Performance Evaluation Report

Senior Care Action Network Health Plan

July 1, 2011–June 30, 2012

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

June 2013

TABLE OF CONTENTS

Performance Evaluation Report – Senior Care Action Network Health Plan

July 1, 2011 – June 30, 2012

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans 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 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 designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more 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.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[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.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, 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.

This report is specific to DHCS's contracted plan, Senior Care Action Network 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, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

Plan Overview

SCAN is a Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP) 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 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 and 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.

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 plan 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 a managed care plan. SCAN functioned as a social health maintenance organization under a federal waiver, which expired at the end of 2007.

In 2008, SCAN entered into a comprehensive risk contract with the State. SCAN receives monthly capitation from both Medicare and Medi-Cal, pooling its financing to pay for all services as a full-risk social managed care plan. DHCS amended SCAN's contract in 2008 to include federal and State requirements for managed care plans. Among these requirements, DHCS specifies that specialty plans participating in MCMC report on two performance measures annually and maintain two internal QIPs.

According to DHCS, as of June 30, 2012, SCAN had 7,247 MCMC members in all three counties combined.

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

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period 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.

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 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from 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

Medical performance reviews are often a collaborative effort by various State entities. DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of DHCS's Medi-Cal Managed Care Division (MMCD) have historically worked in conjunction with the Department of Managed Health Care to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or the Department of Managed Health Care. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

The most recent on-site medical performance review was conducted by A&I in March 2009, for the period of February 1, 2008, through January 31, 2009. The initial results of the review were detailed in SCAN's 2008–2009 plan-specific evaluation report.[3] In SCAN's 2010–2011 plan-specific evaluation report, HSAG reported that in a letter dated November 22, 2010, DHCS's Long-Term Care Division (LTCD) accepted the plan's corrective action plan.

Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

SCAN is unique in that its contract is managed by DHCS's LTCD. For that reason, MR/PIU does not conduct reviews of SCAN.

SCAN is required to report grievances and appeals through CMS' Health Plan Monitoring System, and CMS reviews this information quarterly. Additionally, DHCS's LTCD conducts ongoing desk reviews of SCAN's policies and procedures, including quarterly grievance report submissions, marketing materials, and member rights materials. Other than the information from the medical performance audit, no other member rights and program integrity information for SCAN was available at the time this report was prepared.

Strengths

SCAN has no outstanding deficiencies from the March 2009 medical performance review.

[3] California Department of Health Care Services. *Performance Evaluation Report—Senior Care Action Network (SCAN) Health Plan, July 1, 2008–June 30, 2009*. December 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

Opportunities for Improvement

Since no new information was provided since the last report, no opportunities for improvement were identified.

Conducting the Review

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). DHCS requires that plans collect and report EAS rates, which provide a standardized method for objectively evaluating plans' delivery of services.

Due to the small size of specialty plan populations, 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, DHCS requires specialty plans to report only two performance measures. In collaboration with DHCS, a specialty plan may select measures from the Healthcare Effectiveness Data and Information Set (HEDIS®)[4] or design a measure that is appropriate to the plan's population. The measures put forth by the specialty plan are subject to approval by DHCS. 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.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

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

Performance Measure Validation

HSAG performed a HEDIS Compliance Audit™ of SCAN in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

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 Validation Findings

HSAG's audit of SCAN's two HEDIS measures determined that both measures were reportable. HSAG auditors did not identify any issues that would affect the validity of the plan's rates; however, the following recommendations were made regarding the plan's information systems:

- SCAN implemented the Transaction Portal, which enhanced certain edit functions, provider mapping processes, and the plan's ability to generate multiple reports related to claims processing. SCAN should continue to consider the feasibility of implementing the same functionality in the plan's encounter system.
- Encounter submission rates were monitored for each trading partner, and benchmark-specific thresholds were established to ensure data completeness. SCAN should continue to investigate the possibility of monitoring encounter rejection at the trading partner level.
- SCAN should ensure that the HEDIS Roadmap is completed and updated annually within the time frame required by the National Committee for Quality Assurance (NCQA).

Performance Measure Results

To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS establishes a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability.

SCAN's 2012 performance measures were both HEDIS measures—*Breast Cancer Screening* and *Osteoporosis Management in Women Who Had a Fracture*. In SCAN's 2010–2011 plan-specific evaluation report, HSAG recommended that the plan stop reporting on the *Persistence of Beta-Blocker Treatment After a Heart Attack* measure due to SCAN not having a sufficient denominator to report valid rates on this measure. In response to HSAG's recommendation, SCAN identified the *Osteoporosis Management in Women Who Had a Fracture* measure to report on in 2012.

