Medi-Cal Managed Care Program Technical Report

July 1, 2009–June 30, 2010

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

May 2012

TABLE OF CONTENTS

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to about 4 million beneficiaries (as of June 2010) throughout the State of California through a combination of contracted full-scope and specialty managed care plans (plans).[1] The Code of Federal Regulations (CFR) at 42 CFR §438.358[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 quality and timeliness of and access to the health care services provided by plans.

The technical report must describe how conclusions were drawn as to the quality and timeliness of and access to care furnished by the states' Medicaid managed care plans. The report of results must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness, and access and must make recommendations for improvement. Finally, the report must assess the degree to which plans addressed recommendations made within the previous external quality review (EQR).

To comply with this requirement, the DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to aggregate and analyze Medi-Cal managed care plan data and prepare an annual technical report.

This report provides:

- A description of the Medi-Cal Managed Care Program.
- A description of the scope of EQR activities for the period of July 1, 2009, through June 30, 2010.
- An aggregate assessment of health care timeliness, access, and quality through organizational structure and assessment, performance measures, and quality improvement projects.

Plan-specific evaluation reports, issued in tandem with the technical report, provide an assessment of each plan's strengths and weaknesses regarding the quality and timeliness of, and access to, care and services. These reports are available on the DHCS Web site at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

[1] *Medi-Cal Managed Care Enrollment Report*, June 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

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

Overview of the 2009–2010 External Quality Review

To produce this report, HSAG analyzed and aggregated data from the following three federally mandated EQR activities:

- *Review of compliance with access, structure, and operations standards*. HSAG evaluated the DHCS's results for plans' compliance with State and federal requirements for organizational and structural performance. Additionally, HSAG evaluated the DHCS's compliance monitoring process and recommended modifications to improve the Department's monitoring and reporting of the plans' compliance with State and federal standards.
- *Validation of performance measures*. HSAG validated performance measures required by the DHCS to evaluate the accuracy of performance measure results reported by the plans. The validation also determined the extent to which MCMC-specific performance measures calculated by the plans followed specifications established by the DHCS. HSAG assessed performance measure results and their impact on improving health outcomes of members.
- *Validation of performance improvement projects*. Referred to as quality improvement projects (QIPs) by the DHCS, HSAG reviewed QIPs for each plan to ensure that plans designed, conducted, and reported projects in a methodologically sound manner, assessing for real improvements in care and services and giving confidence in the reported improvements. HSAG assessed plans' QIP outcomes and their impact on improving care and services provided to members.

Report Organization

This report includes ten sections providing an aggregate assessment of health care timeliness, access, and quality across organizational structure and assessment, performance measures, and quality improvement projects.

Section 1—Executive Summary includes a high-level summary of external quality review results.

Section 2—Introduction provides an overview of the MCMC program, a summary of the DHCS's service delivery system, and the assignment of domains of care.

Section 3—Quality Strategy summarizes the DHCS's quality assessment and performance improvement strategy goals and objectives.

Section 4—Medi-Cal Managed Care Program Initiatives highlights the DHCS quality initiatives implemented to improve the quality of care and services for Medi-Cal managed care enrollees as well as initiatives that support plan efforts to improve quality of care and services.

Section 5—Medi-Cal Managed Care Plans' Best and Emerging Practices highlights plan-specific activities that are unique and effective in demonstrating improvements in care or services.

Section 6—Organizational Assessment and Structure Performance

Section 7—Performance Measure Performance

Section 8—Quality Improvement Project Performance

Sections 6, 7, and 8, describe each of the three mandatory activities, HSAG's objectives and methodology for conducting the required activities, HSAG's methodology for aggregation and analysis of data, and an assessment of overall plan strengths and opportunities for improvement.

Section 9—Member Satisfaction Survey is an optional activity that the DHCS conducted during the review period. HSAG presents a summary of aggregate findings, analysis of data, and an assessment of overall plan strengths and opportunities for improvement.

Section 10—Overall Findings, Conclusions, and Recommendations on plans' performance on providing health care quality, access, and timeliness of services provided to Medi-Cal managed care members.

Appendix A—Follow-Up on the Prior Year's Recommendations Grid provides the prior year's EQR recommendations, DHCS actions that address the recommendations, and comments.

Plan-specific evaluation reports are issued in tandem with the technical report and provide specific findings and recommendations for each MCMC plan.

Medi-Cal Managed Care Program Overview

During the review period, July 1, 2009, through June 30, 2010, the DHCS administered the Medi-Cal Managed Care (MCMC) Program, California's Medicaid managed care program. During the period covered by this report, the MCMC program served roughly half of the Medi-Cal population, with the other half enrolled in fee-for-service (FFS) Medi-Cal.

Approximately 4 million beneficiaries enrolled as of June 2010 in the MCMC program received care from 20 full-scope plans, 3 specialty plans, and 1 prepaid health plan operating in 26 of California's 58 counties. The DHCS administers the MCMC program through a service delivery system that encompasses three different plan model types: County-Organized Health System (COHS), Geographic Managed Care (GMC), and Two-Plan.

County-Organized Health System

In a COHS model, the DHCS contracts with one county organized and operated plan in a county to provide managed care services to all Medi-Cal beneficiaries in that county, with very few exceptions. Beneficiaries can choose from a wide network of managed care providers. Beneficiaries in COHS plan counties do not have the option of enrolling in FFS Medi-Cal unless authorized by the DHCS.

Geographic Managed Care

In the GMC model, enrollees choose from three or more commercial plans offered in a county. Beneficiaries with designated mandatory aid codes must enroll in a managed plan. Seniors and individuals with disabilities who are eligible for Medi-Cal benefits under the Supplemental Security Income (SSI) program and a small number of beneficiaries within other specified aid code categories are not required to enroll in a plan but may choose to do so. These voluntary beneficiaries may either enroll in a managed care plan or receive services through the Medi-Cal FFS program. The GMC model type currently operates in San Diego and Sacramento counties.

Two-Plan

In the Two-Plan model, the DHCS contracts with two managed care plans in each county to provide health care services to beneficiaries. Most Two-Plan model counties offer a locally operated, local initiative (LI) plan and a non-governmental commercial plan (CP). As with the GMC model type, the DHCS requires beneficiaries with designated mandatory aid codes to enroll in a plan, while seniors and individuals with disabilities who are eligible for Medi-Cal benefits under the SSI program and a small number of beneficiaries within other specified aid code categories can voluntarily choose either to enroll in a plan or remain in the FFS program.

Specialty and Prepaid Health Plans

In addition to the full-scope plans, the DHCS contracts with several plans to provide health care services to specialized populations (referred to as "specialty plans") and with one plan as a Prepaid Health Plan (PHP). During the 2010 measurement period, the DHCS held contracts with three specialty plans and one PHP. The DHCS requires each specialty plan and PHP to report annually on two DHCS-approved performance measures chosen specifically for each plan.

Note: As of June 1, 2011, enrollment in Two-Plan and GMC Medi-Cal managed care plans will become mandatory for seniors and individuals with disabilities who do not have other health coverage (Medi-Cal only). For more information about this change, see the "Seniors & Persons With Disabilities (SPD)" page on the DHCS Web site at http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDEnrollment.aspx

Domains of Care

The Centers for Medicare & Medicaid Services (CMS) chose the domains of quality, access, and timeliness as keys to evaluating the performance of managed care plans. HSAG used the following definitions to evaluate and draw conclusions about the performance of the plans in each of these domains.

Quality

CMS defines quality in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which a managed care organization (MCO) or prepaid inpatient health plan (PIHP) increases the likelihood of desired health outcomes of its recipients

through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[3]

Access

In the preamble to the CFR,[4] CMS discusses access to and the availability of services to Medicaid enrollees as the degree to which plans implement the standards set forth by the state to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that reflects the needs and characteristics of the enrollees served by the plan.

Timeliness

The National Committee for Quality Assurance (NCQA) defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[5] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the plan—e.g., processing expedited appeals and providing timely follow-up care. The Agency for Healthcare Research and Quality (AHRQ) indicates "timeliness is the health care system's capacity to provide health care quickly after a need is recognized."[6] Timeliness includes the interval between identifying a need for specific tests and treatments and actually receiving those services.[7]

The table on the next page shows HSAG's assignment of the compliance review standards, performance measures, and QIPs into the domains of quality, timeliness, and access.

[3] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 3, October 1, 2005.
[4] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.
[5] National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.
[6] Agency for Healthcare Research and Quality. *National Healthcare Quality Report* 2007. AHRQ Publication No. 08- 0040. February 2008
[7] Ibid.

Table 2.1—Assignment of Activities to Performance Domains

Compliance Review Standards	Quality	Timeliness	Access
Enrollee Rights and Protections Standards		√	√
Access Standards		√	√
Structure and Operations		√	√
Measurement and Improvement	√		
Grievance System		√	√
Performance Measures	**Quality**	**Timeliness**	**Access**
Adolescent Well-Care Visits	√	√	√
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	√		
Breast Cancer Screening	√		√
Cervical Cancer Screening	√		√
Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)	√		
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	√		√
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)	√		
Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)	√		
Comprehensive Diabetes Care—HbA1c Testing	√		√
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	√		
Comprehensive Diabetes Care—LDL-C Screening	√		√
Comprehensive Diabetes Care—Medical Attention for Nephropathy	√		√
Childhood Immunization Status—Combination 3	√	√	√
Use of Imaging Studies for Low Back Pain	√		
Prenatal and Postpartum Care—Timeliness of Prenatal Care	√	√	√
Prenatal and Postpartum Care—Postpartum Care	√	√	√
Appropriate Treatment for Children With Upper Respiratory Infection	√		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	√	√	√
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	√		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	√		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	√		
Quality Improvement Projects	**Quality**	**Timeliness**	**Access**
Statewide Collaborative QIP—Reducing Avoidable ER Visits	√		√
Individual and Small-Group Collaborative QIPs	Domain varied by plan project		

Medi-Cal Managed Care Program Quality Strategy

Federal regulations at 42 CFR §438.200 and §438.202 require that state Medicaid agencies develop and implement a written quality strategy for assessing and improving the quality of health care services offered to their members. The written strategy must describe the standards the state and its contracted plans must meet. The state must conduct periodic reviews to examine the scope and content of its quality strategy, evaluate its effectiveness, and update it as needed.

To comply with federal regulations, during the review period, the DHCS finalized its updated quality strategy to replace the initial 2004 document. The DHCS publically released the updated, final *Medi-Cal Managed Care Program Quality Strategy—December 2009* at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/2009_Quality_Strategy_12-14-09.pdf

The 2009 MCMC quality strategy includes a description of the program history and structure, contractual standards, and oversight and monitoring activities. Additionally, this report outlines the operational processes implemented by the Medi-Cal Managed Care Division (MMCD) to assess the quality of care, make improvements, obtain input from members and stakeholders, ensure compliance with State-established standards, and conduct periodic evaluation of the effectiveness of the strategy.

Quality Strategy Objectives

The DHCS's overall goal is to preserve and improve the health status of all Californians, with the supporting vision that quality health care will be accessible and affordable to all Californians. Consistent with this goal, the DHCS outlined the following objectives of the 2009 MCMC quality strategy:

- Increase access to appropriate health care services for all enrolled beneficiaries.
- Establish accountability for quality health care by implementing formal, systematic monitoring and evaluation of the quality of care and services provided to all enrolled Medi-Cal beneficiaries, including individuals with chronic conditions and special health care needs.
- Improve systems for providing care management and coordination for vulnerable populations, including seniors and individuals of all ages with disabilities and special health care needs.
- Improve the quality of care provided to Medi-Cal beneficiaries by contracted health plans.

