Performance Evaluation Report

Senior Care Action Network Health Plan

July 1, 2012–June 30, 2013

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

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Performance Evaluation Report – Senior Care Action Network Health Plan

July 1, 2012 – June 30, 2013

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and

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

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

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

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Senior Care Action Network Health Plan ("SCAN" or "the MCP") for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care 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 MCP in addition to support services specifically designed for seniors, with a goal to enhance the ability of MCP 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 MCP expanded into Riverside and San Bernardino counties in 1997. In 2006, DHCS, at the direction of the Centers for Medicare & Medicaid Services (CMS), designated SCAN as an MCP. SCAN functioned as a social health maintenance organization under a federal waiver, which expired at the end of 2007.

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

According to DHCS, as of June 30, 2013, SCAN had 87,856 MCMC members in all three counties combined.

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

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the State or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers DHCS's medical performance activities.

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's 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.

For this report, HSAG reviewed the most current medical performance audits and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. HSAG reviewed the most recent monitoring reports available as of June 30, 2013.

SCAN is unique in that its contract is managed by DHCS's Long-Term Care Division (LTCD). As part of the process for producing this MCP-specific evaluation report, HSAG received documentation from DHCS's LTCD regarding the status of SCAN's medical performance reviews. SCAN was due for a medical audit in 2012; however, DHCS did not schedule the audit because DHCS has been in the process of ending its contractual relationship with SCAN to allow SCAN beneficiaries to shift into the Coordinated Care Initiative (CCI). Shifting the beneficiaries into CCI will allow SCAN the opportunity to set up a subcontracting relationship with CCI health plans. Since the implementation of CCI has been delayed, DHCS extended the SCAN contract—first through December 31, 2013, and then through December 31, 2014. If DHCS determines it is necessary to further extend the contract with SCAN, the LTCD will request that A&I conduct medical and financial audits of SCAN during 2014.

Please note that although some of the information included above falls outside the review dates for this report, HSAG has included it since DHCS made the information available to HSAG prior to the report being finalized and the information provides rationale for why an audit with SCAN was not conducted during the review period for this report.

Strengths

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

Opportunities for Improvement

Since no new reviews were conducted with SCAN during the reporting period, HSAG does not have any new recommendations in the area of compliance.

Conducting the EQRO Review

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

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using

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

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

Performance Measure Validation

For 2013, SCAN was required to report two HEDIS measures—*Breast Cancer Screening* and *Osteoporosis Management in Women Who Had a Fracture*.

HSAG performed an NCQA HEDIS Compliance Audit™[5] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the NCQA HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for Senior Care Action Network Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that SCAN followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A review of the MCP's HEDIS audit report revealed the following observations:

- SCAN had well-developed policies and procedures related to its enrollment processes, which included time frames for processing applications and processes to ensure dual eligibility with CMS and Medi-Cal.
- The auditor noted that SCAN should ensure that the HEDIS Roadmap is completed and updated annually within the NCQA-required time frame. The auditor suggested that the MCP use a coordinated team effort to complete the Roadmap and conduct a comprehensive review prior to submission. Because Roadmap completeness has been an issue in previous years, the auditor suggested that SCAN consider implementing an internal action plan to address these concerns.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of SCAN's HEDIS 2013 performance measure results (based on calendar year [CY] 2012 data) compared to HEDIS 2012 performance measure results (based on CY 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.1 shows the MCP's HEDIS 2013 performance compared to the DHCS-established MPLs and HPLs for the two measures SCAN is required to report.

DHCS based the MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively.

Table 3.1—2012–13 Performance Measure Results
SCAN—Los Angeles/Riverside/San Bernardino Counties
Breast Cancer Screening

Performance Measure[1]	Domain of Care[2]	2012 HEDIS Rates[3]	2013 HEDIS Rates[4]	Performance Level for 2013	Performance Comparison[5]	MMCD's Minimum Performance Level	MMCD's High Performance Level (Goal)
Breast Cancer Screening	Q, A	79.9%	81.42%	★★★	↔	44.82%*	62.76%*
Osteoporosis Management in Women Who Had a Fracture	Q, T	27.7%	28.40%	★★	↔	14.87%^	37.96%^

