Medi-Cal Managed Care Division

state of california

Medi-Cal Managed Care External Quality Review Organization

Report of the

2004 Medi-Cal Managed Care Annual Report

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Improving Healthcare in the Communities We Serve.

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Quality Strategy Annual Report

Introduction

The California Department of Health Services (CDHS) is responsible for overseeing the Medi-Cal Managed Care Program. As part of these oversight activities, the federal government mandated that all state Medicaid agencies create a quality strategy that defines a strategic framework for healthcare quality improvement for the state Medicaid agency and its contracted managed care plans. This mandate was a component of the Balanced Budget Act of 1997 (BBA), which also requires that each Medicaid agency produce an annual report that describes the progress toward meeting the goals of the quality strategy as well as assess compliance with the BBA requirements.

This annual report provides an update of CDHS's work on its quality strategy goals during 2004. The quality strategy is scheduled to be reviewed and revised biannually; thus, this review provides information about the CDHS' status regarding attainment of the strategy's core goals. Additionally, this report presents quality strategy achievements from the perspective of the BBA requirements for Medicaid managed care.

The final section of this document includes background information about the State's contracting managed care health plans and examples of specific types of monitoring conducted by the Medi-Cal Managed Care Division (MMCD) to comply with the BBA requirements. For a detailed review of each specific monitoring activity conducted by MMCD, refer to the Medi-Cal plan-specific reports, the Health Employer Data Information Set (HEDIS®) audit reports, and the Consumer Assessment of Health Plan Survey (CAHPS®) report. The HEDIS and CAHPS reports are available on the CDHS website at **http://www.dhs.ca.gov/mcs/mcmcd/ htm/ManagedCareReport.htm**.

Because of the delay in the release of this report, it includes references to activities and program changes taking place after 2004 in order to provide the most current perspective of CDHS' progress towards its quality goals.

Overview of Quality Strategy Goals

The CDHS managed care quality goals are based on the mission and vision statements identified below.

CDHS Mission: To protect and improve the health status of all Californians.

MMCD Vision: All Medi-Cal managed care enrollees will have access to healthcare that is safe, effective, patient centered, timely, efficient, and equitable and serves to reduce the burden of illness and improve the health and functioning of enrolled individuals.

The core goals of the quality strategy are as follows:

- Increase accountability for the quality of care;
- Improve the quality of care;
- Reduce healthcare disparities; and
- Continuously improve CDHS' performance.

CDHS has further enhanced its core goals by integrating them with the Medicaid managed care rules contained within Section 438.204 of the BBA. The following Medicaid managed care rules outline the procedures required of all state Medicaid programs.

Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the managed care organization (MCO)[1] and prepaid inpatient health plan (PIHP) contracts for each Medicaid enrollee at the time of enrollment. (California does not have PIHP delivery systems; therefore, these will not be a part of this report.)

- Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.
- Monitor and evaluate regularly MCO and PIHP compliance with standards.
- Review national performance measures and levels identified by the Centers for Medicare and Medicaid Services (CMS), states, and other relevant stakeholders.
- Conduct annual external independent reviews of the quality outcomes and the timeliness of and access to the services covered under each MCO and PIHP contract.
- Use appropriate intermediate sanctions that, at a minimum, meet the requirements of Subpart I of BBA requirements.

[1] The Centers for Medicare and Medicaid Services (CMS) uses the term "managed care organizations" (MCOs) to refer to health plans providing services to Medicaid enrollees. Throughout the rest of this report, the term "health plan" is used when referring to MCOs in the Medi-Cal managed care program.

- Ensure the presence of an information system that supports initial and ongoing operations and review of the state's quality strategy.
- Have standards at least as stringent as those within the BBA pertaining to access to care, structure and operations, and quality measurement and improvement.

The remainder of this report reviews each major MMCD strategic goal and provides supporting evidence to demonstrate the progress or opportunities toward goal attainment.

Progress Towards Achievement of MMCD Strategic Goals

CDHS Strategic Plan Goal 1

The MMCD will increase and maintain accountability for quality of care.

Evidence of Compliance

Throughout 2004, MMCD convened periodic teleconferences with individual health plans to ascertain each plan's progress with implementation of its quality management programs. An important component of this dialogue was a discussion of barriers to achievement. Additionally, MMCD reviewed the quality improvement project activities and results with its external quality review organization (EQRO), as well as with the health plans. These knowledge-sharing forums were beneficial in helping MMCD to understand health plan progress and issues affecting goal achievement. Further, accountability was achieved through monitoring of each health plan's outcomes for the CDHS-required External Accountability Set (EAS) performance measures and Consumer Assessment of Health Plans Survey (CAHPS). The required EAS consists of selected Health Employer Data Information Set (HEDIS) measures that are audited each year by MMCD's EQRO. MMCD and its EQRO also reviewed findings from the medical review audits conducted by the CDHS Audits and Investigations related to plan quality improvement programs, systems, and processes.

MMCD has targeted a number of initiatives to help enhance its accountability for monitoring quality of care. One proposed initiative was reducing the number of required Quality Improvement Projects (QIPs) from four to two permit health plans to focus resources on fewer projects and, in turn, permit MMCD to increase its level of collaboration and oversight regarding these projects. Although a policy letter to implement this proposed change was initially developed, it was later determined that this policy change would instead be implemented through contract amendments. Although this initiative has been delayed due to the time required to develop and process contract amendments, the State intends to proceed with this change in 2007.

Compliance with BBA Requirements

MMCD complies with BBA requirements through the health plan evaluation processes conducted jointly by CDHS Audits and Investigations (A&I) and the California Department of Managed Health Care (CDMHC). Onsite reviews of health plans are conducted at a minimum of every three years to assess the quality and appropriateness of care provided to plan members. The evaluation process includes, but is not limited to, assessments of the following:

- Member rights;
- Credentialing;
- Utilization management policies and procedures;
- Continuity of care; and
- Availability of and access to care and services.

Health plans are required to complete corrective action plans (CAPs) for areas identified as needing improvement during audits. MMCD reviews and approves these CAPs and notes areas of concern for continued monitoring.