Quality Improvement Strategies

The DHCS established the following seven strategies:

- Establish a process by 2010 that ensures that all beneficiaries enrolled in Medi-Cal managed care have a medical home and increase access to a medical home through geographic managed care expansion into counties with only fee-for-service options.
- Facilitate voluntary enrollment of seniors and individuals with disabilities into Medi-Cal managed care by using the results of the informational and educational outreach pilot project conducted in Alameda, Sacramento, and Riverside counties in 2008 to identify and implement effective approaches to informing and serving this target population in 2009 and 2010.
- Establish an evaluative process by 2010 for health plans to determine the accessibility, capability, and readiness of contracted primary care sites for providing health care services to seniors and individuals with physical disabilities.
- Implement one or more performance standards and measures for Medi-Cal managed care plans to evaluate and improve beneficiary health outcomes for seniors and persons with disabilities by Healthcare Effectiveness Data and Information Set (HEDIS®)[8] measurement year 2010.
- Develop and implement a care coordination/case management policy to identify enrollees' care coordination needs, determine quality improvement (QI) interventions, and develop a systemwide policy appropriate for implementation by all plans by March 2010.
- Achieve by 2011 a 10 percent reduction, compared to each plan's baseline, in the rates of avoidable emergency room (ER) visits for enrolled members 1–19 years of age with diagnosis codes for upper respiratory infections, otitis media, and pharyngitis.
- Increase rates (percentage change to be determined) of assessment, diagnosis, and appropriate treatment of chronic obstructive pulmonary disease (COPD) in members 40 years of age and older with a new COPD diagnosis or newly active chronic COPD per Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines.

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

Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

In the revised *Medi-Cal Managed Care Program Quality Strategy—December 2009*, the DHCS states that MMCD is responsible for the oversight and monitoring of access to provider services, quality of care delivered to enrollees, availability and timeliness of appropriate levels of care, and internal structural systems established by contracted plans. The DHCS also outlines its use of EQR reports that include detailed information about the EQRO's independent assessment process, results, and recommendations.

In June 2010, CMS provided the DHCS with feedback on its revised quality strategy and identified some areas that the DHCS needed to address including:

- A description of the formal process that the DHCS will use to obtain beneficiary stakeholder input and public comment before final adoption.
- The definition the DHCS uses to define "significant" changes to the strategy that would trigger the need to solicit stakeholder input.
- A description of the DHCS's efforts to collect information on ethnicity and primary language spoken for any beneficiary receiving Supplemental Security Income.
- The DHCS's identification, definition, and categorization of race, ethnicity, and primary language spoken.
- A description of how the DHCS uses sanctions against the plans in support of its quality strategy and ensure that plans meet the regulation requirements. Additionally, the description should include the DHCS's methodology for using sanctions as a vehicle for addressing identified quality of care problems.
- A description of health information technology initiatives that support the initial and ongoing operation and review of its quality strategy and progress toward performance targets, as well as initiatives that support the objectives of the strategy.
- A description of the reporting requirements for the plans to the DHCS, and the DHCS to CMS, and consideration to align routine reporting mechanisms with planned evaluation periods.

While these components may have been missing from the formal quality strategy, HSAG has noted many activities that support the occurrence of these functions. The DHCS uses the information from both the EQR technical report and CMS feedback to assess the effectiveness of its strategic goals and objectives and to provide a road map for potential changes and new goals and strategies.

Medi-Cal Managed Care Program Initiatives Driving Improvement

HSAG noted several DHCS initiatives that support the improvement of quality of care and services for MCMC members as well as activities that support plan improvement efforts. All initiatives and activities were in alignment with the State's quality strategy.

External Accountability Set

One mechanism established to monitor accountability for quality health care is the DHCS's External Accountability Set (EAS). The DHCS selects performance measures annually and requires its contracted plans to report rates at the county level unless otherwise specified. While performance measure reporting and validation is a federal requirement, the DHCS has developed an auto-assignment program, which rewards plans in Two-Plan and GMC models for high performance on six performance measures and two safety net provider measures with increased default membership. Additionally, during the reporting period, the DHCS implemented a process to evaluate its EAS and auto-assignment program measures annually to rotate out measures that show consistent, high performance among plans.

During the review period, the DHCS removed the *Use of Appropriate Medications for People With Asthma* and the *Well-Child Visits in the First 15 Months of Life* measures due to high performance. Additionally, the DHCS removed the *Comprehensive Diabetes Care—HbA1c Control (<7.0 Percent)* measure. The DHCS added *Comprehensive Diabetes Care—Blood Pressure Control (140/90 mm Hg)*, *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*, *Use of Imaging Studies for Low Back Pain*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures. This allows the DHCS to identify and select new measures as opportunities for improvement across a broad spectrum of care and services.

Focused Performance Accountability

The DHCS has initiated efforts to focus on low-performing plans and has begun to take more formal corrective action to improve their performance. During the review period, the DHCS has used multiple data sources including internal health information technology and external quality review evaluations to track and trend plans' performance, to prepare for discussions with plans that showed continued low performance. Holding plans more accountable for poor performance should result in improved access, quality, and timeliness of care provided to members.

Quarterly Dashboard Report

MMCD produces an internal quarterly dashboard report that includes key quality metrics: performance measure results, facility site review results, member satisfaction results, and ombudsman statistics. Use of this information by program management reinforces the DHCS's commitment to quality monitoring oversight and improvement. Monitoring of these activities aligns with the *Medi-Cal Managed Care Program Quality Strategy—December 2009* program objectives.

Statewide Collaborative Quality Improvement Projects

The DHCS-led statewide collaborative QIP efforts have shown promise in driving and sustaining improvement. HSAG has been evaluating the success of the current statewide *Avoidable ER Visits* collaborative QIP as remeasurement data became available. Statewide collaborative QIP reports are posted on the DHCS Web site at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

As a result of the collaborative, the State together with its plans identified data patterns that contributed to visits to the ER that could have been more appropriately managed in an outpatient setting. The collaborative launched a statewide member health education campaign and a hospital data exchange pilot as targeted interventions to help drive improvement.

Fraud, Waste, and Abuse Detection and Prevention

MMCD demonstrated an ongoing focus on fraud, waste, and abuse detection and prevention during the reporting period. Both the joint audit process and MRPIU review included aspects that monitor plans' policies and procedures and reporting of fraud, waste, and abuse complaints.

Quality Improvement and Performance Measure Transparency

The DHCS has increased the degree of transparency to the public with the release of quality improvement and performance measurement reports on the DHCS Web site at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx. The DHCS has made efforts to improve the readability of public reports to increase comprehension for members, plans, legislators, advocacy groups, and other stakeholders. This effort promoted informed decision making and opportunities for dialogue.

Seniors and Persons With Disabilities (SPD)

The DHCS worked with its plans and key stakeholders to submit a waiver to enroll more seniors and persons with disabilities into the Medi-Cal managed care program. Activities included extensive planning and requirements to ensure that these members would receive coordinated care and access to necessary care. Furthermore, the DHCS will implement performance standards and measures to evaluate health outcomes for members who are enrolled into the SPD program beginning in June 1, 2011.

During the review period, several MCMC plans demonstrated effective improvements in care or services that resulted in best or promising practices. HSAG reviewed plans' results across required activities—including organizational and structural standards, performance measure results, and quality improvement projects—and identified high performers and factors that may have contributed to those plans' successes.

Organizational and Structural Standards Performance

For organizational and structural standards, plans that demonstrated a high degree of compliance exhibited congruence between their quality improvement program, work plan, and evaluation. These plans had formal processes to link federal and State requirements within the quality improvement program and had formal mechanisms to monitor, analyze, and report results, including formal discussion to identify opportunities for improvement, barriers, and intervention strategies.

Performance Measure Outcomes

Five full-scope plans demonstrated high performance across the EAS, exceeding seven or more of the DHCS's established high performance levels (HPLs), which represent the national Medicaid 90th percentile. San Francisco Health Plan—San Francisco County exceeded the HPL on 11 measures while Central California Alliance for Health—Monterey/Santa Cruz counties and Kaiser Permanente—Sacramento County exceeded the HPL on nine measures, and Kaiser Permanente—San Diego County exceeded the HPL on eight measures, followed by CenCal Health—Santa Barbara County, which had seven measures that exceeded the HPL. The remaining plans had zero to four measures that performed above the HPL.

HSAG noted that San Francisco Health Plan (SFHP) in San Francisco County had outstanding performance on its HEDIS measures. In March 2009, San Francisco Health Plan launched a new program called Strength in Numbers, with funding from San Francisco's universal access program Healthy San Francisco (HSF), California HealthCare Foundation, and Metta Fund. The program aimed to support panel management and the use of clinic registries through standardized measures, incentives, and technical assistance. Strength in Numbers started with four diabetes care measures (testing and control levels for hemoglobin A1c and LDL cholesterol), reported quarterly by eighteen safety net clinics. Through the end of 2010, clinics achieved significant improvements in these four diabetes care measures.

In addition to the Strength in Numbers program, SFHP also uses a member incentives program. The program began with incentives for well adolescent and well child visits initiated in 2002 and 2003, respectively. Like other community health plans, SFHP continues to redesign incentives to accommodate new measures.

Quality Improvement Project Outcomes

Several plans implemented interventions within their QIPs that demonstrated statistically significant and/or sustained improvement during the review period. HSAG noted several potential best and promising practices based on QIP outcomes.

Proper Antibiotic Use

Several plans, including CalOptima in Orange County; Care 1st Health Net in Fresno, Los Angeles, Kern, Sacramento, San Diego, Stanislaus, and Tulare counties; L.A. Care in Los Angeles County; and Molina Healthcare in Riverside/San Bernardino, Sacramento, and San Diego counties, participated in a small-group collaborative (SGC) QIP, *Appropriate Treatment for Children With an Upper Respiratory Infection (URI)*. This SGC began in 2005 with plans implementing the majority of targeted provider and member interventions during the 2007 calendar year. The SGC plans coordinated with the California Medical Association's Alliance Working for Antibiotic Resistance Education (AWARE) and developed the Antibiotic Awareness Provider Toolkit, which they mailed to providers.

Beginning in 2008, the plans mailed information to contracted PCPs that described the URI QIP and the importance of prescribing antibiotics appropriately, as well as a customized report, by PCP, of members diagnosed with a URI who may have been inappropriately prescribed antibiotics in the last year. The report also included an overall rate for the PCP, a rate for the PCP's participating physician group (if applicable), and the plan rate.

The plans' concerted efforts on the collaborative QIP may have contributed to the statistically significant and sustained improvement achieved by most of the collaborating plans. Additionally, the SGC plans identified a large number of "shared" providers among them; as a result, the plans' ability to impact provider behavior as a group with a consistent message also may have contributed to the success of the project.

Reducing Avoidable Emergency Room Visits

All plans that showed improvement implemented a variety of plan-specific interventions. Most of these plans implemented a combination of member, provider, and system interventions.

The most common member interventions used by these plans included the use of small media (brochures, newsletters, posters, Web site) to educate new and existing members on appropriate use of the ER, provide health tips and information, and explain how to access care. Additionally, these plans used case management and nurse advice lines. Finally, these plans used member input and/or feedback from surveys or focus groups on members' experiences with after-hours care, ER services, and other aspects of care and services that impact avoidable ER visits.

Plans that demonstrated improvement used provider interventions that solicited provider input and feedback and alerted providers to members who accessed the ER. These plans also implemented processes to generate and analyze ER data, including frequency and usage reports. In future QIP submissions, HSAG will assess which of these plans showed sustained improvement.

