

Medi-Cal Managed Care Technical Report

July 1, 2011–June 30, 2012

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

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1. EXECUTIVE SUMMARY

Purpose of Report

As of June 2012, the Department of Health Care Services (DHCS) was administering the Medi-Cal Managed Care program (MCMC) to approximately 4.9 million beneficiaries throughout the State of California through a combination of contracted full-scope and specialty Medi-Cal managed care plans (“plans” or “MCPs”).¹ The Code of Federal Regulations (CFR) at 42 CFR §438.358² 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 MCPs.

The technical report must describe how the external quality review organization (EQRO) arrived at its conclusions regarding the quality and timeliness of, and access to, care furnished by the state’s 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 MCP data and prepare an annual technical report.

This report provides:

- ◆ A description of MCMC.
- ◆ A description of the scope of EQR activities for the period of July 1, 2011, through June 30, 2012 (State fiscal year [FY] 2011–12).
- ◆ An aggregate assessment of health care timeliness, access, and quality through organizational structure and operations, 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 website at:

<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>.

¹ *Medi-Cal Managed Care Enrollment Report*, June 2012. 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 Fiscal Year 2011–12 External Quality Review

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

- ◆ ***Review of compliance with organizational structure and operations standards.*** HSAG evaluated the MCPs' results for compliance with State and federal requirements. Additionally, where applicable and appropriate, HSAG made recommendations to MCMC for improving its monitoring and reporting of the MCPs' compliance with State and federal standards.
- ◆ ***Validation of performance measures.*** HSAG validated performance measures required by DHCS to evaluate the accuracy of performance measure results reported by the MCPs. The validation also determined the extent to which DHCS-specific performance measures calculated by the MCPs followed specifications established by MCMC. HSAG used the performance measure rates to assess plans' impact on improving health outcomes of their members.
- ◆ ***Validation of performance improvement projects.*** Referred to as quality improvement projects (QIPs) by MCMC, HSAG reviewed QIPs for each MCP to ensure that each MCP 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 each MCP's QIP outcomes and their impact on improving care and services provided to the MCP's members.

Report Organization

This report includes seven sections providing an aggregate assessment of health care timeliness, access, and quality across organizational structure and operations, 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 MCMC, a summary of its service delivery system, and the assignment of domains of care.

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

Section 4—Health Plan Compliance

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—Overall Findings, Conclusions, and Recommendations on plans’ performance on providing health care quality, access, and timeliness of services to MCMC beneficiaries.

Appendix A—Grid of 2010–11 EQR Recommendations and MCMC’s Follow-Up provides the FY 2010–11 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 MCP.

Medi-Cal Managed Care Program Overview

DHCS administers Medi-Cal, California's Medicaid program. The Medi-Cal Managed Care program (MCMC) serves about 62 percent of the Medi-Cal population, with 38 percent enrolled in fee-for-service (FFS) Medi-Cal. During the review period, July 1, 2011, through June 30, 2012, DHCS contracted with 22 full-scope plans and three specialty plans operating in 30 of California's 58 counties to approximately 4.9 million beneficiaries.

DHCS operates MCMC through a service delivery system that encompasses three plan models for its full-scope services: the County-Organized Health System (COHS), Geographic Managed Care (GMC), and Two-Plan Model.

County-Organized Health System

In a COHS model, DHCS contracts with a county-organized and county-operated plan to provide managed care services to members with designated, mandatory aid codes. Under a COHS plan, beneficiaries can choose from a wide network of managed care providers. These members do not have the option of enrolling in FFS Medi-Cal unless authorized by DHCS.

Geographic Managed Care

In the GMC model, DHCS contracts with several commercial plans within a specified geographic area. Medi-Cal beneficiaries with designated mandatory aid codes must enroll in a managed care plan. Seniors and persons with disabilities (SPDs) who do not have other health coverage (Medi-Cal only) are required to enroll in a GMC or Two-Plan Model plan. A small number of beneficiaries within specified aid code categories can voluntarily choose to enroll in an MCP or remain in FFS Medi-Cal. The GMC model currently operates in San Diego and Sacramento counties.

Two-Plan Model

In the Two-Plan Model, DHCS contracts with two managed care plans in each county to provide health care services to Medi-Cal 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, DHCS requires SPDs who do not have other health coverage (Medi-Cal only) to enroll in a Two-Plan Model or GMC plan. A small number of beneficiaries within specified aid code categories can voluntarily choose to enroll in an MCP or remain in FFS Medi-Cal.

As of June 1, 2011, enrollment in Two-Plan Model and GMC MCPs 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 website at:
<http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDEnrollment.aspx>.

Specialty and Prepaid Health Plans

In addition to the full-scope plans, DHCS contracts with three specialty plans to provide health care services to specialized populations (referred to as “specialty plans”). DHCS requires each specialty plan to report annually on two DHCS-approved performance measures that are relevant to the population served by the specialty plan. Each specialty plan can propose its own performance measures; however, DHCS provides the final approval on selection of measures.

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)⁶ indicates “timeliness is the health care system’s capacity to provide health care quickly after a need is recognized.”⁷ Timeliness includes the interval between identifying a need for specific tests and treatments and actually receiving those services.⁸

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 AHRQ is an agency within the Department of Health and Human Services which supports research that helps people make more informed decisions and improves the quality of health care services.

⁷ Agency for Healthcare Research and Quality. *National Healthcare Quality Report 2007*. AHRQ Publication No. 08-0040. February 2008.

⁸ Ibid.

Table 2.1—HSAG’s Assignment of Domains of Care

Compliance Review Standards*	Quality	Timeliness	Access
Enrollee Rights and Protections Standards		√	√
Access Standards		√	√
Structure and Operations Standards		√	√
Measurement and Improvement Standards	√		
Grievance System Standards		√	√
Performance Measures	Quality	Timeliness	Access
<i>Adolescent Well-Care Visits</i>	√	√	√
<i>All-Cause Readmissions (internally developed measure)</i>	√		√
<i>Ambulatory Care—Emergency Department (ED) Visits**</i>	‡	‡	‡
<i>Ambulatory Care—Outpatient Visits**</i>	‡	‡	‡
<i>Annual Monitoring for Patients on Persistent Medications—ACE</i>	√		
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	√		
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	√		
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>	√		
<i>Cervical Cancer Screening</i>	√		√
<i>Childhood Immunization Status—Combination 3</i>	√	√	√
<i>Children and Adolescents’ Access to Primary Care Practitioners (12–24 Months)</i>			√
<i>Children and Adolescents’ Access to Primary Care Practitioner (25 Months–6 Years)</i>			√
<i>Children and Adolescents’ Access to Primary Care Practitioners (7–11 Years)</i>			√
<i>Children and Adolescents’ Access to Primary Care Practitioners (12–19 Years)</i>			√
<i>Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)</i>	√		
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	√		√
<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)</i>	√		
<i>Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)</i>	√		
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	√		√
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	√		
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	√		√
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	√		√
<i>Immunizations for Adolescents—Combination 1</i>	√	√	√
<i>Use of Imaging Studies for Low Back Pain</i>	√		
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	√	√	√
<i>Prenatal and Postpartum Care—Postpartum Care</i>	√	√	√

Performance Measures	Quality	Timeliness	Access
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	√	√	√
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>	√		
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>	√		
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>	√		
Quality Improvement Projects	Quality	Timeliness	Access
<i>Statewide Collaborative QIP—Reducing Avoidable ER Visits</i>	√		√
<i>All-Cause Readmissions</i>	√		√
Individual and Small-Group Collaborative QIPs	Domain varied by plan project		
* The compliance review standards related to managed care plans are defined within the CFRs at 42 CFR 438.			
** This is a utilization measure.			
‡Domains of care are not assigned to utilization measures.			

3. MEDI-CAL MANAGED CARE QUALITY STRATEGY

Medi-Cal Managed Care Quality Strategy

Federal regulations 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 by contracted health plans to their members. The written strategy must describe the standards the state and its contracted plans must meet. The state must conduct periodic reviews of its quality strategy, to examine its scope and content, evaluate its effectiveness, and update it as needed.