In addition, the EAS annual measurement (through the CDHS-required HEDIS measures) and QIP review processes are integral components that allow MMCD to maintain health plan accountability for care provided to Medi-Cal enrollees. The HEDIS standard measurement process allows MMCD to compare the HEDIS scores of most health plans to one another in each participating county, by model type, and against national averages for Medicaid plans. The HEDIS results can lead to the implementation of QIP activities or other operational changes that will enhance the level of care and service provided to health plan members. These improvements are sometimes evidenced in improved measurement outcomes during the next HEDIS measurement cycle. MMCD requires plans scoring below the Minimum Performance Level (MPL; the 25th percentile of the national Medicaid average) for any required HEDIS measure to submit a CAP describing how the health plan will work to raise its score to or above the MPL.

Measuring member satisfaction through the CAHPS is another approach MMCD uses to ensure accountability for the services and care provided to members. The CAHPS results help MMCD, as well as the health plans, assess member satisfaction relative to the average Medi-Cal satisfaction level. The MMCD specifically questions plans falling substantially above or below the CAHPS Medi-Cal averages in any area of the survey regarding the reason for their ratings and how plans propose to improve their satisfaction levels.

To encourage member engagement in their healthcare choices, in September 2005 MMCD began including member satisfaction information in the *Consumer Guide* provided in enrollment packets for each county (two-plan and Geographic Managed Care models), the Consumer Guide is also available on the CDHS website at http://www.dhs.ca.gov/mcs/mcmcd/htm/ConsumerGuide.htm. Subtitled "My Medi-Cal Choice for Healthy Care", these consumer guides include the CAHPS results for most Medi-Cal health plans in each county. These guides compare the results related to the quality of care provided to children and adults for the health plans in that county (when that information is available). The comparison also indicates how each Medi-Cal health plan scored in relation to other Medi-Cal health plans (higher, average or lower) and among the Medicaid health plans scoring the highest in the United States.

Recommendations

The following recommendations are suggested to enhance the MMCD's existing quality oversight program:

Develop interim annual updates. In addition to the onsite audits of plans conducted every three years by CDHS Audits and Investigations (A&I) and DMHC, it is recommended that MMCD develop an interim annual update between onsite examinations involving staff from MMCD's Plan Management Branch and the Medical Monitoring Unit. MMCD staff could assess how well improvement in the areas of quality, access

and timeliness of care has been sustained as a result of any required Corrective Action Plans (CAP). Health plans determined to have questionable results in one of the areas could be required to submit a formal report to demonstrate adequate performance in the identified area(s). For health plans that appear not to have maintained adequate performance in two or more of the assessed areas, MMCD could initiate an interim onsite visit from A&I and/or DMHC.

Information gained from these interim updates would keep MMCD informed on a timely basis regarding the progress each plan has made toward improved quality of care, delivery of timely care, and network availability and capacity. For these interim updates, quantitative measures should be established by MMCD to be used as an objective means of assessing the adequacy of care and service: the methodology should be shared with health plans. The health plans would then be in a better position to assess their own progress periodically during the three-year period between the required CDHS/DMHC audits. This type of interim monitoring could also enhance the shared accountability for program quality between the health plans and MMCD.

It should be noted that legal restrictions and resource limitations within both CDHS and DMHC very likely preclude adding these interim annual updates to existing staff workload. However, the EQRO and MMCD could discuss how to devise a methodology for using the annual plan specific reports in order to enhance MMCD's quality monitoring activities.

The ongoing monitoring of health plan CAPs also supports health plan oversight. However, the EQRO suggests that the development of structured, standardized criteria for successful CAP completion could help support the effectiveness of the CAP monitoring process.

Integrate audit findings with other health plan data. If feasible, the EQRO recommends that MMCD integrate findings from joint CDHS/DMHC audits with other sources of health plan data, such as that contained in the internal MMCD quarterly *Dashboard Report,* which became available in 2005. Although the Dashboard Report is not publicly released, MMCD could consider including pertinent information from the report in audit reports when the additional information is helpful and when the information is not proprietary. This strategy would give audit findings an even more comprehensive view of health plan operational performance and support even more substantive judgments regarding the healthcare quality provided to members. Integrated data review is more likely to unveil systemic issues and lead to the identification of root causes. Health plans are more likely to find intervention planning and monitoring easier to implement if they have a greater understanding of the issue identified from the integrated data approach.

Provide full reporting relative to audit findings. Currently, MMCD receives only "exception" results as feedback from CDHS Audits and Investigations (A&I) and cannot review full findings of DMHC audits until they are made publicly available. The A&I exception reports make it difficult for MMCD to fully understand the severity of highlighted issues within the context of the full audit; thus, MMCD may not always be able to adequately determine the level of monitoring needed to ensure resolution. For example, audit findings that demonstrate problems with access to care may be more readily understood and resolved if the audit findings from complaint data accompanied the access findings. MMCD's ability to link problems identified in one area with problems in another area would be enhanced by receiving the full audit report from A&I. At present, A&I cannot legally share audit findings until such findings have been finalized and made public.

MMCD acknowledges the need for this information to comprehensively assess each health plan's performance and is working toward establishing periodic meetings between the EQRO and MMCD Medical Monitoring Unit staff involved in the review and approval of CAPs resulting from audit findings. These meetings would help the EQRO obtain a better understanding of the various health plans' opportunities for improvement and also understand the progress made toward correcting identified issues during the formal audits.

CDHS Strategic Plan Goal 2

MMCD will improve the quality of care for Medi-Cal managed care enrollees.

Evidence of Compliance

To accomplish improved quality of care for Medi-Cal enrollees, MMCD developed and implemented several strategies to improve quality through better communication and collaboration among health plans. Collaborative QIPs have been conducted in the clinical areas of childhood immunization, asthma management, diabetes management, and adolescent health. Specifically, the small group collaboratives on diabetes and childhood immunization realized improvement from the baseline measurement. Although the statewide adolescent health collaborative is now in the re-measurement phase, improvement is expected over the baseline measurement, in part due to the involvement of adolescent consultant experts with MMCD and the health plans.