Improving Women's Health

Two plans were able to demonstrate improvement in women's health with concentrated provider interventions. Community Health Group—San Diego County demonstrated a statistically significant increase in the percentage of women who were screened for postpartum depression and also the percentage of women who were screened for postpartum depression using a screening tool. The plan concentrated its improvement strategies toward member and especially provider interventions. By increasing providers' knowledge related to postpartum depression and the screening tools available, and providing links to treatment and community resources, the plan was able to improve the screening rates, which may in turn impact the follow-up treatment for women with postpartum depression. Health Plan of San Joaquin—San Joaquin County improved the quality of care delivered to women by demonstrating a statistically significant increase in the percentage of women screened for chlamydia. Using provider interventions, the plan educated providers regarding guidelines and HEDIS measure expectations. The plan also gave feedback to the providers which included their specific rates and provided tools such as Web-based patient prompts and reminders. The plan also worked with their contracted laboratory to ensure that results were sent directly to the health plan.

Health Plan of San Mateo—San Mateo County improved cervical cancer screening rates and sustained this improvement from baseline to the second remeasurement period. The plan concentrated its efforts to member interventions and most notably modified the interventions based on its study results. The plan provided a gift card incentive to members who received Pap tests. After evaluating the effectiveness of the intervention, however, the plan modified the intervention to offer a gift card to another store.

Operational Performance Standards

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process to assess plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

Conducting the Review

The DHCS has an extensive monitoring process to assess plans' compliance with State and federal requirements at the point of initial contracting and then through subsequent, ongoing monitoring activities.

The *Medi-Cal Managed Care Program Quality Strategy—December 2009* describes the processes that the DHCS uses to assess for specific standards outlined in the Code of Federal Regulations (CFR). The DHCS includes contract provisions for the standards, including the frequency of reporting, monitoring, and enforcement of corrective actions.

Areas within the DHCS responsible for monitoring include the Medi-Cal Managed Care Division's Plan Management Branch (PMB), Member Rights and Program Integrity Unit (MRPIU), Medical Monitoring Unit (MMU), Medical Policy Section (MPS), and Performance Measurement Unit (PMU). In addition, the DHCS's Audits and Investigations Division (A&I) works with MRPIU and MMU, and participates in a joint audit process with the Department of Managed Health Care (DMHC).

To assess performance related to the quality and timeliness of and access to care, HSAG reviewed and aggregated the most recent audit report findings available as of June 30, 2010, for each plan related to compliance monitoring standards within the Code of Federal Regulations. Additionally, HSAG used information from plan-produced internal quality evaluations, as appropriate, in conjunction with the DHCS's monitoring results to make an assessment of each plan's compliance related to the quality and timeliness of and access to care provided to MCMC members.

Objectives

The primary objective of monitoring organizational assessment and structure performance standards is to assess plans' compliance with federal regulations and State-specified standards.

Methodology

The DHCS conducted monitoring of plans' compliance with operational standards through a variety of activities, including:

- Readiness reviews.
- Medical performance audits.
- Member rights and program integrity monitoring reviews.

Table 6.1 displays the areas that conduct each respective monitoring activity across the DHCS and DMHC.

Table 6.1—Department of Health Care Services Monitoring Activities by Responsible Area

Responsible Area	Monitoring Activity		
	Readiness Review	Joint Medical Performance Audit	Member Rights and Program Integrity Review
Plan Management Branch	X		
Member Rights and Program Integrity Unit			X
Medical Monitoring Unit	X	X	
Medical Policy Section	X		
Audits and Investigations		X*	
*This activity performed in tandem with the California Department of Managed Health Care for some plan audits.			

Readiness Reviews

The DHCS assesses plans' operational standards and structure through a review of contract deliverables before the DHCS allows the plan to operate under the MCMC program. Once operational, the DHCS performs ongoing plan monitoring.

Medical Performance Reviews

For ongoing monitoring, A&I and DMHC conduct routine medical performance reviews and surveys of MCMC plans. These medical performance reviews assess plans' compliance with contract requirements and State and federal regulations.

For most plans, a joint review is conducted for each MCMC plan approximately once every three years. The scope of the review covers the areas of utilization management, continuity of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity. The DHCS provides the plan with a report of findings, including any of the plan's corrective actions. Medical performance reviews are released for public review on the DMHC's Web site at: http://www.dmhc.ca.gov/healthplans/med/med_default.aspx.

For some plans, A&I and the DMHC conduct non-joint medical reviews. The DHCS's Medical Monitoring Unit is responsible for follow-up on joint review findings and A&I non-joint reviews, including monitoring of corrective actions.

Member Rights and Program Integrity Reviews

MRPIU is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights. This includes member grievances, prior-authorization request notifications, and cultural and linguistic services. Additionally, MRPIU reviews for program integrity (fraud, waste, and abuse prevention and detection). For the non-COHS plans, the review also includes marketing and enrollment programs.

These reviews are done before a plan becomes operational in the MCMC program, when changes are made to policies and procedures, during contract renewal, and if a plan's service area is expanded. As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance.

Plan Monitoring

During the previous reporting period (July 1, 2008, through June 30, 2009), HSAG, as the new EQRO, evaluated the DHCS's compliance monitoring process of the plans against federal requirements. HSAG identified various strengths and offered several recommendations to the DHCS to improve the compliance monitoring process of its managed care plans.

During the review period covered in this report (July 1, 2009 through June 30, 2010), HSAG reviewed the opportunities for improvement it had made previously to determine the degree to which the State followed up to address the recommendations. From its review, HSAG identified several new strengths of the DHCS's monitoring process, as well as some areas that continue to provide opportunities for improvement. A detailed statement of how the DHCS followed up on the recommendations is provided in Appendix A, "Follow-Up on External Quality Review Recommendations."

Strengths

- Developing thresholds and procedures for HEDIS corrective action plans and developing penalties in other plan performance areas.
- Collaborating with the health plans to ensure that the plans use the correct QIP forms and that data are submitted timely. The DHCS revised the Quality Assurance Guide to clarify changes and enhancements to the process.
- Building review tools for staff to use when reviewing plan deliverables to ensure that requirements are consistently met, and revising and refining these tools as necessary.
- Developing a monitoring initiative to implement a comprehensive approach to tracking and sharing monitoring results, and to ensure results are incorporated into decision making, policy development, and ongoing quality improvement.

Opportunities for Improvement

HSAG's review found the following opportunities for improvement:

- The DHCS lacked a formal scoring mechanism for overall compliance monitoring results to allow for the trending of plan performance over time, the comparison of performance across plans, and the provision of feedback to the plans.
- While DMHC currently provides the DHCS with compliance monitoring results and efforts are being made to streamline the process, the DHCS lacked a central repository for results and a process for aggregating results for plan-specific performance.
- It was not clear that all standards required by CMS were reviewed at least once during the three year period. Many standards were reviewed at the time the plan entered into the initial contract with the DHCS and only upon a change. Additionally, not all plans were reviewed at the required frequency of at least once every three years.
- The DHCS lacked formal documentation of pre-audit conferences and quarterly internal meetings that focused on plan performance, recommendations, and actions should be implemented.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about overall plan performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall primarily under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Operational Performance Standards Results

Plans demonstrated strengths as well as opportunities for improvement with operational performance standards.

Medical Performance Review Findings

Medical performance review results showed that, overall, plans were compliant with most of the standards covered under the quality management and administrative and organizational capacity areas. These areas demonstrated that plans had quality management programs in place and the staffing and structure to support the delivery of care and services.

Audit findings showed common areas of plan deficiencies in the areas of utilization management (UM), continuity of care, availability and accessibility, and member rights.

Utilization Management (UM)

- Findings showed that all plans demonstrated implementation of a UM program supported by policies and procedures and written criteria based on sound medical evidence, and met program requirements.
- Despite most plans showing evidence of monitoring and analyzing data for under- and overutilization of services, audit findings in the UM category were largely the result of prior-authorization issues primarily because many plans lacked a policy and procedure and/or system for tracking and monitoring referrals that require prior authorization.
- Many plans continue to have challenges sending notification to members for denied, modified, or deferred decisions due to deficiencies within plans' policies and procedures. For Notice of Action (NOA) letters sent to members, many plans did not send a timely notification, did not include the name and/or contact information for the professional responsible for the determination, or did not provide a clear and concise clinical reason for denying or modifying the request.
- Many plans that delegated UM functions to other entities continued to lack adequate oversight, particularly for prior-authorization denials. Most plans did not have procedures for annual monitoring of UM delegated activities.

Continuity of Care

- Overall, plans met the requirements for providing medical case management to members and monitoring the coordination of in- and out-of-network services. Case management models varied by plans, with many designating the primary care physician responsible for coordinating care, while other plans used their own case management staff or used a combination of the primary care physician and a case manager. While HSAG noted improvement between prior review period reports and more recent medical performance reports related to coordinating care for members eligible for California Children's Services to ensure that members received necessary medical covered services, deficiencies in this area still exist. Additionally, plans continued to have challenges with ensuring case coordination for all members receiving developmental disabilities services.
- While plans had policies in place for obtaining initial health assessments (IHA) and individual health education behavioral assessments for new members, as well as tracking IHA completion rates, many plans had low member completion rates for these assessments within the required time frame. Most plans failed to monitor their rates and/or take action to improve them as part of their quality improvement program.

Availability and Accessibility of Services

- Despite having policies and procedures for access to and availability of routine, urgent, emergency, prenatal, and specialty care, including procedures for triaging member calls and providing access to care after hours, most plans lack a mechanism for monitoring wait times in providers' offices, hold times for telephone calls, and wait times to obtain various types of appointments. Additionally, some plans failed to demonstrate that they had taken action to address these deficiencies.
- Findings indicate that many plans did not have a process in place to ensure that emergency service claims and family planning claims are processed and paid in a timely manner or did not have established policies specifying the correct percentage of claims to be paid within required timelines.
- Many plans continue to have challenges ensuring that members received an adequate supply of medically necessary medication in an emergency situation and lacked policies and procedures for monitoring and oversight of after-hours pharmacy needs.

Member Rights (Under the Grievance System)

- Overall plans had grievance policies and procedures and a grievance system in place for member complaints, including written policies and procedures for the grievance process; however, many plans did not send timely acknowledgment letters and grievance resolution notices.
- Additionally, quality of care-related grievances were not always appropriately reviewed by clinical staff or timely submitted to the medical director. Many plans lacked medical oversight mechanisms to process, analyze, and report grievance data through their respective quality improvement structures on an ongoing basis.

Member Rights and Program Integrity Review Findings

MRPIU review findings were related to member rights, including member grievances, prior-authorization notifications, and cultural and linguistic services. Findings revealed that overall plans were compliant with most of the program integrity standards.

Member Grievances

MRPIU noted similar findings for member grievances. Many plans' acknowledgment letters exceeded the notification time frames, resolution letters exceeded the time frames, and notifications lacked the inclusion of State fair hearing information.

Prior-Authorization Notifications

A review of prior-authorization notifications showed that many plans did not provide timely member notifications and did not provide notification to members of a denial, termination, or modification. Additionally, the Notice of Actions that were used did not provide a specific citation supporting the action taken by the plan and did not contain required medical or statutory documentation.

Cultural and Linguistic Services

- MRPIU found many plans deficient due to provider offices that did not discourage the use of family, friends, or minors as interpreters, which can compromise the reliability of medical information.
- Many plan providers were unaware of the 24-hour language line.
- Most plans lacked cultural competency, sensitivity, or diversity training for providers.
- MRPIU found that many plan providers did not have a grievance form and did not maintain a grievance log.