Table 3.1 presents a summary of SCAN's HEDIS 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data) for the *Breast Cancer Screening* measure. Table 3.2 shows the plan's HEDIS 2012 performance compared to the DHCS-established MPL and HPL.

DHCS based the MPL and HPL for the *Breast Cancer Screening* measure on NCQA's national percentiles. The MPL and HPL align with NCQA's national Medicaid 25th percentile and 90th percentile.

Table 3.2 presents a summary of SCAN's HEDIS 2012 performance measure results (based on CY 2011 data) for the *Osteoporosis Management in Women Who Had a Fracture* measure. No MPL or HPL was established since this was the first year the plan reported a rate for this measure.

Performance Measure Result Findings

Below, HSAG describes the measures reported by SCAN and presents the performance measure results for the measurement period.

Breast Cancer Screening

Measure Definition

The *Breast Cancer Screening* 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 2011–2012 Rates for Senior Care Action Network Health Plan

	Breast Cancer Screening 2011	Breast Cancer Screening 2012
Rate	**74.8%**	**79.8%**
HPL*	NA	62.9%
MPL*	NA	45.3%

*2011 was the first year of measurement for the *Breast Cancer Screening* measure, so no HPL or MPL was available.

Summary of Results

The rate on this measure improved by 3.6 percentage points from 2011 to 2012, and the measure performed well above the HPL.

Osteoporosis Management in Women Who Had a Fracture

Measure Definition

This measure is used to assess the percentage of women 67 years of age and older who suffered a fracture, and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

Performance Results

Table 3.2—HEDIS 2012 Rate for Senior Care Action Network Health Plan

Osteoporosis Management in Women Who Had a Fracture 2012	
Rate	27.7%

Summary of Results

Since this is the first year SCAN reported this measure, no comparisons or analysis can be made on the measure's performance. Analysis of the plan's performance on this measure will be provided in subsequent years when more than one year of data are available for comparison.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. For each area of deficiency, the plan must submit its steps to improve care to DHCS for approval.

HSAG compared the plan's 2011 IP (if one was required) with the plan's 2012 HEDIS rate for that measure to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

SCAN was not required to submit any IPs in 2012 and will not be required to submit any in 2013 since the plan did not perform below the MPL on the *Breast Cancer Screening* measure in 2012, and 2012 was the first year the plan reported a rate for the *Osteoporosis Management in Women Who Had a Fracture* measure.

Strengths

The *Breast Cancer Screening Measure* performed well above the HPL in 2012.

Opportunities for Improvement

HSAG recommends that SCAN follow the audit recommendations to improve the oversight of data completeness and data accuracy and follow the timelines identified for completing the audit documentation.

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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* 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 plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). 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 Project Objectives

Like full-scope plans, specialty plans must be engaged in two QIPs at all times. However, due to the small and unique populations served, DHCS does not require specialty plans to participate in statewide collaborative QIPs. Instead, specialty plans can design and maintain two internal QIPs focused on improving health care quality, access, and/or timeliness for the plan's MCMC members. For the current review period, SCAN opted to participate in the new statewide collaborative QIP and maintain two internal QIPs. SCAN had one clinical QIP and two clinical QIP proposals in progress during the review period of July 1, 2011–June 30, 2012. The first internal QIP aimed to decrease the incidence of stroke and transient ischemic attack (TIA). SCAN's second internal QIP targeted improving the care provided to older adults.

Additionally, SCAN opted to participate in the new statewide *All-Cause Readmissions* collaborative QIP which focused on reducing readmissions for members aged 21 years and older. All three

QIPs fell under the quality and access domains of care. The new statewide collaborative QIP proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. Readmissions have been associated with the 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.

Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Senior Care Action Network Health Plan—Los Angeles, Riverside, and San Bernardino Counties July 1, 2011, through June 30, 2012

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**	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIPs				
Prevention of Stroke and Transient Ischemic Attacks	Annual Submission	95%	100%	*Met*
Care for Older Adults	Proposal	24%	18%	*Not Met*
	Resubmission	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a 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 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*.

*During the review period, the *All-Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that the initial submission of SCAN's *Prevention of Stroke and Transient Ischemic Attack* QIP received an overall validation status of *Met*.