To comply with federal regulations, during the review period, the Medi-Cal Managed Care program (MCMC) replaced its 2009 quality strategy report by submitting to CMS and publically releasing the *Medi-Cal Managed Care Program Baseline Quality Report—April 2012* on the DHCS website.⁹

MCMC's 2012 quality report 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 MCMC to assess the quality of care, make improvements, obtain input from beneficiaries 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 2012 quality report:

- ◆ 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 MCMC 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 MCMC beneficiaries by MCPs.

⁹ *Medi-Cal Managed Care Program Baseline Quality Report—April 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/Quality_Report_April2012.pdf

Quality Improvement Strategies

MCMC established the following eight strategies in the 2012 baseline quality report:

- ◆ Establish a process by 2013 that ensures all beneficiaries enrolled in MCPs have access to a medical home and to increase access to medical homes through geographic managed care expansion into counties that are currently FFS-only counties.
- ◆ Implement one or more performance standards and measures for MCPs to evaluate and improve beneficiary health outcomes for SPDs by Healthcare Effectiveness Data and Information Set (HEDIS[®])¹⁰ measurement year 2013.
- ◆ Complete all plan contract revisions requiring enhanced case management and coordination of care services for beneficiaries identified as high risk and a process for MCMC to monitor plan compliance by October 2012.
- ◆ Develop and implement an All-Cause Readmissions (ACR) statewide collaborative in 2012 with all plans in order to reduce hospital readmissions and improve transitions of care for all beneficiaries, including SPDs, by 2015.
- ◆ Issue the final report of the results of the previous statewide collaborative, intended to reduce the number of avoidable emergency room visits, by 2012.
- ◆ Administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®])¹¹ survey in all managed care counties in reporting year 2013.
- ◆ Establish a process by 2012 for timely notification to plans that ensures beneficiaries with a recent medical exemption request (MER) denial are contacted for care coordination and to address any special needs.
- ◆ Establish a formal process by 2013 to engage stakeholders and advocates in policy development.

¹⁰ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

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

Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

The *Medi-Cal Managed Care Program Baseline Quality Report—April 2012* states that MCMC 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.

HSAG has noted the following activities MCMC has taken toward addressing its quality improvement strategies:

Medical Home and Medi-Cal Managed Care Expansion

DHCS expanded MCMC into Ventura County by contracting with a new plan, Gold Coast Health Plan, which began serving its members in July 2011. Just prior to the review period, DHCS also expanded into Kings and Madera counties effective March 2011.

Performance Measures for Seniors and Persons With Disabilities

MCMC requires MCPs to stratify selected 2013 performance measures that reflect the measurement period of January 1, 2012, through December 31, 2012, (noted below) for the SPD population using a specified stratification methodology:

- ◆ *Ambulatory Care—Emergency Department (ED) Visits*
- ◆ *Ambulatory Care—Outpatient Visits*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioner (25 Months–6 Years)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- ◆ *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*
- ◆ *All-Cause Readmissions*

All-Cause Readmissions

In June 2011, MCMC met with HSAG and contracted MCPs to discuss a new collaborative QIP that focused on reducing readmissions among MCMC beneficiaries due to all causes within 30 days of an inpatient discharge. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Improving follow-up and care management of beneficiaries at the time of hospital discharge may lead to reduced readmissions and improved health outcomes. During the review period, the State initiated the formal collaborative *All-Cause Readmissions* QIP, which developed the measure specifications, established collaborative guiding principles, developed the project through the study design phase, and developed an evaluation plan. In June 2012, the plans submitted study design phase data, which was used to conduct barrier analyses. The barrier analyses results were then used to develop plan-specific interventions, which will be implemented beginning January 2013.

Reducing Avoidable Emergency Room Visits

The final report for the Statewide Collaborative Quality Improvement Project, *Reducing Avoidable Emergency Room Visits*, was released on June 2012. Of the 38 county-specific results that had remeasurement rates, 55 percent showed statistically significant improvement (a decline) in their avoidable ER visits rate between the second and third remeasurement period. Health plans reported that the collaborative improved communication and coordination with hospitals, improved communication with providers, raised member awareness of alternate options other than the ER, and raised providers' awareness of their members' ER usages. The collaborative also raised public awareness of avoidable ER visits through one health plan's presentation of the collaborative at a national quality conference. HSAG observed good cooperation and active participation from all 20 plans throughout the collaborative process. The State will apply lessons learned to the next collaborative.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

DHCS contracted with HSAG, an EQRO, to administer and report the results of the 2013 CAHPS survey that measures beneficiaries' health care experience over the last six months. HSAG will produce plan- and summary-level results that reflect both adult and child population results. The survey probes aspects of care for which beneficiaries are the best and/or only source of information

about their experiences with the medical care they have received. In addition, HSAG will provide additional program-level analysis of the SPD population.

Medical Exemption Request

A medical exemption request (MER) is a request for temporary exemption from enrollment into an MCP only until the Medi-Cal beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer, without deleterious medical effects, from a physician in FSS Medi-Cal to a physician of the same specialty in an MCP. In July 2012, DHCS issued a provider bulletin outlining the MER process to facilitate timely responses. The bulletin indicated that efforts continue to improve the process.

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.

4. HEALTH PLAN COMPLIANCE

Compliance 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 MCP 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 Baseline Quality Report—April 2012*, DHCS's update to its *Medi-Cal Managed Care Program Quality Strategy—December 2009*, describes the standards and processes DHCS uses to evaluate the operational structure and procedures plans use as required by the Code of Federal Regulations (CFR). For MCMC, contracts between DHCS and the plans include provisions for the standards, including the frequency of reporting, monitoring, and enforcement of corrective actions.

Several areas within DHCS's Medi-Cal Managed Care Division (MMCD) are responsible for monitoring MCPs, including Plan Management Branch, Member Rights and Program Integrity Unit (MR/PIU),¹² Medical Monitoring Unit (MMU), Medical Policy Section, and Performance Measurement Unit (PMU). In addition, DHCS's Audits and Investigations Division (A&I) works in tandem with MR/PIU 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, 2012, 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 its MCMC members.

¹² Future reports will refer to MR/PIU by its new name, Plan Monitoring Unit.

Objectives

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

Methodology

MCMC conducted monitoring of MCP compliance with 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.

Readiness Reviews

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

Medical Performance Reviews

Medical performance reviews assess MCP 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. A&I and MMU have historically worked in conjunction with DMHC to conduct joint audits of MCPs. In some instances, however, medical performance audits are conducted solely by DHCS or DMHC. A medical performance audit is conducted for each MCP approximately every three years.

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 DMHC's website 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 MR/PIU is responsible for monitoring MCP compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, Titles 22 and 28 of the California Code of

Regulations, and applicable MMCD All Plan Letters and Policy Letters pertaining to member rights and program integrity. MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of Member Grievances and Appeals, Prior-Authorization Request Notifications, Marketing (for non-COHS plans), Seniors and Persons with Disabilities Sensitivity Training, Facility Site Accessibility Assessment, Cultural and Linguistic Services, and Program Integrity (fraud and abuse prevention and detection). MR/PIU reviews and approves MCP policies and procedures related to these topics prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon change in the plan's policies and procedures. MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

Plan Monitoring

During the previous reporting period (July 1, 2010, through June 30, 2011), HSAG compared federal compliance monitoring regulations to MCMC's process for monitoring MCP compliance. HSAG identified various strengths and offered several recommendations to MCMC to improve its process for monitoring MCP compliance. A detailed statement provided by MCMC is provided in Appendix A, "Grid of 2010–2011 EQR Recommendations and MMCD's Follow-Up."

During the review period covered in this report (July 1, 2011, through June 30, 2012), 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 many of the same opportunities for improvement.

Strengths

MCMC made strong progress in establishing a central repository for the various audit reports and in taking more formal corrective action with plans that have failed to meet minimum requirements.

Opportunities for Improvement

MCMC still has opportunities to ensure that a comprehensive audit is conducted at least once within a three-year period and assure that all federal requirements are met. This appears to be a challenge as MCMC lacks thorough coordination of oversight to ensure all aspects are reviewed. In addition, the State described its efforts to create a schedule to ensure it conducts audits in a timely manner; however, during the review period, eight plans fell outside of the three-year requirement.