Conclusions

Based on medical performance audits and MRPIU review findings, plans demonstrated compliance with many standards for quality management, utilization management, member rights, continuity of care, availability and accessibility of services, program integrity, and administrative and organizational capacity. Plans had appropriate resources and written policies and procedures in place to support a quality improvement program.

Audit results showed that areas of deficiency for plans were related to standards that demonstrate actual implementation and/or monitoring of processes consistent with policies and procedures. Most commonly, these findings were related to prior-authorization notifications, timely member grievance acknowledgment and resolution, monitoring of delegated entities, monitoring of

provider wait times, and monitoring providers' compliance with cultural and linguistic requirements. These findings primarily impacted the access and timeliness domains of care.

Additionally, plans had challenges analyzing and reporting monitoring activities through the formal quality improvement structure or within the plans' internal evaluation. Many plans had repeat areas of noncompliance from the previous audit, suggesting that they did not incorporate audit and review findings as part of their work plan to ensure action would be taken to correct deficiencies and to conduct ongoing monitoring. These findings related to the quality domain of care.

HSAG's review of the DHCS's monitoring of plan performance related to federal and State standards demonstrated ongoing compliance monitoring activities in many functional areas. The review revealed opportunities for the DHCS to formalize its compliance monitoring process including review criteria standardization, centralized collection of monitoring results, data aggregation, and plan performance trending to provide the DHCS with meaningful information.

Recommendations

HSAG provides the following recommendations to improve plans' compliance with federal and State standards:

- Plans need to incorporate internal systems and mechanisms to continually review and revise their quality management and utilization management program structures to ensure reporting, review, oversight, and actions comply with federal and State standards.
- Plans need to develop and strengthen internal processes to ensure that member prior-authorization notifications and grievance resolution notices are monitored for timeliness and accuracy.
- Plans need to develop, incorporate, and/or strengthen processes for monitoring provider compliance with cultural and linguistic requirements.
- Plans need to identify and incorporate areas of noncompliance within their work plans to ensure that deficiencies are resolved and continually monitored.

HSAG provides the following recommendations to the DHCS to improve its plan compliance monitoring:

- The DHCS needs to develop a central repository for compliance monitoring results across the DHCS and DMHC and develop a process for aggregating results for plan-specific performance.
- The DHCS should develop and implement a formal scoring mechanism for compliance monitoring results to allow the DHCS to trend plan performance over time, compare performance across plans, and provide plans with feedback.

- The DHCS should formalize a process to document concerns with plan performance, recommendations, and actions as appropriate.
- The DHCS should develop and maintain an overall compliance monitoring schedule by plan to ensure that all standards are reviewed at least every three years.

The DHCS has made progress toward meeting all of these opportunities for improvement; however, continued opportunities for improvement remain. HSAG will evaluate the DHCS's and plans' progress toward addressing these remaining opportunities in the next EQR report.

Performance Measure Validation

Validating performance measures is one of the three mandatory external quality review activities described at 42 CFR §438.358(b)(2). The requirement at §438.358(a) allows states, agents that are not an MCO or PIHP, or an EQRO to conduct the mandatory activities. Performance results can be reported to the state by the plan (as required by the state), or the state can calculate the plans' performance on the measures for the preceding 12 months. Performance must be reported by the plans—or calculated by the state—and validated annually.

In accordance with 42 CFR §438.240(b), the DHCS contractually requires plans to have a quality program that calculates and submits performance measure data. The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The EAS is comprised of HEDIS measures from which plans calculate and report data consistent with the most current HEDIS reporting year specifications and within DHCS-specified time frames. The DHCS requires that plans collect and report EAS rates, allowing for a standardized method to objectively evaluate plans' delivery of services.

As permitted by 42 CFR §438.258(a), the DHCS contracted with HSAG to conduct the functions associated with validating performance measures. Validation determines the extent to which plans followed specifications established by the Medi-Cal Managed Care (MCMC) Program for its EAS-specific performance measures when calculating rates.

Conducting the Review

Each full-scope plan calculated and reported plan-specific data for the following DHCS measures in the 2010 EAS:

- *Adolescent Well-Care Visits*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*

- *Comprehensive Diabetes Care*
  - *Blood Pressure Control (<140/90 mm Hg)*
  - *Eye Exam (Retinal) Performed*
  - *Hemoglobin A1c (HbA1c) Testing*
  - *HbA1c Control (<8.0 Percent)*
  - *LDL-C Screening*
  - *LDL-C Control (<100 mg/dL)*
  - *Medical Attention for Nephropathy*
  - *Poor HbA1c Control (>9.0 Percent)*
- *Prenatal and Postpartum Care*
  - *Timeliness of Prenatal Care*
  - *Postpartum Care*
- *Use of Imaging Studies for Low Back Pain*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
  - *BMI Assessment: Total*
  - *Nutrition Counseling: Total*
  - *Physical Activity Counseling: Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Each specialty plan and the prepaid health plan calculated and reported plan-specific data for two measures approved by the DHCS. The measures varied by plan based on the demographics of each plan's population.

Performance Measure Requirements and Targets

The DHCS's quality strategy describes the Department's processes to define, collect, and report plan-specific performance data, as well as overall Medi-Cal managed care performance data on DHCS-required measures. Plans must report county-level rates unless otherwise approved by the DHCS.

The DHCS annually establishes a minimum performance level (MPL) and high performance level (HPL) for each measure, based on the most current national Medicaid 25th and 90th percentiles, respectively. For measures for which a low rate indicates better performance, the DHCS applies the 10th percentile as the HPL and the 75th percentile as the MPL. Plans not meeting the MPLs must submit an improvement plan (IP) that outlines actions and interventions the plan will take to achieve acceptable performance. The DHCS uses the established HPLs as a performance goal and recognizes plans for outstanding performance.

Objectives

Plans underwent a HEDIS Compliance Audit™,[9] or a performance measure validation audit for non-HEDIS measures, conducted by HSAG to evaluate the accuracy of performance measure results reported by the plans and to ensure that the plans followed specifications established by the DHCS.

To assess performance related to quality, access, and timeliness of care, HSAG presents the audited rates for each plan compared to the prior year's rates and the DHCS-established MPLs/HPLs.

Methodology

HSAG conducted HEDIS Compliance Audits in accordance with NCQA's *Volume 5: HEDIS Compliance Audit—Standards, Policies, and Procedures* (2010) for all contracted regular and specialty plans with the MCMC Program. HSAG conducted the audits to ensure that plans captured, reported, and presented data in a uniform manner by performing the following activities:

- Conducted a thorough review of all components of each plan's Record of Administration, Data Management, and Processes (Roadmap) or Information Systems Capabilities Assessment Tool (ISCAT).
- Verified the DHCS-specified EAS measures for 2010.
- Reviewed the plan's programming language for the performance measures of plans not using a certified software vendor. If NCQA-certified software was used, HSAG assessed mapping of plan data into the vendor's required data format and integration of hybrid and administrative data for final rate calculation.
- Performed a convenience sample review from each plan across all required measures.
- Performed a re-review of a random sample of at least 30 medical records for each of two reported measures (if applicable) to ensure the reliability and validity of the data collected.
- Validated all activities that culminated in a rate reported by the plan.
- Provided an audit designation for each measure covered under the scope of the audit.
- Produced preliminary and final audit reports.

Through the audit process HSAG assigns each measure an audit result. Audit results are designated as a valid rate (indicated by a numeric result), *Not Applicable*, *Not Report*, or *No Benefit*.

[9] HEDIS Compliance Audit™ is a trademark of the NCQA.

A numeric result indicates that the plan complied with all HEDIS specifications to produce an unbiased, reportable rate or rates that can be released for public reporting. Although a plan may have complied with all applicable specifications, if the plan's denominator is too small to report (fewer than 30), the audit result is *Not Applicable*. An audit result of *Not Report* indicates that the rate should not be publicly reported because the measure deviated from HEDIS specifications enough to bias the reported rate significantly or that the plan chose not to report the measure. A *No Benefit* audit result indicates that the plan did not offer the benefit required to report the measure.

Findings

Performance Measure Validation Results

Twenty-five contracted plans underwent performance measure validation, twenty-four of which underwent a HEDIS Compliance Audit. Family Mosaic Project (FMP), a specialty plan, reported non-HEDIS measures and, therefore, underwent a performance measure validation audit consistent with CMS protocol.

The MCMC Program as a whole demonstrated average performance for most measures. Compared to 2009 national Medicaid benchmarks, the MCMC Program's 2010 performance was consistent with the 50th percentile with 12 weighted averages falling into this category.

All of the plans complied with HEDIS reporting software and physical control procedures to effectively manage and ensure the integrity of the HEDIS data. Additionally, plans were able to report valid rates for their DHCS-required measures. The plans had sufficient transactional systems that captured the required data elements for producing valid rates. With a few exceptions, HSAG found plans fully compliant with the overall IS standards. For the few plans that did not achieve full compliance with all IS standards, the auditor determined that the deficiencies did not bias any reported rates.

Challenges

HSAG found that some plans' certified software vendors experienced delays in receiving certification, which impacted the timeliness of medical record abstraction and generating preliminary administrative rates.

Some plans had challenges with medical record abstraction being conducted consistent with the technical specifications for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure. This measure was a new DHCS-required measure for 2010. HSAG identified that not all providers were documenting the BMI percentile accurately on the PM-160

form, which many plans used as a supplemental, administrative data source. Although some plans initially failed the medical record validation review, these plans were able address abstraction errors to produce valid rates.

HSAG found that a few plans do not capture complete rendering provider type information from claims and encounters, which limits the ability to use these data to meet compliance for some measures. This can be challenging for group practices or multi-specialty clinics. While the issue did not impact any plan's ability to report the required measures, plans had to rely more heavily on medical record review for hybrid measures. Therefore, the ability to capture complete rendering provider type information presents an opportunity for improvement.

Most of the plans did not meet NCQA's timeline of June 1, 2010, for submitting their rates to HSAG for auditor review. Vendor issues beyond the plans' control as well as internal plan resource issues contributed to the delayed submissions. Late submissions put the plans at risk for a *NR* audit result.

Performance Measure Results

Using the validated performance measure rates, HSAG organized, aggregated, and analyzed the data to draw conclusions about plan performance in providing accessible, timely, and quality care and services to Medi-Cal managed care members.

The table below lists the DHCS-required HEDIS performance measures for 2010 and the abbreviations used for each measure in Table 7.2.

Table 7.1—HEDIS Performance Measures Name Key

Abbreviation	Full Name of HEDIS 2010 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 7.2 presents a summary of the MCMC HEDIS 2010 (based on calendar year 2009 data) performance measure weighted averages compared to MCMC HEDIS 2009 (based on calendar year 2008 data).

For all but one measure, the MCMC Program bases its MPLs and HPLs on the NCQA's national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—a low rate indicates better performance and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the Medicaid 10th percentile.