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011. Rates in 2012 were reported to one decimal place. To be consistent with how NCQA is reporting rates for 2013, two decimal places are used for the 2013 rates. Comparison between the 2012 and 2013 rates for the measure was calculated based on rates reported with two decimal places for both years.
[4] HEDIS 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
* The minimum performance level (MPL) and high performance level (HPL) for this measure are based on NCQA's national Medicaid 25th and 90th percentiles, respectively.
^ The MPL and HPL for this measure are based on NCQA's national Medicare 25th and 90th percentiles, respectively, since no Medicaid benchmarks are available for this measure.
★ = Below-average performance relative to the national Medicaid 25th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles).
★★★ = Above-average performance relative to the national Medicaid 90th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

The rate for the *Breast Cancer Screening* measure was above the HPL for the second consecutive year (2012 was the first year the MCP was held to the MPL for this measure). SCAN continues to demonstrate that it is ensuring that a high percentage of eligible women are being screened for breast cancer within the specified time frame. This is the first year SCAN was held to an MPL for the *Osteoporosis Management in Women Who Had a Fracture* measure, and the rate for the measure was above the MPL.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

Assessment of MCP's Improvement Plans

Since the rate for the *Breast Cancer Screening* measure was above the MPL in 2012 and SCAN was not held to an MPL for the *Osteoporosis Management in Women Who Had a Fracture* measure in 2012, the MCP was not required to submit an IP for either measure. Additionally, since the rates for both measures were above the MPLs in 2013, SCAN will not be required to submit any IPs in 2013.

Strengths

During the HEDIS audit with SCAN, the auditor noted that the MCP had well-developed policies and procedures related to its enrollment processes, which included time frames for processing applications and processes to ensure dual eligibility with CMS and Medi-Cal.

SCAN continues to meet performance measure requirements, with the rates for both required measures being above the MPLs in 2013. Additionally, the MCP's performance on the *Breast Cancer Screening* measure was above average, with the rate being well above the HPL.

Opportunities for Improvement

SCAN has the opportunity to consider implementing an internal action plan to ensure that the HEDIS Roadmap is completed thoroughly and updated annually within the NCQA-required time frame. Additionally, the MCP should consider using a coordinated team effort to complete the Roadmap and conduct a comprehensive review prior to submission.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[6] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

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

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

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

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

Quality Improvement Project Objectives

Specialty MCPs must be engaged in two QIPs at all times. However, due to the small and unique populations served, DHCS does not require them to participate in statewide collaborative QIPs. Instead, specialty MCPs are required to design and maintain two internal QIPs with the goal to improve health care quality, access, and/or timeliness for the specialty MCP's beneficiaries. For the current review period, SCAN opted to participate in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2012–June 30, 2013.

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

Table 4.1—Quality Improvement Projects
SCAN—Los Angeles/Riverside/San Bernardino Counties
July 1, 2012, through June 30, 2013

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Care for Older Adults	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with 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.

Prior to initiation of the statewide collaborative QIP, SCAN had a 30-day readmission rate of 14.31 percent among Medi-Cal beneficiaries. SCAN's entire population is SPD; therefore, no non-SPD rates were reported.

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

Quality Improvement Project Validation Findings

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

Table 4.2—Quality Improvement Project Validation Activity
SCAN—Los Angeles/Riverside/San Bernardino Counties
July 1, 2012, through June 30, 2013

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	Study Design Submission	80%	100%	*Met*
Internal QIPs				
Care for Older Adults	Annual Submission	83%	90%	*Partially Met*
	Annual Resubmission 1	91%	80%	*Not Met*
	Annual Resubmission 2	97%	90%	*Partially Met*
	Annual Resubmission 3	100%	100%	*Met*

[1] **Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.
[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by SCAN of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 80 percent of evaluation elements met. SCAN received a *Partially Met* validation status for its *Care for Older Adults* annual submission. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on the validation feedback and HSAG's technical assistance, SCAN resubmitted the QIP and upon subsequent validations, achieved an overall *Met* validation status with 100 percent of both the critical and evaluation elements being met.

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

Table 4.3—Quality Improvement Project Average Rates*
SCAN—Los Angeles/Riverside/San Bernardino Counties
(Number = 5 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

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%
	V: Valid Sampling Techniques (if sampling is used)	88%	4%	8%
	VI: Accurate/Complete Data Collection**	93%	4%	4%
Design Total		**94%**	**2%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	83%	14%	3%
	VIII: Appropriate Improvement Strategies	94%	6%	0%
Implementation Total**		**87%**	**12%**	**2%**
Outcomes	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total**		**100%**	**0%**	**0%**

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

**The stage and/or activity totals may not equal 100 percent due to rounding.

HSAG validated Activities I through VI for SCAN's *All-Cause Readmissions* study design submission and Activities I through IX for the MCP's *Care for Older Adults* QIP annual submission.

