Performance Evaluation Report

Family Mosaic Project

July 1, 2010–June 30, 2011

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

June 2012

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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 4.3 million beneficiaries (as of June 2011)[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, 2010–June 30, 2011*, 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 2011*, at http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Family Mosaic Project ("FMP" or "the plan"), which delivers care in San Francisco County, for the review period July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

FMP is a specialty plan which provides intensive case management and wraparound services for Medi-Cal managed care children and adolescents in San Francisco County who are at risk of out-of-home placement. FMP is part of the Child, Youth, and Family System of Care operated by the City and County of San Francisco Department of Public Health, Community Behavioral Health Services. To receive services from FMP, a member must meet specific enrollment criteria, including being a San Francisco resident between 3 and 18 years of age, having serious mental health care needs, and being at imminent risk of (or already in) out-of-home placement. The plan submits appropriate clients to the DHCS for approval to be enrolled in FMP's Medi-Cal managed care program. Once a client is approved and included under FMP's contract with the DHCS, the plan receives a per-member, per-month capitated rate to provide mental health and related wraparound services to these members.

FMP became operational with the MCMC Program in February 1993. As of June 30, 2011, the plan had 118 MCMC members.[2]

Due to the plan's unique membership, some of FMP's contract requirements have been modified from the MCMC Program's full-scope health plan contracts.

[2] *Medi-Cal Managed Care Enrollment Report—June 2011*. 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, 2010–June 30, 2011*, 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 FMP'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.

California Department of Mental Health 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 have historically worked in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. Due to the unique nature of FMP's membership and the plan's emphasis on the mental health component of the services it delivers, FMP is not subject to medical performance review audits by the DHCS and DMHC. FMP, as part of San Francisco County's mental health plan, is subject to review by the Division of Program Compliance—Medi-Cal Oversight, Department of Mental Health (DMH).

DMH performs reviews every three years. The most recent DMH audit took place on April 25–28, 2011. The final report was not yet available. The results of the FMP review will be reported in the next annual plan performance evaluation report.

HSAG reviewed the most current medical performance review reports available as of June 30, 2011, to assess the plans' compliance with State-specified standards. HSAG reported the February 2008 DMH review results in the prior year's plan evaluation report.

The 2008 DMH audit focused on the larger San Francisco County mental health plan. HSAG could not determine if any of the audit findings related specifically to FMP and the Medi-Cal managed care program. HSAG recommended that the plan review the audit report to identify any findings that may apply to FMP/Medi-Cal managed care and address those issues.

HSAG identified three findings that applied to the plan's Medi-Cal contract:

- Ensuring second opinions are available through a licensed mental health practitioner.
- Providing written notification to members of termination of a contracted provider within 15 days of receipt.
- Updating various policies and procedures related to changes in behavioral health providers, cultural and linguistic competency requirements, notice of action for denial of Medi-Cal funding for specialized mental health services, appeal and expedited appeal procedures for outpatient mental health Medi-Cal clients, and individual provider selection and retention.

Medi-Cal Managed Care 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. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These member rights reviews are conducted before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2011.

MRPIU conducted a routine monitoring visit of FMP in June 2010 which covered the review period of January 1, 2008, through December 31, 2009. MRPIU conducted a desk review of policies and procedures, reviewed grievance files, and visited four provider office sites.

The review found FMP to be fully compliant with all requirements; no deficiencies were noted. This was an improvement over the prior review results, which noted deficiencies related to timeline requirements when resolving member grievances and maintenance of grievance information.

Strengths

FMP was fully compliant with all areas evaluated by the MRPIU, with no deficiencies found. The plan resolved all of the grievance deficiencies that were identified during the prior MRPIU review conducted in May 2008. FMP also self-reported that the plan had addressed all deficiencies from the 2008 DMH review.

Opportunities for Improvement

Because FMP is evaluated under the larger San Francisco County mental health plan, the plan should identify and continually monitor itself to ensure compliance with all requirements that apply to its Medi-Cal population. The plan has an opportunity to improve the timeliness of written notification to members regarding the termination of its contract with providers as well as an opportunity to update its policies and procedures to reflect changes in: behavioral health providers, cultural and linguistic competency requirements, notice of action for denial of Medi-Cal funding for specialized mental health services, appeal and expedited appeal procedures for outpatient mental health Medi-Cal clients, and individual provider selection and retention.