Table 7.2—2009–2010 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	28.0%	29.1%	★★	↔	20.2%	33.4%
ASM	Q	88.6%	NA	NA	Not Comparable	86.6%	92.1%
AWC	Q,A,T	43.1%	45.1%	★★	↔	37.9%	59.4%
BCS	Q,A	51.7%	54.0%	★★	↑	45.0%	63.0%
CCS	Q,A	69.8%	69.5%	★★	↔	60.9%	79.5%
CDC-BP	Q	NA	63.9%	Not Comparable	Not Comparable	†	†
CDC–E	Q,A	58.0%	54.4%	★★	↓	44.4%	70.8%
CDC–H7 (<7.0%)	Q	29.5%	NA	NA	Not Comparable	25.5%	44.7%
CDC–H8 (<8.0%)	Q	NA	49.4%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	43.5%	37.4%	★★	↑	50.6%	29.2%
CDC–HT	Q,A	81.0%	82.8%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	36.6%	37.9%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	77.8%	79.3%	★★	↔	71.5%	82.5%
CDC–N	Q,A	78.5%	81.1%	★★	↑	73.4%	85.4%
CIS–3	Q,A,T	74.9%	74.5%	★★	↔	62.4%	80.6%
LBP	Q	NA	80.4%	Not Comparable	Not Comparable	†	†
PPC–Pre	Q,A,T	82.2%	83.9%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	59.7%	60.6%	★★	↔	57.9%	72.7%
URI	Q	84.8%	87.1%	★★	↑	81.1%	94.5%
WCC-BMI	Q	NA	56.8%	Not Comparable	Not Comparable	†	†
WCC-N	Q	NA	63.6%	Not Comparable	Not Comparable	†	†
WCC-PA	Q	NA	47.9%	Not Comparable	Not Comparable	†	†
W15	Q,A,T	56.5%	NA	NA	Not Comparable	51.6%	73.9%
W34	Q,A,T	76.9%	76.1%	★★	↔	64.0%	80.3%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA). See Table 7.1 for the full name of each HEDIS measure.
[2] HSAG's assignment of performance measures to the domains of care: quality (Q), access (A), and timeliness (T).
[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[5] Performance comparisons are based on the measures' confidence determined at a *p* value of <0.05.
[6] The MMCD's MPL is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile because a higher rate indicates poorer performance.
[7] The MMCD's HPL is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
† The MMCD's MPL and HPL were not applied to this measure because 2010 is the first year the DHCS required the measure.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (at the 25th percentile or between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.
Not Comparable = Performance could not be compared due to either significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

In 2009, the DHCS's EAS included two measures that were not included in the 2010 EAS, *Use of Appropriate Medications for People With Asthma* and *Well-Child Visits in the First 15 Months of Life*. HSAG excluded these measures in evaluating plan performance.

All of the 2010 MCMC weighted average performance measure results fell between the minimum performance levels (MPLs) and high performance levels (HPLs), which reflect the national Medicaid 25th and 90th percentiles. MCMC performance between 2009 and 2010 was fairly consistent with five out of the 15 applicable measures having statistically significant changes. *Breast Cancer Screening, Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent), Comprehensive Diabetes Care—Medical Attention for Nephropathy,* and *Appropriate Treatment for Children With Upper Respiratory Infection* all had significant increases in performance while *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* was the only measure with a significant decrease. The remaining nine measurements were not comparable to 2009's results because they were either added or removed from the EAS in 2010.

Plan-specific evaluation reports, produced in tandem with this report, provide additional results and findings.

HEDIS Improvement Plans (IPs)

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

For plan measure rates that required a 2009 HEDIS IP, HSAG compared the plan's 2009 IP with the plan's 2010 HEDIS scores 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 IPs and/or to develop new IPs.

In 2009, there were 18 HEDIS measures resulting in a total of 73 IPs required across all plans and counties, a rate of 25 percent. In 2010, there were 21 HEDIS measures resulting in a total of 85 IPs required across all plans and counties, also a rate of 25 percent, which indicates that the percentage of required IPs did not fluctuate year over year. In 2010, two measures (*ASM* and *W15*) were dropped from HEDIS reporting requirements, resulting in 12 IPs that were not required from the 2009 final results, bringing the total number of IPs required in 2010 to 61.

HSAG noted that health plans that produced no significant improvement showed a pattern of year-over-year poor performance. A review of the improvement plans showed that the health plans typically had not implemented new or modified interventions to address poor performance or lack of improvement from prior years. HSAG also noted that some of the health plans'

improvement plans were very broad and generic and did not contain measureable interventions and achievable outcomes.

For other health plans that did not necessarily show a continued pattern of poor performance, HSAG identified two key factors that may have contributed to their lack of success. First, the plans' interventions either did not align with the identified barriers or did not appropriately address the measure(s). Additionally, many plans implemented their interventions late in CY 2009; therefore, some interventions may not have been in place long enough to impact HEDIS 2010 rates.

Conclusions

Five full-scope plans demonstrated high performance across the EAS, exceeding seven or more of the DHCS's established high performance levels (HPLs), which represent the national Medicaid 90th percentile. San Francisco Health Plan—San Francisco County exceeded the HPL on 11 measures while Central California Alliance for Health—Monterey/Santa Cruz counties and Kaiser Permanente—Sacramento County exceeded the HPL on nine measures, and Kaiser Permanente—San Diego County exceeded the HPL on eight measures, followed by CenCal Health—Santa Barbara County, which had seven measures that exceeded the HPL. The remaining plans had zero to four measures that performed above the HPL.

Three plans showed the greatest opportunity for improvement, with 10 or more performance measures below the DHCS-established minimum performance level (MPL), which represents the national Medicaid 25th percentile. Anthem Blue Cross—Contra Costa County was below the MPL for 12 measures, followed by Anthem Blue Cross—Sacramento County with 11 measures, and Anthem Blue Cross—Alameda County with 10 measures. All other plans had zero to six measures that performed below the MPL.

In assessing plans' strengths across the performance measures, HSAG noted that the C*omprehensive Diabetes Care—Low-density Lipoprotein-Cholesterol (LDL-C) Control (<100 mg/dL)* and *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)* measures had the highest number of plans, 10 and 11, respectively scoring at or above the HPL. In addition, nine plans performed at or above the HPL for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure.

HSAG noted that the *Prenatal and Postpartum Care—Postpartum Care* measure showed the greatest opportunity for improvement, with 15 plans scoring below the DHCS-established MPL. In addition, 13 plans ranked below the MPL for *Adolescent Well-Care Visits*, and 11 plans performed below the MPL for *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.*

Recommendations

Based on the review of the 2010 HEDIS results, HSAG provides to the DHCS and the plans the following recommendations for continued improvement:

- Plans should consider selecting performance measures with poor rates as the focus for formal QIPs.
- Plans may consider working with other plans as part of a small-group collaborative QIP to address common areas of low performance since this approach has been effective in improving other performance measure rates.
- Plans need to implement targeted intervention strategies that link to identified barriers to increase performance.
- Plans need to use their data to help drive program decisions for targeted interventions.
- Plans need to consider evidence-based strategies when selecting interventions.
- Plans should evaluate whether intervention strategies used to achieve high performance could be applied to other areas of low performance.
- Plans with best practices should share their success in improving performance measures with other plans and State Medicaid programs.
- The DHCS needs to increase its oversight of HEDIS improvement plans by reviewing the content of the improvement plans to ensure that plans are implementing appropriate strategies that link to identified barriers. Additionally, the DHCS needs to require that plans modify or revise interventions that did not successfully improve rates in the previous year(s) of the improvement plan.
- The DHCS may consider selecting one of its low-performing EAS measures for the next statewide collaborative QIP since this approach has been successful with other measures.
- The DHCS should enforce minimum contract performance requirements through progressive penalties with plans that continue to show a pattern of poor performance over consecutive years.

Quality Improvement Projects

Validating performance improvement projects is one of the three mandatory external quality review activities described at 42 CFR §438.358(b)(1). The requirement allows states, agents that are not an MCO or PIHP, or an EQRO to conduct the mandatory activity.

In accordance with 42 CFR §438.240(d), the DHCS contractually requires plans to have a quality program that: (1) includes an ongoing program of QIPs designed to have a favorable effect on health outcomes and enrollee satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve improvement in quality.
- Evaluating the effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

The DHCS contracted with HSAG to conduct the functions associated with the validation of QIPs.

Conducting the Review

Plans must conduct and/or participate in two QIPs. For full-scope plans, this includes the MCMC-led statewide collaborative project and either an internal QIP (IQIP) or a small-group collaborative (SGC) QIP developed and conducted by at least four health plans, unless MMCD approves a smaller number. Specialty and prepaid health plans do not participate in the statewide collaborative. These plans conduct two IQIPs or a combination of an IQIP and an SGC appropriate to their member population. The DHCS requires plans to conduct QIPs at the county level unless otherwise approved to report combined county rates.

Plans submit QIP proposals to the DHCS for review and approval of the project topic. The DHCS reviews the QIP to determine its relevance to the Medi-Cal managed care population and whether the project has the ability to improve member health, functional status, or satisfaction. Once the DHCS approves the QIP proposal, HSAG conducts validation.

Plans perform data collection and analysis for baseline and remeasurement periods and report results to the DHCS and to HSAG for QIP validation at least annually. Once a QIP is complete,

the plan must submit a new proposal within 90 days to the DHCS to remain compliant with having two QIPs under way at all times.

Quality Improvement Project Requirements and Targets

The DHCS requires that plans achieve an overall *Met* validation status, which demonstrates compliance with CMS' protocol for conducting QIPs. If a plan achieves an overall *Partially Met* or *Not Met* status, the plan must resubmit its QIP after addressing areas of noncompliance.

Objectives

The purpose of a QIP is to achieve through ongoing measurements and interventions significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvement in care and for interested parties to have confidence in the reported improvements, the QIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time.

The primary objective of QIP validation is to determine each plan's compliance with the CMS protocol for conducting QIPs. HSAG validates QIPs using the CMS protocol, *Validating Performance Improvement Projects: A Protocol for Use in Validating Medicaid External Quality Review Activities,* final protocol, Version 1.0, May 1, 2002.

HSAG's review focused on the following areas:

- Assessing the plans' methodology for conducting QIPs.
- Evaluating the overall validity and reliability of study results.

Methodology

HSAG reviewed and assessed plan compliance with the following 10 CMS activities:

- Activity I. Appropriate Study Topic
- Activity II. Clearly Defined, Answerable Study Question(s)
- Activity III. Clearly Defined Study Indicator
- Activity IV. Correctly Identified Study Population
- Activity V. Valid Sampling Methods (if sampling was used)
- Activity VI. Accurate/Complete Data Collection
- Activity VII. Appropriate Improvement Strategies
- Activity VIII. Sufficient Data Analysis and Interpretation
- Activity IX. Real Improvement Achieved
- Activity X. Sustained Improvement Achieved

Each required protocol activity consists of evaluation elements necessary to complete a valid QIP. The QIP Review Team scored the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, or *Not Applicable (NA)*.

To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All of the critical elements had to be *Met* for the QIP to produce valid and reliable results. The scoring methodology also included the *Not Applicable* designation for situations in which the evaluation element does not apply to the QIP. HSAG used the *Not Assessed* scoring designation when the QIP had not progressed to the remaining activities in the CMS protocol.

Findings

HSAG first presents QIP validation findings that relate to the overall study design and structure to support a valid and reliable QIP and then presents QIP outcomes achieved during the review period. Plan-specific evaluation reports released in tandem with the technical report provide detailed analysis of QIP validation and project outcomes at the plan level.

Quality Improvement Project Validation Findings

Table 8.1 summarizes the validation results for all MCMC plan's QIP topics across CMS protocol activities during the review period.

