Medi-Cal Managed Care Program Technical Report

July 1, 2010–June 30, 2011

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

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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care Program ("MCMC," "MCMC Program," or "the Program") to approximately 4.3 million beneficiaries (as of June 2011) throughout the State of California through a combination of contracted full-scope and specialty managed care plans (collectively referred to as "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, DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to aggregate and analyze MCMC 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, 2010, through June 30, 2011.
- 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 2011. 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 2010–2011 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 MCMC's results for plans' compliance with State and federal requirements for organizational and structural performance. Additionally, HSAG evaluated the Program's compliance monitoring process and recommended modifications to improve its monitoring and reporting of the plans' compliance with State and federal standards.
- ***Validation of performance measures.*** HSAG validated performance measures required by MCMC 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 Program. 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 MCMC, 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 nine 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 its service delivery system, and the assignment of domains of care.

Section 3—Medi-Cal Managed Care Program Quality Strategy summarizes the MCMC's quality assessment and performance improvement strategy goals and objectives.

Section 4—Health Plan Operations and Structure

Section 5—Performance Measures

Section 6—Quality Improvement Projects

Sections 4, 5, and 6, 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 7—Medi-Cal Managed Care Program Initiatives highlights MCMC's 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 8—Plan Best and Emerging Practices highlights plan-specific activities that are unique and effective in demonstrating improvements in care or services.

Section 9—Overall Findings, Conclusions, and Recommendations on plans' performance on providing health care quality, access, and timeliness of services provided to MCMC members.

Appendix A—Grid of 2009–2010 EQR Recommendations and MCMC's Follow-Up provides the 2009–2010 EQR recommendations and MCMC's actions that address the recommendations.

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, 2010, through June 30, 2011, 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 4.3 million beneficiaries enrolled as of June 2011 in the MCMC Program received care from 21 full-scope plans, 3 specialty plans, and 1 prepaid health plan operating in 25 of California's 58 counties. DHCS administers the MCMC Program through a service delivery system that mainly encompasses three plan model types: County-Organized Health System (COHS), Geographic Managed Care (GMC), and Two-Plan.

County-Organized Health System

In a COHS model, 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 covered by a COHS plan 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 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 persons 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, 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, DHCS requires beneficiaries with designated mandatory aid codes to enroll in a plan, while seniors and persons 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, DHCS contracted with three specialty 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 2011 measurement period. MCMC requires each specialty plan and PHP to report annually on two MCMC-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 became mandatory for seniors and persons with disabilities who do not have other health coverage (Medi-Cal only). For more information about this change, see the "Medi-Cal Managed Care - 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.

[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.

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.

[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 MCMC Program finalized its updated quality strategy to replace the initial 2004 document. The Program publically released its most current *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.

MCMC's 2009 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 MCMC Program 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

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, MCMC outlined the following objectives in its 2009 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 persons 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

MCMC established the following seven strategies in the Program's 2009 quality strategy:

- Establish a process by 2010 that ensures that all beneficiaries enrolled in the MCMC Program 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 persons with disabilities into the MCMC Program 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 persons with physical disabilities.
- Implement one or more performance standards and measures for MCMC 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 system-wide 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 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

The *Medi-Cal Managed Care Program Quality Strategy—December 2009* states that the Program 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 Program's strategy report 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 MCMC with feedback on its revised quality strategy and identified some areas that the Program needed to address including:

- A description of the formal process that MCMC will use to obtain beneficiary stakeholder input and public comment before final adoption.
- The definition MCMC uses to define "significant" changes to the strategy that would trigger the need to solicit stakeholder input.
- A description of MCMC's efforts to collect information on ethnicity and primary language spoken for any beneficiary receiving Supplemental Security Income (SSI).
- MCMC's identification, definition, and categorization of race, ethnicity, and primary language spoken.
- A description of how MCMC uses sanctions against the plans in support of its quality strategy and ensures that the plans meet the regulation requirements. Additionally, the description should include the Program'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 DHCS's Medi-Cal Managed Care Division's (MMCD's) 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 MCMC Program, and the Program 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. MCMC 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. MCMC is in the process of updating its quality strategy, which is expected to be released in 2012.

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.

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

Areas within MMCD responsible for monitoring include 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, DHCS's Audits and Investigations (A&I) Division works in tandem with MRPIU and MMU and participates in a joint audit process with the California 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, 2011, for each plan related to compliance monitoring standards within the CFR. Additionally, HSAG used information from plan-produced internal quality evaluations as appropriate, in conjunction with MCMC'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 MCMC Program conducted monitoring of plans' compliance with operational standards in collaboration with other State entities through a variety of activities, including:

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

Table 4.1 displays the areas that conduct each respective monitoring activity across DHCS (MMCD and A&I) and DMHC.

Table 4.1—Department of Health Care Services Monitoring Activities by Responsible Area

Responsible Area	Monitoring Activities		
	Readiness Review	Joint Medical Performance Review	Member Rights and Program Integrity Review
MMCD Plan Management Branch	X		
MMCD Member Rights and Program Integrity Unit			X
MMCD Medical Monitoring Unit	X	X	
MMCD Medical Policy Section	X		
DHCS Audits and Investigations		X	

Readiness Reviews

MCMC assesses plans' operational standards and structure through a readiness review of contract deliverables before it allows the plans to operate under the MCMC Program. Once operational, the Program performs ongoing monitoring of the plans.

Medical Performance Reviews

Medical performance reviews assess plans' compliance with contract requirements and State and federal regulations. The scope of these reviews covers the areas of utilization management, continuity of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity. Medical performance reviews are often a collaborative effort by various State entities. DHCS's A&I Division (A&I) and DMHC conduct joint reviews once every three years for most plans. In some instances, however, medical performance reviews are conducted solely by A&I or DMHC. A&I and DMHC conduct non-joint medical reviews for some of the plans.

A&I 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 A&I non-joint reviews and DMHC-A&I joint reviews, MMCD's MMU provides follow-up monitoring of the plan's unresolved findings. MMU provides the plan an additional six months after the audit close-out to resolve remaining deficiencies before issuing a final close-out letter.

