included in Section 4 of this report—Quality Improvement Projects.

Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for SCAN Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that SCAN followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the findings is included below.

SCAN:

- Demonstrated good oversight of provider groups and hospital data.
- Had no enrollment backlogs during the reporting period.
- Increased its number of primary care practitioners to meet expansion needs.

[4] The CMS EQR Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.
[5] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of SCAN's performance measure results for 2012–14.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2012–14, Table 3.1 shows SCAN's performance compared to the DHCS-established MPLs and HPLs for each year for the two required measures. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

Table 3.1—Performance Measure Results
SCAN—Los Angeles/Riverside/San Bernardino Counties

Performance Measure[1]	Domain of Care[2]	2012[3]	2013[4]	2014[5]	Performance Comparison[6]
*Breast Cancer Screening**	Q, A	79.9%	81.42%	79.90%	↓
*Osteoporosis Management in Women Who Had a Fracture^*	Q, T	27.7%	28.40%	41.14%	↑

[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 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011. Rates in 2012 were reported to one decimal place. To be consistent with how NCQA is reporting rates for 2013, two decimal places are used for the 2013 and 2014 rates.
[4] HEDIS 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] HEDIS 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[6] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
* The minimum performance level (MPL) and high performance level (HPL) for this measure are based on NCQA's national Medicaid 25th and 90th percentiles, respectively.
^ The MPL and HPL for this measure are based on NCQA's national Medicare 25th and 90th percentiles, respectively, since no Medicaid benchmarks are available for this measure.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.

Performance Measure Result Findings

While the rate declined significantly from 2013 to 2014 for the *Breast Cancer Screening* measure, it was above the HPL for the third consecutive year. (Note: In 2012, DHCS did not hold the MCP accountable to meet the MPL because 2012 was the first year the MCP reported this measure.) The rate improved significantly from 2013 to 2014 for the *Osteoporosis Management in Women Who Had a Fracture* measure.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act cycle . DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates (measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

Assessment of MCP's Improvement Plans

As rates were above the MPLs for both required performance measures in 2013, SCAN was required to submit no IPs for either required measure. Based on 2014 rates, SCAN will not be required to submit any IPs in 2014.

Strengths

HSAG auditors determined that SCAN followed the appropriate specifications to produce valid performance measure rates and identified no issues of concern. The auditor noted that SCAN demonstrated good oversight of provider groups and hospital data, had no enrollment backlogs during the reporting period, and increased the MCP's number of primary care practitioners to meet expansion needs.

SCAN continues to ensure that a high percentage of eligible women are being screened for breast cancer within the specified time frame. Additionally, for women 67 years of age and older who suffered a fracture, the MCP is making excellent progress increasing the percentage who obtain, within six months of that fracture, either a bone mineral density test or prescription for a drug to treat or prevent osteoporosis.

Opportunities for Improvement

While the rate for the *Breast Cancer Screening* measure was above the HPL for the third consecutive year, the rate declined significantly from 2013 to 2014. HSAG recommends that, to ensure that the rate does not continue to decline, the MCP report the measure one more year (2015) and, in collaboration with DHCS, identify a new measure for 2016. To ensure the MCP's continued high performance for the *Breast Cancer Screening* measure beyond reporting year 2015, HSAG recommends that SCAN develop an internal process for monitoring breast cancer screenings for eligible women.

Conducting the EQRO 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 CMS validation protocol[6] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Specialty MCPs must conduct a minimum of two QIPs; however, because specialty MCPs serve unique populations that are limited in size, DHCS does not require specialty MCPs to participate in the statewide collaborative QIP. Instead, specialty MCPs are required to design and maintain two internal QIPs with the goal to improve health care quality, access, and/or timeliness for the specialty MCP's MCMC members.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

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

[6] The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Quality Improvement Project Objectives

Specialty MCPs must be engaged in two QIPs at all times. However, due to the small and unique populations served, DHCS does not require them to participate in statewide collaborative QIPs. Instead, specialty MCPs are required to design and maintain two internal QIPs with the goal to improve health care quality, access, and/or timeliness for the specialty MCP's beneficiaries. SCAN opted to participate in the statewide collaborative QIP and had two internal QIPs in progress during the review period of July 1, 2013, through June 30, 2014.