Table 8.1—QIP Validation Results from July 1, 2009, through June 30, 2010 (N=77 QIPs)

QIP Study Stage	Activity	Percentage of Applicable Elements†		
		Met	*Partially Met*	*Not Met*
Design	I. Appropriate Study Topic	96% (441/461)	3% (13/461)	1% (7/461)
	II. Clearly Defined, Answerable Study Question(s)	96% (148/154)	4% (6/154)	0% (0/154)
	III. Clearly Defined Study Indicator(s)	92% (453/493)	8% (40/493)	0% (0/493)
	IV. Correctly Identified Study Population	91% (188/206)	9% (18/206)	0% (0/206)
Design Total †		**94% (1230/1314)**	**6% (77/1314)**	**1% (7/1314)**
Implementation	V. Valid Sampling Techniques (if sampling was used)	98% (47/48)	2% (1/48)	0% (0/48)
	VI. Accurate/Complete Data Collection	93% (307/329)	4% (13/329)	3% (9/329)
	VII. Appropriate Improvement Strategies	94% (147/156)	4% (6/156)	2% (3/156)
Implementation Total		**94% (501/533)**	**4% (20/533)**	**2% (12/533)**
Outcomes	VIII. Sufficient Data Analysis and Interpretation	86% (351/408)	13% (52/408)	1% (5/408)
	IX. Real Improvement Achieved	51% (94/184)	13% (24/184)	36% (66/184)
	X. Sustained Improvement Achieved	69% (9/13)	31% (4/13)	0% (0/13)
Outcomes Total		**75% (454/605)**	**13% (80/605)**	**12% (71/605)**
Overall QIP Results		**89% (2185/2452)**	**7% (177/2452)**	**4% (90/2452)**

† The sum of the *Met*, *Partially Met*, and *Not Met* scores in each activity or stage may not equal 100 percent due to rounding.

Beginning July 1, 2009, the DHCS required that plans comply with HSAG's validation requirements. In subsequent review periods, HSAG began providing plans with an overall QIP validation status of *Met, Partially Met,* and *Not Met*. DHCS releases quarterly QIP validation results

prepared by the EQRO on its Web site at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

MCMC plans accurately applied the QIP process for the Design stage, scoring 94 percent of the applicable evaluation elements *Met* for this stage. For the Implementation stage, the plans successfully documented the sampling, data collection, and improvement strategies, also scoring 94 percent of the applicable evaluation elements *Met*. For the Outcomes stage, the plans conducted the appropriate analyses and interpreted the results. However, the score was lowered for this stage since, in Activity IX, only eight of 46 QIPS (17 percent) demonstrated statistically significant improvement (considered "real improvement" or improvement that is unlikely due to chance) for all of the study indicator outcomes. Additionally, only 9 of 13 QIPs (69 percent) that were evaluated for sustained improvement achieved sustained improvement for all study indicator outcomes. However, all 13 of these QIPs achieved sustained improvement for at least one study indicator outcome. Sustained improvement is defined as improvement in performance over baseline which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Strengths

During the period covered by this report, plans demonstrated some success with their QIPs, including the implementation of strong interventions such as targeted case management, pay-for-performance strategies, and use of quality improvement tools throughout the QIP process.

Overall, plans did well with selecting an appropriate study topic by demonstrating the topic's relevance to the plans' MCMC members and using plan data to support the need for improvement. In addition, the DHCS and its partner plans selected a challenging statewide collaborative topic to reduce avoidable ER visits, demonstrating a strong commitment to address an area relevant to MCMC members and plans statewide. HSAG noted an effective process among the DHCS and all plans participating in this collaborative QIP as evidenced by cooperation, compromise, and a willingness to dedicate resources, all of which should ensure positive outcomes for the project.

Challenges

Validation results revealed that except for selecting an appropriate study topic, plans have an opportunity to improve compliance with the CMS protocol for conducting QIPs across activities to produce QIPs that have a greater likelihood of achieving improvement.

During the review period, HSAG also identified opportunities to strengthen the statewide ER collaborative QIP's study design and timeline to better reflect the actual progress of the

collaborative, accounting for delays in plan-specific and collaborative intervention implementation. HSAG recommended realignment of the baseline and remeasurement periods to coincide with measurement of implemented interventions.

Quality Improvement Project Outcomes

HSAG organized, aggregated, and analyzed QIP outcome data to draw conclusions about MCMC plan performance in providing quality, accessible, and timely care and services to its MCMC members.

Emergency Room Collaborative

The DHCS-led statewide collaborative QIP targeted the reduction of avoidable ER visits among members 12 months of age and older who could have been more appropriately managed by and/or referred to a PCP in an office or clinic setting. The statewide ER collaborative QIP fell under the quality and access domains of care. During the review period, plans reported both baseline and remeasurement data. Because they did not report a second remeasurement period, none of the QIPs were evaluated for sustained improvement.

Table 8.2—Emergency Room Collaborative Quality Improvement Project Outcomes July 1, 2009, through June 30, 2010

Plan Name	Statistically Significant Improvement[1]	Sustained Improvement[2]
Alameda Alliance for Health	No	Not Assessed
Anthem Blue Cross Partnership Plan	Yes	Not Assessed
CalOptima	No	Not Assessed
Care 1st	No	Not Assessed
CenCal Health Plan—Santa Barbara	No	Not Assessed
Central California Alliance for Health	Yes	Not Assessed
Community Health Group	Yes	Not Assessed
Contra Costa Health Plan	No	Not Assessed
Health Net^	No	Not Assessed
Health Plan of San Joaquin	Yes	Not Assessed
Health Plan of San Mateo	No	Not Assessed
Inland Empire Health Plan	Yes	Not Assessed
Kaiser Permanente—Sacramento	No	Not Assessed
Kaiser Permanente—San Diego	No	Not Assessed
Kern Family Health Care	No	Not Assessed
L.A. Care Health Plan	No	Not Assessed
Molina Healthcare of California—Riverside	No	Not Assessed
Molina Healthcare of California—San Bernardino	No	Not Assessed
Molina Healthcare of California—Sacramento	No	Not Assessed

Table 8.2—Emergency Room Collaborative Quality Improvement Project Outcomes July 1, 2009, through June 30, 2010

Plan Name	Statistically Significant Improvement[1]	Sustained Improvement[2]
Molina Healthcare of California—San Diego	No	Not Assessed
Partnership Health Plan	No	Not Assessed
San Francisco Health Plan	No	Not Assessed
Santa Clara Family Health	No	Not Assessed
Western Health Advantage	No	Not Assessed

Note: HSAG assessed QIPs for improvement at the overall plan level during the review period since the methodology did not exist for county-level validation when the QIP was initiated.

[1] Statistically significant improvement is defined as improvement between any of the remeasurement periods that is not due to chance.

[2] Sustained improvement is defined as improvement maintained at the last remeasurement period compared to the baseline period, with no statistically significant decrease.

^ All counties in the health plan.

Yes = Statistically significant Improvement noted for at least one of the QIP study indicators.

No = None of the indicators had a statistically significant improvement

Not Assessed = QIPs did not progress to a second remeasurement period; therefore, HSAG could not assess for sustained improvement.

Internal and Small Group Collaborative QIPs

Not including the ER collaborative QIP submissions, a total of 22 QIPs validated during the review period reached the point of at least one remeasurement period. For these QIPs, HSAG assessed for statistically significant improvement defined as improvement that is not due to chance. Of the 22 QIPs that had one remeasurement period, 13 progressed to the point of at least two remeasurement periods. For these 13 QIPs, HSAG assessed for sustained improvement in addition to statistically significant improvement. Sustained improvement is defined as improvement in performance over baseline which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Table 8.3 displays the 22 QIPs assessed for project outcomes during the review period by plan QIP project name, and indicates projects that had statistically significant improvement and/or sustained improvement.

Table 8.3—Quality Improvement Project Outcomes—July 1, 2009, through June 30, 2010

Plan Name	QIP Project Name	Statistically Significant Improvement[1]	Sustained Improvement[2]
AHF Healthcare Centers	*Reducing Adverse Reactions to Coumadin for Patients With HIV/AIDS*	No	Yes
	Controlling High Blood Pressure	Yes	Yes
Alameda Alliance for Health	*Decrease Return ER Visits for Asthmatic Exacerbations in Children 2–18*	No	Not Assessed
CalOptima	*Appropriate Treatment for Children With an Upper Respiratory Infection*	Yes	Yes
Care 1st	*Appropriate Treatment of COPD*	Yes	Yes
	Appropriate Treatment for Children With an Upper Respiratory Infection	Yes	Not Assessed
CenCal Health Plan—Santa Barbara	*Proper Antibiotic Use*	Yes	Yes
Central California Alliance for Health	*Improving Effective Case Management*	Yes	Not Assessed
Community Health Group	*Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD*	No	Not Assessed
	Increasing Screening for Postpartum Depression	Yes	Not Assessed
Health Net^	*Appropriate Treatment for Children With an Upper Respiratory Infection*	Yes	Yes
Health Plan of San Joaquin	*Chlamydia Screening*	Yes	Not Assessed
Health Plan of San Mateo	*Cervical Cancer Screening*	No	Yes
Kaiser Permanente— San Diego	*Improving Blood Sugar Level in Diabetic Members*	Yes	Yes
L.A. Care Health Plan	*Appropriate Treatment for Children With an Upper Respiratory Infection*	Yes	Yes
Molina Healthcare of California–Riverside/San Bernardino	*Appropriate Treatment for Children With an Upper Respiratory Infection*	Yes	Yes
Molina Healthcare of California—Sacramento	*Appropriate Treatment for Children With an Upper Respiratory Infection*	Yes	Yes
Molina Healthcare of California—San Diego	*Appropriate Treatment for Children With an Upper Respiratory Infection*	Yes	Yes
Partnership Health Plan	*Improving Asthma Management*	Yes	Yes
Santa Clara Family Health	*Adolescent Obesity Prevention*	Yes	Not Assessed
SCAN Health Plan	*Prevention of Stroke and Transient Ischemic Attack*	Yes	Not Assessed
	Chronic Obstructive Pulmonary Disease Management	No	Not Assessed

[1] Statistically significant improvement is defined as improvement between the two most recent remeasurement periods that is not due to chance.

[2] Sustained improvement is defined as improvement maintained at the last remeasurement period compared to the baseline period, with no statistically significant decrease.

^ Results are for all of the counties in the health plan since the methodology did not exist for county-level validation at the beginning of the QIP.

Yes = (1) Statistically significant Improvement over the prior measurement period noted for at least one of the QIP study indicators, or (2) sustained improvement was achieved for at least one of the study indicators.

No = (1) None of the indicators had a statistically significant improvement over the prior measurement period, or (2) sustained improvement was not achieved for any of the study indicators.

Not Assessed = (1) QIP did not progress to a second remeasurement period, or (2) a subsequent measurement period was not reported after first achieving improvement over baseline; therefore, HSAG could not assess for sustained improvement.

Seventeen of the 22 QIP submissions assessed for statistically significant improvement achieved statistical significance for at least one of the QIP study indicators during the review period. Eight of the 17 achieved statistically significant improvement for all QIP study indicators.

Of the 13 QIPs assessed for sustained improvement, all 13 achieved sustained improvement for at least one of the QIP study indicators. Sustained improvement is defined as improvement in performance over baseline which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

QIP outcomes during the review period resulted in the following:

Asthma Management

- Partnership Health Plan in Napa, Solano, and Yolo counties improved and sustained the percentage of members with asthma who received controller medications. Additionally, the plan increased the percentage of persistent asthmatics with less than nine canisters of beta-agonist medication and the percentage of persistent asthmatics without ED visits. The results of these three indicators reflected improved quality of care.

Childhood Obesity Prevention

- Santa Clara Family Health—Santa Clara County improved the quality of care delivered to adolescents by increasing the obesity screening rate from baseline to the first remeasurement period. With the proper documentation of BMI, the plan can target counseling for nutrition and physical activity to the adolescents requiring a reduction in BMI.