Other approaches to enhance collaboration and sharing have also been implemented, such as the MMCD's website for health plan Medical Directors, which is a venue for sharing information among the health plans. The annual Quality Improvement Conference sponsored by MMCD also provides a forum for health plans and other participants to share information and learn new skills related to quality management. Both the 2005 and 2006 conferences focused on the theme, *The Culture of Quality*. Participants learned how quality tools such as disease registries, small group collaboratives, and community advocacy can be used as adjunct activities to assist in monitoring the quality of care provided to members.

MMCD sought to improve the quality of care provided to managed care enrollees through restructuring its quality improvement requirements for health plans. To initiate this process, MMCD staff spent several sessions with the EQRO reviewing health plan QIPs. During these meetings, MMCD jointly decided with the EQRO if QIPs should be continued or retired after multiple measurement periods were achieved. Prior to this review, many health plans had not changed study topics for four to five years. MMCD and the EQRO now routinely evaluate whether specific QIPs should be extended beyond 12 to 36 months. MMCD also advocated that health plans utilize the rapid cycle improvement methodology to achieve improvement within the targeted timeframes of the QIPs. Rapid cycle improvement methodology involves defining the scope of the project, developing the actions thought to obtain the desired change, implementing the changes, assessing the impact on what is being measured, and spreading the new processes leading to the changes – all in a condensed timeframe rather than the 12 to 24 months organizations generally use to assess change.

As mentioned earlier, MMCD also proposed that health plans be required to participate in only two QIPs each year, a small group collaborative and the statewide collaborative, rather than the four QIPs currently required (the statewide collaboration, one small group collaborative, one internal QIP and a fourth QIP which can be either an IQIP or another small group collaborative). The rationale for proposing the change was to allow health plans to devote more time and resources to implementing more meaningful and effective QIPs. Because this change must be implemented through contract amendment, MMCD still requires health plans to participate in four QIPS each year; however, the intent is to implement the new requirement in 2007.

In 2004, MMCD began requiring health plans to submit a subset of the HEDIS® use of services data in order to standardize the manner in which health plans were reviewed for under/over-utilization. This data allows MMCD to monitor the frequency of selected procedures, inpatient utilization, ambulatory care and outpatient drug utilization to assess under/over-utilization. The EQRO agrees that the areas selected for monitoring provides MMCD with a comprehensive way of discerning issues relative to under/over-utilization within Medi-Cal managed care. Analysis of this data is gradually being integrated into MMCD's quality oversight activities.

Beginning in 2004, MMCD leadership clarified its guidelines for health plans participating in collaboratives:

- Collaboratives must include a minimum of two health plans;
- Collaborative activities must use standardized measures and clinical practice guidelines;
- All health plans participating in the same collaborative must agree upon the same timelines for development, implementation, and measurement;
- Interventions for collaboratives must be evidence-based. If there is no evidence for the particular intervention, the health plan must provide rationale supporting the selected intervention; and
- All QIP proposals and status reports must be submitted using the National Committee for Quality Assurance (NCQA) Quality Improvement Activity (QIA) form.

MMCD also established minimum and high performance levels (MPLs and HPLs) to be used in the assessment of the HEDIS® 2005 rates (based on services provided in 2004). Health plans that score below the MPL in any of the targeted HEDIS measures are now required to submit a corrective action plan (CAP) for that measure. The EQRO fully supports this change because health plans with performance below the MPL need to conduct a root cause analysis in order to effectively address the issue requiring corrective action. The root cause analysis is a critical component to an effective CAP; thus, the likelihood of a CAP successfully addressing an identified issue is enhanced due when a substantive root cause analysis has been conducted.

MMCD's decision to share information with consumers regarding the quality of care offered by the Medi-Cal managed care plans was also related to this quality improvement goal. Consumers and advocacy groups continued to express great interest in understanding how quality is delivered within Medi-Cal managed care, and MMCD wanted to find effective ways to share more information with the consumer. As previously indicated, one approach used by MMCD is including quality information in the *Consumer Guides* published for each Medi-Cal managed care county using either a two-plan or geographic managed care model. These booklets are included in the enrollment packets sent to potential enrollees by the enrollment contractor and are also available on the CDHS website at:
http://www.dhs.ca.gov/mcs/mcmcd/htm/ConsumerGuide.htm.
The annual HEDIS reports and the CAHPS reports are also available on the website at
http://www.dhs.ca.gov/mcs/mcmcd/htm/ManagedCareReports.htm.

The MMCD advisory group was envisioned as another venue for informing and soliciting input from consumers and other interested stakeholders, including persons with disabilities and chronic medical conditions, about the Medi-Cal managed care program and its impact in improving the quality of care and health status of enrollees. In the opinion of the EQRO, enhancement of the advisory group membership should continue to be a goal. The reciprocal exchange of information between various stakeholders and MMCD can be an important resource for enhancing the effectiveness of quality improvement within the Medi-Cal managed care program.

Beginning in 2005, MMCD uses a default enrollment strategy as an incentive to health plans to improve the quality of care offered to enrollees. This strategy assigns more Medi-Cal beneficiaries in the geographic managed care (GMC) and two plan counties to health plans that have demonstrated high quality performance for selected HEDIS® measures. These defaulted members are Medi-Cal members who are required to enroll in a managed care plan but have not selected a health plan within the required timeframe established by the CDHS. Although the direct benefit to those Medi-Cal eligibles is without question, the EQRO also perceives an indirect benefit to all Medi-Cal managed care enrollees. The ability to grow membership is usually a goal of all managed care plans. MMCD's default enrollment strategy very likely creates competition among Medi-Cal managed care plans to achieve high quality outcomes in the selected performance measures in order to

enhance membership growth. As a result of this competition for higher HEDIS scores, the quality of care is elevated for all health plans to the benefit of all Medi-Cal plan enrollees.

