Medi-Cal Managed Care Program Technical Report

July 1, 2008–June 30, 2009

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

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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.6 million beneficiaries (as of July 2009)throughout the State of California through a combination of contracted full-scope and specialty managed care plans (plans).[1] The Code of Federal Regulations (CFR) at 42 CFR §438.358[2] requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the quality and timeliness of and access to the health care services provided by plans.

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

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

This report provides:

- A description of the Medi-Cal Managed Care Program.
- A description of the scope of EQR activities for the period of July 1, 2008, through June 30, 2009.
- An aggregate assessment of health care timeliness, access, and quality through organizational structure and assessment, performance measures, and quality improvement projects.
- Recommendations to the DHCS to improve plan compliance with federal requirements and, subsequently, to improve the quality and timeliness of and access to services provided to Medi-Cal managed care members.

[1] *Medi-Cal Managed Care Enrollment Report*, June 2009. 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.

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

Overview of the 2008–2009 External Quality Review

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

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

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

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

Quality

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

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

For this report, HSAG used the MCMC 2009 performance measure rates (which reflect 2008 measurement data), QIP validation results and outcomes, and compliance review standards related to measurement and improvement to assess the quality domain of care.

To create a uniform standard for assessing plans on MCMC-required performance measures, the DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPLs indicate low performance, rates at or above the HPLs indicate high performance, and rates at the MPLs or between the MPLs and HPLs demonstrate average performance. HSAG used the MCMC HEDIS®[3] 2009 weighted averages and compared them to the MCMC-established MPLs and HPLs to assess overall performance.

All of the MCMC 2009 performance measure weighted averages fell between the established MPLs and HPLs. MCMC performed best on *Childhood Immunization Status—Combination 3 (CIS-3)* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34),* both of which exceeded the national Medicaid 75th percentiles. The percentiles cited in this report were established by the National Committee for Quality Assurance (NCQA) by aggregating national data submitted by Medicaid plans for HEDIS reporting. Both performance measures spanned the quality, access, and timeliness domains of care and were strengths of the plan during the review period.

No MCMC weighted averages fell below the MPLs. Two MCMC measures had statistically significant increases, and there were no measures with statistically significant decreases. Four MCMC weighted average rates were between the 25th and 50th percentiles and represented the greatest opportunities for improvement as a whole. These measures related to prenatal and postpartum care, appropriate medications for asthma, and well-child visits in the first 15 months of life.

During the review period, 13 of the 17 QIPs that had progressed to at least one remeasurement period achieved statistical significance, defined by CMS as "real" improvement, for at least one study indicator. HSAG assessed 11 QIPs for sustained improvement, of which 10 achieved a higher rate at the last remeasurement period compared with the baseline period, without a statistically significant decline, for at least one study indicator. QIPs that had positive health outcomes under the quality domain of care during the review period included such areas as

[3] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

reducing adverse reactions to medications for members with HIV/AIDS, improving diabetes management, using antibiotics properly, increasing childhood immunizations, improving control of asthma, and providing timely prenatal and postpartum care.

Based on DHCS's compliance monitoring findings during the review period, overall plans met the standards for quality management and organizational capacity, both of which support the delivery of quality care. Additionally, the DHCS updated its *Medi-Cal Managed Care Program Quality Strategy—December 2009* for the MCMC Program. The revised objectives and quality improvement strategies demonstrated commitment and support at the State level to improve and deliver quality care.

The DHCS can improve the quality of care for its MCMC members by increasing performance measure rates that fall below the national Medicaid 50th percentiles. Despite the success of QIP outcomes during the review period, plans have an opportunity to improve documentation of QIPs to meet compliance with federal requirements for conducting a QIP. Following the CMS protocol for conducting a QIP increases the likelihood that a plan will achieve real and sustained improvement of health outcomes.

Based on compliance monitoring findings, the plans' greatest opportunity for improvement under quality-related standards related to improving the analysis and reporting of monitoring activities through the plans' formal quality improvement structure and within the plans' internal program evaluation.

Access

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

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

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

MCMC had strengths as well as opportunities for improvement under the access domain of care. HSAG based its assessment on 2009 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 mixed performance for access. The program exceeded the national Medicaid 75th percentile for childhood immunizations and well-child visits in the third, fourth, fifth, and sixth years of life. However, the program fell below the national Medicaid 50th percentile for prenatal and postpartum care and well-child visits in the first 15 months of life.

QIP outcomes during the review period showed an improved diabetic eye exam rate, suggesting adequate or enhanced access to eye care professionals for one plan. While the overall program had low rates for prenatal and postpartum care, one QIP showed improved prenatal and postpartum care rates, which demonstrated timely access to obstetrical/gynecological care. Finally, several QIPs aimed at improving immunization rates and well-care visits had increased rates, which suggests appropriate access to primary care for children.

Compliance standards that related to access showed that overall plans had appropriate policies and procedures in place to monitor access and availability of care, including after-hours access to care. Audit findings revealed several opportunities to improve access to care, including the monitoring of wait times in providers' offices, wait times for telephone calls, and wait times to obtain various types of appointments. Many plans need a formal process for analyzing results from access and availability monitoring reports, identifying opportunities for improvement, and implementing intervention strategies to improve access. While all plans had continuity of care standards in place, many plans struggled to provide care coordination for carve-out services for members eligible for California Children's Services, early intervention services, and developmental disability services. Many plans had providers that were not compliant with cultural and linguistic service requirements, presenting a barrier to accessing care.

Timeliness

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

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

Based on 2009 performance measure rates for providing timely care, QIP outcomes, and compliance review standards, the DHCS demonstrated both strengths and challenges in the timeliness domain of care.

Performance measure results related to timeliness of care were within the MPLs and HPLs. QIPs showed success with childhood immunizations and prenatal and postpartum care; however, the MCMC program as a whole still had opportunities to improve performance measure results for prenatal and postpartum care.

Compliance review findings showed that overall plans had a utilization management program and a member grievance system supported by policies and procedures that met program requirements to facilitate timely care decisions. Despite adequate systems, plans had challenges related to prior-authorization notifications, including sending notice of action letters to members in a timely manner, using clear and concise language in the notices, and providing State fair hearing information in the notices. For member grievances, plans did not always send timely acknowledgment letters. Many plans also had challenges with ensuring that new members completed an initial health assessment and initial behavioral health education assessment, which could delay access to care and coordination of needed services. These areas impact the timeliness of care provided to members and represent opportunities for improvement.

Conclusions and Recommendations

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

MCMC 2009 performance measure weighted averages all fell between the MPLs and HPLs and demonstrated steady and improved results compared with 2008 rates, with two statistically significant increases and no statistically significant declines. Performance measures fall primarily under the quality domain of care, although several measures also impact the access and timeliness domains of care. HSAG noted two key factors that may have contributed to individual plan performance below the MPLs—misalignment between identified barriers and interventions and implementation of interventions late in the measurement year.

QIPs assessed for real and sustained improvement demonstrated successful health outcomes by reducing adverse reactions to medications for members with HIV/AIDS, improving diabetes management, using antibiotics properly, increasing childhood immunizations, improving control of asthma, and providing timely prenatal and postpartum care. The plans' QIPs all had initiatives that impacted the quality domain of care. Some QIPs also had an impact on access to and timeliness of care. Despite the success demonstrated in many QIPs during the review period, the plans' greatest improvement opportunity is to increase compliance with HSAG's application of the CMS requirements for conducting a QIP. No QIP submitted during the review period fully met HSAG's validation requirements.