SCAN demonstrated a strong application of the Design stage, meeting 94 percent of the requirements for all applicable evaluation elements within the stage for both QIPs. For the *All-Cause Readmissions* QIP, SCAN did not provide a comprehensive description of the MCP's systematic method for collecting baseline and remeasurement data, included two different measurement period dates, and SCAN did not describe its data analysis plan, which resulted in a lower score for Activity VI. For the *Care for Older Adults* QIP, the MCP did not provide all of the information for the sampling methods or the total population sizes, resulting in a lower score for Activity V.

Only the *Care for Older Adults* QIP progressed to the Implementation and Outcomes stages. SCAN demonstrated a strong application of the Implementation stage, meeting 87 percent of the requirements for all applicable evaluation elements within the study stage for this QIP. Although SCAN met 100 percent of the requirements for all applicable evaluation elements for this stage on

the third resubmission, the MCP's average percentage of requirements met across all submissions was 87 percent. Following are the issues that resulted in lower scores for activities within this stage prior to the MCP correcting them in the third resubmission:

- The MCP's interpretation of the results did not include a comparison of the study indicator rates to the goals.
- The MCP did not provide accurate rates and Chi-square values for the study indicators.
- SCAN included information about planned follow-up activities; however, the MCP did not document how successful interventions will be evaluated, standardized, and monitored for continued success.

Only Activity IX in the Outcomes stage was assessed for the *Care for Older Adults* QIP. The MCP met 100 percent of the requirements for all evaluation elements in Activity IX since the rates for both study indicators achieved statistically significant improvement from baseline to Remeasurement 1. This QIP will be assessed for sustained improvement (Activity X) at Remeasurement 2.

Quality Improvement Project Outcomes and Interventions

Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

The *All-Cause Readmissions* QIP did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no outcome information for this QIP is included in the table or report.

Table 4.4—Quality Improvement Project Outcomes for SCAN—Los Angeles/Riverside/San Bernardino Counties July 1, 2012, through June 30, 2013

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

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

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

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

Care for Older Adults QIP

SCAN's objective for the *Care for Older Adults* QIP was to achieve statistically significant improvement over baseline for the rates for both study indicators. The MCP achieved its goal in the first remeasurement period, with the rates for both study indicators having statistically significant improvement. The QIP was successful at increasing the percentage of eligible members receiving at least one functional status assessment and at least one pain screening/pain management plan. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- SCAN initially did not include all required documentation in the QIP Summary Form, resulting in the need for three resubmissions. The MCP should carefully review the QIP Completion Instructions prior to each QIP submission to ensure that all documentation requirements for each activity have been addressed to avoid the need for multiple QIP resubmissions.
- The MCP reported that some planned interventions were not implemented because DHCS was delayed in approving the QIP.
- The MCP indicated that it disseminated guidelines to practitioners on functional status assessments and pain screenings. Additionally, the MCP mailed care plans to primary care provider offices for members enrolled in SCAN's Case Management Program.

Strengths

Overall, SCAN demonstrates a strong application of the QIP process. SCAN's *Care for Older Adults* QIP was successful at improving the care provided to the MCP's members, with a significantly higher percentage of functional status assessments being conducted and a significantly higher percentage of pain screenings/pain management plans being provided at Remeasurement 1 when compared to the baseline period. Additionally, with a more complete assessment, SCAN has a better understanding of the care issues for its beneficiaries aged 66 years and older.