This auto assignment strategy has been implemented in other states such as Michigan, New Mexico, and New York. However, these states have combined performance-based auto assignment with other incentives. The EQRO suggests that MMCD assess the impact of the default enrollment to determine whether this strategy is effective in promoting enhanced quality among the health plans. This evaluation of the default auto-assignment incentive will allow MMCD to identify any needed adjustments to help sustain the health plans' gains in quality improvement.

A few states have proposed incentives for Medicaid managed care enrollees as opposed to the health plans or providers. Florida, Kentucky and West Virginia are proposing an "enhanced benefit" package for enrollees. Under this concept, managed care enrollees are offered services not normally covered under Medicaid as a reward for participating in healthy behaviors. The enrollee earns this enhanced benefit package as a reward for participating in certain wellness and/or prevention programs offered by the health plan. If these "enhanced benefit programs" prove cost-effective, more states will undoubtedly consider implementing similar programs.

As MMCD progressively raises the "quality bar" for health plans contracted with the Medi-Cal managed care program, it may be necessary to explore other meaningful incentives (financial and non-financial) that could potentially help "spread quality" in other areas of care and service. The EQRO recognizes that budget limitations may make financial incentives difficult; however, some methodologies can be used to minimize the outlay of new dollars to fund an incentive program. For example, some states (Maryland and New Mexico) use financial withholds from the capitation pool to fund monetary incentives for health plans that exceed state-established quality targets. Maryland also assesses monetary penalties on health plans that fail to meet established quality targets.

States also can require health plans to develop mandatory incentive programs focused on improving the quality of care and service to members and/or providers. Another non-financial incentive for consideration is periodic exemption from A&I oversight visits for health plans that meet or exceed high performance targets for quality measures and sustain a threshold level for satisfaction indicators and/or quality of care or service complaints. In Bailit's model of performance incentives in *Ensuring Quality Health Plans: A Purchaser's Toolkit for Using Incentives.*, this is considered a reduction in administrative requirements. While this incentive strategy would require a law change and/or regulatory approval, its potential to increase performance rates makes it a viable alternative worth exploring.

Public reporting, also recognized as a non-financial incentive by Bailit, is another strategy that MMCD uses in relation to the required HEDIS measure included in its External Accountability Set (EAS). Plans that score

above the 90 percentile based on national Medicaid averages are eligible for an annual Quality Award. Three levels of award – gold, silver and bronze – are presented to the highest-scoring plans at MMCD's annual Quality Improvement Conference. MMCD is currently exploring the possibility of additional award categories for the 2007 conference.

While strategies for developing an incentive program vary, the following attributes are cited as most compatible with Medicaid state incentive programs in *The Quality Matters* article "Issue of the Month: Pay for Performance in Medicaid" (M.B. Dyer, 2004):

- Consistent communication between the state and contracted health plans as well as the involvement of the contracted plans in development of the incentive program.
- Use of performance incentives as one component within a more comprehensive value-based program design.
- Selection of performance targets which are challenging yet obtainable.
- Selection of meaningful incentives, not all of which are financially based.

Whatever types of incentives are used to improve quality, MMCD must assure that objective criteria are established to assess the behavior under study. Most states use a subset of the HEDIS performance measures as the objective criteria upon which the incentive is based.

Currently, MMCD uses Minimum Performance Levels (MPLs) to determine the need for corrective action related to the required HEDIS measures in the EAS. However, as the quality performance expectations are increased over time, more complex methodologies may be helpful in more fully engaging health plans in the incentive program. Health plans that demonstrate difficulty in attaining or sustaining improvement due to barriers such as location or provider resources are likely to benefit from adjustments to the MPLs and HPLs. Adjustment strategies could be used to allow health plans to become more competitive with high performing health plans. Considering "barriers to improvements" as impacting factors that can be statistically mitigated could be an impetus to lower performing health plans to improve their quality performance. Refining the current MPL/HPL methodology could lead to the development of regional thresholds for state performance levels. As new criteria are established for measuring performance improvement, MMCD must continue to ensure that incentives are developed based on established criteria with effective sanctions for suboptimal performance. Ongoing evaluation of the impact of the effectiveness of any incentive program is critical to assure that the expended resources are producing the desired outcome--improved quality of care.

Compliance with the BBA Requirements

Each approach CDHS has used to comply with Strategic Goal 2 has focused on improving the quality of care through the sharing of health plan information. Some of this information, such as Chlamydia screening results, is used by other programs within CDHS, as well as by MMCD. In addition to the recommendations already presented related to compliance with CDHS Strategic Goal 2, the EQRO offers the following:

Recommendations

Conduct semi-annual review of utilization data of services or care stratified by ethnicity and regional factors, as well as by demographic information, such as age and sex. This level of information could provide MMCD with focused data identifying which population segments, if any, contribute significantly to areas of quality improvement. Such data analysis would provide information that would help health plans target the use of limited resources to achieve improvement among the enrollees with the greatest needs. This information would also provide MMCD and health plans with a better understanding of ethnic disparities related to the quality of care and health outcomes within Medi-Cal managed care populations.

Although much can be gained by using stratified demographic and ethnic data, obtaining and validating such data presents many difficulties. Dr. Olivia Carter-Pokras from the Federal Office of Minority Health (OMH) states that, although this type of data helps monitor trends related to socioeconomic inequality and declining health among populations over time at national, state and local levels, this data is usually collected on a voluntary basis and therefore often not completed. Completion of the information by workers interacting with the enrollee may be problematic due to the discrepancy between the worker's classification of the enrollee verses the enrollee's own racial/ethnic identification. A related concern is that this data, as currently available, may not support sound analytical work, given that the data is incomplete and does not provide adequate sample sizes for statistical significance.

Another concern is the perception by members and advocates that collecting such data may lead to discriminatory practices. In the 2000 U.S. Census data, approximately 22 percent of the long form survey respondents perceived the questions regarding race and ethnicity as too personal. This perception creates barriers to collecting ethnic/racial data. The OMH funded the National Health Law Project (NHELP) to review state laws and regulations governing the collection and reporting of data by health plans and insurers. Through this activity, the OMH learned that California statutorily prohibits private health insurers from requesting racial/ethnic data during certain transactions. However, California does allow Medicaid managed care plans to request racial and/or ethnic data in certain situations. The defeat of California's Proposition 54 in 2003 allowed public agencies and groups receiving state funding to continue to collect ethnic and racial data.