MCMC plans as a whole demonstrated compliance with most DHCS standards for structure and operations, quality measurement and improvement, and program integrity. Plans have improvement opportunities related to access and availability, prior-authorization notifications, member grievances, and cultural and linguistic services requirements, which primarily impact the access and timeliness domains of care. Plans had challenges related to the implementation of existing policies and procedures and formal monitoring of activities.

HSAG's review of DHCS' efforts in monitoring the plans for compliance with federal and State standards revealed the department's robust and thorough readiness review process required of plans prior to the onset of providing services to MCMC members, its ongoing monitoring activities, and its collaborative approach with plans to resolve areas of concern. Opportunities exist for the DHCS to formalize its compliance monitoring process to provide meaningful information for future program decisions.

Based on the overall assessment of the MCMC Program in the areas of quality and timeliness of and access to care, HSAG provides the DHCS with the following global recommendations:

- Reevaluate the effectiveness of HEDIS improvement plans as a means for increasing performance measure rates for plans that fall below the MPLs and incorporate a process to review the content of the improvement plans to ensure proper alignment between proposed interventions and causal barriers.
- Explore factors that contribute to performance measure results that fall below the national Medicaid averages and develop strategies to address areas of low performance.
- Identify plans with consistently poor performance and implement progressive penalties until performance rates reach the acceptable levels as required by the contract.
- Continue efforts to improve plans' compliance with the CMS protocol for conducting QIPs through revisions of program requirements and technical assistance.
- Develop and implement a formal scoring mechanism for compliance monitoring results across activities and provide the mechanism to plans to improve their compliance with federal and State standards.

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

HSAG will evaluate DHCS's progress with these recommendations along with its continued successes in the next annual review.

Report Organization

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

Section 1—Executive Summary includes a high-level summary of external quality review results and overall findings, conclusions, and recommendations.

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

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

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

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

Section 6—Organizational Assessment and Structure Performance

Section 7—Performance Measure Performance

Section 8—Quality Improvement Project Performance

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

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

Medi-Cal Managed Care Program Overview

During the review period, June 1, 2008, through July 1, 2009, the DHCS administered the Medi-Cal Managed Care (MCMC) Program, California's Medicaid managed care program. During the period covered by this report, the MCMC program served roughly half of the Medi-Cal population, with the other half enrolled in fee-for-service (FFS) Medi-Cal.

Approximately 3.6 million beneficiaries enrolled as of June 2009 in the MCMC program received care from 21 full-scope plans, 3 specialty plans, and 1 prepaid health plan operating in 27 counties throughout California. The DHCS administers the MCMC program through a service delivery system that encompasses three different plan model types: County-Organized Health System (COHS), Geographic Managed Care (GMC), and Two-Plan.

County-Organized Health System

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

During the measurement period for this report, the DHCS had contracts with five COHS plans operating in nine counties.

Geographic Managed Care

In the GMC model, enrollees choose from three or more commercial plans offered in a county. Beneficiaries with designated mandatory aid codes must enroll in a managed care plan. A small number of beneficiaries in several other aid codes are not required to enroll in a plan but may choose to do so. These "voluntary" beneficiaries may either enroll in a managed care plan or receive services through the Medi-Cal FFS program.

During the measurement period for this report, the GMC model type was operating in San Diego and Sacramento counties.

Two-Plan

In the Two-Plan model, the DHCS contracts with two managed care plans in each county to provide health care services to beneficiaries. Most Two-Plan model counties offer a locally operated local initiative (LI) plan and a non-governmental commercial plan (CP). Like the GMC model, the DHCS requires beneficiaries with designated mandatory aid codes to enroll in a plan.

As in the GMC model, a small number of beneficiaries in several other "voluntary" aid codes can choose either to enroll in a plan or remain in the FFS program.

During the measurement period, the Two-Plan model was operating in 12 counties.

Specialty and Prepaid Health Plans

In addition to the full-scope plans, the DHCS, in some instances, also contracts with specialty plans to provide unique services, usually to a smaller population. The DHCS holds contracts with three specialty plans. The DHCS also contracts with one prepaid health plan in two counties, although that contract will end in July 2011, by which time both those counties will have converted to a COHS model.

Domains of Care

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."[4]

Access

In the preamble to the CFR,[5] 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.

[4] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 3, October 1, 2005.
[5] 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."[6] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the plan—e.g., processing expedited appeals and providing timely follow-up care. The Agency for Healthcare Research and Quality (AHRQ) indicates "timeliness is the health care system's capacity to provide health care quickly after a need is recognized."[7] Timeliness includes the interval between identifying a need for specific tests and treatments and actually receiving those services.[8]

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

Table 2.1—Assignment of Activities to Performance Domains

Compliance Review Standards	Quality	Timeliness	Access
Enrollee Rights and Protections Standards		√	√
Access Standards		√	√
Structure and Operations		√	√
Measurement and Improvement	√		
Grievance System		√	√
Performance Measures	**Quality**	**Timeliness**	**Access**
Adolescent Well-Care Visits	√	√	√
*Adults' Access to Preventive/Ambulatory Health Services**	√		√
Appropriate Testing for Children With Pharyngitis	√		
Appropriate Treatment for Children With Upper Respiratory Infection	√		
Avoidance of Inappropriate Antibiotic Treatment in Adults With Acute Bronchitis	√		√
Breast Cancer Screening	√		√
Cervical Cancer Screening	√		√
Childhood Immunization Status—Combination 3	√	√	√
*Colorectal Cancer Screening**	√		√
Comprehensive Diabetes Care	√		√
*Glaucoma Screening in Older Adults**	√		√

[6] National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.
[7] Agency for Healthcare Research and Quality. *National Healthcare Quality Report* 2007. AHRQ Publication No. 08- 0040. February 2008
[8] Ibid.

Table 2.1—Assignment of Activities to Performance Domains

Performance Measures	Quality	Timeliness	Access
*Inpatient Hospitalizations**	√		
*Out-of-Home Placements**	√		
*Persistence of Beta-Blocker Treatment After a Heart Attack**	√		
Prenatal and Postpartum Care: Postpartum Care	√	√	√
Prenatal and Postpartum Care: Timeliness of Prenatal Care	√	√	√
Use of Appropriate Medications for People With Asthma	√		
Well-Child Visits in the First 15 Months of Life	√	√	√
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	√	√	√
Quality Improvement Projects	**Quality**	**Timeliness**	**Access**
Statewide Collaborative QIP—Reducing Avoidable ER Visits	√		√
Individual and Small-Group Collaborative QIPs	Domain varied by plan project		
* Specialty plan measures			

Medi-Cal Managed Care Program Quality Strategy

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

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

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

Quality Strategy Objectives

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

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

Quality Improvement Strategies

The DHCS established the following seven strategies:

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

Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

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

The DHCS uses the information to assess the effectiveness of its strategic goals and objectives and to provide a road map for potential changes and new goals and strategies.

Medi-Cal Managed Care Program Initiatives Driving Improvement

HSAG noted several DHCS initiatives that support the improvement of quality of care and services for MCMC members as well as activities that support plan improvement efforts.

Quality Strategy

During the review period, the DHCS revised its initial *Medi-Cal Managed Care Program Quality Strategy—May 2004*. Part of this process entailed soliciting input and recommendations from various stakeholders, including advocates, MCMC members, and plan representatives. The revised *Medi-Cal Managed Care Program Quality Strategy—December 2009* included input from the various stakeholders as well as incorporated strategies to ensure access, program monitoring, and evaluation of services for seniors and persons with disabilities (SPDs), a growing segment of the covered population, in addition to its large population of low-income children and families. The *Medi-Cal Managed Care Program Quality Strategy—December 2009* also included steps for periodic revision along with DHCS staff responsibilities.