Conducting the Review

For its full-scope plans, the DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. Due to the small size and unique populations served by the specialty plans, the DHCS modified the performance measure requirements applied to these plans. The DHCS required specialty plans to report 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.

Standardized performance measures such as HEDIS do not apply to FMP's population or services provided. During the prior evaluation period (July 1, 2009–June 30, 2010), HSAG assisted FMP in developing written specifications for two performance measures specific to the plan's specialized services. During the current evaluation period, the plan was able to report two performance measures: *Inpatient Hospitalizations* and *Out-of-Home Placements*.

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, 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 FMP's performance in providing quality, accessible, and timely care and services to its MCMC members. The *Inpatient Hospitalizations* measure fell under the Quality domain, and the *Out-of-Home Placements* fell under both the quality and access domains.

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

Performance Measure Validation

HSAG validated the two performance measures that were calculated and reported by FMP. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities,* Final Protocol, Version 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol). The validation process included three phases:

- The pre-on-site phase included a review of the Information Systems Capabilities Assessment (ISCA) tool completed by FMP, supportive documentation, and source code used to calculate the performance measures; and planning for the on-site visit.
- The on-site visit included system evaluation and demonstration, review of data integration and data control, evaluation of data output files, and primary source verification of performance measure member-level files.
- The post-on-site phase included review of follow-up documentation and preliminary performance measure results, and final approval of calculations and final results.

Based on the validation findings, HSAG determined that each performance measure was fully compliant with the written specifications and was calculated accurately. The review team noted that the performance measures were collected and calculated using data extracted from three separate systems and several manual processes that were not well documented.

Performance Measure Results

HSAG presents the performance measure results for each reported measure for the measurement period.

Inpatient Hospitalizations

Measure Definition

Inpatient Hospitalizations measures the percentage of members enrolled into Family Mosaic Project with one or more acute, mental health inpatient hospitalizations during the measurement year. For this measure, a lower rate indicates better performance.

Performance Results

Table 3.1—2010–2011 Performance Measure Rates for Family Mosaic Project—San Francisco County

Inpatient Hospitalizations			
Year	Reported Rates		
	1 Admission*	2 Admissions*	3+ Admissions*
1/1/2009–12/31/2009	1.4%	0.9%	0%
1/1/2010–12/31/2010	1.7%	0.6%	0%

*There are no MPLs or HPLs for these measures.

Summary of Results

There was a slight increase in the rate for 1 Admission from measurement year 2010 to measurement year 2011 and a slight decrease for 2 Admissions from measurement year 2010 to measurement year 2011. The admissions rate remained unchanged at 3+ Admissions. All percentage changes were statistically insignificant.

Out-of-Home Placements

Measure Definition

Out-of-Home Placements measures the percentage of members enrolled in Family Mosaic Project who were discharged to an out-of-home placement (foster care, group home, or residential treatment facility) during the measurement period.

Performance Results

Table 3.2—2010–2011 Performance Measure Rates for Family Mosaic Project—San Francisco County

Out-of-Home Placements		
	Out-of-Home Placements* 2010 1/1/2009–12/31/2009	Out-of-Home Placements* 2011 1/1/2010–12/31/2010
Rate	13.6%	12.2%

*There is no MPL or HPL for this measure.

Summary of Results

The rate of *Out-of-Home Placements* dropped from 13.6 percent in measurement year 2010 to 12.2 percent in measurement year 2011. The percentage decrease in *Out-of-Home Placements* reflected an improvement in performance, although the change was not statistically significant.

Strengths

The *Out-of-Home Placements* measure had an improvement in performance during the measurement period.

Opportunities for Improvement

Both measures require additional measurement periods to objectively evaluate performance in this area and to determine if opportunities exist.

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, 2010–June 30, 2011*, 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 FMP's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Projects Conducted

Specialty plans must be engaged in two QIPs at all times. However, because specialty plans serve unique populations that are limited in size, the DHCS does not require specialty plans to participate in the statewide collaborative QIP. Instead, specialty plans are required to design and maintain two internal QIPs with the goal to improve health care quality, access, and/or timeliness for the specialty plan's MCMC members.

The DHCS, in collaboration with HSAG, required FMP to submit one QIP proposal in May 2010, and a second QIP proposal in January 2011. HSAG provided ongoing technical assistance to the plan, which included strategies toward addressing data collection challenges. FMP continued to experience delays in the internal implementation of a data system, which impacted the development of the QIP proposals.