Table 4.1 lists SCAN's QIPs whether the QIP is clinical or nonclinical, and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

Table 4.1—Quality Improvement Projects
SCAN—Los Angeles/Riverside/San Bernardino Counties
July 1, 2013, through June 30, 2014

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Care for Older Adults	Clinical	Q, A
Patient Safety Analysis—Use of High-Risk Medication in the Elderly	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members, leading to improved health outcomes.

SCAN's *Care for Older Adults* QIP, targeted improving the care provided to Medi-Cal adults aged 66 or older. SCAN's Medi-Cal beneficiaries face two major barriers: lack of geriatric training for primary care providers (PCPs) and lack of standardized assessments for the older population. SCAN's QIP focused on addressing these barriers to improve the care being provided to the older population.

The *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIP sought to reduce the use of high-risk medications among its elderly members. At the initiation of the QIP, approximately 16.45 percent of the targeted population were prescribed at least one high-risk medication and 1.99 percent were prescribed two high-risk medications. SCAN aims to achieve a statistically significant reduction in the use of high-risk medications.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Validation Activity
SCAN—Los Angeles/Riverside/San Bernardino Counties
July 1, 2013, through June 30, 2014

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]
Statewide Collaborative QIP				
All-Cause Readmissions	Annual Submission	75%	86%	*Partially Met*
	Annual Resubmission 1	100%	100%	*Met*
Internal QIPs				
Care for Older Adults	Annual Submission	97%	100%	*Met*
Patient Safety Analysis—Use of High-Risk Medication in the Elderly	Study Design Submission	80%	80%	*Partially Met*
	Study Design Resubmission 1	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP 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 noncritical) 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*.

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that SCAN's annual submission of its *All-Cause Readmissions* QIP received an overall validation status of *Partially Met*. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, SCAN resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score. The *Care for Older Adults* QIP annual submission received an overall validation status of *Met*, with 97 percent of the evaluation elements and 100 percent of the critical elements receiving a met score. Finally, the *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIP study design submission QIP received an overall validation status of *Partially Met*. Based on HSAG's validation feedback, SCAN resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score.

Table 4.3 summarizes the aggregate validation results for SCAN's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
SCAN—Los Angeles/Riverside/San Bernardino Counties
(Number = 5 QIP Submissions, 3 QIP Topics)
July 1, 2013, through June 30, 2014

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)	80%	20%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	91%	9%	0%
Design Total		**95%**	**5%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	82%	0%	18%
	VIII: Appropriate Improvement Strategies	86%	14%	0%
Implementation Total		**83%**	**4%**	**13%**
Outcomes	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**100%**	**0%**	**0%**

* 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.

HSAG validated Activities I through VIII for SCAN's *All-Cause Readmissions* QIP annual submission, Activities I through X for the MCP's *Care for Older Adults* QIP annual submission, and Activities I through VI for the *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIP study design submission.

SCAN demonstrated a strong application of the Design stage, meeting 97 percent of the requirements for all applicable evaluation elements within the study stage for all three QIPs. The MCP did not describe the data analysis plan for the *All-Cause Readmissions* QIP, resulting in a lower score for Activity VI. SCAN met all requirements for all applicable evaluation elements within the Design stage for its *Care for Older Adults* QIP. For the *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIP, SCAN did not provide a clearly-defined study question and did not describe the data analysis plan, resulting in lower scores for Activity II and VI. SCAN corrected the deficiencies in the resubmission, resulting in the QIP achieving an overall *Met* validation status.