External Accountability Set

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

Quarterly Dashboard Report

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

Statewide Collaborative Quality Improvement Projects

The DHCS-led statewide collaborative QIP efforts have shown promise in driving and sustaining improvement. The prior collaborative project to improve the screening, counseling, and health education that adolescents received from primary care providers (PCPs) improved the overall MCMC weighted average for the *Adolescent Well-Care Visits* performance measure. HSAG will evaluate the success of the statewide *Avoidable ER Visits*, collaborative QIP as remeasurement data become available. Statewide collaborative QIP reports are released on the DHCS Web site at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

Fraud, Waste, and Abuse Detection and Prevention

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

Quality Improvement and Performance Measure Transparency

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

Medical Home

The DHCS established a medical home work group during the reporting period to support efforts to ensure that all MCMC care members have an established medical home. The work group began meeting in early 2009 with a focus on establishing a definition of medical home within the MCMC framework.

Seniors and Persons With Disabilities

Several initiatives during the review period focusing on SPDs included efforts to increase voluntary enrollment of seniors and persons with disabilities; improving systems for providing care management and coordination; developing an evaluative process for plans to use to determine the accessibility, capability, and readiness of contracted primary care sites; and exploring performance standards and measures to evaluate health outcomes.

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

Organizational and Structural Standards Performance

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

Performance Measure Outcomes

Four plans demonstrated high performance across the EAS by exceeding the DHCS-established high performance levels (HPLs), which represents the national Medicaid 90th percentiles, for at least six measures.[9] Kaiser Permanente in San Diego County, Kaiser Permanente in Sacramento County, CenCal Health in Santa Barbara County, and San Francisco Health Plan in San Francisco County were the high performers.

Kaiser plans in San Diego County and Sacramento County had complete and robust administrative data sources, primarily due to their closed-system model and use of an electronic medical record, which has helped the plans improve and sustain performance measure results. The adoption of electronic medical records (EMRs), a systems-based intervention, to improve care is supported by the literature as an evidence-based strategy.

CenCal Health in Santa Barbara County demonstrated success among several diabetes indicators. The plan attributed its high performance to its Diabetes SMART ("Successful Management Always Requires a Team") Program, a comprehensive care management model that is centered on the primary care physician and includes self-management education, specialist referrals, and coordination of local resources and support. An online tool for tracking health outcome information supported the program.

[9] California Department of Health Care Services. *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program.* July 2010.

HSAG noted that San Francisco Health Plan in San Francisco County was fully compliant with cultural and linguistic service requirements and demonstrated an ongoing commitment to provide culturally responsive care to the plan's diverse MCMC membership. The plan's efforts in this area may be one factor that contributed to the overall performance measure success as the plan has taken effective action to minimize any access-related cultural and linguistic barriers for members. In addition to ensuring interpreter services, San Francisco Health Plan's efforts include ensuring access to PCPs who speak predominant member languages. The plan has demonstrated strong success in childhood immunizations, achieving rates of more than 90 percent for the last several years. The plan attributed its success to interventions expanding use of the California Immunization Registry to its pediatric providers.

Quality Improvement Project Outcomes

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

Improving Diabetes Management

Anthem Blue Cross had sustained improvement for diabetic retinal exams across its nine counties—Alameda, Contra Costa, Fresno, San Francisco, San Joaquin, Santa Clara, Sacramento, Stanislaus, and Tulare. Interventions implemented to increase retinal exams included the following:

- Patient reminders.
- Small media—education packets and calendars.
- Referrals to case management, disease management, and health education classes.
- Member mailings that included a listing of ophthalmologists.
- Materials translated in Spanish.
- Targeted telephonic outreach linking members to appointments.
- Dissemination of clinical guidelines.
- Provider notification of incomplete screenings.

These interventions not only provided education and increased awareness, but also helped reduce barriers related to access and availability of services by helping to link members to an eye professional for services. The multipronged approach may have increased the plan's likelihood for success.

San Francisco Health Plan in San Francisco County had sustained improvement for four diabetes measures by implementing both member and provider interventions. One intervention implemented was a $50 incentive for high-risk diabetic members who underwent all required screening. The plan appropriately evaluated the success of this intervention and, based on the results, expanded the incentive to all diabetic members at a reduced incentive amount.

Proper Antibiotic Use

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

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

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

Increasing Childhood Immunizations

Kern Family Health Care in Kern County demonstrated sustained improvement for all four of its study indicators within its immunization QIP. The plan increased the use of high-volume providers using the regional immunization registry and increased the percentage of children seen by providers who accessed and used the registry.

The plan used member, provider, and system interventions, which contributed to both real and sustained improvement of the childhood immunization rates. Interventions selected by Kern Family Health Care in Kern County to increase member awareness included television commercials and materials distributed to members during prenatal and postpartum provider visits.

The plan also joined the Central Valley Immunization Information System (registry) and implemented targeted interventions to increase provider registry participation, including distribution of risk pool money.

Timeliness of Prenatal and Postpartum Care

Western Health Advantage in Sacramento County used a strategy to concentrate improvement efforts on its highest-volume providers to improve timeliness of prenatal care. The plan added nurse practitioners and provided priority scheduling to late-entry prenatal members. Providers began scheduling postpartum appointments at 36 weeks gestation. Additionally, the plan created a database to identify members after delivery and contacted all members failing to attend their scheduled appointment. By 2007, the plan had achieved statistically significant improvement in both of the QIP's study indicators. Between 2007 and 2008, the plan implemented educational improvement strategies targeting both study indicators, which were consistent with the HEDIS measures for timeliness of prenatal care and postpartum care. The plan documented continued improvement for both prenatal and postpartum care.

Operational Performance Standards

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

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

Conducting the Review

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

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

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

To assess performance related to the quality and timeliness of and access to care, HSAG reviewed and aggregated the most recent audit report findings available as of June 30, 2009, for each plan related to compliance monitoring standards within the Code of Federal Regulations. Additionally, HSAG used information from plan-produced internal quality evaluations, as appropriate, in conjunction with DHCS's monitoring results to make an assessment of each plan's compliance related to the quality and timeliness of and access to care provided to MCMC members.

Objectives

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

Methodology

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

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

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

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

Monitoring Activity	Plan Management Branch	Member Rights & Program Integrity Unit	Medical Monitoring Unit	Medical Policy Section	Audits and Investigations
Readiness Review	X		X	X	
Joint Medical Performance Audit			X		X
Member Rights and Program Integrity Review		X			

Readiness Review

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

Medical Performance Audits

For ongoing monitoring, A&I and DMHC conduct routine medical performance reviews/surveys (joint audits) of MCMC plans. These medical performance audits assess plans' compliance with contract requirements and State and federal regulations. For most plans, a joint audit is conducted for each MCMC plan approximately once every three years. The scope of the audit covers the areas of utilization management, continuity of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity. The DHCS provides the plan with a report of findings, including any of the plan's corrective actions. Joint audit reports are

released for public review on the DMHC's Web site at: http://www.dmhc.ca.gov/healthplans/med/med_default.aspx.

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

Member Rights and Program Integrity Review

MRPIU is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud, waste, and abuse prevention and detection). These reviews are done before a plan becomes operational in the MCMC program, when changes are made to policies and procedures, during contract renewal, and if a plan's service area is expanded. As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance.

Plan Monitoring

HSAG evaluated DHCS's compliance monitoring process of the plans to evaluate compliance with federal requirements. HSAG offers recommendations to improve the compliance monitoring process at the end of this section.