The plan received a *Not Met* validation status for its *Care for Older Adults* QIP submission. As of July 1, 2009, DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation

status. Based on the validation feedback and HSAG's technical assistance, the plan resubmitted the QIP and, upon subsequent validation, achieved an overall *Met* validation status.

For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score. Due to unique, one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

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

Table 4.2—Quality Improvement Project Average Rates* for Senior Care Action Network Health Plan—Los Angeles, Riverside, and San Bernardino Counties (Number = 3 QIP Submissions, 2 QIP Topics) July 1, 2011, through June 30, 2012

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	83%	11%	6%
	II: Clearly Defined, Answerable Study Question(s)	67%	33%	0%
	III: Clearly Defined Study Indicator(s)	84%	16%	0%
	IV: Correctly Identified Study Population	67%	33%	0%
Design Total		**79%**	**19%**	**2%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	50%	50%	0%
	VI: Accurate/Complete Data Collection	67%	11%	22%
	VII: Appropriate Improvement Strategies	57%	43%	0%
Implementation Total		**61%**	**26%**	**13%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved	75%	0%	25%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**92%**	**0%**	**8%**

*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.

For the *Prevention of Stroke and Transient Ischemic Attack* QIP, Remeasurement 3 data were submitted; therefore, HSAG validated Activities I through X. The included *Care for Older Adults* QIP proposal progressed through Activity VII.

For the design stage, SCAN was scored lower for the *Care for Older Adults* QIP, since the plan did not initially provide a clear focus of the study topic, did not provide plan-specific data, and did not

clearly describe the study population. Additionally, the plan's initial study question was not specific, and the study indicators were not completely defined. For the implementation stage, the *Care for Older Adults* QIP was initially scored down for not providing any of the required documentation for sampling. Additionally, the plan did not provide the needed information related to the administrative and manual data collection. The plan did not provide documentation of its barrier analyses or clearly identify the relevance of its improvement strategies. All of the above-mentioned deficiencies were successfully addressed in the plan's resubmission of the *Care for Older Adults* QIP.

Only the *Prevention of Stroke and Transient Ischemic Attack* QIP progressed to the outcomes stage. For this QIP, SCAN was scored down in Activity IX for not demonstrating statistically significant improvement for either of its project's outcomes in the most recent measurement period. The score for Activity X reflects the plan's success in achieving sustained improvement for both project outcomes. 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 and Interventions

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 Senior Care Action Network Health Plan—Los Angeles, Riverside, and San Bernardino Counties July 1, 2011, through June 30, 2012

QIP #1—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**	**Remeasurement 3 7/1/10–6/30/11**	**Sustained Improvement¥**
Incidence rate of new stroke/TIA for SCAN H5425 *Medi-Medi* members with no prior history of stroke^	NA	7.0%	5.6%	5.6%	Yes
Incidence rate of new stroke/TIA for SCAN H9014 *Medi-Medi* members with no prior history of stroke^	8.4%	7.7%	7.2%	6.8%	Yes
QIP #2—Care for Older Adults					
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 eligible members 66 years of age or older with at least one functional status assessment	‡	‡	‡		‡
Percentage of eligible members 66 years of age or older with at least one pain screening or pain management plan	‡	‡	‡		‡

^ A lower percentage indicates better performance.

¥ 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.

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

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

Prevention of Stroke and Transient Ischemic Attack QIP

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. For these measures, a lower rate indicates better performance. The plan's project goal was to reduce the incidence rate by 5 percent for each measurement period. Both outcome measures exceeded the plan's project goal. The rates for both study indicators decreased from the beginning of the project to the end of the project. Although the improvement was not statistically significant, the plan achieved sustained improvement for the project. A critical analysis of the plan's improvement strategy led to the following observations:

- The plan conducted a planning session to identify barriers and develop interventions. The plan did not provide any specific results of the barrier analysis or any data-driven rationale for the selection of the interventions.
- Plan-specific interventions focused on member and provider education delivered primarily through member and provider letters and newsletters. This non-targeted education did not lend itself to evaluation and was not associated with any statistically significant improvement in performance.
- Letters sent to providers identifying members at high-risk for stroke were only sent once a year. The plan acknowledged that the year-long time lag reduced the benefit of the information.

Based on SCAN's performance and overall success of the *Prevention of Stroke and Transient Ischemic Attack* QIP, the QIP was closed.