Opportunities for Improvement

SCAN has the opportunity to improve QIP documentation, as evidenced by the MCP needing to resubmit the *Care for Older Adults* QIP three times before the QIP achieved a *Met* validation status. The MCP would likely benefit from carefully reviewing the QIP Completion Instructions prior to each QIP submission to ensure that all documentation requirements for each activity have been addressed to avoid the need for multiple QIP resubmissions.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services. For full-scope MCPs, DHCS contracted with HSAG to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] survey. Specialty MCPs are required to administer their own annual consumer satisfaction survey to evaluate Medi-Cal member satisfaction regarding care and services provided by the MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG reviewed SCAN's 2012 member satisfaction survey results. The MCP provided a spreadsheet listing each survey question with the results broken down by the MCP's various member populations. Following are the areas assessed:

- Overall satisfaction with the MCP
- Overall MCP rating
- Whether the MCP had improved the member's ability to manage his/her health
- Whether the MCP had improved the member's ability to live independently
- Whether the member would recommend the MCP to a friend

Strengths

Overall, SCAN received high ratings on all areas assessed, showing that the members are extremely satisfied with the services being received by the MCP.

Opportunities for Improvement

The area with the most opportunity for improvement is members' overall satisfaction with the MCP.

[7] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Conducting the Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[8] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[8] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

SCAN's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

Encounter Data Validation Findings

Review of Encounter Systems and Processes

The information provided in SCAN's Roadmap and supplemental survey consistently demonstrated that the MCP has sound operational policies and practices for the creation, validation, correction, and ongoing monitoring of encounter data submission. SCAN took on additional projects increasing the monthly volume of encounter data, and now holds quarterly meetings with the clearinghouses to monitor encounter processing and correct errors efficiently.

Record Completeness

Overall, SCAN had low record omission (≤8.3 percent) and record surplus (≤3.5 percent) rates, indicating relatively complete data when comparing the DHCS data and the encounter data extracted from SCAN's data system for this study. These rates had higher performance than the statewide rates for all claim types except one—the record omission rate of 5.6 percent for long-term care (LTC) encounters was worse than the statewide record omission rate of 1.1 percent. However, this only indicated that 62 LTC records were omitted from the DHCS data warehouse. Some of the record omission and surplus were because (1) the plan codes that HSAG assigned based on the eligibility file SCAN provided were different from those in the DHCS data warehouse, and (2) HSAG could not include records without plan codes in the comparative analysis. San Bernardino County had the highest record omission rates and Los Angeles County had the lowest. The record surplus rates were fairly consistent among the counties and among the four claim types.

Data Element Completeness

SCAN had remarkable data element completeness results, with element omission and element surplus rates of 0.0 percent for all key data elements except three, which had element omission rates substantially worse than the respective statewide rates. For the Medical/Outpatient claim type, *Rendering Provider Number* and *Provider Specialty* had element omission rates 22.3 and 47.6 percentage points above the statewide element omission rates, respectively. For the Pharmacy claim type, *Drug/Medical Supply* had an element omission rate of 7.8 percent, which was worse than the statewide rate of 1.0 percent. This was due to the *Drug/Medical Supply* value of "9999MZZ" being in the MCP file and not in the DHCS data. The element omission rates had minimal variation among the three counties.

Data Element Accuracy

SCAN had very high data element accuracy, with only two key data elements that did not achieve complete (100.0 percent) accuracy. The *Referring/Prescribing/Admitting Provider Number* for the Pharmacy data had an element accuracy rate of 96.7 percent due to an additional digit appearing at the end of the provider number in the DHCS file for some of the records. However, this accuracy rate still exceeded the statewide rate of 91.0 percent. The county-level analysis showed that the counties had very consistent performance, with accuracy rates ranging between 94.6 percent for San Bernardino County and 97.5 percent for Riverside County. For the LTC claim type, there was 0.0 percent accuracy for *Provider Type* because all provider types were "24" in SCAN's data file and "16" in the DHCS data file. This rate fell below the statewide data element accuracy rate of 99.4 percent.

SCAN had acceptable all-element accuracy rates with the highest rate of 100.0 percent for the Hospital/Inpatient claim type and the lowest rate of 0.0 percent for the LTC claim type. The low rate for LTC encounters, failing to meet the statewide rate of 32.4 percent, was due to the 0.0 percent matching for data element *Provider Type*. The Pharmacy data had fairly good all-element accuracy with a rate of 89.2 percent. The Medical/Outpatient claim type had a low all-element accuracy rate of 15.9 percent, falling 48.1 percentage points below the statewide rate, which was due to the high element omission rates for *Provider Specialty* and *Rendering Provider Number*. The three counties performed similarly.