To assess DHCS's process, HSAG worked with MMCD staff to identify the areas within DHCS that conducted compliance monitoring activities. HSAG reviewed the monitoring process for each area responsible for monitoring and conducted staff interviews and document review to:

- Determine the monitoring activities conducted and the responsible areas.
- Determine the frequency of monitoring.
- Determine how monitoring results are collected, analyzed, reported.
- Determine how monitoring results are communicated to the plan.

HSAG conducted reviews and interviews between January 2010 and July 2010. Areas in which staff were interviewed included PMB, MRPIU, MMU, and MPS. The PMU provided HSAG with background information and assisted with identifying monitoring areas and scheduling the interviews.

As a result of the review process, HSAG identified several strengths of DHCS's monitoring process, as well as some opportunities for improvement.

Strengths

- The DHCS conducted a thorough readiness review prior to approval for plans to provide services to MCMC members, which helped ensure that plans met all federal and State requirements before providing services to MCMC recipients.
- There was evidence of ongoing compliance monitoring activities conducted by various areas, including the MRPIU, MMU, MPS, PMB, and A&I.
- DHCS staff members interviewed demonstrated knowledge about their respective areas of monitoring.
- DHCS staff demonstrated a collaborative approach with plans regarding compliance monitoring findings and resolution.

Opportunities for Improvement

- Although monitoring of plan compliance with contract standards occurred, there was no evidence that a tool was used that identified the specific Code of Federal Regulations requirements that were part of each respective area's review. Therefore, it was difficult to determine the exact CFR requirements the DHCS was monitoring, the frequency at which the monitoring occurred, and the appropriateness and adequacy of the monitoring.
- Due to the division of compliance monitoring efforts among different areas within the DHCS, the State lacked a process for aggregating results from each monitoring area and lacked a central repository of plan performance.
- The DHCS monitoring units lacked established criteria, thresholds, or guidelines when reviewing plan deliverables.
- The DHCS monitoring units lacked a formal scoring mechanism. As a result, there was not a current process to trend plan performance over time, compare performance across plans, and provide plans with feedback.
- The DHCS lacked a process to formally document plan monitoring concerns and areas of noncompliance.
- Due to budget and resource issues, the DHCS was not conducting the required comprehensive compliance monitoring review of all plans every three years.
- While the DHCS conducted a thorough readiness review prior to plans providing services to MCMC members, many aspects of this review, such as the review of plans' policies and procedures, were not conducted on a routine basis unless the plan acknowledged a change or a plan expansion occurred.

Findings

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

Operational Performance Standards Results

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

Joint Audit Findings

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

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

Under the UM category, all plans demonstrated implementation of a UM program. The programs, supported by policies and procedures and written criteria, were based on sound medical evidence and met program requirements. Most plans showed evidence of monitoring and analyzing data for under- and overutilization of services. Audit findings in the UM category were largely the result of prior-authorization issues. Plans had challenges sending notification to members for denied, modified, or deferred decisions. For notice of action (NOA) letters sent to members, many plans did not send timely notification and/or the NOA letters did not contain a clear and concise reason for denying or modifying the request. The audit showed that many plans lacked the required language in the NOA, including State fair hearing information. Many plans that delegated UM functions to other entities lacked adequate oversight, particularly for prior-authorization denials.

For continuity of care standards, most plans met the requirements for providing medical case management to members and monitoring the coordination of services in- and out-of-network. Case management models varied by plans, with many designating the primary care physician responsible for coordinating care, while other plans used their own case management staff or used a combination of the primary care physician and a case manager. Common findings under this category included lack of care coordination for members eligible for California Children's Services

to ensure that members received medically necessary covered services. Additionally, plans had challenges with ensuring case coordination for all members receiving early intervention services and developmental disabilities services. While plans had policies in place for obtaining initial health assessments and individual health education behavioral assessments for new members, as well as tracking completion rates, many plans had low member completion rates for these assessments. Few plans demonstrated monitoring of their rates and/or taking action to improve these rates as part of their quality improvement program. Many of the findings in this area were noted as repeat audit deficiencies.

Under the availability and accessibility of services category, most plans had policies and procedures for access to and availability of routine, urgent, emergency, prenatal, and routine specialty care. The plans maintained procedures for triaging member calls and providing access to care after hours. Common findings for many plans included lack of monitoring of wait times in providers' offices, wait times for telephone calls, and wait times to obtain various types of appointments. Few plans reported access and availability reports within the QI committee structure and within the plans' internal QI evaluation. Many plans did not analyze results from access and availability monitoring activities to identify opportunities for improvement and/or implement strategies to improve access to care. Many plans had challenges ensuring that members received an adequate supply of medically necessary medication in an emergency situation.

The audit results from the member rights area showed that overall plans had grievance policies and procedures and a grievance system in place for member complaints. Plans followed policies and procedures for timely PCP selection and assignment for members. Overall, plans had adequate policies and procedures to meet confidentiality requirements. Audit findings showed that while plans had written policies and procedures for the grievance process, many plans did not send timely acknowledgment letters and grievance resolution notices, based on the grievance files reviewed. Additionally, not all quality of care-related grievances were appropriately reviewed by clinical staff. Many plans lacked analysis of grievance data and reporting of data through the QI committee structure on a regular basis.

Member Rights and Program Integrity Findings

MRPIU findings revealed that overall plans were compliant with most of the standards covered in the areas of marketing and enrollment programs and program integrity.

Review findings were related to members rights, including member grievances, prior-authorization notifications, and cultural and linguistic services.

A review of prior-authorization notifications showed that many plans did not use the DHCS-approved NOA form, did not provide member notifications in a timely manner, and did not

provide notification to members of a denial, termination, or modification. Additionally, the NOAs that were used did not provide a specific citation supporting the action taken by the plan.

MRPIU noted similar findings for member grievances. Many plans' acknowledgment letters exceeded the notification time frames, resolution letters exceeded the time frames, and notifications lacked the inclusion of State fair hearing information. Several plans did not have a procedure for reviewing quality of care grievances by medical staff for resolution. Finally, many of the plans' providers interviewed as part of the review indicated that they do not report grievance information to the plan.

Under the cultural and linguistic requirements, MRPIU found many plans deficient due to:

- Providers' noncompliance with the required 24-hour oral interpreter service requirements.
- Provider offices that did not discourage the use of family, friends, or minors as interpreters, which can compromise the reliability of medical information.
- Providers' noncompliance with the requirement to document in the medical record a request for or refusal of language/interpreter services by a member with limited English proficiency.
- Not providing cultural competency, sensitivity, or diversity training for providers.

Conclusions

Based on medical performance audits and MRPIU review findings, overall, plans demonstrated compliance with standards for quality management, organizational capacity, marketing and enrollment, and program integrity. Plans had appropriate resources and written policies and procedures in place to support a quality improvement program.

Audit results showed that areas of deficiency for plans were related to standards that demonstrate actual implementation and/or monitoring of processes consistent with policies and procedures. Most commonly, these findings were related to prior-authorization notifications, member grievance acknowledgment and resolution, monitoring of delegated entities, monitoring of provider wait times, and monitoring providers' compliance with cultural and linguistic requirements. These findings primarily impacted the access and timeliness domains of care.

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

HSAG's review of DHCS's monitoring of plan performance related to federal and State standards demonstrated ongoing compliance monitoring activities in many functional areas. The review

revealed opportunities for the DHCS to formalize its compliance monitoring process. This included opportunities for the DHCS to standardize review criteria, centralize collection of monitoring results, aggregate data, and trend plan performance to provide the DHCS with meaningful information.