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 beneficiaries. 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

HSAG assessed the dates of each plan's medical performance review to determine which were conducted within three years of the start of the review period for this report (July 1, 2011). Eight plans had reviews that fell outside the three-year time frame, meaning their reviews occurred prior to July 1, 2008. Below, HSAG summarizes the findings from reviews conducted from July 1, 2008, through June 12, 2012. Information from reviews conducted prior to July 1, 2008, is considered outdated. It should be noted that HSAG included the details of the findings from the outdated medical performance reviews in the plan-specific reports to ensure documentation of the information and included in the plan-specific recommendations that plans should ensure all outstanding deficiencies are resolved.

Medical performance review results showed that most plans were compliant with most of the standards. Plans had comprehensive quality management programs in place and the staffing and structure to support the delivery of quality, accessible, and timely health care services to MCMC beneficiaries. Below, HSAG summarizes the findings within each review area.

Utilization Management

- ◆ Evidence demonstrated that all plans implemented a Utilization Management (UM) program supported by policies and procedures and written criteria based on sound medical evidence.
- ◆ Plans demonstrated that they were monitoring and analyzing data for under- and overutilization of services.
- ◆ Findings in the referral tracking system were noted for several plans; however, all plans resolved the findings through the corrective action plan (CAP) process for medical performance reviews or by providing documentation of the actions taken to resolve the findings as part of the document submission process for the development of their plan-specific reports.

- ◆ Most of the findings in the area of UM were due to the plans either lacking a policy or procedure or not following established processes, and most of the plans resolved these issues through the CAP process or by providing documentation of the actions taken to resolve the finding as part of the document submission process for the development of their plan-specific reports.

Continuity of Care

- ◆ Plans were generally compliant with all standards in the area of Continuity of Care.
- ◆ Several plans had challenges ensuring that the initial health assessments (IHAs) were completed for each member within the required time frame. Although most plans had policies and procedures in place to ensure completion of the IHAs, completion rates were low. All but one plan fully resolved the findings regarding IHAs through the CAP process or by providing documentation of the actions taken to resolve the finding as part of the document submission process for the development of their plan-specific reports.

Availability and Accessibility of Services

- ◆ The area of Availability and Accessibility of Services had the most opportunities for improvement.
- ◆ Several plans did not provide timely payment for services, including family planning, emergency transportation, and emergency services. Some plans also did not timely notify members when services were denied, deferred, or modified. Although some plans provided documentation to fully resolve the findings, several did not.
- ◆ Several plans did not have processes in place to ensure access to medication in emergency situations. While some plans provided evidence of actions to resolve the deficiencies, several did not.
- ◆ Most plans with findings regarding monitoring wait time in providers' offices, hold times for telephone calls, and wait times to obtain various types of appointments provided evidence of actions taken to ensure adequate monitoring of these issues.

Member Rights (Under the Grievance System)

- ◆ Overall, plans had grievance policies and procedures in place and a grievance system for member complaints; however, several plans had findings in the area of member grievances. Most plans fully resolved the findings through the CAP process or by providing documentation of the actions taken to resolve the finding as part of the document submission process for the development of their plan-specific reports.
- ◆ A few plans did not show evidence of implementation of policies and procedures regarding members' right to confidentiality; however, all but one plan fully resolved the findings through

the CAP process or by providing documentation of the actions taken to resolve the finding as part of the document submission process for the development of their plan-specific reports.

Quality Management

- ◆ Plans generally performed well in the area of Quality Management, demonstrating that plans have strong quality improvement programs and are monitoring the quality of care delivered to their MCMC members.

Administrative and Organizational Capacity

- ◆ Several plans had findings in the area of Fraud and Abuse Reporting. Some plans did not provide evidence that fraud and abuse policies complied with requirements, while others did not provide evidence that fraud and abuse policies were approved by the required entities or that the policies were being implemented and monitored. Most plans fully resolved the findings through the CAP process or by providing documentation of the actions taken to resolve the finding as part of the document submission process for the development of their plan-specific reports.
- ◆ Several plans were not compliant with the requirement to provide documentation that MCMC Provider training was being conducted within 10 days of the provider's active status. Subsequent to the medical performance review, all but one plan fully resolved the finding through the CAP process or by providing documentation of the actions taken to resolve the finding as part of the document submission process for the development of their plan-specific reports.

State Supported Services/Other Contract Requirements

- ◆ Plans were compliant with most of the requirements in the area of State Supported Services/Other Contract Requirements.
- ◆ Several plans were cited for a deficiency in the area of abortion services; however, all of the plans fully resolved the finding through the CAP process or by providing documentation of the actions taken to resolve the finding as part of the document submission process for the development of their plan-specific reports.

Member Rights and Program Integrity Review Findings

Most MR/PIU findings were in the areas of Member Grievances, Prior Authorization Notifications, and Cultural and Linguistic Services. Findings revealed that, overall, plans were compliant with standards in the areas of Marketing, False Claims Act Requirements, Member Services, Seniors and Persons with Disabilities (SPD) Training, and Physical Accessibility.

Below, HSAG summarizes the findings within each review area.

Member Grievances

- ◆ Overall, plans were fully compliant with standards in the area of Member Grievances, demonstrating evidence of having systems in place to ensure the plan is responsive to members' complaints and concerns.
- ◆ Several plans were cited for not sending acknowledgement and resolution letters within the required 30-day time frame. Additionally, some of the letters did not contain all required information. While a couple of plans provided evidence of resolving this issue, most plans did not.

Prior Authorization Notifications

- ◆ More than half of the plans had findings regarding notice of action (NOA) letters, and most plans did not provide evidence that the findings were fully resolved. Findings included:
 - NOA letters not being sent within the required time frame.
 - Member files missing the NOA letter.
 - The "Your Rights" brochure not being included with the NOA letter.
 - The NOA letter not citing the regulation or plan authorization procedures supporting the plan's action.
 - The NOA letter citing the wrong plan.

Cultural and Linguistic Services

- ◆ Almost half of the plans had providers that did not discourage the use of family, friends, or minors as interpreters, which can compromise the reliability of medical information between the provider and member. Most of the plans did not provide evidence that they implemented processes to ensure providers are complying with this requirement.
- ◆ Some plans did not demonstrate that they were providing training on cultural and linguistic services to providers; however, following the review, most of these plans fully resolved the findings through the CAP process or by providing documentation of the actions taken to resolve the finding as part of the document submission process for the development of their plan-specific reports.

Conclusions

Taking into account the medical performance and MR/PIU findings, plans were compliant with most or all of the standards in the areas of Continuity of Care, Quality Management, State Supported Services/Other Contract Requirements, Marketing, False Claims Act Requirements,

Member Services, SPD Training, and Physical Accessibility. Plans generally had appropriate resources and written policies and procedures in place to support a quality improvement program.

As in prior years, most of the findings from the medical performance and MR/PIU reviews impacted the access and timeliness domains of care. Plans resolved most of the findings through the CAP process or by providing documentation of the actions taken to resolve the findings as part of the document submission process for the development of their plan-specific reports. The areas with the most opportunity for improvement were Availability and Accessibility of Services and Authorization Notifications.

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 ensure that UM policies and procedures are developed, implemented, and monitored.
- ◆ Plans must ensure timely payment for services.
- ◆ Plans must ensure implementation of processes to timely notify members when services are denied, deferred, or modified.
- ◆ Plans must develop and implement processes to ensure members' access to medication in emergency situations.
- ◆ Plans must develop and implement processes to ensure that grievance acknowledgement and resolution letters are sent within the required 30-day time frame and that the letters contain all required information.
- ◆ Plans must develop and implement processes to ensure NOA letters are sent within the required time frame and include all required information.
- ◆ Plans must ensure providers are aware of the requirement that they must discourage the use of family, friends, or minors as interpreters and implement processes to monitor provider compliance with this requirement.

In addition to the recommendations to improve plans' compliance with federal and State standards, HSAG recommends that MCMC develop policies and procedures to ensure comprehensive audits of contracted MCPs are conducted at least once within a three-year period to assure that all federal requirements are met.