In the Agency for Healthcare Research and Quality report *Cultural Competence California Style*, Brach, Paez and Fraser found that most California Medicaid health plans do not collect racial/ethnic or language data but rather rely on the receipt of this data through the Medi-Cal enrollment worker. They also reported that the California health plans involved in the study acknowledge that receiving accurate race/ethnic data help the plans develop more culturally appropriate programs. In the study, "Collection of Racial and Ethnic Data by Health Plans to Address Disparities: Final Report Summary", researchers reported that health plans recommended that the federal government champion a systematic approach for the collection of racial and

ethnic data since most states do not have laws that require the collection of racial and ethnic data by state Medicaid agencies.

In the Office of Minority Health 2001 report *Challenges and Controversies*, Dr. Carter-Pokras lists the following managed care barriers to collecting racial and/or ethnic data:

- Anti-discrimination obligations.
- Perceived legal barriers to collecting racial and/or ethnic data.
- Confidentiality concerns.
- Cost of collecting racial/ethnic data in terms of time and money.
- Consumer perceptions regarding the use of such data.

Although the EQRO views this data as extremely important, it recognizes that there is much work to be done in the field of social policy and education advocacy before this recommendation can be realized. Yet, from the work of Brach, Paez, and Fraser, California appears to be a leader in fostering the collection of racial and/or ethnic data. The EQRO recommends that, in spite of these barriers related to this goal, MMCD retain this objective as part of its quality strategy.

Compare statewide fee-for-service Medi-Cal data with Medi-Cal managed care data to assess differences in utilization and, when possible, differences in expected health outcomes. The EQRO suggests this activity as an additional approach toward demonstrating the effectiveness of the managed care system in order to potentially increase the allocation of resources to MMCD. It is clear that the areas where MMCD is less successful in meeting its quality improvement goals are activities that depend heavily on data. MMCD critically needs dedicated analytical support to meet its objectives. Although the data system appears to be adequate to support the data collection needs that satisfy the quality strategy, the staff resources needed to use the data for robust analysis have not been adequate. MMCD indicates that CDHS' various data systems will gradually become better integrated over time. Further, even with better integrated data systems, comparing fee-for-service utilization data, which is based on claims, with managed care data, which is based largely on encounters (most services are capitated), will continue to present many challenges.

Establish a protocol for changing MPLs and HPLs. To improve the quality of care, MMCD must clearly define thresholds for adequate care. MMCD currently does this by establishing Minimum and High Performance Levels (MPLs and HPLs) for the required HEDIS measures. However, what is not present is a trigger or threshold that alerts MMCD to revise these levels. Some states select a performance target that is annually adjusted, e.g. an increase of some percentage each year over the baseline year or the prior year's performance attainment.

MMCD understands that only focusing on improvement over the baseline year is not be a successful long-term strategy and that a goal of sustained improvement is likely to produce more improvement over time.

For calendar year 2006 and thereafter, CDHS decided to use the national Medicaid averages from the most current version of NCQA's *Quality Compass* to establish the MPLs and HPLs for each year, rather than remaining with the same baseline percentiles for more than one year. However, NCQA doesn't release the updated Medicaid averages for the current year until very late each year (e.g., 2006 national averages based on 2005 services will not be available until approximately November 2006). To allow its contracted plans time to understand areas where improvement is most needed and to implement corrective action plans, MMCD will use the most currently available national averages (e.g., 2005 averages for 2004 services) to establish the MPLs & HPLs that are applied to the plans' most current HEDIS rates (e.g., 2006 rates for 2005 services). The EQRO applauds MMCD's effort to use more challenging criteria to raise the "quality bar" for Medi-Cal managed care plans.

Information available from other states indicates that most use the HEDIS percentiles published in NCQA's *Quality Compass* as the basis for determining their threshold targets. Many states use the 50th percentile performance score value as the minimum value for consideration of an incentive award for quality. New York varies in its methodology by using the 75th percentile score from the prior two-year measurement period as the basis for an incentive. Other states, such as Rhode Island, consider levels of performance not only for clinical measures, but also for member services measures such as the percentage of grievance and appeals resolved within the timeframes mandated by the BBA. In the future, MMCD may elect to adapt one of these methodologies or devise another methodology compatible with available analytical resources to assess the need for changes in the performance level thresholds from one year to the next.

Regardless of the methodology used, meaningful consequences for achievement above and below the established performance levels need to be integrated into the performance level standards to enhance the motivation for health plans to demonstrate improvement. MMCD's current incentive strategy of auto-assignment of enrollees is shared by a few other states. Of the nine states for which published information about incentive programs was found, almost half use this incentive strategy alone or in combination with other strategies.

MMCD may want to consider an additional approach in evaluating the effectiveness of this strategy. A potential evaluation methodology could consist of a review of one or two measures within the selected measures for the auto-enrolled membership in the high performing plans. Although specific improvement within the auto-enrolled membership is not a stated goal of the incentive program, assessing the impact of the incentive program on the health status of these members could be helpful in evaluating the impact of the incentive program.

CDHS Strategic Plan Goal 3

MMCD will develop and implement programs to reduce health disparities.

Evidence of Compliance

Understanding what motivates members to seek healthcare is an important objective in effectively delivering healthcare to Medi-Cal enrollees. Managed care programs that incorporate culturally sensitive strategies into health promotion often are successful in having the population seek recommended care. Understanding health disparities among particular ethnic groups within the Medi-Cal population is an important goal, and MMCD is currently developing workable approaches to achieving this. Although the Medi-Cal Eligibility Data System contains an ethnicity identifier, this information is self-reported to county staff during the application process for Medi-Cal assistance. Thus, validation of the ethnicity data is currently not possible.