Recommendations

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

- Plans need to review and revise their quality management and utilization management program structures to ensure reporting, review, oversight, discussion, action, and approval of activities.
- Plans need to develop an internal process to ensure monitoring of prior-authorization notifications and grievance resolution notices to members for timeliness and accuracy.
- Plans need to develop a process to monitor providers' compliance with cultural and linguistic requirements.
- Plans need to incorporate areas of noncompliance within their work plans to ensure that deficiencies are resolved and monitored on an ongoing basis.
- Plans should include analysis of monitoring activities within their internal program evaluations as a mechanism for identifying opportunities for improvement, developing intervention strategies, and trending performance over time.

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

- The DHCS should consider conducting a crosswalk of all State and federal requirements across monitoring activities to determine the area responsible for monitoring and to ensure that all requirements are monitored at a frequency of at least every three years.
- The DHCS needs to develop a central repository for compliance monitoring results across the DHCS and DMHC and develop a process for aggregating results for plan-specific performance.
- The DHCS should establish thresholds or guidelines for staff when reviewing plan deliverables to ensure that requirements are consistently applied.
- The DHCS should develop and implement a formal scoring mechanism for compliance monitoring results to allow the DHCS to trend plan performance over time, compare performance across plans, and provide plans with feedback.
- The DHCS should formalize a process to document concerns with plan performance, recommendations, and actions as appropriate.
- The DHCS should develop and maintain an overall compliance monitoring schedule by plan to ensure that all standards are reviewed at least every three years.

As a result of informal feedback from HSAG to the DHCS regarding opportunities to improve monitoring of plans' compliance, MMCD has implemented a monitoring initiative. The purpose of the initiative is to develop a comprehensive approach to tracking and sharing monitoring results throughout MMCD in order to ensure results are incorporated into decision making, policy development, and ongoing quality improvement. HSAG will evaluate MMCD's progress within the next EQR report.

Performance Measure Validation

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

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

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

Conducting the Review

Each full-scope plan calculated and reported plan-specific data for the following DHCS measures in the 2009 EAS:

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

- *Prenatal and Postpartum Care*
- *Use of Appropriate Medications for People With Asthma*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

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

Performance Measure Requirements and Targets

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

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

Objectives

Plans underwent a HEDIS Compliance Audit™,[10] or a performance measure validation audit for non-HEDIS measures, conducted by HSAG to evaluate the accuracy of performance measure results reported by the plans and to ensure that the plans followed specifications established by the DHCS.

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

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

Methodology

HSAG conducted HEDIS Compliance Audits in accordance with the 2009 NCQA HEDIS *Compliance Audits: Standards, Policies, and Procedures, Volume 5,* for 24 plans reporting HEDIS measures. HSAG conducted performance measure validation for one plan reporting non-HEDIS measures using CMS' protocol for conducting performance measure validation.[11] HSAG conducted the audits to ensure that plans captured, reported, and presented data in a uniform manner by performing the following activities:

- Conducted a thorough review of all components of each plan's Record of Administration, Data Management, and Processes (Roadmap) or Information Systems Capabilities Assessment Tool (ISCAT).
- Verified the DHCS-specified EAS measures for 2009.
- Reviewed the plan's programming language for the performance measures of plans not using a certified software vendor. If NCQA-certified software was used, HSAG assessed mapping of plan data into the vendor's required data format and integration of hybrid and administrative data for final rate calculation.
- Performed a convenience sample review from each plan across all required measures.
- Performed a re-review of a random sample of at least 30 medical records for each of two reported measures (if applicable) to ensure the reliability and validity of the data collected.
- Validated all activities that culminated in a rate reported by the plan.
- Provided an audit designation for each measure covered under the scope of the audit.
- Produced preliminary and final audit reports.

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

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

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

Findings

Performance Measure Validation Results

Of the 25 DHCS-contracted plans, 24 underwent performance measure validation for the 2009 reporting year (based on calendar year 2008 data). Family Mosaic Project, a specialty plan, did not have established performance measures in place for data reporting during the 2008 measurement year.

Strengths

All plans were compliant with the required information systems (IS) standards. Overall systems and processes to receive and enter medical and service data were efficient, accurate, timely, and complete.

Despite some challenges with medical record abstraction vendors, the plans implemented processes for reliable and accurate data abstraction. HSAG noted that many plans have knowledgeable and skilled HEDIS project staff dedicated to accurate HEDIS reporting.

All of the plans complied with HEDIS reporting software and physical control procedures to effectively manage and ensure the integrity of the HEDIS data.

HSAG noted many best practices among plans to improve data accuracy, data completeness, or HEDIS rates. They include the following:

- A financial or provider incentive program to encourage providers to gather and submit timely encounter data.
- Use of electronic health records to increase the capture of administrative data.
- Alignment of pay-for-performance and quality initiatives with HEDIS measures.
- Use of regional immunization registry data and other supplemental databases.

Challenges

Some plans experienced challenges with contracted vendors failing to initiate timely and accurate medical record abstraction, which resulted in the need for greater oversight at the plan level. In addition, plans transitioning to a new medical record abstraction vendor or medical record abstraction tools had to modify their timelines and processes. Not all plans had an ongoing over-read process throughout the medical record abstraction period, which could have resulted in abstraction errors that were not corrected.

Several plans had a significant claims backlog. In some cases this was due to a transition between claims vendors or large-scale systems conversions. Plans resolved the backlogs by the time they finalized their HEDIS measures for reporting.

Many plans received a *Not Report* for their *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<7.0 Percent)* measure, which had significant revisions to the measure specifications from the previous year. Plans had difficulty achieving the required sample size due to a high number of unexpected member exclusions. For many plans, the added cost to re-sample and abstract medical records to report a valid rate was a barrier, and some plans opted to receive a *Not Report*.

One plan was not able to report its eye exam rate under the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure due to material bias.

An opportunity exists for some plans to either decrease the number of manual processes or implement formal audit processes to adequately monitor data entry accuracy, the receipt of claims and encounter data, and manual crosswalks.

Most plans still rely on medical record review to obtain lab values instead of obtaining these data electronically, which increases the resource burden on plans and providers.

Plans that obtain data from vendors such as vision, pharmacy, or laboratory vendors once a year or at the end of the year may be missing some data not accounted for due to claims lag. In addition, not all plans have adequate tracking and trending of the volume of vendor data to identify potential data issues or missing data concurrently and are not able to address these issues proactively.

Performance Measure Results

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

The table below lists the DHCS-required HEDIS performance measures for 2009 and the abbreviations used for each measure in Table 7.2.

Table 7.1—HEDIS Performance Measures Name Key

Abbreviation	Full Name of HEDIS Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ASM	*Use of Appropriate Medications for People With Asthma*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–E	*Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed*
CDC–H7	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)*
CDC–H9	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC	*Comprehensive Diabetes Care—LDL-C Control*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W15	*Well-Child Visits in the First 15 Months of Life (Six or More Visits)*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Table 7.2 presents a summary of the MCMC HEDIS 2009 (based on calendar year 2008 data) performance measure weighted averages compared to MCMC HEDIS 2008 (based on calendar year 2007 data). In addition, the table displays the MCMC HEDIS 2009 weighted averages compared to the MCMC-established MPLs and HPLs.