Both the *All-Cause Readmissions* and *Care for Older Adults* QIPs progressed to the Implementation stage during the review period. SCAN demonstrated an adequate application of the Implementation stage, meeting 83 percent of the requirements for all applicable evaluation

elements within the study stage for this QIP. For the *All-Cause Readmissions* QIP, SCAN did not indicate if any factors threatened the internal or external validity of the findings, did not provide an interpretation of the baseline results, and did not include an evaluation plan for each intervention, resulting in lower scores for Activities VII and VIII. SCAN corrected the deficiencies in its resubmission, resulting in the QIP achieving an overall *Met* validation status. For the *Care for Older Adults* QIP, the MCP did not indicate whether or not any factors threatened the internal or external validity of the findings, resulting in a lower score for Activity VII.

Only the *Care for Older Adults* QIP progressed to the Outcomes stage during the review period. SCAN demonstrated an excellent application of the Outcome stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage. Both study indicators achieved statistically significant improvement over baseline at Remeasurement 1 and sustained the improvement at Remeasurement 2.

Quality Improvement Project Outcomes and Interventions

The *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIP did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information is included in this report.

All-Cause Readmissions QIP

The *All-Cause Readmissions* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP's interventions for the *All-Cause Readmissions* QIP:

- Implemented a care transitions program that included a multi-media sharing and messaging component wherein care transition coaches developed and recorded individualized video messages sent electronically to the member and/or the member's caregivers.
- Implemented a home-visit pilot to remove barriers related to readmissions. The home visit helped improve members' understanding of their discharge plans and ensured that they received needed support services.
- Partnered with skilled nursing facilities and acute care facilities to improve care transition to skilled nursing facilities and reduce readmissions to the acute care environment.

Outcome information for the *All-Cause Readmissions* QIP will be included in SCAN's 2014–15 MCP-specific evaluation report.

Care for Older Adults QIP

Table 4.4 summarizes the *Care for Older Adults* QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained

improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

Table 4.4—Quality Improvement Project Outcomes for SCAN—Los Angeles/Riverside/San Bernardino Counties July 1, 2013, through June 30, 2014

QIP #1—Care for Older Adults			
Study Indicator 1: Percentage of eligible members 66 years of age or older with at least one functional status assessment.			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
54.9%	63.0%*	75.5%	Yes
Study Indicator 2: Percentage of eligible members 66 years of age or older with at least one pain screening or pain management plan.			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
26.2%	40.4%*	65.2%	Yes

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement over the baseline measurement period (p value < 0.05).

For the *Care for Older Adults* QIP, SCAN accomplished its goal of the QIP indicators achieving statistically significant improvement over baseline at Remeasurement 1 and sustaining the improvement at Remeasurement 2. The QIP was successful at increasing the percentage of eligible members receiving at least one functional status assessment and at least one pain screening/pain management plan. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- SCAN completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through the data analysis and a quality improvement process. The documentation included system interventions likely to have a long-term effect and described problem-solving techniques using data analysis to identify possible causes and solutions.
- SCAN included a Plan-Do-Study-Act worksheet to show the MCP's continued efforts to improve the QIP's outcomes.
- SCAN indicated that several of its interventions were ongoing and described how the MCP monitors the interventions for efficacy in improving the rate. The MCP also provided information about the success of the quality improvement actions and how the interventions were standardized and monitored.
- The following interventions resulted in improved QIP outcomes:
  - Improving provider and member education.
  - Realigning network management to improve outreach and communication with providers.

- Collaborating with medical directors and provider networks to improve communication in geriatric education and barrier identification.
- Implementing provider incentive programs.
- Sending information to members and conducting member focus groups.
- Developing standardized screening tools and clinical practice guidelines.

Due to the success of the QIP in improving the care for older adults, HSAG recommended that SCAN close the QIP and identify a new area in need of improvement.

Strengths

SCAN demonstrated an excellent application of the QIP process for the Design stage for all QIPs. Additionally, the MCP achieved an overall *Met* validation status on the first submission for the *Care for Older Adults* QIP.

SCAN excelled at developing and implementing interventions that positively affected the rates for the *Care for Older Adults* QIP. The MCP took advantage of the QIP process to improve the rate for this measure. The QIP achieved and sustained statistically significant improvement over baseline; therefore, this QIP was closed.