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 assessment and performance improvement program that calculates and submits performance measure data. DHCS annually selects a set of performance measures to evaluate the quality of care delivered by contracted plans to their MCMC members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The EAS is composed of HEDIS measures and non-HEDIS (internally developed) measures. 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 MCMC 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 2012 EAS:

- ◆ *Adolescent Well-Care Visits*
- ◆ *All-Cause Readmissions (internally developed measure)*
- ◆ *Ambulatory Care—Emergency Department (ED) Visits*
- ◆ *Ambulatory Care—Outpatient Visits*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin*

- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Cervical Cancer Screening*
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- ◆ *Comprehensive Diabetes Care*
 - *Blood Pressure Control (< 140/90 mm Hg)*
 - *Eye Exam (Retinal) Performed*
 - *Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*
 - *HbA1c Poor Control (>9.0 Percent)*
 - *HbA1c Testing*
 - *LDL-C Control (<100 mg/dL)*
 - *LDL-C Screening*
 - *Medical Attention for Nephropathy*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *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 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 DHCS-required measures. Plans must report county-level rates unless otherwise approved by DHCS.

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

HSAG conducted a HEDIS Compliance Audit^{TM13} (or a performance measure validation audit for non-HEDIS measures) 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 2012 indicate that plans are responsible for adhering to the *HEDIS 2012 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 AuditTM: 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.

¹³ NCQA HEDIS Compliance AuditTM is a trademark of the National Committee for Quality Assurance.

The HEDIS process begins well in advance of plans reporting their rates. Plans calculated their 2012 HEDIS rates with measurement data from January 1, 2011, to December 31, 2011. Performance measure calculation and reporting typically involves three phases: Pre-On-site, On-site, and Post-On-site.¹⁴

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.

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.

¹⁴ 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.

DHCS 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* (a specialty plan measure)
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Breast Cancer Screening*
- ◆ *Persistence of Beta-Blocker Treatment After a Heart Attack* (a specialty plan measure)
- ◆ *Use of Imaging Studies for Low Back Pain*

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 DHCS-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* (a specialty plan measure)
- ◆ *Comprehensive Diabetes Care*
- ◆ *Controlling High Blood Pressure* (a specialty plan measure)
- ◆ *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*

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, only two of MCMC's contracted plans currently report rates in this manner—Kaiser–Sacramento County and Kaiser–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 2012 MCMC 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. Using the weighted average is a better estimate of care for all MCMC beneficiaries than a straight average of MCPs' performance.

Findings

Performance Measure Validation Results

Twenty-three contracted plans underwent performance measure validation. Twenty-two 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. Either HSAG's NCQA-certified compliance auditors or HSAG's subcontracted NCQA-certified compliance auditors performed all 23 plan audits for the 2012 reporting year. Of the 23 audited plans, 20 used an NCQA-certified software vendor to produce rates. All of these software vendors achieved full certification status for the reported HEDIS measures. For the three plans that did not use a certified software vendor, HSAG reviewed and approved the source code. HSAG also reviewed and approved 20 health plans' source code, either internal or vendor created, for the *All-Cause Readmissions—Statewide Collaborative QIP* measure since this measure is not certified under software certification for Medicaid.

Strengths

All plans were able to report valid rates for their DHCS-required measures. The plans had sufficient transactional systems that captured the required data elements for producing valid rates. With a few exceptions, HSAG found plans fully compliant with the overall IS standards. For the few plans that did not achieve full compliance with all IS standards, the auditor determined that the deficiencies did not bias any reported rates.

Challenges

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 that the plans with highly capitated payment models run a risk of incomplete encounter data. To determine if this is an opportunity for improvement at the individual plan level, the plans may consider conducting analysis of medical record numerator compliant hits gained from hybrid pursuit and determine if there are patterns among providers that do not submit service data.

Recommendations

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

- ◆ Ensure that the rendering provider type is included on all submitted claims, specifically for services performed at a multispecialty clinic.
- ◆ Explore the use of supplemental data to enhance HEDIS reporting.
- ◆ Work with providers to encourage the submission of LOINC and CPT Level II codes that include results values that will minimize the burden of medical record review.
- ◆ Closely monitor timelines, milestones, and deliverables of contracted providers. Health plans should consider implementing sanctions for vendors that do not meet contract requirements.
- ◆ Work to increase electronic data submission.

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 MCP members.

Table 5.1 below lists the MCMC-required performance measures for 2012 and the abbreviations used for each measure in Table 5.2.

Table 5.1—Name Key for Performance Measures in External Accountability Set

Performance Measure Abbreviation	Full Name of 2012 Reporting Year[†] Performance Measure
AAB	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
ACR	<i>All-Cause Readmissions[‡]</i>
AMB–ED	<i>Ambulatory Care—Emergency Department (ED) Visits</i>
AMB–OP	<i>Ambulatory Care—Outpatient Visits</i>
AWC	<i>Adolescent Well-Care Visits</i>
CAP–1224	<i>Children and Adolescents’ Access to Primary Care Practitioners (12–24 Months)</i>
CAP–256	<i>Children and Adolescents’ Access to Primary Care Practitioners (25 Months–6 Years)</i>
CAP–711	<i>Children and Adolescents’ Access to Primary Care Practitioners (7–11 Years)</i>
CAP–1219	<i>Children and Adolescents’ Access to Primary Care Practitioners (12–19 Years)</i>
CCS	<i>Cervical Cancer Screening</i>
CDC–BP	<i>Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)</i>
CDC–E	<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>
CDC–H8 (<8.0%)	<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)</i>
CDC–H9 (>9.0%)	<i>Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)</i>
CDC–HT	<i>Comprehensive Diabetes Care—HbA1c Testing</i>
CDC–LC (<100)	<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>
CDC–LS	<i>Comprehensive Diabetes Care—LDL-C Screening</i>
CDC–N	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>
CIS–3	<i>Childhood Immunization Status—Combination 3</i>
IMA–1	<i>Immunizations for Adolescents—Combination 1</i>
LBP	<i>Use of Imaging Studies for Low Back Pain</i>
MPM–ACE	<i>Annual Monitoring for Patients on Persistent Medications—ACE</i>
MPM–DIG	<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>
MPM–DIU	<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>
PPC–Pre	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>
PPC–Pst	<i>Prenatal and Postpartum Care—Postpartum Care</i>
W-34	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
WCC–BMI	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>
WCC–N	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>
WCC–PA	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>
[†] The reporting year represents the year the measure rate is reported and generally represents the previous calendar year’s data. [‡] The ACR measure is a DHCS-developed measure for use in the <i>All-Cause Readmissions Statewide Collaborative Quality Improvement Project</i> .	

Table 5.2 presents a summary of the MCMC HEDIS 2012 (based on calendar year 2011 data) performance measure weighted averages compared to MCMC HEDIS 2011 (based on calendar year 2010 data).

For all but one measure, MCMC 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—2011–12 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