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

Table 7.2—2008–2009 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	28.4%	28.0%	★★	↔	20.6%	35.4%
ASM	Q	88.8%	88.6%	★★	↔	86.1%	91.9%
AWC	Q,A,T	39.6%	43.1%	★★	↑	35.9%	56.7%
BCS	Q,A	50.4%	51.7%	★★	↔	44.4%	61.2%
CCS	Q,A	68.7%	69.8%	★★	↔	56.5%	77.5%
CDC–E	Q,A	58.1%	58.0%	★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	32.6%	29.5%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	42.6%	43.5%	★★	↔	52.5%	32.4%
CDC–HT	Q,A	82.1%	81.0%	★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	34.2%	36.6%	★★	↔	25.1%	42.6%
CDC–LS	Q,A	77.8%	77.8%	★★	↔	66.7%	81.8%
CDC–N	Q,A	78.3%	78.5%	★★	↔	67.9%	85.4%
CIS–3	Q,A,T	72.0%	74.9%	★★	↑	59.9%	78.2%
PPC–Pre	Q,A,T	82.6%	82.2%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	59.1%	59.7%	★★	↔	54.0%	70.6%
URI	Q	83.1%	84.8%	★★	↔	79.6%	94.1%
W15	Q,A,T	60.2%	56.5%	★★	↔	44.5%	73.7%
W34	Q,A,T	75.8%	76.9%	★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Table 7.1 for the full name of each HEDIS measure.
[2] HSAG's assignment of performance measures to the domains of care: quality (Q), access (A), and timeliness (T).
[3] HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.
[4] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[5] Performance comparisons are based on the *z* test of statistical significance with a *p* value of <0.05.
[6] The MMCD's MPL is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile because a higher rate indicates poorer performance.
[7] The MMCD's HPL is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
† The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (at the 25th percentile or between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

All of the 2009 MCMC weighted average performance measure results fell between the MPL and HPL, which reflect the national Medicaid 25th and 90th percentiles. MCMC performance between 2008 and 2009 was fairly consistent with only two statistically significant changes noted. Both the *Adolescent Well-Care Visits (AWC)* and *Childhood Immunization Status—Combination 3 (CIS–3)* measures had statistically significant improvements. No measures fell below the MPL.

MCMC performance was above the national Medicaid 75th percentile for two measures: *Childhood Immunization Status—Combination 3 (CIS–3)*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*. MCMC performance was between the 25th and 50th percentiles for four measures: *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)*, *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)*, *Use of Appropriate Medications for People With Asthma (ASM)*, and *Well-Child Visits in the First 15 Months of Life (W15)*.[12]

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

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 the DHCS for each area of deficiency, outlining the steps they will take to improve care.

Plans were required to submit a total of 74 improvement plans based on 2008 HEDIS rates compared to 73 improvement plans based on 2009 HEDIS rates. Several measures were new measures in 2008; therefore, the DHCS did not establish MPLs or HPLs in the first year of the measure and did not require HEDIS improvement plans. The comparable number of HEDIS improvement plans between 2008 and 2009 decreased.

As a result of the 2008 HEDIS improvement plans, many plans achieved improvement that eliminated the 2009 improvement plan requirement for the same measure(s) by achieving the MPLs. Despite improving rates, some plans remained below the MPLs and will need to continue their improvement plans until they achieve the MPLs.

Other plans struggled to improve their rates. HSAG noted that plans who produced no significant improvement showed a pattern of year-over-year poor performance. A review of the improvement plans showed that the plans typically had not implemented new or modified interventions to address the poor performance or lack of improvement from prior years.

[12] California Department of Health Care Services. *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program.* July 2010.

For plans that did not necessarily show a pattern of poor performance, HSAG identified two key factors that may have contributed to the lack of success. First, the plan interventions either did not align with the identified barriers or did not appropriately address the measure(s). For example, a plan may have documented the initiation of a member mailing to educate members with asthma on the importance of getting an influenza vaccination as an intervention for the *Appropriate Medications for People With Asthma* (ASM) measure. While the plan may feel it is important for its members with asthma to get a flu shot as part of managing the chronic disease, this intervention will likely have no impact on ensuring that members with asthma are receiving their asthma controller medications. Additionally, many plans implemented their interventions late in 2008; therefore, some interventions may not have been in place long enough to impact HEDIS 2009 rates.

Conclusions

HSAG found all plans that underwent a performance measure audit were compliant with the required information system standards. Overall, plans demonstrated the ability to process, receive, and enter medical and service data efficiently, accurately, timely, and completely. Several plans experienced challenges with their medical record review vendors that resulted in some plans providing more oversight and resources than planned or anticipated.

Overall, MCMC performed between the MPL and HPL for all 2009 performance measures, which spanned the quality, access, and timeliness domains of care. MCMC performed best on *Childhood Immunization Status—Combination 3 (CIS–3)* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34),* which both exceeded the national Medicaid 75th percentile.

Four MCMC weighted average rates were between the national Medicaid 25th and 50th percentiles and represented the greatest opportunities for improvement as a whole. These measures related to prenatal and postpartum care, appropriate medications for asthma, and well-child visits in the first 15 months of life. No MCMC weighted averages fell below the MPLs.

Based on 2009 plan performance, HSAG identified four plans as high performers, exceeding six or more performance measure HPLs.[13] Four plans had seven or more performance measures below the MPLs, accounting for almost half of all improvement plans.[14]

While the DHCS-required HEDIS improvement plans helped some plans formalize a plan to address and achieve the MPLs, several plans continued to perform poorly on the same measures. Factors that may have contributed to this lack of success included having no new or modified

[13] California Department of Health Care Services. *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program.* July 2010.
[14] Ibid.

intervention strategies, interventions that did not align to identified barriers and/or the performance measure, and late implementation of interventions.

Recommendations

Based on the 2009 performance measure validation and performance measure rates, HSAG provides the following recommendations for improving the quality, access, and timeliness of care and services for members:

- Plans should improve oversight of their vendors by incorporating an over-read process throughout the chart abstraction phase and including performance guarantees in the contract related to project timelines.
- Plans may consider developing a formal small-group QIP collaborative with other plans that share an area of low performance, as this has been an effective strategy for some MCMC plans in improving performance measure rates.
- The DHCS needs to incorporate a process to review the content of HEDIS improvement plans to ensure that proposed interventions align with causal barriers.
- The DHCS needs to explore corrective action or progressive penalties for plans showing a consistent pattern of poor performance without improvement.
- The DHCS may consider selecting one of the low-performing measures for the next statewide collaborative QIP since this approach has been successful with other measures, such as *Adolescent Well-Care Visits (AWC).*

Quality Improvement Projects

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

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

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

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

Conducting the Review

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

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

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

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

Quality Improvement Project Requirements and Targets

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

Objectives

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

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

HSAG's review focused on the following areas:

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

Methodology

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

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

- Step IX. Real Improvement Achieved
- Step X. Sustained Improvement Achieved

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

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

Findings

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

Quality Improvement Project Validation Findings

Table 8.1—QIP Validation Results from July 1, 2008, through June 30, 2009 (N=52 QIPs)

Activity		Percentage of Applicable Elements†		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	92%	5%	3%
II.	Clearly Defined, Answerable Study Question(s)	15%	2%	83%
III.	Clearly Defined Study Indicator(s)	63%	22%	15%
IV.	Correctly Identified Study Population	22%	31%	46%
V.	Valid Sampling Techniques (if sampling was used)	79%	2%	19%
VI.	Accurate/Complete Data Collection	47%	21%	31%
VII.	Appropriate Improvement Strategies	65%	23%	11%
VIII.	Sufficient Data Analysis and Interpretation	47%	17%	36%
IX.	Real Improvement Achieved	51%	12%	37%
X.	Sustained Improvement Achieved	45%	36%	18%
Percentage Score of Applicable Evaluation Elements *Met*		**56%**		
Validation Status		***Not Applicable****		

† The sum of the *Met*, *Partially Met*, and *Not Met* scores in each activity may not equal 100 percent due to rounding.
* QIPs were not given an overall validation status during the review period.