Member Rights and Program Integrity Reviews

MMCD's MRPIU is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud, waste, and abuse prevention and detection). 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, 2009, through June 30, 2010), HSAG, as the new EQRO, evaluated MCMC's compliance monitoring process of the plans against federal requirements. HSAG identified various strengths and offered several recommendations to MCMC to improve the compliance monitoring process of its managed care plans.

During the review period covered in this report (July 1, 2010, through June 30, 2011), 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 mostly consistent strengths of MCMC's monitoring process, as well as many of the same opportunities for improvement. A detailed statement provided by MCMC is provided in Appendix A, "Grid of 2009–2010 EQR Recommendations and MCMC's Follow-Up."

Strengths

- Evaluating plan performance over time and implementing corrective action plans (CAPs) with plans that demonstrate continued poor performance in the area of performance measures.
- 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.

- Continuing a monitoring initiative to create 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

- Although MCMC annually tracks HEDIS scores, the Program should implement 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 MCMC with compliance monitoring results and efforts are being made to streamline the process, MCMC should develop a central repository for results and a process for aggregating results for plan-specific performance.
- MCMC must ensure that all plans are reviewed at a frequency of at least every three years. Additionally, the Program must ensure that all federal standards are reviewed within the three-year period.
- MCMC should implement more progressive penalties for plans that continue to have repeat areas of deficiency.

Findings

HSAG organized, aggregated, and analyzed results from MCMC's compliance monitoring reviews to draw conclusions about overall plan performance in providing quality, accessible, and timely health care and services to 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.

Review 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)

- Evidence demonstrated that all plans implemented a UM program supported by policies and procedures and written criteria based on sound medical evidence.
- Several plans faced a challenge with oversight of delegated utilization management activities. Several plans did not have procedures for annual monitoring of UM delegated activities. A number of plans lacked sufficient oversight, especially in the area of prior-authorization denials.
- A common challenge shared by numerous plans was failing to send notification to members for denied, modified, or deferred decisions. Often, this deficiency was due to insufficiencies within plans' policies and procedures. Specifically, in the area of Notice of Action (NOA) letters sent to members, many plans did not send timely notifications, did not provide clear and concise clinical reasons for denying or modifying requests, or did not include names and/or contact information for employees responsible for the determinations.
- The majority of plans demonstrated that they were monitoring and analyzing data for under- and overutilization of services. Most audit findings in the UM category were the result of issues with prior-authorization, primarily because plans either did not have a policy and procedure or a system for tracking and monitoring referrals that require prior authorization.

Continuity of Care

- Generally, plans were compliant with the requirements for providing medical case management to members and monitoring the coordination of in- and out-of-network services. Some plans had challenges with ensuring case coordination for all members receiving developmental disabilities services. Models for case management differed by plan. Some designated 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.
- A common challenge faced by many of the plans was in the area of initial health assessments (IHAs). Several plans were not monitoring their rates and/or taking action to improve them as part of their quality improvement program. While plans had policies in place for obtaining IHAs, as well as tracking completion rates, many plans had low member completion rates for these assessments within the required time frame.

Availability and Accessibility of Services

- Several plans faced challenges guaranteeing that members received an adequate supply of medically necessary medication in an emergency situation. A number of plans did not have policies and procedures for monitoring and oversight of after-hours pharmacy needs.
- Several plans did not have established policies and procedures that specified the correct percentage of claims to be paid within required timelines. 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.

- Appropriate policies and procedures on access to and availability of care notwithstanding, many 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. Many plans did not demonstrate that they had taken action to address these findings.

Member Rights (Under the Grievance System)

- Generally, plans had grievance policies and procedures and a grievance system in place for member complaints. However, many plans did not send acknowledgment letters and grievance resolution notices in a timely manner.
- A challenge faced by several of the plans was a lack of medical oversight of processing, analyzing, and reporting grievance data through the quality improvement (QI) structure on an ongoing basis. Additionally, grievances related to quality of care were not always appropriately reviewed by clinical staff or timely submitted to the medical director.

Quality Management

- Several plans did not have a system in place for ensuring accountability and monitoring of delegated quality improvement activities or did not document how the plan performed these activities.
- Several plans did not forward results of delegated quality improvement monitoring to quality committees for further review, analysis, and action.
- A challenge faced by one plan was a lack of oversight of credentialing and recredentialing activities delegated to prescription benefits management.

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.

Prior-Authorization Notifications

- Many plans did not notify members of a denial, termination, or modification.
- In several cases, the NOAs that were reviewed did not provide a specific citation supporting the action taken by the plan and did not contain required medical or statutory documentation.
- Several plans were not timely with their member notifications.
- For one plan, prior authorization files contained an NOA letter with a date that was prior to the date the decision was made.
- One plan's NOA letters were missing the reason for the health plan's decision.
- A challenge one plan faced was the use of an outdated template for the NOA letter and "Your Rights" attachment.

Cultural and Linguistic Services

- A number of plan providers were unfamiliar with the 24-hour language line.
- Several plans did not discourage the use of family, friends, or minors as interpreters, which can compromise the reliability of medical information.
- Many plans lacked cultural competency training for providers.
- In one instance, a plan did not note members' preferred languages (if other than English) in the medical record.

Member Grievances

- Many plans' notifications lacked the inclusion of State Fair Hearing information.
- Acknowledgement and resolution letters often exceeded the notification time frame requirements.
- Several plan providers did not have a grievance form or did not maintain a grievance log.
- A challenge for one plan was that resolution letters sent to the beneficiaries contained only the last page of the five-page instructions that provide members with guidance on the State Fair Hearing process.
- In one instance, the "Your Rights" attachment was missing a clear and concise explanation outlining the circumstances under which the medical service shall be continued while a fair hearing decision is pending.

Conclusions

Taking into account the medical performance reviews and MRPIU review findings, plans were compliant 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 generally had appropriate resources and written policies and procedures in place to support a quality improvement program.

Findings from these reviews showed that areas of deficiency for plans primarily impacted the access and timeliness domains of care. The most common deficiencies were related to timely member grievance acknowledgment and resolution, prior-authorization notifications, monitoring of delegated entities, and monitoring of provider wait times.