The Medi-Cal managed care program has established contract requirements for its plans designed to provide culturally sensitive plan choice assistance to new enrollees and to promote cultural competence among members. MMCD's enrollment contractor provides enrollment information in 13 different "threshold languages," and call center representatives are available who speak all the threshold languages, as well as interpreter services for all other languages.

Medi-Cal managed care plans are required to promote cultural competence among enrolled members by providing member information in all required threshold languages. Plans must assure that their provider networks include PCPs who speak these languages and that interpreter and translation services in all threshold languages are available 24 hours/day at all provider sites. Much of the work by Medi-Cal managed care plans to improve cultural competence in order to reduce health disparities was done in response to MMCD policy letters issued in 1999 requiring plans to improve cultural competence.

Recommendations

Due to the difficulties discussed above, the goal of reducing health disparities is likely to be difficult for MMCD, as well as other states, to completely achieve. However, MMCD may want to suggest that the health plans conduct minority focus groups to discuss barriers surrounding access, availability, and health issues for specific ethnic populations served by the health plans and submit the findings to MMCD. MMCD and the health plans could then mutually agree upon a quality improvement activity to address some specific issue identified in the focus groups. This could be done not only by individual health plans, but also as a small group or statewide collaborative. The ultimate outcome of this project would be to transition successful interventions into ongoing operating health plan procedures.

Another recommendation is that MMCD collaborate with the CDHS Office of Multicultural Health to explore other avenues for collecting this data or conducting focus groups. The Office of Multicultural Health could be used as a source of technical expertise in this effort.

Although holding focus groups does not directly address the stated goal, the feedback would provide MMCD and the Health plans with information that could be used to support efforts to reduce health disparities. This quality strategy goal could be revised to reflect MMCD's desire to understand the unique barriers, if any, that impede the collection of racial/ethnic data since there are no federal laws that prohibit obtaining it. After obtaining this information, MMCD could partner with the health plans to address state and local entities that interface with potential enrollees to explain the importance of this data and how it is and is not used. Working with entities such as advisory groups, the enrollment contractor, and county staff, MMCD could help build coalitions targeted to enhance and promote voluntary racial and ethnic data collection whenever possible. This potential ability to identify health disparities among ethnic groups at a statewide level could inspire strategies focused on improving the health status of ethnic populations as opposed to segments of the overall population.

Compliance with BBA Requirements

The same recommendations offered for CDHS Strategic Goal 2 apply for Strategic Goal 3.

CDHS Strategic Plan Goal 4

MMCD will strive to continually improve performance in order to fulfill its commitment to improving the quality of care for Medi-Cal managed care enrollees.

Evidence of Compliance

As an objective to meet this goal, MMCD sought to improve staff expertise through developing and implementing an orientation and training program that addresses the science of quality improvement. Resource limitations have impacted MMCD's progress toward this goal, but it remains a priority.

Compliance with BBA Requirements

Knowledgeable staff in the field of quality is a basic requirement for any state Medicaid program. MMCD continuously strives toward developing or obtaining the tools needed to enhance and leverage the expertise of division staff. MMCD's focus has been on enhancing the training and development of its current staff as opposed to seeking increased staffing levels in order to attain its quality strategy goals. CDHS has promoted the following activities to help MMCD staff obtain and maintain competence in quality improvement:

- Attainment of the Certified Professional in HealthCare Quality (CPHQ) certification by some staff working in the area of quality improvement and performance measurement;
- Participation of key staff in attending training programs sponsored by NCQA or other quality-focused organizations; and
- MMCD sponsored training that includes the EQRO contractor as a presenter for onsite training and development sessions for staff.

This leveraging of knowledge and skills has helped MMCD staff provide the required program oversight, performance measurement evaluation, and health plan guidance necessary to attain and sustain improved care and services for its Medi-Cal enrollees.

Final Thoughts

MMCD has made progress toward achieving its quality improvement objectives. The division has realized its greatest achievements in those areas that are directly within its span of control, such as implementation of performance measurement and oversight monitoring of the same. Less progress has been achieved in areas that require external resources. Although resource constraints have been the primary reason for delayed progress toward some objectives, MMCD is compliant with each BBA requirement. However, EQRO believes that it could render a more accurate and substantiated assessment of MMCD's program quality with enhanced data integration.

In regard to the MPLs and HPLs used to assess plan performance for the selected measures, the EQRO would like to have more information to review regarding the level of quality provided by the Medi-Cal managed care program. More comprehensive data focused on delivery of care and service would provide a stronger foundation for assessing the level of quality provided. The addition of complaint and grievance data would provide more insight into the type and extent of issues that act as barriers to receipt of care or services. For example, grievances related to network accessibility and quality of care can be good indicators of quality issues. As a step in this direction, MMCD has begun sharing the quarterly grievance reports submitted by the health plans with the EQRO. Additional data such as these integrated with the current data obtained through performance measurement and quality improvement activities would allow the EQRO to make more definitive assessments of the overall quality of care and services provided through the Medi-Cal managed care program. Integrated data provides a multidimensional and interdependent view of the many program components needed to comprehensively assess program quality.

Overall, MMCD is performing very well in relation to its quality strategy. As a result of assessing the program goals MMCD achieved in 2004, the EQRO expects that MMCD will continue to achieve its quality improvement goals for the Medi-Cal managed care program and remain in compliance with BBA requirements.

Appendix

Table 1. Background Information: Medi-Cal Managed Care Plans.