Once a standardized performance measure was developed and validated, FMP opted to focus its first QIP on reducing out-of-home placements. The plan submitted the initial QIP proposal to the DHCS in July 2010. The data from this measure revealed that out of 81 distinct FMP clients (100 percent), only 11 distinct clients (13.58 percent) had an out-of-home discharge living situation

code. Research has demonstrated adverse effects on the health and well-being of children and youth who were placed out-of-home in foster care, group homes, and residential treatment facilities as well as community treatment facilities.

The plan submitted its second proposal in January 2011, which focused on increasing the rate of school attendance for its members. The plan's data clearly showed that school attendance is a marked problem for children and youth within FMP, more so than for children and youth receiving services outside of FMP—approximately 60 percent of children and youth entering FMP experience serious problems with school attendance. The data showed that over 47 percent of children and youth missed at least two days per week on average and 11 percent were generally truant or refused to go to school.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for Family Mosaic Project—San Francisco County July 1, 2010, through June 30, 2011

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				
Reduction of Out-of-Home Placement	Proposal	100%	100%	*Met*
	Annual Submission	93%	90%	*Partially Met*
	Resubmission	96%	100%	*Met*
Increase the Rate of School Attendance	Proposal	24%	11%	*Not Met*
	Resubmission	100%	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*.

Validation results during the review period of July 1, 2010, through June 30, 2011 showed that FMP's QIP proposal of *Reduction of Out-of-Home Placement* received an overall validation status of *Met*. Its annual submission of the same QIP received an overall *Partially Met* validation status. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met*

validation status. The plan incorporated the validation feedback and upon subsequent resubmission, the plan received a *Met* validation status.

The plan's submission of the *Increase the Rate of School Attendance* QIP proposal received a *Not Met* validation status. The plan requested technical assistance before it resubmitted the QIP. Applying the information received during technical assistance, FMP was able to resubmit the QIP proposal and receive a *Met* validation status.

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

Table 4.2—Quality Improvement Project Average Rates*
for Family Mosaic Project—San Francisco County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2010, through June 30, 2011

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	75%	25%	0%
	IX: Real Improvement Achieved	‡	‡	‡
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		**75%**	**25%**	**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.

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

For the *Increase the Rate of School Attendance* QIP, the plan had not progressed to the phase of reporting baseline data. The QIP was only assessed through Activity V. For the *Reduction of Out-of-Home Placement* QIP, the plan had progressed to the point of reporting baseline data; therefore, the QIP could only be assessed through Activity VIII.

FMP demonstrated the proper application of the design and implementation stages, scoring 100 percent on all six of the applicable activities. For the outcomes stage, FMP was scored down for not providing a complete data analysis plan that included the type of statistical testing that would be used to determine statistically significant differences between measurement periods.

Quality Improvement Project Outcomes

Table 4.3 summarizes 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 Family Mosaic Project—San Francisco County (Number = 2 QIP Submissions, 2 QIP Topics) July 1, 2010, through June 30, 2011

QIP #1—Reduction of Out-of-Home Placement				
QIP Study Indicator	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
Percentage of members who are discharged to out-of-home placement.	13.6%	‡	‡	‡
QIP #2—Increase the Rate of School Attendance				
QIP Study Indicator	**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¥**
Percentage of 6 month and discharge CANS assessments scored "2" or "3".	‡	‡	‡	‡

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

¥ Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

FMP had only progressed to the point of reporting baseline data for the *Reduction of Out-of-Home Placement* QIP. Neither QIP could be assessed for real or sustained improvement.

Strengths

FMP selected two QIP topics that are specific and important to the specialty Medi-Cal managed care population with serious emotional disturbances and mental health challenges, in their childhood and adolescence. Additionally, FMP demonstrated an understanding of the design and implementation stages and received *Met* scores for all six of the applicable activities. Although

FMP had to resubmit both QIPs, the plan used the technical assistance available before its resubmissions, resulting in improved validation scores.

Opportunities for Improvement

FMP should ensure that a barrier analysis is conducted annually, at a minimum. Interventions should directly link to the identified barriers. Due to the plan's unique population and services provided, FMP should request technical assistance if it has any questions regarding the activities in the outcomes stage, especially statistical tests and interpretation of the results.