Additionally, several plans had challenges in the domain of quality. A common challenge was analyzing and reporting monitoring activities through the formal quality improvement structure or within the plans' internal evaluation. A number of plans were noncompliant in this area in the previous review suggesting that they did not incorporate review findings as part of their work plan to ensure corrective action would be taken, nor did they conduct ongoing monitoring.

Recommendations

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

- Plans must incorporate areas of noncompliance into their work plans to ensure that corrective action is taken, and deficiencies are continually monitored.
- Plans must improve oversight of processing, analyzing, and reporting grievance data and of delegated utilization management activities.
- Plans need to identify, develop, and incorporate processes for monitoring provider compliance with cultural and linguistic requirements.
- Plans should develop and strengthen internal processes to ensure that member prior-authorization notifications and grievance resolution notices are monitored for timeliness and accuracy.
- Plans must ensure that grievances related to quality of care are appropriately reviewed by clinical staff or timely submitted to the medical director.

As a result of last year's report, the plans have made some progress toward meeting these opportunities for improvement; however, continued opportunities for improvement remain. HSAG will evaluate 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), DHCS contractually requires plans to have a quality program that calculates and submits performance measure data. The MCMC Program 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 MCMC-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 MCMC-specified time frames. MCMC 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), 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 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 MCMC measures in the 2011 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 DHCS. The measures varied by plan based on the demographics of each plan's population.

Performance Measure Requirements and Targets

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

MCMC 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, MCMC applies the 10th percentile as the HPL and the 75th percentile as the MPL. Plans not meeting the MPLs must submit an improvement plan that outlines actions and interventions the plan will take to achieve acceptable performance. MCMC 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 MCMC.

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

To assist plans in standardized reporting, NCQA develops and makes available technical specifications that provide information on how to collect data for each measure, with general guidelines for sampling and calculating rates. DHCS's EAS requirements for 2011 indicate that plans are responsible for adhering to the *HEDIS 2011 Technical Specifications, Volume 2*.

To ensure that plans calculate and report performance measures consistent with HEDIS specifications and that the results can be compared to other plans' HEDIS results, the plans must undergo an independent audit. NCQA publishes *HEDIS Compliance Audit™: Standards, Policies, and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an information systems (IS) capabilities assessment and an evaluation of compliance with HEDIS specifications for a plan. MCMC requires that plans undergo an annual compliance audit conducted by its contracted EQRO.

The HEDIS process begins well in advance of plans reporting their rates. Plans calculated their 2011 HEDIS rates with measurement data from January 1, 2010, to December 31, 2010. Performance measure calculation and reporting typically involves three phases: Pre-on-site, On-site, and Post-on-site.[10]

Pre-on-site Activity (October through February)

- Plans prepare for data collection and the on-site audit.
- Plans complete the HEDIS Record of Administration, Data Management, and Processes (Roadmap), a tool used by plans to communicate information to the auditor about the plans' systems for collecting and processing data for HEDIS.

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

[10] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Calculating Performance Measures: A Protocol for use in Conducting Medicaid External Quality Review Activities*. Final Protocol, Version 1.0. May 1, 2002.

On-site Activity (February through April)

- Plans conduct data capture and data collection.
- The EQRO conducts on-site audits to assess the plans' capabilities to collect and integrate data from internal and external sources.
- The EQRO provides preliminary audit findings to the plans.

Post-on-site Activity (May through October)

- The EQRO provides final audit reports to plans.
- Plans submit final audited rates to DHCS (June).
- The EQRO analyzes data and generates the HEDIS aggregate report in coordination with DHCS.

Data Collection Methodology

NCQA specifies two methods for data capture: the administrative method and the hybrid method.

Administrative Method

The administrative method requires plans to identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. In addition, plans derive the numerator(s), or services provided to members in the eligible population, solely from administrative data sources. Plans cannot use medical records to retrieve information. When using the administrative method, the entire eligible population becomes the denominator because NCQA does not allow sampling.

MCMC selected the following EAS measures for which NCQA methodology requires the administrative method to derive rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Appropriate Testing for Children With Pharyngitis**
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Breast Cancer Screening*
- *Persistence of Beta-Blocker Treatment After a Heart Attack**
- *Use of Imaging Studies for Low Back Pain*

* A specialty or PHP plan measure

The administrative method is cost-efficient, but it can produce lower rates due to incomplete data submission by capitated providers.

Hybrid Method

The hybrid method requires plans to identify the eligible population using administrative data and then extract a systematic sample of members from the eligible population, which becomes the denominator. Plans use administrative data to identify services provided to those members. When administrative data do not show evidence that a service was provided, plans then review medical records for those members.

The hybrid method generally produces higher rates but is considerably more labor-intensive. For example, a plan that has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure may perform the hybrid method. After randomly selecting 411 eligible members, the plan finds that 161 members have evidence of a postpartum visit using administrative data. The plan then obtains and reviews medical records for the 250 members who do not have evidence of a postpartum visit using administrative data. Of those 250 members, the plan finds 54 additional members who have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would be (161 + 54)/411, or 52 percent.

In contrast, using the administrative method, if the plan finds that 4,000 members out of the 10,000 had evidence of a postpartum visit using only administrative data, the final rate for this measure would be 4,000/10,000, or 40 percent.

Listed below are the MCMC-selected EAS measures for which NCQA methodology allows hybrid data collection:

- *Adolescent Well-Care Visits*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Colorectal Cancer Screening**
- *Comprehensive Diabetes Care*
- *Controlling High Blood Pressure**
- *Prenatal and Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

* A specialty or PHP measure

Plans that have complete and robust administrative data may choose to report measures using only the administrative method and avoid labor-intensive medical record review; however, currently only two of MCMC's contracted plans report rates in this manner, Kaiser Permanente (North), Sacramento County, and Kaiser Permanente (South), San Diego County. The Kaiser plans have IS

capabilities, primarily due to their closed-system model and electronic medical records, that support administrative-only reporting because medical record review does not generally yield additional data beyond what the plan had already captured administratively.