Care for Older Adults QIP

The *Care for Older Adults* QIP had not progressed to the point of reporting results. However, the plan reported activities related to the development of tools and guidelines, which would eventually be distributed to the providers. These interventions were proposed without the documented results of any barrier analyses. Additionally, the development of the interventions was documented as occurring as late as October 2011. If the interventions are implemented after development, the project will have already progressed to the second remeasurement period, limiting any possible effect of the interventions on the study outcomes.

Strengths

SCAN reported incremental reductions of the incidence of a new stroke or TIA for its Medi-Medi members over the course of the project, achieving sustained improvement.

Opportunities for Improvement

The plan should include detailed results of the barrier analyses in the QIP documentation, including the type of analysis, the identified barriers, and the prioritization of the barriers.

The plan should consider implementing system interventions, e.g., 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. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

With the implementation of any intervention and especially for multiple interventions, the plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance. The results of the intervention's evaluation should be provided for every measurement period.

The plan should consider reporting one overall rate for its Medicaid population with future QIP submissions to get a better picture of performance across its Medicaid population.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care.

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for its MCMC members through the provision of health care services and the plan's structural and operational characteristics.

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries 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, 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 *Breast Cancer Screening* measure performed above the HPL. This reflects that a high number of female members are receiving breast cancer screening services, which provides the opportunity for early detection and treatment of breast cancer.

The plan's quality documents describe a structure to ensure quality care is provided to members, including a process to ensure providers are using evidence-based guidelines, administration of an annual member satisfaction survey, and implementation of monitoring activities to ensure the provision of quality care.

No new medical performance review information was available, and SCAN is not subjected to reviews by DHCS's Member Rights and Program Integrity Unit (MR/PIU); so HSAG is not able to provide an assessment of the plan's compliance with quality-related areas assessed in these reviews.

All of the plan's QIPs fell into the quality domain of care. The plan demonstrated understanding of the QIP design and implementation stages, receiving an overall validation score of *Met* on the first submission of the *Prevention of Stroke and Transient Ischemic Attack* QIP. Although SCAN received a *Not Met* validation status for its *Care for Older Adults* QIP submission, the plan resubmitted the QIP and, upon subsequent validation, achieved an overall *Met* validation status. The *Prevention of Stroke and Transient Ischemic Attack* QIP was successful at reducing the incidence rate of new strokes/TIAs.

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 MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and 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.

SCAN's *Breast Cancer Screening* measure, which falls into the access domain of care, performed well above the HPL, suggesting that the plan's female members have access to mammography.

In addition to falling into the quality domain of care, the plan's QIPs fall into the access domain of care. As indicated above, SCAN's *Prevention of Stroke and Transient Ischemic Attack* QIP was successful at reducing the incidence rate of new strokes/TIAs.

No new medical performance review information was available, and SCAN is not subjected to reviews by MR/PIU; so HSAG is not able to provide an assessment of the plan's compliance with access-related areas assessed in these reviews.

SCAN's quality documents describe processes to assess and improve members' access to care, including administration of an annual member satisfaction survey, monitoring member access to services, and contracting with additional interpreter service vendors to improve member access to interpreters.

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.

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.

No new medical performance review information was available, and SCAN is not subjected to reviews by MR/PIU; so HSAG is not able to provide an assessment of the plan's compliance with timeliness-related areas assessed in these reviews. Additionally, the plan's reported performance measures and QIPs did not fall under the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-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 plan:

- Continue to consider the feasibility of implementing the same functionality as used in the Transaction Portal in the plan's encounter system.
- Continue to investigate the possibility of monitoring encounter rejection at the trading partner level.
- Ensure that the HEDIS Roadmap is completed and updated annually within the NCQA-required time frame.
- Document detailed results of the QIP barrier analyses, including the type of analysis, the identified barriers, and the prioritization of the barriers.
- For QIPs, consider implementing system interventions, e.g., 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. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

- Ensure that each QIP intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance. The results of the intervention's evaluation should be provided for every measurement period.
- Report both performance measure and QIP rates for the overall Medicaid population in subsequent years.