HSAG began QIP validation as the new EQRO July 1, 2008. Through the validation review process, HSAG found that plans documented and reported QIPs using the quality improvement activity (QIA) form developed by NCQA. While NCQA has eliminated use of this form except for Medicare studies, the DHCS required that plans submit QIPs using the QIA form during the reporting period. HSAG found that the QIA form did not capture all the elements for conducting QIPs from the CMS protocol; therefore, plans submitting projects using the QIA form were likely to miss critical elements necessary to validate the QIP.

Validation review also revealed that HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the Medi-Cal managed care plans. Feedback from plans after they received their initial validation results from HSAG showed that plans needed significant technical assistance to better understand the CMS protocols, HSAG's scoring methodology, and the instructions for using HSAG's forms. As a result of this feedback, the DHCS eliminated the QIP resubmission requirement for plans from July 1, 2008–June 30, 2009, providing the plans with a transition period during which HSAG would provide technical assistance and training. As part of the technical assistance and training, HSAG prepared a *Quality Improvement Assessment Guide for Plans* that the DHCS released on its Web site at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx. During the review period, HSAG provided plans with results for each evaluation element and activity but did not provide an overall QIP validation status.

Beginning July 1, 2009, the DHCS required that plans comply with HSAG's validation requirements. In subsequent review periods, HSAG began providing plans with an overall QIP validation status of *Met, Partially Met,* and *Not Met*. DHCS releases quarterly QIP validation results prepared by the EQRO on its Web site at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

Strengths

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

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

cooperation, compromise, and a willingness to dedicate resources, all of which should ensure positive outcomes for the project.

Challenges

The transition to a new EQRO for QIP validation was challenging for plans since HSAG's application of the CMS protocol for conducting and validating QIPs was more rigorous than previously experienced by plans.

Validation results revealed that except for selecting an appropriate study topic, plans have an opportunity to improve compliance with the CMS protocol for conducting QIPs across activities to produce QIPs that have a greater likelihood of achieving improvement. Plans need a better understanding of the CMS protocols for conducting and validating QIPs as well as technical assistance with documenting their QIPs. In addition, most plans could benefit from using statistical testing methods to measure improvement.

During the review period, HSAG also identified opportunities to strengthen the statewide ER collaborative QIP's study design and timeline to better reflect the actual progress of the collaborative, accounting for delays in plan-specific and collaborative intervention implementation. HSAG recommended realignment of the baseline and remeasurement periods to coincide with measurement of implemented interventions.

Quality Improvement Project Outcomes

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

The DHCS-led statewide collaborative QIP targeted the reduction of avoidable ER visits among members 12 months of age and older who could have been more appropriately managed by and/or referred to a PCP in an office or clinic setting. The statewide ER collaborative QIP fell under the quality and access domains of care. During the review period, plans reported both baseline and remeasurement data; however, plans and the collaborative were not able to implement interventions during the remeasurement period. While HSAG validated the QIPs based on the QIP submission, the DHCS agreed to realign the QIP measurement periods. Therefore, HSAG will present the updated baseline and remeasurement results and outcomes in the next evaluation report.

Not including the ER collaborative QIP submissions, a total of 17 QIPs validated during the review period reached the point of at least one remeasurement period. For these QIPs, HSAG assessed for statistically significant improvement. Of the 17 QIPs that had one remeasurement

period, 11 progressed to the point of at least two remeasurement periods. For these 11 QIPs, HSAG assessed for sustained improvement in addition to statistically significant improvement.

Table 8.2 displays the 17 QIPs assessed for project outcomes during the review period by plan QIP project title, and indicates projects that had statistically significant improvement and sustained improvement.

Table 8.2—Quality Improvement Project Outcomes—July 1, 2008, through June 30, 2009

Plan Name	QIP Project Name	Statistically Significant Improvement[1]	Sustained Improvement[2]
AHF Healthcare Centers	*Reducing Adverse Reactions to Coumadin for Patients With HIV/AIDS*	↑(s)	NA
Anthem Blue Cross	*Improving Diabetes Care*		↑(s)
CalOptima	*Appropriate Treatment for Children With an Upper Respiratory Infection*	↑(s)	NA
CenCal Health Plan	*Proper Antibiotic Use*	↑(s)	↑(s)
Contra Costa Health Plan	*Reducing Health Disparities*	↑(s)	↑(s)
Health Net	*Appropriate Treatment for Children With an Upper Respiratory Infection*	↑	NA
Health Plan of San Joaquin	*Chlamydia Screening*		NA
Health Plan of San Mateo	*Cervical Cancer Screening*		NA
Inland Empire Health Plan	*Child Upper Respiratory Infections*	↑	↑
Kaiser Permanente— South (San Diego)	*Improving Blood Sugar Level in Diabetic Members*	↑(s)	↑(s)
Kaiser PHP	*Smoking Prevention*	↑	↑
Kaiser PHP	*Cervical Cancer Screening*		
Kern Family Health Care	*Use of Immunization Registry for Children*	↑(s)	↑
L.A. Care Health Plan	*Appropriate Treatment for Children With an Upper Respiratory Infection*	↑	NA
Partnership Health Plan	*Asthma Spread*	↑(s)	↑(s)
San Francisco Health Plan	*Diabetes Care Management*	↑(s)	↑
Western Health Advantage	*Improving Timeliness of Prenatal and Postpartum Care*	↑	↑

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.

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

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

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

↑= Improvement noted for all QIP study indicators.

↑(s) = Improvement noted for some QIP study indicators.

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

Of the 11 QIPs assessed for sustained improvement, 10 achieved a higher rate at the last remeasurement period compared to the baseline period, without a statistically significant decline, for at least one of the QIP study indicators. Five of the 11 QIPs achieved sustained improvement for all QIP study indicators.

QIP outcomes during the review period resulted in the following:

Reducing Adverse Reactions to Medications

- AHF Healthcare Centers—Los Angeles County's QIP to reduce adverse reactions in members on continuous Coumadin demonstrated good quality of care and access to care for members. The rates for all three of the QIP's indicators improved during the first remeasurement period. The plan increased the percentage of patients with seven or more International Normalized Ratio (INR) results during the measurement year, showing that patients have access to providers and laboratory services to have their blood drawn for the test. More frequent monitoring of these levels allows providers to make adjustments as needed, which may prevent patients from having adverse reactions. The plan also demonstrated better INR levels for members, which may be the result of more frequent monitoring. INR levels that exceed 4.0 indicate an increased risk of bleeding, with no therapeutic benefit.[15] Although AHF did not have a statistically significant decrease in the rate of anticoagulation-related hospital admissions, the plan had meaningful improvement. In 2008, three members were hospitalized. In 2009, none of the plan's members was hospitalized due to an adverse reaction to Coumadin.

Improving Diabetes Management

- Anthem Blue Cross' QIP, *Improving Diabetes Care,* which spanned its nine counties—Alameda, Contra Costa, Fresno, San Francisco, San Joaquin, Sacramento, Santa Clara, Stanislaus, and Tulare—achieved sustained improvement over the baseline rate for diabetic retinal eye exams. At the county level, Anthem demonstrated some statistically significant increases between remeasurement periods for this measure. Based on the plan's performance across its counties, rates for the diabetic retinal eye exam measure were all above the DHCS-established MPL for HEDIS 2009. The plan used a multipronged approach to its intervention, providing education and increased awareness as well as reducing barriers related to access and availability of services by helping link members to an eye professional for services.
- Kaiser Permanente—San Diego County's QIP demonstrated statistically significant and sustained improvement for increasing hemoglobin A1c (HbA1c) testing for members with

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

diabetes who had at least one glycemic test within the previous 12 months. By improving testing rates, the plan has a greater opportunity to intervene with members to control the HbA1c level, a more important determinant of member health.