HSAG computed the 2010 MCMC Program weighted average for each measure using plan-reported rates and weighted these by each plan's reported eligible population size for the measure. Rates reported as *Not Applicable (NA)* or *Not Reported (NR)* were not included in the calculations of these averages. This is a better estimate of care for all MCMC enrollees than a straight average of MCMC plans' performance.

Findings

Performance Measure Validation Results

Twenty-five contracted plans underwent performance measure validation. Twenty-four of those plans had a HEDIS Compliance Audit. Family Mosaic Project (FMP), a specialty plan, reported non-HEDIS measures; therefore, the plan underwent a performance measure validation audit consistent with the CMS protocol for conducting performance measure validation.[11]

Either HSAG's NCQA-certified compliance auditors or HSAG's subcontracted NCQA-certified compliance auditors performed all 24 plan audits for the 2011 reporting year.

Of the 24 audited plans, 19 used an NCQA-certified software vendor to produce rates. All but one of these software vendors achieved full certification status for the reported HEDIS measures. The software vendor that did not achieve full certification status was not certified for sampling methodology; therefore, HSAG reviewed and approved source code submitted by the vendor for sampling methodology and found it to comply with specified requirements. For the five plans that did not use a certified software vendor, HSAG reviewed and approved the source code.

Strengths

All plans were able to report valid rates for their MCMC-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.

[11] Department of Health and Human Services, Centers for Medicare and Medicaid Services. *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, Final Protocol, Version, 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol).

Challenges

Most of the challenges and opportunities were health plan specific and there were few challenges that were applicable to all or most of the plans. However, HSAG did identify the following opportunity for improvement.

HSAG found that a few plans do not capture complete rendering provider type information from claims and encounters, which limits the plan's 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, this offers an opportunity for improvement.

Recommendations

Based on the results of the audit findings, HSAG provides the following recommendations for improved reporting capabilities by the plans:

- Plans should scrutinize the claims submittal process to ensure that the rendering provider detail is accurately submitted and captured from all sources, especially multi-specialty and group practices.
- Plans may consider the use of PM-160 data as a supplemental data source that may improve rates for several measures.
- The plans' claims or analytics department should run monthly monitoring reports for vendor encounter data to track monthly volumes for accuracy.

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.

Table 5.1 below lists the MCMC-required HEDIS performance measures for 2011 and the abbreviations used for each measure in Table 5.2.

Table 5.1—HEDIS Performance Measures Name Key

Abbreviation	Full Name of HEDIS 2011 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 5.2 below presents a summary of the MCMC HEDIS 2011 (based on calendar year 2010 data) performance measure weighted averages compared to MCMC HEDIS 2010 (based on calendar year 2009 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 5.2—2010–2011 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MCMC's Minimum Performance Level[6]	MCMC's High Performance Level (Goal)[7]
AAB	Q	29.1%	26.8%	★★	↓	19.7%	35.9%
AWC	Q,A,T	45.1%	44.9%	★★	↔	38.8%	63.2%
BCS	Q,A	54.0%	54.0%	★★	↔	46.2%	63.8%
CCS	Q,A	69.5%	68.6%	★★	↔	61.0%	78.9%
CDC-BP	Q	63.9%	64.6%	★★	↔	53.5%	73.4%
CDC–E	Q,A	54.4%	50.5%	★★	↓	41.4%	70.1%
CDC–H8 (<8.0%)	Q	49.4%	49.2%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	37.4%	40.2%	★★	↓	53.4%	27.7%
CDC–HT	Q,A	82.8%	83.6%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	37.9%	39.4%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	79.3%	79.1%	★★	↔	69.3%	84.0%
CDC–N	Q,A	81.1%	80.5%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	74.5%	74.9%	★★	↔	63.5%	82.0%
LBP	Q	80.4%	80.4%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	83.9%	83.7%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	60.6%	61.5%	★★	↔	58.7%	74.4%
URI	Q	87.1%	87.8%	★★	↑	82.1%	94.9%
WCC-BMI	Q	56.8%	60.9%	★★	↑	13.0%	63.0%
WCC-N	Q	63.6%	66.3%	★★	↔	34.3%	67.9%
WCC-PA	Q	47.9%	49.8%	★★	↔	22.9%	56.7%
W34	Q,A,T	76.1%	77.1%	★★	↔	65.9%	82.5%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Table 5.1 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 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on comparing the 95-percent confidence levels associated with 2010 and 2011 rates.
[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.

★ = 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.

Performance Measure Result Findings

MCMC's 2011 results were very similar to 2010. The MCMC Program as a whole demonstrated average performance for most measures, noting some strengths as well as areas that need improvement. MCMC's 2011 performance results had 10 measures with improved rates over the 2010 rates, while nine measures had results with a decrease in performance and two remained steady. All of MCMC's 2011 performance measure rates were between the MPLs and HPLs.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. Plans that have rates below these minimum levels must submit an improvement plan to MCMC for each area of deficiency, outlining the steps they will take to improve care.

In 2011, a total of 47 improvement plans were required between all of the plans. In addition, MCMC initiated a CAP with Anthem Blue Cross in lieu of a required improvement plan for 39 measures that were below the MPLs. The measures that had the poorest performance, thus requiring the most improvement plans were *Prenatal and Postpartum Care—Postpartum Care, Adolescent Well-Care Visits,* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed,* all with at least 10 plans required to complete an improvement plan for the measure.

The measures that proved to be more difficult than the others to improve above the MPLs were *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis, Cervical Cancer Screening,* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*. These measures all had at least five more counties perform below the MPLs in 2011 compared to 2010, indicating that the plans' improvement plans need to be bolstered by more effective processes for improvement.

High and Low Plan Performers

HSAG provides detailed analysis of performance measure results at the plan and county level for each of the plans in the plan-specific evaluation reports. However, HSAG did assess overall performance of the plans to identify high and low performers.

Four full-scope plans demonstrated high performance across the EAS, exceeding 10 or more of DHCS's established HPLs, which represent the national Medicaid 90th percentiles. Kaiser Permanente (South), San Diego County, exceeded the HPLs on 15 measures, while San Francisco Health Plan, San Francisco County, exceeded the HPLs on 14 measures. Kaiser Permanente (North), Sacramento County, exceeded the HPLs on 12 measures, followed by Central CA Alliance for Health in Monterey/Santa Cruz counties, which exceeded the HPLs on 11 measures. The remaining plans had zero to eight measures that performed above the HPLs.