Opportunities for Improvement

In response to HSAG's recommendations in SCAN's 2012–13 MCP-specific evaluation report, SCAN implemented various processes to ensure that the QIP Summary Form was complete and accurate (see Appendix A). The MCP had to resubmit the *All-Cause Readmissions* and *Patient Safety Analysis—Use of High-Risk Medication in the Elderly* QIPs due to incomplete or inaccurate documentation; therefore, the MCP demonstrates continued opportunities for improving its QIP documentation. The MCP should continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Although HSAG uses a standardized scoring process to evaluate each full-scope Medi-Cal MCP's performance measure rates and QIP performance in the three domains of care—quality, access, and timeliness—HSAG does not use this scoring process for specialty MCPs, due to the small size of the specialty MCPs' populations. To determine the degree to which specialty MCPs provide quality, accessible, and timely care to beneficiaries, HSAG assesses each specialty MCP's performance related to medical audit/SPD medical survey reviews (as applicable), performance measure rates, QIP validation, QIP outcomes, member satisfaction surveys (as available), and accuracy and completeness of the MCP's encounter data (as applicable).

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[7]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP 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, DHCS monitors aspects of an MCP'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. DHCS also uses the results of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

As part of the process for producing this report, HSAG reviewed the quality documents SCAN submitted. The MCP's quality improvement program description includes details of SCAN's

[7] This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

operational structure, which includes resources dedicated to ensuring that quality care is delivered to members.

Both of SCAN's performance measures fall into the quality domain of care. While the rate declined significantly from 2013 to 2014 for the *Breast Cancer Screening* measure, the rate was above the HPL for the third consecutive year (Note: In 2012, DHCS did not hold the MCP accountable to meet the MPL because 2012 was the first year the MCP reported this measure). The rate improved significantly from 2013 to 2014 for the *Osteoporosis Management in Women Who Had a Fracture* measure.

All three of SCAN's QIPs fall into the quality domain of care. Only the *Care for Older Adults* QIP progressed to the Outcomes stage. The QIP was successful at improving the quality of care to members, with a significantly higher percentage of functional status assessments being conducted and a significantly higher percentage of pain screenings/pain management plans being provided at Remeasurement 1 when compared to the baseline period. The improvement was sustained at Remeasurement 2, resulting in HSAG recommending that the MCP close the QIP and identify a new QIP for an area in need of improvement.

Overall, SCAN showed above-average performance related to the quality domain of care based on both performance on required measures and success of the *Care for Older Adults* QIP.

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care.

When reviewing the quality documents SCAN submitted as part of the process for producing this report, HSAG found descriptions of processes designed to monitor and ensure access to care.

The *Breast Cancer Screening* measure falls into the access domain of care. As indicated above, while the rate declined significantly from 2013 to 2014 for the *Breast Cancer Screening* measure, the rate was above the HPL for the third consecutive year. The high rate for this measure demonstrates that SCAN continues to ensure that female members have access to breast cancer screening services.

All three of SCAN's QIPs fall into the access domain of care. As indicated above, only the *Care for Older Adults* QIP progressed to the Outcomes stage. The QIP was successful at achieving statistically significant improvement over baseline at Remeasurement 1 and sustaining the improvement at Remeasurement 2, resulting in the QIP being closed.

Overall, SCAN showed above-average performance related to the access domain of care based on both performance measure results and success of the *Care for Older Adults* QIP.

Timeliness

The timeliness domain of care relates to an MCP'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.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' 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 that assess if a health care service is provided within a recommended period of time after a need is identified are used to assess if MCPs are ensuring timeliness of care. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

SCAN's quality improvement program description provides details about the MCP's organizational structure and activities related to grievances, care coordination, and utilization management, which can all affect the timeliness of care delivered to members.

The *Osteoporosis Management in Women Who Had a Fracture* measure falls into the timeliness domain of care. As indicated previously, the rate for this measure improved significantly from 2013 to 2014.

Overall, SCAN showed average performance related to the timeliness domain of care based on the rate for the *Osteoporosis Management in Women Who Had a Fracture* measure being above the MPL.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2012–13 MCP-specific evaluation report. SCAN's self-reported responses are included in Appendix A.