Performance Measure ¹	Domain of Care ²	2011 HEDIS Rates ³	2012 HEDIS Rates ⁴	Performance Level for 2012	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	26.8%	25.3%	★★	↓	18.8%	31.6%
AMB-ED	‡	--	39.6	--	Not Comparable	--	--
AMB-OV	‡	--	273.1	--	Not Comparable	--	--
AWC	Q,A,T	44.9%	54.8%	★★	↑	39.6%	64.1%
CAP-1224	A	--	95.7%	--	Not Comparable	--	--
CAP-256	A	--	87.1%	--	Not Comparable	--	--
CAP-711	A	--	86.9%	--	Not Comparable	--	--
CAP-1219	A	--	85.8%	--	Not Comparable	--	--
CCS	Q,A	68.6%	69.7%	★★	↔	64.0%	78.7%
CDC-BP	Q	64.6%	67.5%	★★	↑	54.3%	76.0%
CDC-E	Q,A	50.5%	55.5%	★★	↑	43.8%	70.6%
CDC-H8 (<8.0%)	Q	49.2%	50.8%	★★	↔	39.9%	59.1%
CDC-H9 (>9.0%)	Q	40.2%	38.0%	★★	↔	52.1%	29.1%
CDC-HT	Q,A	83.6%	84.2%	★★	↔	77.6%	90.9%
CDC-LC (<100)	Q	39.4%	40.5%	★★	↔	27.3%	45.9%
CDC-LS	Q,A	79.1%	79.4%	★★	↔	70.4%	84.2%
CDC-N	Q,A	80.5%	81.9%	★★	↔	73.9%	86.9%
CIS-3	Q,A,T	74.9%	78.2%	★★	↑	64.4%	82.6%
IMA-CO1	Q,A,T	--	63.0%	--	Not Comparable	--	--
LBP	Q	80.4%	81.0%	★★	↔	72.3%	82.3%
MPM-ACE	Q	--	81.5%	--	Not Comparable	--	--
MPM-DIG	Q	--	86.4%	--	Not Comparable	--	--
MPM-DIU	Q	--	80.4%	--	Not Comparable	--	--
PPC-Pre	Q,A,T	83.7%	83.8%	★★	↔	80.3%	93.2%
PPC-Pst	Q,A,T	61.5%	61.7%	★★	↔	59.6%	75.2%
W34	Q,A,T	77.1%	76.8%	★★	↔	66.1%	82.9%
WCC-B	Q	60.9%	68.3%	★★	↑	19.7%	69.8%
WCC-N	Q	66.3%	72.1%	★★★	↑	39.0%	72.0%
WCC-P	Q	49.8%	56.0%	★★	↑	28.5%	60.6%

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.

⁴ HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.

⁵ Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.

⁶ DHCS's minimum performance level (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.

⁷ DHCS's high performance level (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.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.

★ = 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 (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.

↔ = No statistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

MCMC's 2012 results improved over 2011. Seven performance measures showed statistically significant improvement in rates, and only one measure had a statistically significant decline in performance. MCMC as a whole demonstrated average performance for most measures, noting some strengths as well as areas that need improvement.

As shown in Table 5.2, the majority of MCMC's 2012 performance results were between the 50th and 74th national Medicaid percentiles with 12 weighted averages falling into this category. MCMC performed at or above the 90th national percentile for one of the HEDIS measures (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling*). MCMC had four measures that scored between the 75th and 89th national Medicaid percentiles, and two measures ranked between the 25th and 49th national Medicaid percentiles.

Eleven performance measures were not measured against the HPLs and MPLs in 2012. Eight were new measures for the 2012 reporting year, two were utilization measures, and one was an internally developed measure for the statewide collaborative quality improvement project. These measures were:

- ◆ *Ambulatory Care*
 - *Outpatient Visits*
 - *Emergency Department Visits*
- ◆ *Annual Monitoring for Patients on Persistent Medications*
 - *ACE Inhibitors or ARBs*
 - *Digoxin*
 - *Diuretics*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners*
 - *Children 12 to 24 months who had a visit with a PCP during the measurement year*
 - *Children 25 months to 6 years who had a visit with a PCP during the measurement year*
 - *Children 7 to 11 years who had a visit with a PCP during the measurement year or the year prior to the measurement year*
 - *Adolescent 12 to 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *All-Cause Readmissions*

MCMC's weighted average exceeded the HPL for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling*.

The top four performance measure rates, those with the smallest differences between the MCMC weighted averages and the HPLs, were as follows:

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling*, with a -0.1 percentage point difference.
- ◆ *Use of Imaging Studies for Low Back Pain*, with a 1.3 percentage point difference.
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment*, with a 1.5 percentage point difference.
- ◆ *Childhood Immunizations Status, Combination 3*, with a 4.4 percentage point difference.

The four lowest-scoring performance measure rates, those with the largest differences between the MCMC weighted averages and the HPLs, were as follows:

- ◆ *Comprehensive Diabetes Care Eye Exam (Retinal) Performed*, with a 15.1 percentage point difference.
- ◆ *Prenatal and Postpartum Care—Postpartum Care*, with a 13.5 percentage point difference.
- ◆ *Prenatal and Postpartum Care—Prenatal Care*, with a 9.4 percentage point difference.
- ◆ *Adolescent Well-Care Visits*, with a 9.3 percentage point difference.

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.

High and Low Plan Performers

Four full-scope MCPs demonstrated high performance across the EAS, with each MCP exceeding DHCS's established HPLs on 14 or more measures. None of these plans performed below the MPLs for any single measure. HSAG also identified these plans as the top performers in 2011. San Francisco Health Plan—San Francisco County exceeded the HPLs on 16 measures, Kaiser—Sacramento County exceeded the HPLs on 15 measures, and both Kaiser—San Diego County and Central CA Alliance for Health—Monterey/Santa Cruz counties exceeded the HPLs on 14 measures.

Four plans showed the greatest opportunity for improvement, with seven or more performance measures below DHCS-established MPLs, which represents the national Medicaid 25th percentiles. Anthem Blue Cross—Alameda and Contra Costa counties each had 12 measures

below the MPLs, followed by Anthem Blue Cross—Sacramento County with 10 measures, and Anthem Blue Cross—San Joaquin County with 7 measures below the MPLs.

Model Type Performance

The County-Organized Health System (COHS) model type outperformed the Geographic Managed Care (GMC) and Two-Plan model types on 23 of the 27 performance measures (*Ambulatory Care—Outpatient Visits* and *Ambulatory Care—ED Visits* were not considered because they are utilization measures). The Two-Plan model outperformed the other model types for *Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis*, *Cervical Cancer Screening*, and *Comprehensive Diabetes Care—HbA1c Poor Control*. The GMC model type outperformed the other model types on the *Immunizations for Adolescents—Combination*. Because the COHS model type is the only option MCMC provides in certain counties, this structure may have an advantage over other model types on performance measures. With fewer members shifting between plans and a relatively stable provider network, the COHS structure may provide a better opportunity for continuity and coordination of care for members.

Performance Measure Compliance Audit—Key Findings

HSAG conducted performance measure validation of all MCPs. All plans were able to report valid rates for their DHCS-required measures, and all plans were compliant with the information system standards.

Conclusions

MCMC demonstrates a commitment to monitor and improve the quality of care delivered to its enrollees through its development of an EAS that supports MCMC's overall quality strategy. Each plan's performance contributes to MCMC's overall weighted averages, which were at or above the national Medicaid 50th percentiles for most measures. MCMC continued a variety of mechanisms that support the improvement efforts of plans. The auto-assignment program offers an increased incentive for plans in the GMC and Two-Plan model types to perform well by rewarding higher-performing plans with increased default membership. During 2011, DHCS met with its contracted plans to obtain input on potential measure changes to the 2013 EAS, including changes that may impact auto-assignment. DHCS may make modifications to the auto-assignment measures in 2013 to continue to emphasize improved performance across the measure set. Additionally, DHCS has supported plans in selecting performance measures as formal quality improvement projects (QIPs) to help structure improvement efforts to increase the likelihood of achieving statistically significant improvement and sustained improvement. DHCS has taken a more active role in reviewing plan QIP proposals to ensure that plans are selecting areas that are actionable and need improvement rather than selecting topics of consistent or high performance. DHCS evaluates its EAS and auto-assignment program measures annually to rotate out measures that show consistent,

high performance among plans. For the 2012 EAS, DHCS retired the *Appropriate Treatment for Children With Upper Respiratory Infection* and *Breast Cancer Screening* measures to focus on five new measures. This process allows DHCS to identify and select new measures as opportunities for improvement. Finally, has improved its oversight process of the plans' performance over time and has begun to work with plans that have demonstrated poor performance over several years on multiple measures.

Recommendations

Based on the review of the 2012 HEDIS results, HSAG provides the following recommendations for continued improvement to the plans:

- ◆ Plans need to place a greater emphasis on moving from compliance by documentation of low HEDIS rates and HEDIS improvement plans to efforts that actually address improved health outcomes.
- ◆ Plans need to critically evaluate intervention effectiveness to identify those interventions that have been successful and should be continued and those that were not successful and can be discontinued or modified.
- ◆ Plans should consider selecting performance measures with poor rates as the focus for formal QIPs as this strategy has been effective for many plans across a wide number of performance measures.
- ◆ Plans need to consider evidence-based strategies when selecting interventions.
- ◆ Plans should consider working with the EQRO to provide more intensive technical assistance for measures 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 multispecialty and group practices.