Five plans showed the greatest opportunity for improvement, with eight or more performance measures falling below the DHCS-established MPLs, which represent the national Medicaid 25th percentiles. Anthem Blue Cross, Contra Costa County, was below the MPLs for 13 measures; followed by Anthem Blue Cross, Alameda County, with 12 measures; Anthem Blue Cross, Fresno County, with nine measures; and Anthem Blue Cross, Sacramento County, and Anthem Blue Cross, Stanislaus County, with eight measures each. All other plans had zero to seven measures that performed below the MPLs.

Conclusions

In assessing plans' strengths across the performance measures, HSAG noted that the top four performance measures, those with the smallest difference between the HPLs and the weighted average rates, were *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling* with a 1.6 percentage point difference, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment* with a 2.1 percentage point difference, *Use of Imaging Studies for Low Back Pain* with a 3.7 percentage point difference, and *Comprehensive Diabetes Care—LDL-C Screening* with a 4.9 percentage point difference.

The four lowest-scoring performance measures, those with the largest difference between the HPLs and the weighted averages, were *Comprehensive Diabetes Care Eye Exam (Retinal) Performed* with a 19.6 percentage point difference, *Adolescent Well-Care Visits* with an 18.3 percentage point difference, *Prenatal and Postpartum Care—Postpartum Care* with a 12.9 percentage point difference, and *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)* with a 12.5 percentage point difference.

Recommendations

Based on the review of the 2011 HEDIS results, HSAG provides the following recommendations for continued improvement to the plans:

- Plans need to consider selecting performance measures with poor rates as the focus for formal QIPs.
- Plans need to implement targeted intervention strategies that link to identified barriers to increase performance.
- Plans need to evaluate the effectiveness of their 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.
- Plans should consider working with the EQRO to provide more intensive technical assistance for measures with performance rates that remain low over consecutive years.
- Plans should scrutinize the claims process to ensure that the rendering provider detail is accurately submitted and captured from all sources, especially multi-specialty and group practices.

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), 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.

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. DHCS requires plans to conduct QIPs at the county level unless otherwise approved to report combined county rates.

Plans submit QIP proposals to DHCS for review and approval of the project topics. DHCS reviews each 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 DHCS approves the QIP proposal, HSAG conducts validation.

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

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

Quality Improvement Project Requirements and Targets

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 6.1 summarizes the validation results for all submissions of the MCMC plans' QIP topics across CMS protocol activities during the review period.

Table 6.1—QIP Validation Results from July 1, 2010, through June 30, 2011 (Number = 104 QIP Submissions)

QIP Study Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Appropriate Study Topic	97% (599/616)	1% (6/616)	2% (11/616)
	II. Clearly Defined, Answerable Study Question(s)†	93% (194/208)	6% (13/208)	0% (1/208)
	III. Clearly Defined Study Indicator(s)	96% (628/652)	4% (23/652)	0% (1/652)
	IV. Correctly Identified Study Population	95% (271/284)	5% (13/284)	0% (0/284)
Design Total		**96% (1692/1760)**	**3% (55/1760)**	**1% (13/1760)**
Implementation	V. Valid Sampling Techniques (if sampling was used)	91% (225/248)	3% (7/248)	6% (16/248)
	VI. Accurate/Complete Data Collection	89% (613/687)	5% (31/687)	6% (43/687)
	VII. Appropriate Improvement Strategies	85% (221/260)	7% (17/260)	8% (22/260)
Implementation Total†		**89% (1059/1195)**	**5% (55/1195)**	**7% (81/1195)**
Outcomes	VIII. Sufficient Data Analysis and Interpretation	82% (523/635)	10% (64/635)	8% (48/635)
	IX. Real Improvement Achieved	55% (114/207)	10% (21/207)	35% (72/207)
	X. Sustained Improvement Achieved	20% (8/41)	12% (5/41)	68% (28/41)
Outcomes Total		**73% (645/883)**	**10% (90/883)**	**17% (148/883)**
Overall QIP Results†		**88% (3396/3838)**	**5% (200/3838)**	**6% (242/3838)**

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

MCMC plans accurately applied the QIP process for the Design stage, scoring 96 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

89 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 11 of 52 QIPS (21 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 eight of 52 QIPs (15 percent) that were evaluated for sustained improvement achieved sustained improvement for all study indicator outcomes. However, an additional seven 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

Validation results revealed that plans have improved compliance with the CMS protocol for conducting QIPs across activities to produce QIPs that have a greater likelihood of achieving improvement.

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, 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 DHCS and all plans participating in this collaborative QIP as evidenced by cooperation, compromise, and a willingness to dedicate resources, all of which should improve the likelihood of positive outcomes for the project.

Challenges

During the review period, HSAG also identified opportunities for plans to strengthen the documentation of their improvement strategies, including providing more details of the barrier analysis process and results, as well as the prioritization of the barriers.

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. Summaries of the QIP outcomes follow.

Emergency Room Collaborative

The MCMC-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 a second remeasurement period and were evaluated for sustained improvement.

Table 6.2—Emergency Room Collaborative Quality Improvement Project Outcomes
July 1, 2010, through June 30, 2011
(Number = 24 QIP Submissions, 20 Health Plans)

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

**Table 6.2—Emergency Room Collaborative Quality Improvement Project Outcomes
July 1, 2010, through June 30, 2011
(Number = 24 QIP Submissions, 20 Health Plans)**

Plan Name	Statistically Significant Improvement[1]	Sustained Improvement[2]
Partnership Health Plan	No	No
San Francisco Health Plan	No	No
Santa Clara Family Health	No	No

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 over the prior measurement period (p value < 0.05).
[2] Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.
^ Results based on the overall plan rate, which included all counties in the health plan.
Yes = (1) Statistically significant Improvement over the prior measurement period was 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 = QIPs did not progress to a second remeasurement period; therefore, HSAG could not assess for sustained improvement.