- San Francisco Health Plan—San Francisco County demonstrated sustained improvement for all four study indicators and statistically significant improvement for three of the four indicators. The plan's success with its diabetes QIP was reflected in the plan's improved diabetic performance measure rates. The HEDIS 2009 rates for three of the four *Comprehensive Diabetes Care* measures included in the QIP—*Eye Exam (Retinal) Performed (CDC–E), HbA1c Testing (CDC–HT),* and *Medical Attention for Nephropathy (CDC–N)*—were above the HPL and demonstrated the plan's ability to sustain the improvement documented in the QIP.

Proper Antibiotic Use

To improve appropriate treatment for URIs in children, CalOptima—Orange County; Health Net in Fresno, Los Angeles, Kern, Sacramento, San Diego, Stanislaus, and Tulare counties; and L.A. Care—Los Angeles County, participated as collaborative partners with 16 health plans on the California Medical Association's Alliance Working for Antibiotic Resistance Education (AWARE) to develop and disseminate the Antibiotic Awareness Provider Toolkit. The small-group collaborative QIP yielded success among MCMC plan partners.

- CalOptima—Orange County's *Appropriate Treatment for Children With an Upper Respiratory Infection* (*URI*) QIP showed a statistically significant increase for one of its study indicators, which increased the percentage of children 3 months to 18 years of age who received appropriate treatment for a URI in the first remeasurement period.
- Health Net in Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties showed statistically significant improvement for both study indicators in its *Appropriate Treatment for Children With an Upper Respiratory Infection* QIP. The plan increased the percentage of its high-volume primary care physicians who provided appropriate treatment of URI. Additionally, the plan improved the overall percentage of children not prescribed an antibiotic for an upper respiratory infection.
- L.A. Care—Los Angeles County's *Appropriate Treatment for Children With an Upper Respiratory Infection* QIP showed statistically significant improvement from its baseline rate to its Remeasurement 1 rate for both indicators. The plan improved from 52.5 percent to 62.2 percent the percentage of primary care physicians with a 90 percent compliance rate for treating URI. Additionally, the plan increased the percentage of children who were diagnosed with a URI and not dispensed an antibiotic to 80.0 percent.

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

- Inland Empire Health Plan in Riverside and San Bernardino counties demonstrated a statistically significant increase between baseline and the first remeasurement period and again between the first and second remeasurement periods for its URI QIP. The plan achieved both

real and sustained improvement for the URI QIP, improving the initial baseline rate of 41.3 percent to 80.8 percent upon the second and final remeasurement.

- CenCal Health—Santa Barbara County demonstrated statistically significant and sustained improvement for appropriate treatment of adults with acute bronchitis. The plan also showed improvement of appropriate treatment for children with pharyngitis. Both study indicators improved the quality of care delivered to members by helping to ensure that providers were practicing according to practice guidelines.

Increasing Childhood Immunizations

- Contra Costa Health Plan—Contra Costa County demonstrated statistically significant and sustained improvement for increasing immunization rates for Hispanic, Black, and White children. The plan's success with this indicator for its *Reducing Health Disparities* QIP also had an impact on its childhood immunization performance measure, which was above the national Medicaid 90th percentile. Additionally, Contra Costa Health Plan increased the percentage of children who received six or more well-child visits in the first 15 months of life among Hispanic and Black members, and showed sustained improvement for both of these groups.
- Kern Family Health Care—Kern County demonstrated sustained improvement for all four of its study indicators within its *Use of Immunization Registry for Children* QIP. The plan showed a statistically significant increase in the rate of Combination 3 immunizations from 65.1 percent at baseline to 80.8 percent for Remeasurement 4. Kern Family Health Care increased use of the regional immunization registry by high-volume providers and increased the percentage of children seen by providers who accessed and used the registry.

Improving Control of Asthma

- Partnership Health Plan in Napa, Solano, and Yolo counties improved and sustained the percentage of members with asthma who received controller medications. Additionally, the plan increased and sustained the percentage of members accessing the emergency department who were seen by an asthma or allergy specialist within 21 days of discharge. The results of both indicators reflected improved quality of care.

Timeliness of Prenatal and Postpartum Care

Western Health Advantage—Sacramento County's *Improving Timeliness of Prenatal and Postpartum Care* QIP demonstrated statistically significant and sustained improvement for both study indicators between 2004 and 2008. The plan increased the percentage of its MCMC members receiving prenatal care within the first trimester. Additionally, the plan improved its rate of postpartum care. The plan effectively revised and modified its early intervention strategies that did not result in improvement to achieve desired outcomes.

Quality Improvement Outcome Challenges

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

- Plans did not link interventions to specific barriers associated with the QIP study indicators.
- Plans implemented interventions late in the measurement year that may not have been in place long enough to yield improvement.
- Plans implemented interventions based on past success without conducting a barrier analysis to determine if the same barrier exists.
- Plans did not document enough information in the QIP to produce valid and reliable results. For instance, although Kaiser Prepaid Health Plan's smoking prevention QIP aimed to show statistically significant and sustained improvement, the QIP lacked sufficient documentation for HSAG to determine whether efforts by the plan contributed to the increase in rates.
- Plans had baseline rates for their QIP study indicator that were high and therefore left little room for improvement.

Conclusions

During the review period, the State and plans adjusted to a new EQRO's validation requirements, which were more rigorous than the plans had experienced before. None of the QIPs validated during the review period fully met HSAG's validation requirements for compliance with CMS' protocol for conducting a QIP.

The DHCS demonstrated a commitment to improve QIPs by taking immediate action in January 2009 to remedy deficiencies as a result of the first *QIPs Status Report: July 1, 2008, through December 31, 2008*, which revealed plan challenges with QIP validation. The DHCS followed all recommendations provided by HSAG, including the dissemination of CMS protocols for conducting and validating QIPs; transitioning plans from using the QIA form to using HSAG's QIP Summary Form; releasing the *Quality Improvement Assessment Guide for Plans*, which includes instructions for completing HSAG's forms and serves as a guide to the CMS protocols; coordinating two formal HSAG technical assistance training sessions for plans; and updating the ER collaborative time frame.

Despite challenges with validation requirements, the plans had many QIPs during the review period that demonstrated statistically significant improvement and/or sustained improvement. These successful QIPs resulted in outcomes that spanned the quality, access, and timeliness

domains of care. Plans demonstrated improvement by reducing adverse reactions to medications, increasing proper antibiotic use, improving diabetes management, increasing childhood immunizations, improving control of asthma, and providing timely prenatal and postpartum care.

Recommendations

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

- Plans have an opportunity to improve compliance with the CMS protocol for conducting QIPs across activities to produce QIPs that have a greater likelihood of achieving improvement.
- Plans could benefit from technical assistance with statistical testing and need to incorporate a process for conducting statistical testing between baseline and each remeasurement period.
- Plans need to implement targeted interventions that link to specific barriers identified as part of the barrier analysis.
- Plans should conduct QIP data analysis and implement and/or modify interventions as early as possible during the measurement period to provide enough time for the interventions to succeed.
- Plans should select QIP study indicators based on areas of actionable performance.