6. QUALITY IMPROVEMENT PROJECTS

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

Medi-Cal managed care plans (“MCPs” or “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 MCMC approves a smaller number. Specialty and prepaid health plans are not required to participate in the statewide collaborative. These plans usually 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 MCMC for review and approval of the project topics. MCMC 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 MCMC approves the QIP proposal, HSAG conducts validation.

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

plan must submit a new proposal to MCMC 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, *Validation of Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. HSAG's review focused on the following areas:

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

Additionally, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plans' QIP objectives (QIP results). HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about the plans' performance in providing quality, accessible, and timely care and services to its MCMC members.

Methods

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 sound and effective 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. MCMC requires that QIPs receive an overall *Met* validation status; therefore, MCPs must resubmit a QIP until it achieves a *Met* validation status, unless otherwise specified.

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

During the current review period, there were two statewide collaborative QIPs in progress. The first was the ongoing *Reducing Avoidable Emergency Room Visits* QIP, which was in its final measurement period. The second was the new *All-Cause Readmissions (ACR)* statewide collaborative QIP, which was in its design phase. The *ACR* QIP proposals were scored as *Pass/Fail* only. Due to the unique, one-time validation scoring used for the initial submission of the *ACR* proposals, these QIPs will not be included in the following QIP validation table. Additionally, since these QIPs had not progressed to the Implementation stage, they will not be included in the outcomes table or discussion. Only the collaborative *Reducing Avoidable Emergency Room Visits* QIPs and the plan-initiated internal QIPs will be included in the following QIP sections.

Table 6.1 summarizes the validation results for all submissions of the MCPs’ QIP topics across CMS protocol activities during the review period. The new statewide collaborative *All-Cause Readmissions* QIPs were excluded from the summary.

**Table 6.1—QIP Validation Results from July 1, 2011, through June 30, 2012
(Number = 104 QIP Submissions)**

QIP Study Stage	Activity	Percentage of Applicable Elements		
		<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>
Design	I. Appropriate Study Topic	98%	1%	1%
	II. Clearly Defined, Answerable Study Question(s)	95%	5%	0%
	III. Clearly Defined Study Indicator(s)	97%	3%	0%
	IV. Correctly Identified Study Population	94%	5%	1%
Design Total[^]		97%	3%	1%
Implementation	V. Valid Sampling Techniques (if sampling was used)	89%	4%	7%
	VI. Accurate/Complete Data Collection [^]	89%	4%	8%
	VII. Appropriate Improvement Strategies	91%	8%	1%
Implementation Total		89%	5%	6%
Outcomes	VIII. Sufficient Data Analysis and Interpretation	82%	9%	9%
	IX. Real Improvement Achieved	62%	7%	31%
	X. Sustained Improvement Achieved	45%	0%	55%
Outcomes Total		75%	8%	17%
Overall QIP Results		89%	5%	6%
*The validation results for the <i>All-Cause Readmissions</i> QIP are not included in this table since the proposals were scored as <i>Pass/Fail</i> only.				
[^] The sum of the <i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i> scores in each activity or stage may not equal 100 percent due to rounding.				

MCPs accurately applied the QIP process for the Design stage, scoring 97 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 31 of 71 QIP submissions (44 percent) demonstrated statistically significant improvement (considered “real improvement” or improvement that is unlikely due to chance) for at least one of the study indicator outcomes. Additionally, only 17 of 38 QIP submissions (45 percent) that were evaluated for sustained improvement achieved sustained improvement for at least one study indicator outcome. 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.

Table 6.2 summarizes the validation results by study stage for all submissions of the MCPs’ QIPs across CMS protocol activities during the last three review periods.

Table 6.2—Quality Improvement Project Study Stage Validation Results Comparison by Review Period

QIP Study Stage	Activities	Percentage of Applicable Evaluation Elements Scored <i>Met</i>		
		7/1/2009–6/30/2010 (N=77 QIP Submissions)	7/1/2010–6/30/2011 (N=104 QIP Submissions)	7/1/2011–6/30/2012 (N=104 QIP Submissions)
Design	I–IV	94%	96%	97%
Implementation	V–VII	94%	89%	89%
Outcomes	VIII–X	75%	73%	75%
Overall Percentage of Applicable Evaluation Elements Scored <i>Met</i>		89%	88%	89%

An evaluation of the aggregate QIP validation results for the last three review periods shows consistent performance across the study stages despite changes in plans, counties served by a specific plan, and internal and collaborative QIP topics. Plans’ performance demonstrates adequate and consistent documentation of the Design and Implementation stages of the QIP process. However, consistent low scores for the Outcomes stage represent a lack of improved and sustained project outcomes.

With MCMC’s emphasis on quality and outcomes, HSAG will collaborate with MCMC to facilitate more effective plan-specific improvement strategies. QIP validation will include a critical analysis of plans’ improvement strategies and expanded feedback in the QIP Validation Tool provided to plans.

Additionally, beginning with the collaborative *All-Cause Readmissions* QIP, HSAG will be more proactive and direct in its feedback to plans’ improvement strategies. Rather than limiting feedback to the annual QIP submissions, discussions will occur during one-on-one technical assistance calls. MCMC and HSAG will evaluate barrier analyses and interventions and provide feedback to plans at the beginning of the first remeasurement period. By providing feedback at the time in the QIP process when interventions are being implemented, there is a greater likelihood of plans being able to incorporate recommendations and develop tracking and monitoring processes that maximize the plans’ improvement efforts instead of after resources have already been expended.

Strengths

Validation results revealed that plans have complied with the CMS protocol for conducting QIPs across activities to produce QIPs that are valid and reliable.

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, MCMC and its MCPs selected a challenging statewide collaborative topic to reduce hospital readmissions, demonstrating a strong commitment to address an area timely and relevant to MCPs statewide and beneficial to MCMC beneficiaries. HSAG documented an effective process between MCMC and all MCPs engaging in this collaborative QIP as evidenced by strong participation, cooperation, and dedicated resources, all of which should increase the likelihood of successful project outcomes.

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 MCP 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 primary care physician (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 third remeasurement period and were evaluated for sustained improvement.

**Table 6.3—Emergency Room Collaborative Quality Improvement Project Outcomes
July 1, 2011, through June 30, 2012
(Number = 26 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 [^]	Yes	Yes
CalOptima	No	No
Care1st Partner Plan	No	No
CenCal Health—San Luis Obispo County	Yes	No
CenCal Health—Santa Barbara County	No	No
Central California Alliance for Health	Yes	Yes
Community Health Group Partnership Plan	Yes	Yes
Contra Costa Health Plan	Yes	No
Health Net Community Solutions, Inc. [^]	Yes	No
Health Plan of San Joaquin	Yes	Yes
Health Plan of San Mateo	No	No
Inland Empire Health Plan	Yes	Yes
Kaiser—Sacramento County	No	No
Kaiser—San Diego County	No	No
Kern Family Health Care	Yes	Yes
L.A. Care Health Plan	Yes	No
Molina Healthcare of California Partner Plan, Inc.—Riverside County	No	No
Molina Healthcare of California Partner Plan, Inc.—San Bernardino County	No	No
Molina Healthcare of California Partner Plan, Inc.—Sacramento County	No	No
Molina Healthcare of California Partner Plan, Inc.—San Diego County	No	No
Partnership HealthPlan of California	Yes	No
San Francisco Health Plan	Yes	No
Santa Clara Family Health Plan	Yes	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.

While 14 plans achieved statistically significant improvement over the prior measurement period, six plans achieved sustained improvement from baseline through the final remeasurement period. All six plans that achieved sustained improvement provided outreach to members after they had an ER visit. Additionally, the six plans implemented the following plan-specific interventions:

Anthem Blue Cross Partnership Plan

- ◆ Evaluated all interventions at the county level.
- ◆ Concentrated on access to after-hours care.

