Performance Evaluation Report

Senior Care Action Network (SCAN) Health Plan

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*. 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 dual-eligible Medicare and Medi-Cal managed care members enrolled in the plan in Los Angeles, Riverside, and San Bernardino counties, 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

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, 2011, the plan had approximately 7,686 MCMC members in all three counties combined.

SCAN 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 had 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 this funding to pay for all services as a full-risk Medicare Advantage plan (Medicare contract numbers, H9104 and H5425, respectively). 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 elect to enroll both their Medicare and Medi-Cal benefits in SCAN, and who may be certified as eligible for nursing home placement. The plan does not enroll individuals with end-stage renal disease or individuals who have In-Home Supportive Services (IHSS). 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.

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 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) have historically worked in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. A&I 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. 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 did 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.

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. Four of the CAP items were not approved: (1) the requirement to make pharmaceutical denials within twenty-four hours, (2) provider organizations not maintaining an effective referral tracking system, (3) the timeliness of adjudication of claims, and (4) the timeliness and content of grievance letters and the proper review of grievances by a medical director. SCAN resubmitted its CAP to the DHCS's Long Term Care Division (LTCD) on April 13, 2010. The CAP was approved October 11, 2010, and the LTCD issued its approval of the plan's CAP resubmission in a final acceptance of CAP letter dated November 22, 2010.

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. 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 (MMCD) of the DHCS.

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

The Long Term Care Division 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 these areas: utilization management, continuity of care, availability and accessibility, member rights, and administrative and organizational capacity. SCAN was able to fully address the remaining issues that were identified in A&I's 2009 medical audit in its CAP resubmission.

Opportunities for Improvement

Based on the plan's successful resubmission of its CAP, there were no opportunities for improvement identified in this review period.

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 plans to 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®)[2] 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, 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 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.

[2] 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 2011 to determine whether the plan followed the appropriate specifications to produce valid rates.[3] Based on results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

SCAN reported HEDIS rates consistent with its Medicare contract numbers (H9104 and H5425) since all of its Medi-Cal managed care members are dually eligible for and enrolled in SCAN for Medicare as well as Medi-Cal. One of SCAN's contract numbers represents an older demonstration project with a very small population and the other is the newer Medicare contract. These contracts have members that span several counties and are not county specific. For the purposes of this report, HSAG aggregated the data from both contracts to derive an aggregate weighted average.

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results.

Breast Cancer Screening

Measure Definition

The *Breast Cancer Screening* measure is reported using only the administrative method. This measure calculates the percentage of women 40 through 69 years of age who had a mammogram in the prior two years.

Performance Results

Table 3.1—HEDIS 2011 Rates for SCAN Health Plan

	Breast Cancer Screening
Rate±	**74.7%**
MPL*	---
HPL*	---
± Represents an aggregate rate for the H9104 and H5425 contracts. *2011 was the first year of measurement for *Breast Cancer Screening.*	

Summary of Results

The DHCS did not establish an MPL or HPL since 2011 was the first year in which SCAN Health Plan reported rates for this measure. Additional analysis of performance measure results will be provided in subsequent years when more than one year of data are available for comparison.

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

Persistence of Beta-Blocker Treatment After a Heart Attack

Measure Definition

The *Persistence of Beta-Blocker Treatment After a Heart Attack* HEDIS measure reports the percentage of members 18 years of age and older who were hospitalized and discharged with a diagnosis of acute myocardial infarction (heart attack) and who received persistent beta-blocker treatment for six months after discharge.

Performance Results

Table 3.2—HEDIS 2010–2011 Rates for SCAN Health Plan

	Persistence of Beta-Blocker Treatment After a Heart Attack 2010	Persistence of Beta-Blocker Treatment After a Heart Attack 2011
Rate	**NA***	**NA***
HPL	90.5%	91.4%
MPL	75.8%	78.4%
*Not applicable due to the plan's denominator being too small to report a valid rate (less than 30).		