Of the 24 QIP submissions, only five submissions demonstrated statistically significant improvement in the percentage of avoidable ER visits from the first to the second remeasurement period. None of the plans achieved sustained improvement from baseline to Remeasurement 2.

Internal and Small Group Collaborative QIPs

Not including the ER collaborative QIP submissions, a total of 12 QIPs validated during the review period documented statistically significant improvement over the prior measurement period and/or sustained improvement from baseline to the most recent measurement period. For these QIPs, HSAG assessed for statistically significant improvement, defined as improvement that is not likely due to chance. Of the 12 QIPs that had one remeasurement period, 9 progressed to the point of at least two remeasurement periods. For these 9 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 6.3 displays the QIPs assessed for project outcomes during the review period by plan QIP project name that had statistically significant improvement and/or sustained improvement.

Table 6.3—Quality Improvement Project Outcomes—July 1, 2010, through June 30, 2011 (Number = 13 QIP Submissions)

Plan Name	QIP Project Name	Statistically Significant Improvement[1]	Sustained Improvement[2]
Alameda Alliance for Health	*Decrease Return ER Visits for Asthmatic Exacerbations in Children 2–18*	Yes	Not Assessed
CalOptima	*Appropriate Treatment for Children With an Upper Respiratory Infection*	Yes	Yes
Care 1st	*Appropriate Treatment for Children With an Upper Respiratory Infection*	Yes	Yes
CenCal Health Plan—Santa Barbara	*Weight Assessment and Counseling for Nutrition and Physical Activity*	Yes	Not Assessed
Central California Alliance for Health	*Improving Effective Case Management*	No	Yes
Community Health Group	*Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD*	Yes	No
	Increasing Screening for Postpartum Depression	No	Yes
Health Plan of San Joaquin	*Chlamydia Screening*	Yes	Yes
Kaiser Permanente—San Diego	*Postpartum Care*	Yes	Not Assessed
Partnership Health Plan	*Improving Care and Reducing Acute Readmissions for People With COPD*	Yes	Not Assessed
Santa Clara Family Health	*Adolescent Health and Obesity Prevention*	No	Yes
SCAN Health Plan	*Prevention of Stroke and Transient Ischemic Attack*	No	Yes

[1] Statistically significant improvement is defined as improvement over the prior measurement period (p value < 0.05).
[2] Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.
Yes = (1) Statistically significant Improvement over the prior measurement period was 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.

Eight of the twelve QIP submissions assessed for statistically significant improvement achieved statistical significance for at least one of the QIP study indicators during the review period. Three of the eight QIPs achieved statistically significant improvement for all QIP study indicators.

Of the eight QIPs assessed for sustained improvement, seven 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

- Alameda Alliance for Health, Alameda County, improved asthma management in children, aged 2 to 18 years, by decreasing the number of return visits to the ER due to asthma exacerbations. Improved asthma control indicates improved quality of care for these children.

Childhood Obesity Prevention

The plans improved the quality of care delivered to adolescents by improving obesity screening rates. With the proper documentation of BMI, plans can target counseling for nutrition and physical activity to the adolescents requiring a reduction in BMI.

- CenCal Health Plan, Santa Barbara County, improved obesity screening rates and counseling for nutrition from baseline to the first remeasurement period.
- Santa Clara Family Health, Santa Clara County, maintained improvement in obesity screening rates and counseling for nutrition and physical activity from baseline to the second remeasurement period.

COPD Assessment, Diagnosis, and Treatment

The plans improved the quality of care delivered to members with COPD by improving aspects of care such as testing, treatment, and hospitalizations. Proper diagnostic testing and medication are critical for COPD management.

- Community Health Group, San Diego County, reported statistically significant improvement between the first and second remeasurement periods for reducing the percentage of inpatient hospitalization discharges of members with COPD and reducing ER visits for COPD. Additionally, the plan increased the percentage of inpatient discharged members who were dispensed a systemic corticosteroid within 14 days.
- Partnership Health Plan in Napa, Solano, and Yolo counties demonstrated statistically significant improvement for spirometry testing and the dispensing of corticosteroids and bronchodilators from baseline to the first remeasurement period.

Effective Case Management

- Central California Alliance for Health in Monterey and Santa Cruz counties sustained a decrease in hospital discharges for congestive heart failure (CHF) from baseline to a second remeasurement period, which represents overall improved 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, was able to sustain improvement from baseline to the second remeasurement period for the percentage of women who were screened for postpartum depression, screened for postpartum depression using a screening tool, and received follow-up care. By improving the 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. Providing the necessary follow-up care is essential to ensure the mental health of the member.
- Health Plan of San Joaquin, San Joaquin County, improved the quality of care to women with statistically significant improvement in the percentage of women receiving a chlamydia screening test from the second to the third remeasurement period. Additionally, the improvement was sustained from baseline to the third remeasurement period.
- Kaiser Permanente, San Diego County, reported a statistically significant improvement in timely postpartum visits from baseline to the first remeasurement period. Improvement in the appropriate follow-up care after delivery contributes to better physical and mental health of the woman.

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 in 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 third 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.
- 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 statistically significant and sustained improvement from baseline to the second remeasurement period for the percentage of high-volume PCPs who appropriately treated URIs for members less than 19 years of age.

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:

- Alameda Alliance for Health, Alameda County
- Care 1st, San Diego County
- Contra Costa Health Plan, Contra Costa County
- Health Net in Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties
- Kern Family Health Care, Kern County

Stroke and TIA Prevention

- SCAN Health Plan in 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. SCAN sustained the improvement in the incidence of stroke and TIA for members without a prior history of stroke from baseline to the second remeasurement period.

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 conduct annual barrier analysis.
- Plans implemented interventions such as letters or newsletters that are often insufficient to produce long-term improvement.
- Plans did not incorporate methods to evaluate the efficacy of their interventions.

Conclusions

During the review period, many of the plans' QIPs 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 increasing proper antibiotic use, improving asthma and COPD management, improving childhood obesity documentation, improving women's health, and reducing avoidable ER visits.