Community Health Group Partnership Plan

- ◆ Established the Multiple Admitter's Program (MAP) as a permanent, focused case management project to provide intensive follow-up for members with multiple hospital inpatient and/or emergency department admissions.
- ◆ Contracted with retail Minute Clinic to provide an alternative setting for urgent care visits.
- ◆ Contracted with Palomar Express to provide an alternative setting for urgent care visits in the northern portion of San Diego County.

Central California Alliance for Health

- ◆ Providers receive quarterly mailings of members who have been to the ER three or more times during the last quarter. Reports are modified to include an indicator to let the provider know if the visit met the criteria of an avoidable visit.
- ◆ PCPs participate in an incentive program where 10 percent of the money allocated is aimed at reducing ER utilizations. Providers are compared against their peer groups.

Health Plan of San Joaquin

- ◆ Expanded or established working relationships with three different hospitals.
- ◆ Established the Nurse Practitioner program to visit members in their homes, addressing issues including ER visits.

Inland Empire Health Plan

- ◆ Nine health navigators worked to educate members on a variety of health care topics including ER utilization during home visits.
 - An additional navigator in the ER, hired by the hospital, assisted members with their follow-up care and making the necessary appointments after an ER visit.
- ◆ A comprehensive provider profile report is distributed monthly.

Kern Family Health Care

- ◆ Emphasized timely communication with all members seen in the ER.

Internal Quality Improvement Projects

During the review period July 1, 2011, through June 30, 2012, 78 internal QIP (IQIP) submissions were assessed. Of the 16 IQIPs assessed for statistically significant and sustained improvement, 13 (81 percent) demonstrated statistically significant improvement over the prior measurement period, and 7 (44 percent) achieved sustained improvement from baseline to the current measurement period.

Table 6.4 displays the 16 IQIPs that were assessed for project outcomes during the review period by plan, QIP project name, and whether the outcomes demonstrated statistically significant improvement and/or sustained improvement.

Table 6.4—Quality Improvement Project Outcomes—July 1, 2011, through June 30, 2012

Plan Name	QIP Project Name	Statistically Significant Improvement ¹	Sustained Improvement ²
Alameda Alliance for Health	<i>Decreasing Return Emergency Room Visits for Asthmatic Exacerbations in Children 2–18 Years of Age</i>	No	Yes
Anthem Blue Cross Partnership Plan—Alameda County	<i>Improving HEDIS Postpartum Care Rates</i>	Yes	Not Assessed
Anthem Blue Cross Partnership Plan—Contra Costa County	<i>Improving HEDIS Postpartum Care Rates</i>	Yes	Not Assessed
Anthem Blue Cross Partnership Plan—Santa Clara County	<i>Improving HEDIS Postpartum Care Rates</i>	Yes	Not Assessed
Anthem Blue Cross Partnership Plan—Tulare County	<i>Improving HEDIS Postpartum Care Rates</i>	Yes	Not Assessed
CalOptima	<i>Improving the Rates of Cervical Cancer Screening</i>	Yes	Not Assessed
CenCal Health—San Luis Obispo County	<i>Weight Assessment and Counseling for Nutrition and Physical Activity</i>	Yes	Not Assessed
CenCal Health—Santa Barbara County	<i>Weight Assessment and Counseling for Nutrition and Physical Activity</i>	Yes	Yes
Community Health Group Partnership Plan	<i>Increasing Screening for Postpartum Depression</i>	Yes	Yes
Community Health Group Partnership Plan	<i>Improving Assessment, Diagnosis, and Appropriate Treatment of Chronic Obstructive Pulmonary Disease (COPD)</i>	Yes	Yes
Contra Costa Health Plan	<i>Reducing Childhood Obesity</i>	Yes	Not Assessed
Health Net Community Solutions, Inc.—Fresno County	<i>Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities (SPD)</i>	Yes	Not Assessed
Kaiser—Sacramento County	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i>	Yes	Not Assessed
Kaiser—San Diego County	<i>Improving Postpartum Care</i>	No	Yes

Plan Name	QIP Project Name	Statistically Significant Improvement ¹	Sustained Improvement ²
Partnership HealthPlan of California	<i>Improving Care and Reducing Acute Readmissions for People With COPD</i>	Yes	Yes
Senior Care Action Network Health Plan	<i>Prevention of Stroke and Transient Ischemic Attack (TIA)</i>	No	Yes
<p>¹ Statistically significant improvement is defined as improvement over the prior measurement period (p value < 0.05).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>			

Successful QIPs affected the health of the MCMC members in the following areas.

Asthma Management

- ◆ Alameda Alliance for Health—The plan was able to reduce the percentage of children with more than two ER visits for asthmatic exacerbations and sustain that improvement through the final remeasurement period.

Childhood Obesity

- ◆ CenCal Health—Both San Luis Obispo and Santa Barbara counties demonstrated statistically significant improvement in BMI assessment and documentation of referrals for nutrition and physical activity counseling during the course of the project. Additionally, the improvement was sustained in Santa Barbara County. With a more complete assessment and an improved referral process related to obesity, CenCal Health has a better understanding of the obesity issues for members aged 3 to 17 years.
- ◆ Contra Costa Health Plan—The plan demonstrated statistically significant improvement in providing documentation of counseling for nutrition and physical activity during the course of the project. With increased counseling for nutrition and physical activity related to obesity, the plan has an opportunity to begin to address the obesity issues for members aged 3 to 11 years.
- ◆ Kaiser-Sacramento County—The plan has increased the BMI assessment and improved the referral/counseling process related to obesity, thereby achieving a better understanding of the obesity issues for its members aged 3 to 17 years.

COPD Assessment, Diagnosis, and Treatment

- ◆ Community Health Group Partnership Plan—For its members with COPD, the plan was able to significantly improve care by increasing spirometry testing, decreasing ER visits, and decreasing inpatient discharges over the course of the project.
- ◆ Partnership HealthPlan of California—The plan successfully improved the quality of care delivered to members with COPD. Partnership increased the use of spirometry testing to diagnose and classify the stage of severity of newly diagnosed COPD in its members aged 42 years and older. For members aged 40 years and older with a COPD exacerbation that resulted in an inpatient admission or an ER visit, the plan improved the medication management of these members by appropriately dispensing systemic corticosteroids and bronchodilators. Additionally, the plan documented a reduction in the readmissions of members with COPD for the first time since the initiation of the project.

Women's Health

- ◆ Anthem Blue Cross Partnership Plan—The plan increased the percentage of appropriately timed postpartum visits for women in Alameda, Contra Costa, Santa Clara, and Tulare counties.
- ◆ CalOptima—The plan was able to significantly increase the percentage of women who received a Pap test from the top 200 high-volume providers.
- ◆ Community Health Group Partnership Plan—The plan was able to increase depression screening and the use of a depression screening tool at the time of a member's postpartum visit. Additionally, the plan increased the percentage of women who received follow-up care after a positive depression screen.
- ◆ Health Net Community Solutions, Inc.—By the first remeasurement period, the plan documented a statistically significant increase in cervical cancer screening for the SPD population in Fresno County.
- ◆ Kaiser–San Diego County—The plan was able to achieve and sustain statistically significant improvement for the project, which resulted in a greater percentage of women receiving timely postpartum care.

Stroke and TIA Prevention

- ◆ Senior Care Action Network Health Plan—The plan reported incremental reductions of the incidence of a new stroke or TIA for its Medi-Cal and Medicaid dual-eligible members over the course of the project, achieving sustained improvement.

Quality Improvement Outcome Challenges

During the review period, HSAG identified opportunities for plans to strengthen their improvement strategies to achieve and sustain improvement of their project outcomes. Opportunities included using plan-specific data in the barrier analysis process, identifying interventions that directly address the barriers, and identifying the intervention's targeted population. The documentation provided by the plans did not incorporate intervention tracking, monitoring, and evaluation; therefore, it was difficult for plans to attribute improvement or the lack of improvement of project outcomes directly to specific interventions. Similarly, plans did not provide sufficient rationale as to why interventions were continued, modified, or discontinued. Plans did not document the level of detail necessary to effectively evaluate their improvement strategies and, in turn, allow HSAG to provide meaningful feedback.