Summary of Results

Due to the plan's demographics for its dual-eligible population, the plan did not have a sufficient denominator to report valid rates. Based on 2010 and 2011 performance measure results, HSAG recommends that the plan and DHCS explore another measure that is meaningful for this plan's population and that will provide a sufficient number of MCMC members to report a valid rate.

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 with rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline steps to improve care.

For measures requiring a 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with 2011 HEDIS scores to assess whether the plan was successful in achieving, or progressing towards, the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or develop new improvement plans. Based on HEDIS 2010 rates, SCAN was not required to submit any improvement plans in 2011.

Strengths

There were no strengths of note for this reporting period.

Opportunities for Improvement

HSAG recommends SCAN work with the DHCS to select an alternative measure for *Persistence of Beta-Blocker Treatment After a Heart Attack* in 2012. The selected measure should be actionable and meaningful to SCAN's membership.

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 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, 2010–June 30, 2011. 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—Los Angeles, Riverside, and San Bernardino Counties 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				
Chronic Obstructive Pulmonary Disease (COPD) Management	Annual Submission	68%	70%	*Partially Met*
	Resubmission	92%	100%	*Met*
Prevention of Stroke and Transient Ischemic Attack	Annual Submission	56%	45%	*Not Met*
	Resubmission	97%	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 the annual submission by SCAN of its *COPD Management* QIP and *Prevention of Stroke and Transient Ischemic Attack* QIP received an overall validation status of *Partially Met* and *Not Met*, respectively. 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 and technical assistance, 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 CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for SCAN Health Plan—Los Angeles, Riverside, and San Bernardino Counties (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	94%	6%	0%
	IX: Real Improvement Achieved	75%	0%	25%
	X: Sustained Improvement Achieved	50%	0%	50%
Outcomes Total†		**85%**	**4%**	**12%**

***** 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.

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

SCAN submitted Remeasurement 2 data for both QIPs; therefore, HSAG validated Activity I through Activity X. SCAN applied the documentation requirements for the activities of the design and implementation stages, scoring 100 percent on all evaluation elements for all six applicable activities. Conversely, for the outcomess stage, SCAN was scored lower in Activity VIII for the plan's incomplete interpretation of results for its *COPD Management* QIP. For Activity IX, none of the study indicators for the two QIPs demonstrated statistically significant improvement; therefore, the score was lowered. Additionally for Activity X, the plan did not achieve sustained improvement for the *COPD Management* QIP. Sustained improvement is defined as improvement in performance over baseline that 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.

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 SCAN Health Plan—Los Angeles, Riverside, and San Bernardino Counties July 1, 2010, through June 30, 2011

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%	17.4%	No
Prevention of Stroke and Transient Ischemic Attack				
QIP Study Indicator	**Baseline Period 7/1/07–6/30/08**	**Remeasurement 1 7/1/08–6/30/09**	**Remeasurement 2 7/1/09–6/30/10**	**Sustained Improvement¥**
1) Incidence rate of new stroke/TIA for SCAN H5425 *Medi-Medi* members with no prior history of stroke.	NA	7.0%	5.6%	‡
2) Incidence rate of new stroke/TIA for SCAN H9014 *Medi-Medi* members with no prior history of stroke.	8.4%	7.7%	7.2%	Yes

¥ Sustained improvement is defined as improvement in performance over baseline that 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.
NA No eligible members; rate not applicable.
‡ The QIP did not progress to this phase during the review period and could not be assessed.
* A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05)

SCAN's two Medicare contract populations are H5425 and H9014. H9014 represents dually-eligible Medicare and Medi-Cal managed care members and was originally set up under SCAN's Medicare contract as a demonstration project; and H5425 represents the remainder of SCAN's dually-eligible managed care population also under a Medi-Cal contract.