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, 2010–June 30, 2011 Performance Evaluation Report

for Senior Care Action Network Health Plan

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with SCAN's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table A.1—Grid of SCAN's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	SCAN's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Conduct periodic, internal grievance file audits to ensure compliance with the DHCS's standards.	During 2011 and 2012, SCAN Health Plan ("SCAN") performed focus audits on grievances to ensure compliance with standards (i.e., timeliness, acknowledgement letters, and closure letters). In January 2012, SCAN implemented a monthly routine grievance metric reporting process to monitor adherence to regulatory requirements. These reports include all grievance types. The reports measure compliance with regulated notifications to members, processes, and turnaround times.
Continue efforts to educate providers on cultural and linguistic services and conduct routine monitoring to ensure compliance with policies and procedures.	SCAN's oversight process includes the review of cultural and linguistic capabilities and practices of the provider organizations, as well as primary care providers that provide services to SCAN's dual eligible members. All oversight activity is reported to SCAN's Delegation Oversight Review Committee. Should the provider organization or provider be noncompliant with the standard, a corrective action plan is requested and monitored through implementation. SCAN works closely with the providers to ensure the member needs are met. The following outlines the elements that are included in the oversight process: **Services Provided with Cultural Competence (CMS Addendum**) The Provider Organization ensures that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally and linguistically appropriate and competent manner, including services provided to members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds. 42 C.F.R. § 422.112(a)(8); Manual Ch. 4 - Section 120.2 **RR 3. B (NCQA Tool)** The organization provides interpreter or bilingual services in its Member Services Department and telephone function based on the linguistic needs of its members. **FSR (Primary Care Physicians assigned Medi-Cal members)** Request and review of documentation of the Physician and Staff Language Capabilities Form as well as a review of the patient population languages that the office serves to ensure that the office can provide literature that is language specific. Each provider office receives a linguistic service sheet including interpretation services resource and Web site information for tools for serving diverse populations. The providers are encouraged to contact the SCAN Diversity Member Education Department for additional materials. **Medical Record Review** Medical Record Review includes identification of member language.

Table A.1—Grid of SCAN's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	SCAN's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Identify an alternative performance measure that assesses quality, access, and/or timeliness of care provided to SCAN members.	The QIP for Improving Spirometry Testing to Confirm Diagnosis of COPD was retired in 2010 due to conflicting guidelines regarding the efficacy of spirometry testing, difficulties in equipping doctors with spirometers, small target population, and narrow (<6 mos) window of opportunity to implement interventions. As an alternative performance measure, SCAN submitted a new QIP proposal, *Care For Older Adults*, approved fall 2011. The target population was significantly expanded and the two performance measures, completion of annual functional status assessment and pain screening, were selected to ensure that Medi-Cal/Medicare dually eligible members, many of whom have limitations with activities of daily living, receive comprehensive care that prevents further decline in health status. The QIP for Prevention of Stroke was also retired as there were incremental reductions in incidence of stroke each measurement period. Starting in 2012, SCAN has joined the statewide *All Cause Readmissions* (ACR) collaborative and the proposal was approved in 2012.
Incorporate a method to evaluate the efficacy of the QIP interventions.	Efficacy of interventions for *All Cause Readmissions* (ACR) will be monitored by monthly update of internally generated ACR rates. Efficacy for *Care For Older Adults* is being monitored by completeness of case management data capture on FSA/pain screening; by increased use of CPTII codes among practitioners to document FSA/pain screening; by tracking the number of practitioners completing SCAN's online CME courses on geriatric care and assessment; and by annual HEDIS measurement of FSA and pain screening rates for the target population, conducted by medical record review during the HEDIS data collection season. Progress reports will be presented to SCAN's Quality Management Committee and standing workgroup meetings for review and discussion.
Develop system interventions to target identified barriers and improve QIP outcomes.	System interventions for ACR are pending decision by the statewide collaborative. The following interventions have been implemented for the QIP on *Care For Older Adults*: - Monthly health risk assessment questionnaire administered via IVR to determine whether members qualify for case management services. Data from the survey capture FSA. Capture of data fields for pain screening will be completed in Q4 2012. - Patient profile generated from patient response to annual Health Risk Assessment are mailed to PCPs, and guidelines on FSA and Pain Screening with corresponding CPT Level II codes are included in the mailing packet.

Table A.1—Grid of SCAN's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	SCAN's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
	- Develop and disseminate to practitioners standardized screening tools: a new on-line CME course on office-based geriatric assessment is available on the SCAN CME Web site which features comprehensive geriatric assessment. Included are checklist on assessments, preventive and chronic care, and advance care plan to be used as reference during an office visit. Patient Health Guidebook with Healthy Rewards incentives was developed and mailed to all SCAN beneficiaries. Information contained guidelines on improving health with rewards coupons for completing Annual Wellness exams and visiting the doctor regularly for preventive and chronic care management.