Recommendations

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

- To ensure that the rate for the *Breast Cancer Screening* measure does not continue to decline, report the measure one more year (2015) and, in collaboration with DHCS, identify a new measure for 2016.
  - To ensure the MCP's continued high performance for the *Breast Cancer Screening* measure beyond reporting year 2015, HSAG recommends that SCAN develop an internal process for monitoring breast cancer screenings for eligible women.
- Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

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

Appendix A. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

for SCAN Health Plan

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with SCAN's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table A.1—SCAN's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

2012–13 External Quality Review Recommendation Directed to SCAN	Actions Taken by SCAN During the Period July 1, 2013–June 30, 2014, that Address the External Quality Review Recommendation
1. Consider implementing an internal action plan to ensure that the HEDIS Roadmap is completed thoroughly and updated annually within the NCQA-required time frame. Additionally, consider using a coordinated team effort to complete the Roadmap and conduct a comprehensive review prior to submission.	The HEDIS team copies over the 2013 submissions to the 2014 templates as soon as the 2014 templates become available and then sends out these templates to the parties responsible for each section to review and update as necessary, with a deadline of December 2, 2013. At the same time, a tracking sheet is created showing who each section was sent to and the date it was sent. As updates are received, they are noted on this tracking sheet, and reminder e-mails are sent out to those who have not responded a week before the deadline. Upon receipt, the templates are reviewed for obvious errors (i.e., use of dates in 2013 which would indicate that review was not completed by the respondent) and then compared with the 2013 Issue Log to ensure that any past concerns have been addressed and any mistakes from the previous year were not repeated. Once this review has been completed, the Roadmap is uploaded to the auditor by the HEDIS specialist.
2. Thoroughly review the QIP Completion Instructions prior to submitting QIPs to ensure that all required documentation is included in the QIP Summary Form to avoid having to resubmit QIPs multiple times.	In 2013 SCAN developed QIP Workgroup with identified roles and responsibilities including medical directors, quality and compliance, medical management, healthcare informatics, pharmacy, and health care services. The workgroup has outlined the requirements and identified responsibilities of each requirement in the QIP monitoring and management process. In addition, a detailed quality assessment is in place to ensure all the requirements have been elucidated in detail.
3. Review the MCP's detailed member satisfaction survey results and determine if there are strategies the MCP can implement to improve members' overall satisfaction with SCAN.	SCAN continues to review and implement strategies to improve members' overall satisfaction with the MCP, including ways to better communicate with members as well as engaging members to assist them in obtaining needed services and treatment. In 2013, SCAN created the "SCAN Buddy" program designed to assist members and limit barriers to needed care. In addition, SCAN has created programs that address both the needs of the population and working with focus groups including senior members to assist with further development of member-friendly programs to meet the needs of the member population.

2012–13 External Quality Review Recommendation Directed to SCAN	Actions Taken by SCAN During the Period July 1, 2013–June 30, 2014, that Address the External Quality Review Recommendation
	SCAN also conducts an independent member satisfaction survey each year, wherein a brief 5-question survey is mailed to 7,500 randomly selected members in California and Arizona. Overall, member satisfaction has been extremely high. For instance, to the question, "Are you satisfied with SCAN health plan?" 97.1 percent of members that completed the survey responded "Yes" in 2012 and 96.4 percent responded "Yes" in 2013. Similarly, to another question on the survey, "How likely are you to recommend SCAN to a friend?" where "0" is extremely unlikely and "10" is very likely, the overall average was 9.1 in 2012 and 9.0 in 2013.
4. Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.	SCAN's Encounter Data Team evaluated all findings from the study report and has made minor adjustments to Provider Type and Specialty code values and logic within the existing files. These two issues directly or indirectly caused most of the findings within the study report. Further, SCAN is migrating to DHCS' new American National Standards Institute 837v5010 encounter data submission methodology by October 1, 2014, which has given SCAN an additional opportunity to reinforce data completeness and accuracy concerns in the encounter data submission to DHCS.