For the *Prevention of Stroke and Transient Ischemic Attack* QIP, the validation was limited to the two study indicators that measured the rate of new stroke or TIA for the *Medi-Medi* population. Both study indicators improved from Remeasurement 1 to Remeasurement 2, although the improvement

was not statistically significant. The plan was able to achieve sustained improvement from baseline to Remeasurement 2 for the H9014 contract members; for the H5425 contract members, however, an additional measurement period will be necessary before sustained improvement can be assessed. The plan's interventions included 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 improved from Remeasurement 1 to Remeasurement 2; however, the improvement may have been due to chance. From baseline to Remeasurement 2, the outcome remained basically unchanged; therefore, the plan did not achieve sustained improvement. SCAN's improvement strategy consisted of letters to providers identifying members with COPD and an article in the member newsletter discussing COPD management.

Strengths

SCAN applied the documentation requirements for the activities of the design and implementation stages, scoring 100 percent on all evaluation elements for each of the six applicable activities.

For each measurement period, the plan reported incremental reductions of the incidence of a new stroke or TIA for its Medi-Medi members.

Opportunities for Improvement

For both QIPs, SCAN should only report results for 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, the identified barriers, and the prioritization of the barriers. SCAN should then develop targeted interventions to address the barriers. The plan should consider implementing system interventions, i.e., educational efforts, changes in policies, targeting of additional resources, or other organization-wide initiatives, which are associated with real and sustained improvement. Interventions such as letters or newsletters are often insufficient to produce long-term improvement. Additionally, the plan should incorporate a method to evaluate the efficacy of each intervention implemented and to determine which interventions should be continued and which ones should be revised.

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.

The plan showed average performance based on SCAN's 2011 performance measure rates (which reflect 2010 measurement data), QIP outcomes, medical performance, and member rights reviews.

SCAN had average performance in the quality domain. As reflected in the medical performance review, the plan was fully compliant with quality management; however, the plan had several issues requiring a corrective action plan. The plan was able to address all issues related to quality as documented in the report.

SCAN demonstrated average performance with QIPs. The plan scored 100 percent on all evaluation elements for the design and implementation stages. For the *Prevention of Stroke and Transient Ischemic Attack* QIP, the plan reported a reduction in incidences of new stroke or TIA in each measurement period; however, improvements were not statistically significant. For the *COPD Management* QIP, the plan reported an increase in COPD members who received a spirometry test from the first to the second remeasurement period; however, the second remeasurement rate did not show significant improvement over the baseline rate.

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

The plan demonstrated average performance based on review of 2011 performance measure rates, results of the medical performance, and member rights reviews.

The medical performance review report described the plan as having issues with oversight of providers and with ensuring members were receiving enough prescription medications in emergency situations to last until the member could reasonably be expected to have a prescription filled. These concerns were addressed in the resubmission of its corrective action plan.

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 improved from 13.3 to 17.4 percent from the first to the second remeasurement period. The rate was not a significant improvement over the baseline rate of 17.2 percent. The plan will need to implement new or revised improvement strategies to positively affect the level of access for members in need of this testing.

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 in areas such as enrollee rights and protections, grievance system, continuity/coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal/postpartum care are under the timeliness domain of care.

SCAN had average performance in the timeliness domain of care based on medical performance review standards.

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. SCAN did not provide a response.

Conclusions and Recommendations

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

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

- Conduct periodic, internal grievance file audits to ensure compliance with DHCS standards.
- Continue efforts to educate and monitor providers on cultural and linguistic policies and procedures.
- Identify an alternative performance measure to assess quality, access, and/or timeliness of care.
- Incorporate a method to evaluate the efficacy of QIP interventions.
- Develop system interventions to target identified barriers and improve QIP outcomes.

In the next annual review, HSAG will evaluate SCAN'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 SCAN Health Plan

SCAN did not provide a response to the recommendations provided by the external quality review organization on the plan's 2009–2010 plan-specific evaluation report; therefore, this report does not contain the table (grid).