Recommendations

Based on its review, HSAG recommends the following:

- The Medical/Outpatient encounters in the DHCS data warehouse did not contain any outpatient records as identified by data element *Claim Type* of "1" (Outpatient). However, all Medical/Outpatient records had value "16" (community hospital inpatient) populated in the data element *Provider Type*. SCAN should evaluate whether there were any encounters from provider types such as "Physician," "Physician Group," etc., and whether the values populated in the data element *Provider Type* were correct for the Medical/Outpatient encounters.
- The encounter data SCAN submitted to HSAG for this EDV study contained additional *Rendering Provider Numbers* for the Medical/Outpatient records. SCAN should evaluate whether the encounter data submitted to DHCS contained all available values for data element *Rendering Provider Number*.
- Although the file from the DHCS data warehouse did not contain any *Provider Specialty* information, SCAN was able to provide HSAG with provider specialties for more than 50 percent of the Medical/Outpatient records. SCAN should evaluate whether the encounter data submitted to DHCS should contain values for the data element *Provider Specialty*.
- SCAN should investigate the *Drug/Medical Supply* value of "9999MZZ," which was populated in the file SCAN submitted to HSAG. There were no instances of this value in the DHCS file.
- The provider types for LTC encounters should be evaluated, since all the provider types were "24" in the data SCAN submitted to HSAG while all the provider types were "16" in the DHCS data.
- SCAN should work with DHCS to investigate the *Referring/Prescribing/Admitting Provider Number* for the Pharmacy claim type as DHCS had an additional digit added to the end of the *Referring/Prescribing/Admitting Provider Number* for 3.3 percent of matched Pharmacy records.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[9]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, DHCS monitors aspects of an MCP's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems. DHCS also uses the results of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

HSAG reviewed the quality documents SCAN submitted as part of the process for producing this MCP-specific evaluation report. The MCP's quality improvement program structure supports the

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

provision of quality care to the MCP's members and includes continuous quality improvement goals and processes.

Both of SCAN's performance measures fall into the quality domain of care. The rate for the *Breast Cancer Screening* measure was above the HPL for the second consecutive year, demonstrating that a high number of the MCP's female members received breast cancer screening services, which provided the opportunity for early detection and treatment of breast cancer. The rate for the *Osteoporosis Management in Women Who Had a Fracture* measure was above the MPL in 2013, which was the first year the MCP was held to the MPL for this measure.

Both of SCAN's QIPs fall into the quality domain of care. Since the *All-Cause Readmissions* QIP did not progress to the Outcome's stage, HSAG was not able to assess the QIP's success at improving the quality of care delivered to the MCP's members. The *Care for Older Adults* QIP was successful at improving the quality of care to members, with a significantly higher percentage of functional status assessments being conducted and a significantly higher percentage of pain screenings/pain management plans being provided at Remeasurement 1 when compared to the baseline period.

HSAG's review of SCAN's member satisfaction survey results found that members appear to be extremely satisfied with the quality of care being provided by the MCP.

Overall, SCAN showed average performance related to the quality domain of care based on the MCP's 2013 performance measure rates (which reflect 2012 measurement data), QIP validation results, and member satisfaction survey results.

Access

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

When reviewing the quality documents SCAN submitted as part of the process for producing this MCP-specific evaluation report, HSAG found activities and goals with a focus on ensuring members' access to needed care. The MCP's quality improvement program description indicates that SCAN was founded by individuals who were frustrated by their lack of access to services, showing that from the beginning, ensuring access to services was a priority for the MCP.

The *Breast Cancer Screening* measure falls into the access domain of care. As indicate above, the rate for this measure was above the HPL for the second consecutive year. The high rate for this measure demonstrates that SCAN continues to ensure that female members have access to this very important screening service.

Both of SCAN's QIPs fall into the access domain of care. As indicated above, the *All-Cause Readmissions* QIP did not progress to the Outcome's stage; therefore, HSAG was not able to assess the QIP's success at improving access to needed services. Also indicated above, the *Care for Older Adults* QIP was successful at significantly increasing the percentage of functional status assessments being conducted and significantly increasing the percentage of pain screenings/pain management plans being provided. The increase in functional status assessments, pain screenings, and pain management plans will allow for more accurate understanding of members' needs which allows for improved access to needed services.

HSAG's review of SCAN's member satisfaction survey results found that members appear to be extremely satisfied with their level of access to needed health care services.

Overall, SCAN showed average performance related to the access domain of care based on the MCP's 2013 performance measure rates (which reflect 2012 measurement data), QIP validation results, and member satisfaction survey results.