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:

- At a minimum, barrier analysis should be performed to identify and prioritize barriers for each measurement period.
- Plans should incorporate a method to evaluate the efficacy of each intervention implemented and to determine which interventions should be continued and which ones should be revised.
- Plans should consider implementing system interventions, i.e., educational efforts, changes in policies, targeting of additional resources, or other organization-wide initiatives, which are associated with real and sustained improvement.

Medi-Cal Managed Care Program Initiatives Driving Improvement

HSAG noted several MCMC Program initiatives that support the improvement of quality of care and services for its 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 MCMC's External Accountability Set (EAS). The Program continues to select 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, MCMC 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, MCMC has continued to solicit plan input annually when updating and selecting its EAS measures. For the 2011 EAS set, reflecting the measurement period of 2010, the Program elected to keep the measures consistent with those selected in 2010 to allow the plans an opportunity to focus on providing services to the Seniors and Persons with Disabilities (SPD) population that began to enroll into Medicaid managed care beginning in June 2011. MCMC will work with plans, key stakeholders, and the EQRO on selecting future EAS measures to take into account the SPD population and measures that are relevant to this population. Additionally, the Program is considering changes to its auto-assignment program to rotate out measures that show consistent, high performance among plans.

Focused Performance Accountability

MCMC has initiated efforts to focus on low-performing plans and has begun to take more formal corrective action to improve plan performance. During the review period, the Program 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. MCMC initiated a CAP with one plan based on repeat, poor performance with meeting minimum performance levels for its HEDIS measures. Holding plans more accountable for poor performance should result in improved access, quality, and timeliness of care provided to members.

Quarterly Dashboard Report

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

Statewide Collaborative Quality Improvement Projects

MCMC-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 are 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.

Quality Improvement and Performance Measure Transparency

The MCMC Program continues to be a leader in transparency to the public with ongoing releases of quality improvement and performance measurement reports on the DHCS Web site at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx. MCMC has made efforts to improve the readability of public reports to increase comprehension for members, plans, legislators, advocacy groups, and other stakeholders. This effort promotes more informed decision making and better opportunities for dialogue.

Seniors and Persons With Disabilities (SPD) Integration

MCMC 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 Program will implement performance standards and measures to evaluate health outcomes for SPD members who are enrolled into the MCMC Program. MCMC will work with its plans, key stakeholders, and the EQRO during the next review period to outline measures appropriate for evaluating quality, access, and timeliness of care.

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 QI 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

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.

From its inception, Strength in Numbers achieved the following as of June 30, 2010:

- Medical homes' self-reported data (n=18) showed improvement from baseline in all four diabetes measures.
- A robust data analysis was completed for participating clinics of the Department of Public Health (n=10). The analysis showed statistically significant results in three out of the four diabetes measures—HbA1c Testing, HbA1c Poor Control, and LDL Testing—over the past year.

Strength in Numbers 2011 has an expanded set of measures that target high priority areas in clinical and patient experience: prevention and screening (breast and colon cancer screening), timely access (third next available appointment), meaningful use (electronic documentation of smoking status and blood pressure), and efficiency (continuity and patient show rates). Whereas previously the Strength in Numbers program was entirely supported by HSF, Strength in

Numbers 2011 is co-sponsored by HSF and SFHP, reflecting that efforts to improve panel management in the safety net support the care of all patients, regardless of payer source.[12]

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.

Improving Women's Health

Two of the three plans demonstrating improvement in women's health did so 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, screened using a screening tool, and provided follow-up care for a positive screen. 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 statistically significant and sustained improvement 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 providers which included their specific rates and provided tools such as Web-based patient prompts and reminders. The plan also worked with its contracted laboratory to ensure that results were sent directly to the health plan.

Proper Antibiotic Use

Several plans, including CalOptima in Orange County; Care 1st in San Diego County; 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

[12] San Francisco Health Plan. *Our Journey to Improve Quality and the Health of Our Population.* July 2011. Available at: http://www.sfhp.org/files/PDF/SFHP_Improvement_Journey_White_Paper.pdf

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 primary care physicians (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.

CalOptima, Orange County, showed both statistically significant and sustained improvement for increasing the percentage of children 3 months to 18 years of age who received appropriate treatment for a URI. Care 1st, San Diego County, also showed statistically significant and sustained improvement for increasing the percentage of children 3 months to 18 years of age who received appropriate treatment for a URI and the percentage of high-volume PCPs who appropriately treated URIs for members less than 19 years of age. 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. 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 may also have contributed to the success of the project.

Reducing Avoidable Emergency Room Visits

The five plans that showed statistically significant 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 (e.g., brochures, newsletters, posters, Web sites) 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.

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 MCMC Program'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.

MCMC uses performance measures and QIP results to assess care delivered to a plan's members 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, MCMC 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 2011 performance measure rates (which reflect 2010 measurement data), QIP validation results and outcomes, and compliance review standards 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 Program 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® 2011 weighted averages and compared them to the MCMC-established MPLs and HPLs to assess overall performance.

All plans were able to report valid HEDIS 2011 performance measures rates, and all of the MCMC rates related to quality were between the MPLs and HPLs. The top four quality-related performance measures, those with the smallest difference between the HPLs and the MCMC weighted averages, were *Weight Assessment and Counseling for Nutrition and Physical Activity for*

Children/Adolescents—Nutrition Counseling with a 1.6 percentage point difference, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI* with a 2.1 percentage point difference, *Use of Imaging Studies for Low Back Pain* with a 3.7 percentage point difference, and *Comprehensive Diabetes Care—LDL-C Screening* with a 4.9 percentage point difference.

The MCMC Program had two statistically significant increases in quality-related performance measures rates: *Appropriate Treatment for Children With Upper Respiratory Infection* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total.* However there were three quality-related measures that had statistically significant declines in performance in 2011: *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis, Comprehensive Diabetes Care—Eye Exam (Retinal) Performed, and Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent).*

Quality of care performance measures showing the greatest opportunity for improvement, those measures with the largest difference between the HPLs and the weighted averages, were *Comprehensive Diabetes Care Eye Exam (Retinal) Performed* with a 19.6 percentage point difference, *Adolescent Well-Care Visits* with an 18.3 percentage point difference, *Prenatal and Postpartum Care—Postpartum Care* with a 12.9 percentage point difference, and *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)* with a 12.5 percentage point difference.