Controlling Hypertension

- AHF Healthcare Centers—Los Angeles County, from baseline to the second remeasurement period, improved and sustained the percentage of members with a diastolic blood pressure below 90 mm Hg and the percentage of members with a systolic blood pressure below 140 mm Hg, thereby improving the quality of care for members diagnosed with hypertension.

COPD Assessment, Diagnosis, and Treatment

- For Care 1st—San Diego County's *Appropriate Treatment for COPD* QIP, all study indicators demonstrated improvement, and the improvement in the percentage of COPD members that were provided smoking cessation counseling was statistically significant. Additionally, the plan was able to demonstrate sustained improvement from baseline to the second remeasurement period for providing members with COPD spirometry testing, pneumococcal vaccinations, and counseling on smoking cessation, which demonstrated improved quality of care for these members.

Diabetes Management

- Kaiser Permanente—San Diego County's QIP demonstrated statistically significant and sustained improvement for increasing hemoglobin A1c (HbA1c) testing for members with diabetes who had at least one glycemic test within the previous 12 months. By improving testing rates, the plan has a greater opportunity to intervene with members to control the HbA1c level, a more important determinant of member health.

Effective Case Management

- Central California Alliance for Health—Monterey and Santa Cruz counties documented a statistically significant decrease in hospital discharges for congestive heart failure (CHF),which represents an increase in performance. The plan's project improved the quality of care delivered to members with CHF and may also indicate more effective case management of chronic diseases.

Improving Women's Health

- Community Health Group—San Diego County demonstrated a statistically significant increase in the percentage of women who were screened for postpartum depression and also the percentage of women who were screened for postpartum depression using a screening tool. By improving screening rates, the plan can identify members who test positive for depression and provide the necessary follow-up care, thereby improving the quality of care.
- Health Plan of San Joaquin—San Joaquin County improved the quality of care delivered to women by demonstrating a statistically significant increase in the percentage of women screened for chlamydia. Improved screening rates potentially address both suboptimal care and limited access to PCPs.
- Health Plan of San Mateo—San Mateo County improved cervical cancer screening rates and sustained the improvement from baseline to the second remeasurement period. Improved screening rates are an indicator of increased preventive services and improved quality of care delivered to women.

Proper Antibiotic Use

To improve appropriate treatment for URIs in children, CalOptima—Orange County; Care 1st—San Diego County; Health Net in Fresno, Los Angeles, Kern, Sacramento, San Diego, Stanislaus, and Tulare counties; L.A. Care—Los Angeles County; and Molina—Riverside, Sacramento, San Bernardino, and San Diego counties, participated as collaborative partners with 16 health plans on the California Medical Association's Alliance Working for Antibiotic Resistance Education (AWARE) to develop and disseminate the Antibiotic Awareness Provider Toolkit. The small-group collaborative QIP yielded success among MCMC plan partners in improving the quality of care to children. Each plan submitted an *Appropriate Treatment for Children With an Upper Respiratory Infection* (*URI*) QIP.

- CalOptima—Orange County showed a statistically significant increase over baseline which was sustained from baseline to the second remeasurement period for one of its study indicators, which increased the percentage of children 3 months to 18 years of age who received appropriate treatment for a URI. Additionally, the plan reported a statistically significant increase in the percentage of high-volume PCPs who appropriately treated URIs for members less than 19 years of age.
- Care 1st—San Diego County also showed a statistically significant increase over baseline which was sustained from baseline to the second remeasurement period for increasing the percentage of children 3 months to 18 years of age who received appropriate treatment for a URI. Additionally, the plan reported a statistically significant increase in the percentage of high-volume PCPs who appropriately treated URIs for members less than 19 years of age.
- Health Net in Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties demonstrated statistically significant improvement for both study indicators in its *URI* QIP. The plan increased the percentage of its high-volume primary care physicians that provide appropriate treatment of URI to at least 80 percent of eligible URI patients. Additionally, the plan improved the overall percentage of children not prescribed an antibiotic for an upper respiratory infection.
- L.A. Care—Los Angeles County's reported statistically significant and sustained improvement from baseline to Remeasurement 2 rate for the percentage of children who were diagnosed with a URI and not dispensed an antibiotic.
- Molina—Riverside, Sacramento, San Bernardino, and San Diego counties all demonstrated statistically significant improvement and sustained improvement from baseline to the second remeasurement period for decreasing the inappropriate prescribing of antibiotics for URI by PCPs and increasing the appropriate treatment of URI for children ages 3 months to 18 years.

Individual plan QIPs related to proper antibiotic use resulted in additional improvement.

- CenCal Health—Santa Barbara County demonstrated statistically significant and sustained improvement from baseline to the second remeasurement period for appropriate treatment for children with pharyngitis and appropriate treatment for children with a URI. Both study indicators improved the quality of care delivered to members by helping to ensure that providers were prescribing according to practice guidelines.

Reducing Adverse Reactions to Medications

- AHF Healthcare Centers—Los Angeles County's QIP to reduce adverse reactions in members on continuous Coumadin demonstrated good quality of and access to care for members. The plan demonstrated better international normalized ratio (INR) levels for members. INR levels that exceed 4.0 indicate an increased risk of bleeding, with no therapeutic benefit.[10] AHF was able to sustain the statistically significant improvement over the baseline rate. Although AHF did not have a statistically significant decrease in the rate of anticoagulation-related hospital

[10] AHF Healthcare Centers. 2008–2009 QIP Summary Form. Reducing Adverse Reactions to Coumadin for Patients with HIV/AIDS.

admissions, the plan was able to sustain the improvement reached that none of the plan's members were hospitalized due to an adverse reaction to Coumadin.

Reducing Avoidable Emergency Room Visits

MMCD selected reducing avoidable ER visits as the statewide collaborative topic beginning in 2007 in response to utilization patterns and findings from the Institute of Medicine's report, *Emergency Medical Services at the Crossroads*. MMCD also selected the topic to improve member access to primary care while encouraging preventive care, which can avoid or minimize the damaging effects of chronic disease. The QIP outcome was to reduce the percentage of avoidable ER visits among members older than 1 year of age. The following plans achieved statistically significant improvement between the most recent measurement periods:

- Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulane counties
- Central Coast Alliance for Health—Merced, Monterey, and Santa Cruz counties
- Community Health Group—San Diego County
- Health Plan of San Joaquin—San Joaquin County
- Inland Empire—Riverside and San Bernardino counties

Stroke and TIA Prevention

- SCAN Health Plan—Los Angeles, Riverside, and San Bernardino counties' QIP to decrease the incidence of stroke and transient ischemic attack (TIA) demonstrated good quality of care for members. By the first remeasurement period, SCAN reported a statistically significant decrease in the incidence of stroke and TIA for members without a prior history of stroke.

Quality Improvement Outcome Challenges

While most plans experienced some success with QIP outcomes, a few plans had challenges with demonstrating improvement, and many had difficulty achieving improvement for all study indicators. HSAG's review of the QIPs showed several factors that may have contributed to the lack of desired results.

- Plans did not link interventions to specific barriers associated with the QIP study indicators.
- Plans implemented interventions late in the measurement year that may not have been in place long enough to yield improvement.
- Plans implemented interventions based on past success without conducting a barrier analysis to determine if the same barrier exists.

Conclusions

Despite challenges with validation requirements, the plans had many QIPs during the review period that demonstrated statistically significant improvement and/or sustained improvement. These successful QIPs resulted in outcomes that spanned the quality, access, and timeliness domains of care. Plans demonstrated improvement by reducing adverse reactions to medications, increasing proper antibiotic use, improving diabetes management, increasing childhood immunizations, improving control of asthma, and providing timely prenatal and postpartum care.

Recommendations

HSAG provides the following recommendations for improving the quality and timeliness of, and access to, care and services that plans provide to members based on QIP performance findings:

- Plans need to implement targeted interventions that link to specific barriers identified as part of the barrier analysis.
- Plans should conduct QIP data analysis and implement and/or modify interventions as early as possible during the measurement period to provide enough time for the interventions to succeed.
- Plans should select QIP study indicators based on areas of actionable performance.

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with managed care plans, measure and report on performance to assess the quality and appropriateness of care and services provided to members. The California Department of Health Care Services (DHCS) periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members.

The administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] Surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS Surveys are administered to both adult members and parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

Findings

In order to assess the overall performance of the MCMC Program, HSAG aggregated results and compared them to the National Committee for Quality Assurance's (NCQA's) HEDIS benchmarks and thresholds or NCQA's national Medicaid data, where applicable. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating (i.e., *Poor*) and five is the highest possible rating (i.e., *Excellent*).

Table 9.1 shows the MCMC Program's star ratings for each global rating and composite measure.

Table 9.1—Medi-Cal Managed Care Program 2010 CAHPS National Comparisons Results

Measure	Adult Medicaid	Child Medicaid
Global Ratings		
Rating of Health Plan	★	★★
Rating of All Health Care	★	★
Rating of Personal Doctor	★	★★
Rating of Specialist Seen Most Often	★★	★★★
Composite Measures		
Getting Needed Care	★	★
Getting Care Quickly	★	★
How Well Doctors Communicate	★	★
Customer Service	★	★★
Shared Decision Making	★	★

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

The MCMC Program results showed generally *Poor* or *Fair* star rating performance across the global ratings and composite measures for both the adult and child populations when compared to national Medicaid data. The *Rating of Specialist Seen Most Often* measure for the child Medicaid survey was the exception and showed *Good* performance when compared to national data.

Conclusions and Recommendations

The MCMC Program demonstrates a commitment to monitor and improve members' satisfaction through the administration of the CAHPS Survey. The CAHPS Survey plays an important role as a quality improvement tool for plans. The standardized data and results can be used to identify relative strengths and weaknesses in performance, identify areas for improvement, and trend progress over time.

Based on 2010 CAHPS performance, there are opportunities to improve members' satisfaction with care and services within the plans. Most measures received *Poor* or *Fair* star ratings when compared to national Medicaid data.

The *Rating of Health Plan*, *Getting Needed Care*, and *Getting Care Quickly* measures offer the greatest opportunities for plan improvement. Low performance in these areas may point to issues with access to and timeliness of care.

HSAG provides the following global recommendations for improvement:

- The plans need to conduct a barrier analysis or focus groups to identify factors contributing to areas of low performance and consider implementing interventions.
- Plans should consider selecting member satisfaction measure(s) as a formal quality improvement project and strategy for improving results.
- Plans that demonstrated above average performance should share initiatives and strategies that have been successful in meeting and exceeding members' expectations.

Findings, Conclusions, and Recommendations Regarding Health Care Quality, Access, and Timeliness

The Centers for Medicare & Medicaid Services (CMS) chose the domains of quality, access, and timeliness as keys to evaluating the performance of Medicaid managed care plans. HSAG provides overall findings, conclusions, and recommendations regarding the DHCS's aggregate performance during the review period for each domain of care.

Quality

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

The DHCS uses performance measures and QIP results to assess care delivered to members by a plan in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, the DHCS monitors aspects of a plan's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems.

For this report, HSAG used the MCMC 2010 performance measure rates (which reflect 2009 measurement data), QIP validation results and outcomes, compliance review standards, and CAHPS results related to measurement and improvement to assess the quality domain of care.

To create a uniform standard for assessing plans on MCMC-required performance measures, the DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPLs indicate low performance, rates at or above the HPLs indicate high performance, and rates at the MPLs or between the MPLs and HPLs demonstrate average performance. HSAG used the MCMC HEDIS® 2010 weighted averages and compared them to the MCMC-established MPLs and HPLs to assess overall performance.