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 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.

The plan showed average performance based on FMP's 2011 performance measure rates (which reflect 2010 measurement data) and the results of member rights reviews as they related to measurement and improvement. Although there are no external benchmarks available for comparison of the performance measure results, the inpatient hospitalization measure results appear relatively low, while the rate for out-of-home placements allows room for improvement. The plan addressed the areas of findings identified by the DMH review, and the most recent MRPIU review found FMP fully compliant with all areas evaluated.

FMP was able to submit two QIPs addressing the reduction of out-of-home placements and improving school attendance. The plan is now fully compliant with DHCS requirements to have two active QIPs in progress. During the next measurement period the plan will submit remeasurement data allowing for HSAG to assess for real and sustained improvement in achieving these outcomes.

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, and access to covered services under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. The *Out-of-Home Placements* measure falls under the domains of quality and access because members rely on access to services and their availability to receive care to impact successful outcomes.

The plan demonstrated average performance based on a review of 2010 performance measure rates related to access and results of the member rights review regarding availability and accessibility of care. The *Out-of-Home Placements* rate had no national comparison benchmark available; however, room for improvement was noted. FMP was fully compliant with cultural and linguistic standards evaluated by the MRPIU, reflecting no access-related concerns in that area.

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.

FMP exhibited above average performance in the timeliness domain of care based on 2010 member rights reviews.

FMP was fully compliant with all timeliness-related standards when evaluated by the MRPIU review, including prior authorization processes and procedures for collecting and resolving member grievances.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 plan-specific evaluation report. FMP's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, FMP achieved average performance in the quality and access to care domains. The plan demonstrated above-average performance in providing timely services. The plan has made excellent progress and consistent effort in developing performance measures and QIPs to meet DHCS requirements over the last two years.

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

- Conduct periodic, internal reviews to ensure compliance with the Department of Mental Health and Medi-Cal Managed Care's Member Rights and Program Integrity Unit standards.
- Ensure consistent measurement of each performance measure, maintaining complete documentation of all steps taken for data collection and measure calculations.
- As QIPs progress, ensure QIP documentation meets validation requirements and obtain technical assistance as needed.

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

Appendix A. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

for Family Mosaic Project

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with FMP's self-reported actions that address the recommendations. Neither Health Services Advisory Group, Inc. (the external quality review organization for Medi-Cal Managed Care) nor any State agency has confirmed implementation of the actions that the plan self-reported in the grid.

Table A.1—Grid of FMP's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	FMP's Self-Reported Actions That Address the EQR Recommendation
Conduct periodic, internal reviews to ensure compliance with the DMH and MRPIU standards.	Per MRPIU audits, FMP has been fully compliant with all areas. This was noted in the FMP 2009-2010 Performance Evaluation report. FMP does conduct internal reviews to ensure compliance both for MRPIU and DMH. In April of 2011, DMH conducted their on-site compliance audit (every three years) on SFCBHS—we passed it with a 97%. The DMH final report will be ready by the end of February 2012. As soon as we get this report, we will forward this to HSAG and DHCS.
Ensure consistent measurement of each performance measure, maintaining complete documentation of all steps taken for data collection and measure calculations.	FMP has demonstrated consistent measurement of each performance measure including documentation. The FMP QI team reviews every closed/discharged medical record to ensure that the living situation code has been entered. The last HSAG performance validation site visit found that FMP Health Plan has been fully compliant on both measures and were acceptable and validated.
As QIPs progress, ensure QIP documentation meets all CMS requirements by referencing the Quality Improvement Assessment Guide for Medi-Cal Managed Care Plans and obtaining technical assistance as needed.	FMP has been obtaining technical assistance as needed from HSAG. Both QIPs have been validated by HSAG.
Explore factors that impact FMP youth satisfaction with the location of services and take action to address these concerns.	Per FMP 201-2011 Satisfaction Survey results, item #11 in the survey, the location was convenient (public transportation, distance, parking, etc.) Here are the average responses per the FMP site, 5 being the highest: FMP Bay view = 4.37; FMP Mission = 4.62; FMP Chinatown = 4.43. The policy at FMP is that if a client/family is unable to come to the FMP site, the FMP Care Manager meets the client/family at a location that is most convenient to the client/family (e.g., client's home, school, another FMP site).