County	Health Plan	Membership	Health Plan Model			
			Two Plan	Local Initiative	County Organized	Geographic Managed
Alameda	Alameda Alliance for Health	79,132		√		
	Blue Cross	28,987	√			
Contra Costa	Contra Costa Health Plan	43,740	√			
	Blue Cross	9,503	√			
Fresno	Blue Cross	136,120	√			
	Health Net	27,395	√			
Kern	Kern Family Health Care	84,776	√			
	Health Net	25,306				
Los Angeles	L.A. Care Health Plan	739,749		√		
	Health Net	478,971	√			
Monterey	Central Coast Alliance for Health	55,128			√	
Napa	Partnership Health Plan of California	10,061			√	
Orange	CalOptima	295,814			√	
Riverside	Inland Empire Health Plan	113,542		√		
	Molina Healthcare of California	39,705	√			

County	Health Plan	Membership	Health Plan Model			
			Two Plan	Local Initiative	County Organized	Geographic Managed
Sacramento	Blue Cross	79.450				√
	Health Net	32,125				√
	Kaiser Permanente	19,745				√
	Molina Healthcare of California	19,918				√
	Western Health Advantage	14,340				√
San Bernardino	Inland Empire Health Plan	134,048	√			
	Molina Healthcare of California	55,871	√			
San Diego	Blue Cross	17,517				√
	Community Health Group	71,186				√
	Health Net	10,381				√
	Kaiser Permanente	7,685				√
San Francisco	San Francisco Health Plan	32,955	√			
	Blue Cross	14,626	√			
San Joaquin	Health Plan of San Joaquin	57,790	√			
	Blue Cross	24,324	√			
San Mateo	Health Plan of San Mateo	48,395			√	
Santa Barbara	Santa Barbara Regional Health Authority	53,584			√	

County	Health Plan	Membership	Health Plan Model			
			Two Plan	Local Initiative	County Organized	Geographic Managed
Santa Clara	Santa Clara Family Health Plan	71,130		√		
	Blue Cross	33,105	√			
Santa Cruz	Central Coast Alliance for Health	27,813			√	
Solano	Partnership Health Plan of California	48,380			√	
Stanislaus	Blue Cross	29,873		√		
Tulare	Blue Cross	66,921		√		
	Health Net	15,453	√			
Yolo	Partnership Health Plan of California	23,562			√	

Membership as of December 2004.

Table 2. Monitoring of Quality of Care Indicators: 2004 Measurement Year

Health Plan	Childhood Immunization Combo I	Childhood Immunization Combo II	Retinal Eye Screening	Chlamydia Screening	Breast Cancer Screening	Cervical Cancer Screening	Appropriate Medications for Asthma
AAH – Alameda	67.8%	67.1%	NR	55.0%	59.8%	69.0%	67.4%
BC of CA – Alameda	68.3%	67.8%	NR	53.9%	49.3%	68.7%	63.3%
BC of CA – Contra Costa	60.3%	59.6%	NR	46.4%	51.0%	55.5%	56.2%
BC of CA – Fresno	66.8%	66.1%	NR	60.9%	47.4%	74.4%	72.5%
BC of CA – Sacramento	66.9%	66.0%	NR	38.6%	49.3%	68.7%	59.0%
BC of CA – San Diego	74.3%	73.4%	NR	48.0%	56.6%	66.7%	55.7%
BC of CA – San Francisco	75.1%	74.6%	NR	57.7%	69.5%	77.1%	61.6%
BC of CA – San Joaquin	61.8%	61.3%	NR	49.5%	49.1%	57.8%	62.6%
BC of CA – Santa Clara	69.6%	69.1%	NR	38.2%	70.6%	75.5%	58.2%
BC of CA Stanislaus	65.7%	63.9%	NR	53.3%	49.7%	60.5%	63.3%
BC of CA – Tulare	71.5%	71.1%	NR	60.7%	57.4%	76.6%	66.6%
CalOptima – Orange	75.5%	74.3%	57.0%	32.5%	52.2%	64.1%	61.8%

Health Plan	Childhood Immunization Combo I	Childhood Immunization Combo II	Retinal Eye Screening	Chlamydia Screening	Breast Cancer Screening	Cervical Cancer Screening	Appropriate Medications for Asthma
CCAH – Monterey and Santa Cruz	76.6%	75.7%	62.2%	49.4%	56.5%	70.6%	68.4%
CCHP – Contra Costa	60.5%	60.2%	NR	48.8%	56.7%	63.9%	60.5%
CHG – San Diego	72.0%	70.3%	49.1%	36.2%	57.9%	64.0%	60.0%
Health Net – Fresno	66.9%	66.9%	NR	62.3%	56.6%	71.5%	69.9%
Health Net – Los Angeles	60.7%	60.2%	NR	43.0%	53.0%	62.1%	55.6%
Health Net – Sacramento	61.3%	60.3%	NR	30.3%	58.9%	49.2%	62.5%
Health Net – San Diego	74.6%	73.5%	NR	45.0%	50.8%	60.5%	62.7%
Health Net – Tulare	69.0%	47.2%	NR	59.1%	45.6%	70.1%	61.6%
HPSJ – San Joaquin	68.4%	67.6%	NR	42.3%	43.3%	61.9%	54.8%
HPSM – San Mateo	65.3%	61.7%	54.9%	55.2%	56.1%	50.4%	55.5%
IEHP – San Bernardino and Riverside	76.3%	74.9%	50.7%	42.6%	51.4%	69.7%	64.0%
Kaiser (N) – Sacramento	71.4%	70.6%	NR	73.6%	59.1%	75.8%	65.6%
Kaiser (S) – San Diego	76.2%	75.7%	NR	73.5%	69.7%	75.7%	61.9%

Health Plan	Childhood Immunization Combo I	Childhood Immunization Combo II	Retinal Eye Screening	Chlamydia Screening	Breast Cancer Screening	Cervical Cancer Screening	Appropriate Medications for Asthma
Health Net – Tulare	69.0%	47.2%	NR	59.1%	45.6%	70.1%	61.6%
HPSJ – San Joaquin	68.4%	67.6%	NR	42.3%	43.3%	61.9%	54.8%
HPSM – San Mateo	65.3%	61.7%	54.9%	55.2%	56.1%	50.4%	55.5%
IEHP SB/RS	76.3%	74.9%	50.7%	42.6%	51.4%	69.7%	64.0%
Kaiser (N) – Sacramento	71.4%	70.6%	NR	73.6%	59.1%	75.8%	65.6%
Kaiser (S) – San Diego	76.2%	75.7%	NR	73.5%	69.7%	75.7%	61.9%
KFHC – Kern	65.8%	65.1%	NR	49.8%	47.4%	57.7%	64.9%
LA Care – Los Angeles	57.2%	56.3%	NR	33.3%	56.3%	65.6%	58.9%
Molina – Sacramento	59.7%	58.8%	47.7%	53.3%	45.5%	66.5%	51.0%
Molina – San Bernardino and Riverside	70.1%	68.4%	46.9%	31.0%	58.8%	62.9%	56.4%
PHP of CA – Solano, Yolo, and Napa	72.0%	70.7%	60.9%	38.4%	57.0%	68.2%	67.9%
SBRHA – Santa Barbara	81.0%	79.4%	77.6%	48.1%	59.9%	75.5%	71.4%
SCFHP – Santa Clara	73.6%	73.1%	NR	42.8%	68.4%	72.3%	58.5%