MCMC and HSAG will need to provide ongoing communication to the plans outlining the level of detail that plans should include in their QIP submissions. Through written and verbal communications, MCMC and HSAG should facilitate discussions with the plans to gain a better understanding of areas where plans may need additional assistance, such as rapid cycle improvement or intervention evaluation using intermediate outcomes.

Conclusions

While validation scores have been strong for both the Design and Implementation stages of the QIP process and consistent over the last three review periods, plans have received lower scores for the Outcomes stage due to plans' varied levels of ability to achieve statistically significant improvement and sustain their project goals.

Moving forward, MCMC and HSAG will place greater emphasis on achieving and sustaining improvement of the project outcomes. The maximum benefit to MCMC beneficiaries is only realized when the project outcomes are improved and the QIPs are successful. MCMC and HSAG will be working with the plans to improve the effectiveness of their improvement strategies and the corresponding documentation.

Recommendations

Plans should improve their documentation of barrier analyses by providing the supporting results, identifying the targeted population, and documenting their rationales for how they prioritized the barriers.

The interventions implemented should directly address the high-priority barriers. It may be an overall more effective strategy to implement interventions that are data-driven and targeted, especially with a growing Medi-Cal population and finite resources.

With the implementation of any intervention (and especially for multiple interventions), plans should ensure that each intervention includes an evaluation plan. Plans should document the evaluation method and the results of the intervention's evaluation for each measurement period. Without a method to evaluate the effectiveness of each intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions; the absence of these data elements reduces the likelihood of achieving project objectives and improving performance.

7. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

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'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 MCP 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 of 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 2012 performance measure rates (which reflect 2011 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 DHCS-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 2012 performance measure weighted averages and compared them to the MCMC-established MPLs and HPLs to assess overall performance.

All plans were able to successfully report valid HEDIS 2012 performance measure rates, and the MCMC weighted average rates for all quality measures exceeded the MPLs. One performance measure rate for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling* exceeded the MCMC HPL.

MCMC had seven quality-related performance measures with statistically significant increases in rates, and only one measure had a statistically significant decline in performance (*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*).

Some plans continued to struggle with the effectiveness of their HEDIS improvement plans, and one plan contributed to the poorest performance among all MCPs in four of its counties, a continued trend. A review of the improvement plans showed that the 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 plans' improvement plans were not data driven and did not contain measurable interventions and achievable outcomes.

All seven QIPs reviewed for sustained improvement achieved it; however, HSAG has noted that the current definition of sustained improvement does not require a statistically significant improvement over the baseline period, and several of the plans with sustained improvement failed to achieve a statistically significant improvement. Therefore, the program has an opportunity to work with the EQRO to place greater emphasis in achieving actual health outcomes by ensuring that the plan achieves statistically significant improvement before it assesses for sustained improvement in future years.

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.

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 MCMC beneficiaries.

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

MCMC had strengths as well as opportunities for improvement under the access domain of care. HSAG based its assessment on 2012 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. The statewide collaborative QIP aimed at reducing avoidable ER visit rates showed six plans with sustained improvement for 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 MR/PIU 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.

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, 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 2012 performance measure rates for providing timely care, QIP outcomes, and compliance review standards, MCMC 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 women's health measures, such as postpartum care and cervical cancer screening, 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, MCMC and its contracted plans implemented various initiatives and demonstrated success with many aspects of providing quality, accessible, and timely health care services to MCMC beneficiaries.

Taking into account the medical performance reviews and MR/PIU 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 2012 performance measure weighted averages all were between the MPLs and HPLs, with one measure exceeding the HPL and seven rates achieving statistically significant improvement. Overall, the plans are making incremental improvement from the prior year. Performance measures were primarily categorized 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, the plans' QIPs showed mixed results with many QIPs showing statistically significant improvement and/or sustained improvement, while others failed to achieve an improvement in the health outcomes. The successful QIPs resulted in outcomes that spanned the quality, access, and timeliness domains of care. Plans demonstrated improvement by improving asthma and COPD management, improving childhood obesity documentation, improving women's health, and reducing avoidable ER visits.

Based on the overall assessment of MCMC in the areas of quality and timeliness of, and access to, care, HSAG provided detailed recommendations for each of the three required activities in previous 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 2010–11 EQR Recommendations and MMCD’s Follow-Up

The table below provides the 2010–11 EQR recommendations and the Department of Health Care Service’s Medi-Cal Managed Care Division’s (MMCD’s) actions taken through June 30, 2012, that address the recommendations.

2010–11 EQR Recommendation	MMCD Actions through June 30, 2012, that Address the Recommendation
<p>MMCD 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.</p>	<p>MMCD has limitations in developing a formal scoring mechanism. Medi-Cal managed care health plans (Plans) are audited, surveyed, or reviewed by DHCS’s A&I Division and MMCD, and DMHC. The fact that audits range in complexity, length, and scoring criteria make it very challenging to develop a uniform scoring system. Nonetheless, MMCD is reviewing best practices of other state Medicaid programs and is willing to explore all ideas pertaining to a uniform audit scoring system.</p> <p>MMCD has tracked plans’ HEDIS scores since 1999, including those that fall below the MPLs, with a trending tool. MMCD uses 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. In 2011, MMCD initiated a pilot HEDIS CAP with one of its health plans that had demonstrated a clear downward trend in performance. As part of the HEDIS CAP development, MMCD is designing a process to assess annually whether each plan met DHCS-designated HEDIS performance thresholds.</p>
<p>MMCD should develop and maintain an overall compliance monitoring schedule by plan to ensure that all standards are reviewed at least once every three years.</p>	<p>DHCS and DMHC have entered into an Interagency Agreement (IA) to have DMHC, on behalf of DHCS, conduct financial audits, medical surveys, and a review of the provider networks of the Plans participating in the mandatory enrollment of seniors and persons with disabilities (SPDs). DHCS and DMHC are also negotiating an IA to conduct similar audit duties for the Rural Expansion, Healthy Families, and Coordinated Care Initiative transitions. In the interest of coordination, collaboration, and efficiency, DHCS and DMHC have developed a process to coordinate the DHCS A&I Division and DMHC IA audits.</p> <p>DHCS and DMHC are in the process of finalizing an audit schedule. The audit schedule will contain the DHCS A&I Division annual audits and a coordinated audit with DMHC on a triennial basis.</p> <p>MMCD has internally restructured to form a new unit—the Plan Monitoring Unit (PMU). The primary job functions of PMU include, but are not limited to, managing the DHCS central repository for DHCS and DMHC audits, managing and approving CAPs for all audits, providing technical assistance when needed, and spot checking audit findings that are considered resolved to verify compliance. Once a CAP has been</p>

2010–11 EQR Recommendation	MMCD Actions through June 30, 2012, that Address the Recommendation
	submitted, PMU will work with the Plan to ensure that all findings have been resolved through technical assistance, policy and procedure review, operational and system enhancements, and reviewing and approving work plans.
MMCD 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.	<p>DHCS has created a central repository where all DHCS and DMHC audits are stored. The PMU, formerly the “Member Rights/Program Integrity Unit,” has assumed the lead role managing the central repository, and a formal procedure and tracking mechanism has been implemented.</p> <p>For monitoring the SPD population, DHCS’s IA with DMHC requires that DHCS provide data as outlined in the IA to DMHC for a review of DHCS’s health plan networks. To facilitate this transfer of information, a SharePoint website was created for both parties to access.</p>
MMCD should enforce minimum contract performance requirements through progressive penalties with plans that continue to show a pattern of poor performance over consecutive years.	<p>MMCD strengthened its HEDIS Improvement Plan (IP) process by requiring plans to provide a more rigorous analysis of barriers and targeted interventions to achieve better quality improvement outcomes.</p> <p>In 2011, MMCD initiated a pilot HEDIS CAP with one of its health plans that had demonstrated a clear downward trend in performance. Since then, DHCS has collected quarterly CAP update submissions from this plan with parallel goals of monitoring the CAP and developing a formal CAP process for all MCPs demonstrating poor HEDIS performance. In addition, MMCD interfaced its upgraded IP process with this new CAP process since both are required of plans for HEDIS rates scored below the MPLs.</p>