All plans were able to report valid HEDIS 2010 performance measures rates, and all of the MCMC rates were between the MPL and HPL. The plans greatest collective strength was in delivering quality care to members with diabetes. HSAG noted that the *Comprehensive Diabetes Care—Low-density Lipoprotein-Cholesterol (LDL-C) Control (<100 mg/dL)* and *Comprehensive Diabetes Care—Poor HbA1c*

Control (>9.0 Percent) measures had the highest number of plans, 10 and 11, respectively, scoring at or above the HPL. In addition, nine plans performed at or above the HPL for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure. The MCMC program had four statistically significant increases in quality-related performance measures rates, two relating to diabetes care, one for breast cancer screening, and one for increasing rates for the appropriate treatment for children with upper respiratory infection.

Quality of care performance measures showing the greatest opportunity for improvement are the *Prenatal and Postpartum Care—Postpartum Care* measure (15 plans scored below the DHCS-established MPL) and *Adolescent Well-Care Visits* (13 plans ranked below the MPL).The DHCS requires that plans perform above the MPL for all measures and those that are not compliant are required to submit HEDIS improvement plans. Approximately half of the required HEDIS improvement plans based on the 2009 HEDIS rates resulted in rates above the MPL in 2010.

Despite some improvement, the measures for thirty-two of the improvement plans remained below the MPLs; therefore, the health plans will need to continue implementing their improvement efforts until they achieve the MPLs. HSAG noted that health plans that produced no significant improvement showed a pattern of year-over-year poor performance. A review of the improvement plans showed that the health plans typically had not implemented new or modified interventions to address poor performance or lack of improvement from prior years, which represents an opportunity for improvement. HSAG also noted that some of the health plans' improvement plans were very broad and generic and did not contain measureable interventions and achievable outcomes.

Plans were most successful with QIP validation results related to the study design and implementation phases of a QIP. Many plans struggled to achieve statistically significant improvement and/or sustained improvement in health care outcomes, while some plans showed improvement in the areas of proper antibiotic use and women's health measures such as chlamydia, cervical cancer, and postpartum depression screening.

Medical performance review findings during the review period revealed that overall, plans met the standards for quality management and organizational capacity, both of which support the delivery of quality care. Opportunities for improvement in the area of medical performance review relate to plans' analyzing and reporting monitoring activities through the formal quality improvement structure or within the plans' internal evaluation. Many plans had repeat areas of noncompliance from the previous audit, suggesting that they did not incorporate audit and review findings as part of their work plan to ensure action would be taken to correct deficiencies and to conduct ongoing monitoring.

Member satisfaction survey results were low across child and adult surveys. The *Rating of Health Plan*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often* measures all impact the quality of care delivered to members.

Access

The access domain of care relates to a plan's standards, established by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members.

The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess plan compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

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

MCMC had strengths as well as opportunities for improvement under the access domain of care. HSAG based its assessment on 2010 performance measure weighted average rates that related to access, QIP outcomes that addressed access, compliance review standards, and CAHPS results related to the availability and accessibility of care.

MCMC weighted average rates showed mixed performance regarding access, with all measures falling between the MPL and HPL; however, many plans continued to have challenges providing postpartum care to woman and providing well-care visits to adolescents. The statewide collaborative QIP aimed at reducing avoidable ER visit rates had few plans demonstrate success in reducing these rates. Those that had success implemented strategies to improve access to care for members in alternative settings.

Based on medical performance audits and MRPIU review findings, overall, plans demonstrated compliance with many aspects of availability and accessibility of services; however, areas of deficiency for plans were related to standards that demonstrate actual implementation and/or monitoring of processes consistent with policies and procedures. These findings were related to monitoring of provider wait times and monitoring providers' compliance with cultural and linguistic requirements.

Member satisfaction survey results showed some of the lowest performance for both child and adults in the areas of *Getting Needed Care* and *Getting Care Quickly*. These areas may point to issues with access to care.

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, minimize any disruptions to care, and provide a health care service quickly after a need is identified.

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, the grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service after a need is identified within a recommended period of time.

Based on 2010 performance measure rates for providing timely care, QIP outcomes, compliance review standards, and CAHPS results, the DHCS demonstrated both strengths and challenges in the timeliness domain of care.

All 2010 MCMC weighted average performance measure scores related to timeliness of care fell between the MPLs and HPLs.

QIPs showed some success in improving screening rates for women's health measures, which can be linked to improved performance for providing care after a need is identified.

Compliance review findings showed that, overall, plans had an established utilization management program and a member grievance system supported by policies and procedures that met program requirements to facilitate timely care decisions. Despite adequate systems, findings in the timeliness domain of care were related to prior-authorization notifications and timely member grievance acknowledgment and resolution.

Low member satisfaction results related to *Getting Needed Care* and *Getting Care Quickly* measures spans across both timeliness and access domains of care; both measures represent a significant opportunity for improvement.

Conclusions and Recommendations

Overall, the DHCS and its contracted plans implemented various initiatives and demonstrated success with many aspects of providing quality, accessible and timely health care services to MCMC members.

MCMC 2010 performance measure weighted averages all fell between the MPLs and HPLs and remained steady compared with 2009 rates, with four statistically significant increases and one statistically significant decline. Performance measures fall primarily under the quality domain of care, although several measures also impact the access and timeliness domains of care. HSAG noted two key factors that may have contributed to individual plan performance below the MPLs—misalignment between identified barriers and interventions, and implementation of interventions late in the measurement year.

QIPs assessed for real and sustained improvement demonstrated successful health outcomes by improving proper antibiotic use and increasing women's health measures in the areas of chlamydia, cervical cancer, and postpartum depression screening. Despite the success demonstrated in many QIPs during the review period, the plans' greatest opportunity is to improve the Outcomes stage of the QIP.

MCMC plans as a whole demonstrated compliance and resolution of many outstanding medical performance review findings. Opportunities exist in the areas of prior-authorization notifications and member grievances which primarily impact the access and timeliness domains of care. However, by incorporating monitoring of these deficient areas into their quality programs, many plans can help to ensure that issues are resolved and improve overall program effectiveness.

HSAG's review of the DHCS's efforts in monitoring the plans for compliance with federal and State standards revealed the Department's robust and thorough readiness review process. Before providing any services to MCMC members, all plans are required to complete this process. HSAG also became aware of the DHCS's ongoing monitoring activities and its collaborative approach with plans to resolve areas of concern. Opportunities exist for the DHCS to formalize its compliance monitoring process to provide meaningful information for future program decisions.

Based on the overall assessment of the MCMC Program in the areas of quality and timeliness of and access to care, HSAG provided detailed recommendations for each of the three required activities in subsequent sections of this report. Additionally, HSAG provided recommendations to each plan in the plan-specific evaluation reports. These recommendations were based on individual plan results as they related to the quality and timeliness of and access to care.

HSAG will evaluate plans' progress with these recommendations along with their continued successes in the next annual review.

APPENDIX A: GRID OF 2008–2009 EQR RECOMMENDATIONS AND THE DHCS'S FOLLOW-UP

The table below provides the 2008–2009 EQR recommendations and DHCS actions taken through June 30, 2010, that address the recommendations.

Table A.1—Grid of 2008–2009 EQR Recommendations and DHCS Follow-Up

2008–2009 EQR Recommendation	DHCS Actions Through June 30, 2010, That Address the Recommendation
Identify plans with consistently poor performance and implement progressive penalties until performance rates reach the acceptable levels as required by the contract.	The DHCS annually tracks plans' HEDIS scores, including those that fall below the MPL. The tracking tool used by the DHCS shows HEDIS trending since 1999. The DHCS has initiated discussions regarding developing thresholds and procedures for corrective action plans for health plans that consistently score below the established MPLs. The DHCS has also initiated discussions regarding the feasibility of implementing penalties in other plan performance areas such as encounter data quality.
Continue efforts to improve plans' compliance with the CMS protocol for conducting QIPs through revisions of program requirements and technical assistance.	The DHCS improved its tracking and communication process to ensure that plans are using the correct QIP form and to encourage plans to make timely submissions. The DHCS will update the Quality Assurance Guide for release in November 2010, which will clarify changes and enhancements to the process.
Develop and implement a formal scoring mechanism for compliance monitoring results across activities and provide the mechanism to plans to improve their compliance with federal and State standards.	DHCS staff meet quarterly to discuss plans' performance in order to identify areas that require intervention. The DHCS also regularly monitors contractually required submissions including, but not limited to, network adequacy, grievances and appeals, and call center reports. The DHCS initiated discussions in order to: (1) improve the meeting process to strengthen follow-through with affected health plans, and (2) investigate the feasibility of implementing a formal scoring mechanism for compliance monitoring using current health plan contract submissions and other plan performance data.
The DHCS should consider conducting a crosswalk of all State and federal requirements across monitoring activities to determine the area responsible for monitoring and to ensure that all requirements are monitored at a frequency of at least every three years.	Prior to receiving contract approval from CMS, the DHCS is required to include all federal requirements in each contract. The DHCS accomplishes this through the use of a tool, commonly called the "BBA Checklist." In addition, the DHCS crosswalks the requirements outlined in the Knox-Keene licensee requirements (Department of Managed Health Care has oversight) against the DHCS's regulation, statute, and contract requirements. The DHCS uses established guidelines to review all plan submissions, policies, procedures, and corrective action plans. These guidelines reference applicable federal and State regulations, DHCS All Plan Letters, and contract requirements.

Table A.1—Grid of 2008–2009 EQR Recommendations and DHCS Follow-Up

2008–2009 EQR Recommendation	DHCS Actions Through June 30, 2010, That Address the Recommendation
The DHCS needs to develop a central repository for compliance monitoring results across the DHCS and Department of Managed Health Care (DMHC) and develop a process for aggregating results for plan-specific performance.	The DHCS and DMHC operate as separate departments and review the health plans for different areas of compliance. The DHCS conducted an internal review to determine the next steps to create a central repository for compliance monitoring results across the DHCS and DMHC.
The DHCS should establish thresholds or guidelines for staff when reviewing plan deliverables to ensure that requirements are consistently applied.	The DHCS's monitoring units have established guidelines for staff to review all plan submissions, policies and procedures, and corrective action plans. These guidelines reference applicable federal and State regulations, DHCS All Plan Letters, and contract requirements. MMCD is continually revising and refining review and monitoring tools and guidelines.
The DHCS should develop and implement a formal scoring mechanism for compliance monitoring results to allow the DHCS to trend plan performance over time, compare performance across plans, and provide plans with feedback.	The DHCS annually tracks plans' HEDIS scores that fall below or above the MPL and HPL. The tracking tool used by the DHCS shows HEDIS trending since 1999. The DHCS is developing HEDIS thresholds and procedures for HEDIS corrective action plans. The DHCS's monitoring unit annually summarizes the performance of and compares performance across health plans.
The DHCS should formalize a process to document concerns with plan performance, recommendations, and actions as appropriate.	The DHCS conducts pre-audit conferences between the Member Rights/Program Integrity Unit, the Medical Monitoring Unit, and the Audits and Investigations Division to discuss and document concerns. The DHCS conducts quarterly internal meetings in which staff document and discuss concerns with plan performance in order to take appropriate actions.
The DHCS should develop and maintain an overall compliance monitoring schedule by plan to ensure that all standards are reviewed at least every three years.	The DHCS's monitoring units have regularly scheduled monitoring reviews of health plans. Monitoring reviews vary in occurrence, from annually to every three years. Reviews are conducted by MMCD's Member Rights and Program Integrity Unit biennially. The DHCS's Audits & Investigations Division conducts audits, supplemented by the Medical Monitoring Unit's close-out reports, which are scheduled to occur every three years.