Plans continued to struggle with the effectiveness of their HEDIS improvement plans. 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.

QIP validation results showed that plans were most successful with the study design and implementation phases of a QIP. Some plans demonstrated 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. Some plans struggled to achieve statistically significant improvement and/or sustained improvement in health care outcomes; however seven of the eight QIPs that were assessed for sustained improvement achieved it for at least one study indicator.

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. As a whole, plans had appropriate resources and written policies and procedures in place to support a quality improvement program. A common challenge for the plans was the analyzing, reporting, and monitoring of activities through a formal quality improvement structure. A number of plans were noncompliant in this area in the previous review suggesting that they did not

incorporate review findings/suggestions as part of their work plan to ensure corrective action would be taken, nor did they conduct ongoing monitoring.

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.

DHCS has contract requirements for plans to ensure access to and the availability of services to members. The MCMC Program 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 2011 performance measure weighted average rates that related to access, QIP outcomes that addressed access, and compliance review standards related to the availability and accessibility of care.

MCMC weighted average rates showed average performance regarding access, with all measures falling between the MPLs and HPLs. No access-related performance measures achieved a statistically significant increase in 2011; however, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* did have a statistically significant decrease. 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 were in accordance with many of the aspects of availability and accessibility of services. Some 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 mostly to the monitoring of provider wait times and compliance with cultural and linguistic requirements. Also, several plans faced challenges guaranteeing that members received an adequate supply of medically necessary medication in an emergency situation. A number of plans did not have policies and procedures for monitoring and oversight of after-hours pharmacy needs.

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.

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 2011 performance measure rates for providing timely care, QIP outcomes, and compliance review standards, the MCMC Program demonstrated both strengths and challenges in the timeliness domain of care.

MCMC weighted average performance measure results 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 a majority of the plans having adequate systems, most of the findings in the timeliness domain of care were related to the timeliness of prior-authorization notifications and timely member grievance acknowledgment and resolution.

Conclusions and Recommendations

Overall, the MCMC Program 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.

Taking into account the medical performance reviews and MRPIU review findings, plans were compliant with most standards for quality management, utilization management, member rights, continuity of care, availability and accessibility of services, program integrity, and administrative and organizational capacity. Plans generally had appropriate resources and written policies and procedures in place to support quality improvement programs.

MCMC 2011 performance measure weighted averages all fell between the MPLs and HPLs and remained steady compared with 2010 rates, with two statistically significant increases and three statistically significant decreases. Performance measures fell primarily under the quality domain of care, although several measures also impacted the access and timeliness domains of care. MCMC supported plans in selecting performance measures as formal QIPs to help structure improvement efforts to increase the likelihood of achieving statistically significant and sustained improvement.

During the review period, many of the plans' QIPs 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 increasing proper antibiotic use, improving asthma and COPD management, improving childhood obesity documentation, improving women's health, and reducing avoidable ER visits.

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 2009–2010 EQR Recommendations and MCMC's Follow-Up

The table below provides the 2009–2010 EQR recommendations and the Department of Health Care Service's Medi-Cal Managed Care (MCMC) Program's actions taken through June 30, 2011, that address the recommendations.

2009–2010 EQR Recommendation	MCMC Actions Through June 30, 2011, That Address the Recommendation
MCMC needs to develop a central repository for compliance monitoring results across DHCS and DMHC and develop a process for aggregating results for plan-specific performance.	MCMC and DMHC operate as separate organizations and review the health plans for different areas of compliance. During this reporting period, MCMC began to create a centralized compilation of completed medical audit reviews and corresponding close-out reports.
MCMC should develop and implement a formal scoring mechanism for compliance monitoring results to allow the Program to trend plan performance over time, compare performance across plans, and provide plans with feedback.	MCMC continues to tracks plans' HEDIS scores, including those that fall below the MPLs, with trending since 1999. MCMC used this HEDIS trending tool in tandem with reports from other areas of the Program to analyze and identify plans demonstrating a downward trend of performance quality. In April, 2011, MCMC initiated a CAP with a specific health plan that had demonstrated a clear downward trend in performance.
MCMC should formalize a process to document concerns with plan performance, recommendations, and actions as appropriate.	Pre-audit conferences involving Medi-Cal Managed Care Division's (MMCD's) Member Rights and Program Integrity Unit, MMCD's Medical Monitoring Unit, DHCS's Audits and Investigations Division, and the Department of Managed Health Care are held to discuss and document concerns about specific health plans. MCMC conducts quarterly internal meetings in which staff discuss and document concerns with plan performance in order to take appropriate actions.
MCMC should develop and maintain an overall compliance monitoring schedule by plan to ensure that all standards are reviewed at least every three years.	DHCS's monitoring units have a monitoring/review schedule for the 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. DHCS's Audits and Investigations Division conducts audits, supplemented by MMCD's Medical Monitoring Unit's close-out reports, which are scheduled to occur every three years.

2009–2010 EQR Recommendation	MCMC Actions Through June 30, 2011, That Address the Recommendation
MCMC should enforce minimum contract performance requirements through progressive penalties with plans that continue to show a pattern of poor performance over consecutive years.	MCMC held internal discussions regarding barriers to implementing monetary penalties on health plans. MCMC initiated the development of a formal process for identifying poor-performing plans with the goal of annually assessing all plans to determine if a CAP is appropriate. After identifying numerous performance issues with a specific health plan, MCMC initiated its first HEDIS-centered CAP in April 2011.
MCMC 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, MCMC needs to require that plans modify or revise interventions that did not successfully improve rates in the previous year(s) of the improvement plan.	As part of the HEDIS improvement plan (IP) process, MCMC updated the HEDIS IP submission form with the goal of gathering higher-quality information. An improved IP submission form will allow MCMC to increase its oversight of the health plans' IP barriers and interventions.
MCMC 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.	MCMC's Statewide Collaborative QIP is a collaboration between DHCS and its contracted health plans. As part of the topic selection process, DHCS administered a survey questionnaire to all health plans participating in the Collaborative. The survey established the minimum criteria for topic selection which included improvement needed for low-performing quality measures.