Timeliness

The timeliness domain of care relates to an MCP's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures that assess if a health care service is provided within a recommended period of time after a need is identified are used to assess if MCPs are ensuring timeliness of care. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

SCAN's quality improvement program description provides details about the MCP's activities related to member rights and responsibilities, grievances, coordination and continuity of care, and utilization management, which all impact the timeliness of care delivered to members.

The *Osteoporosis Management in Women Who Had a Fracture* measure falls into the timeliness domain of care. As indicated above, the rate for this measure was above the MPL in 2013, which was the first year the MCP was held to the MPL for this measure.

HSAG's review of SCAN's member satisfaction survey results found that members appear to be extremely satisfied with the time it takes to receive health care services.

Overall, SCAN showed average performance related to the timeliness domain of care based on the MCP's 2013 performance measure rates (which reflect 2012 measurement data) and member satisfaction survey results.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-specific evaluation report. SCAN's self-reported responses are included in Appendix A.

Recommendations

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

- Consider implementing an internal action plan to ensure that the HEDIS Roadmap is completed thoroughly and updated annually within the NCQA-required time frame. Additionally, consider using a coordinated team effort to complete the Roadmap and conduct a comprehensive review prior to submission.
- Thoroughly review the QIP Completion Instructions prior to submitting QIPs to ensure that all required documentation is included in the QIP Summary Form to avoid having to resubmit QIPs multiple times.
- Review the MCP's detailed member satisfaction survey results and determine if there are strategies the MCP can implement to improve members' overall satisfaction with SCAN.
- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

Appendix A. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

for Senior Care Action Network Health Plan

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with SCAN's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table A.1—SCAN's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	SCAN's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. Continue to consider the feasibility of implementing the same functionality as used in the Transaction Portal in the plan's encounter system.	Due to the various purposes of encounter data, SCAN has decided not to perform "clean claim" edits during encounter intake, but rather impose those edits for the purpose of CMS Encounter data submission. As such, those edits occur further downstream in the Encounter Data Processing System.
2. Continue to investigate the possibility of monitoring encounter rejection at the trading partner level.	SCAN's clearinghouses for encounter data perform very limited data validation for SCAN; therefore, it is more useful to SCAN to monitor encounter submission rates, including rejection rates, on a provider partner basis rather than a trading partner level.
3. Ensure that the HEDIS Roadmap is completed and updated annually within the NCQA-required time frame.	The HEDIS team copies over the 2013 submissions to the 2014 templates as soon as the 2014 templates become available, and then sends out these templates to the parties responsible for each section to review and update as necessary with a deadline of 12/2/2013. At the same time, a tracking sheet is created showing who each section was sent to and the date it was sent. As updates are received, they are noted on this tracking sheet, and reminder e-mails are sent out to unresponsive parties a week before the deadline. Upon receipt, the templates are reviewed for obvious errors (i.e., use of dates in 2013 which would indicate that review was not completed by the respondent), and then compared with the 2013 Issue Log to ensure that any past concerns have been addressed and any mistakes from the previous year were not repeated. Once this review has been completed, the Roadmap is uploaded to the auditor by the HEDIS specialist.
4. Document detailed results of the QIP barrier analyses, including the type of analysis, the identified barriers, and the prioritization of the barriers.	In the 2013 QIP Annual Update submission, SCAN outlines the detailed results of the barrier analysis as defined. In addition, the CCIP/QIP Team created and included a barrier analysis with mapped interventions. This process will be replicated with the new QIP submission.

2011–12 External Quality Review Recommendation	SCAN's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
5. 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.	In the 2013 QIP Annual Update submissions, SCAN re-evaluated the interventions and initiatives that would better support real and sustained improvement using evidence-based best practice guidelines. This process will be replicated with the new QIP submission.
6. 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.	In the 2013 QIP Annual Update submissions, SCAN performed an in-depth barrier analysis and identified lessons learned. These processes allowed for the inclusion of interventions that are real and can be sustained as well as establishing the evaluation plan of those interventions. This process will be replicated with the new QIP submission.
7. Report both performance measure and QIP rates for the overall Medicaid population in subsequent years.	In the 2013 QIP Annual Update submission, SCAN reported both performance measure and QIP rates for the identified population. This process will be replicated with the new QIP submission.