Health Plan	Childhood Immunization Combo I		Childhood Immunization Combo II		Retinal Eye Screening		Chlamydia Screening		Breast Cancer Screening		Cervical Cancer Screening		Appropriate Medications for Asthma	
SFHP – San Francisco	73.7%		73.4%		NR		53.5%		68.3%		60.3%		68.5%	
WHA –Sac.	48.4%		47.8%		45.5%		58.5%		61.3%		68.1%		64.2%	
Total	68.3%		67.4%		56.0%		43.6%		56.3%		63.9%		62.1%	
Weighted Average All	65.8%		64.9%		61.0%		43.6%		55.0%		66.1%		62.1%	
MPL and HPL	56.5%	75.2%	52.2%	72.7%	37.8%	59.7%	37.1%	62.6%	51.2%	66.7%	57.3%	77.6%	60.6%	73.0%

Table 3. Measure Indicators of Access to Care: Reporting Year 2004

Health Plan	Timeliness of Prenatal Care		Postpartum Care	
AAH – Alameda	80.9%		61.3%	
BC of CA – Alameda	84.5%		59.5%	
BC of CA – Contra Costa	73.7%		51.8%	
BC of CA – Fresno	83.6%		61.1%	
BC of CA – Sacramento	80.9%		56.7%	
BC of CA – San Diego	82.1%		53.5%	
BC of CA – San Francisco	87.1%		60.7%	
BC of CA – San Joaquin	80.0%		47.0%	
BC of CA – Santa Clara	76.4%		58.1%	
BC of CA – Stanislaus	82.3%		57.6%	
BC of CA – Tulare	79.9%		62.7%	
CalOptima – Orange	83.3%		62.3%	
CCAH – Monterey and Santa Cruz	88.1%		69.8%	
CCHP – Contra Costa	79.6%		53.0%	
CHG – San Diego	72.0%		44.3%	
Health Net – Fresno	88.4%		67.6%	
Health Net – Los Angeles	73.8%		48.8%	
Health Net – Sacramento	77.3%		53.9%	
Health Net – San Diego	83.6%		63.85	
Health Net – Tulare	86.7%		61.4%	
HPSJ – San Joaquin	79.3%		57.2%	
HPSM – San Mateo	71.1%		55.4%	
IEHP – San Bernardino and Riverside	85.9%		65.7%	
Kaiser (N) – Sacramento	76.7%		55.4%	
Kaiser (S) – San Diego	85.2%		60.6%	
KFHC – Kern	77.0%		64.6%	
LA Care – Los Angeles	73.8%		52.8%	
Molina – Sacramento	71.5%		47.6%	
Molina – San Bernardino and Riverside	75.5%		50.8%	
PHP of CA – Solano, Yolo, and Napa	88.7%		69.5%	
SBRHA – Santa Barbara	83.5%		73.9%	
SCFHP – Santa Clara	80.0%		62.4%	
SFHP – San Francisco	84.2%		58.5%	
WHA – Sacramento	67.7%		44.1%	
Total	80.0%		58.0%	
Weighted Average All	79.4%		58.0%	
MPL and HPL	56.5%	75.2%	50.1%	68.6%

Table 4. Measurement Indicators for Timeliness of Care: Reporting Year 2004

Health Plan	WCC 15 Months		WCC 3–6 Years		AWC Visits	
AAH – Alameda	60.7%		70.8%		45.5%	
BC of CA – Alameda	61.4%		68.3%		38.2%	
BC of CA – Contra Costa	45.2%		62.5%		34.75	
BC of CA – Fresno	56.3%		77.3%		39.6%	
BC of CA – Sacramento	53.4%		71.3%		38.2%	
BC of CA – San Diego	44.4%		65.2%		26.9%	
BC of CA – San Francisco	73.9%		76.2%		42.4%	
BC of CA – San Joaquin	57.0%		69.2%		32.4%	
BC of CA – Santa Clara	41.55		66.2%		35.4%	
BC of CA – Stanislaus	45.75		62.5%		29.4%	
BC of CA – Tulare	47.75		69.9%		29.6%	
CalOptima – Orange	44.7%		NR		40.0%	
CCAH – Monterey and Santa Cruz	65.7%		NR		40.45%	
CCHP – Contra Costa	51.1%		68%		33.8%	
CHG – San Diego	36.5%		67.9%		29.7%	
Health Net – Fresno	58.6%		73.9%		37.0%	
Health Net – Los Angeles	36.4%		67.2%		36.9%	
Health Net – Sacramento	46.7%		73.2%		32.1%	
Health Net – San Diego	34.2%		68.0%		23.8%	
Health Net – Tulare	43.1%		71.1%		26.8%	
HPSJ – San Joaquin	60.6%		70.8%		38.4%	
HPSM – San Mateo	56.3%		NR%		32.2%	
IEHP – San Bernardino and Riverside	74.3%		77.8%		52.2%	
Kaiser (N) – Sacramento	67.4%		53.9%		24.7%	
Kaiser (S) – San Diego	NA		54.8%		24.4%	
KFHC – Kern	46.7%		54.8%		37.2%	
LA Care – Los Angeles	44.0%		70.6%		36.7%	
Molina – Sacramento	48.1%		67.9%		45.6%	
Molina – San Bernardino and Riverside	55.6%		71.8%		43.1%	
PHP of CA – Solano, Yolo, and Napa	55.5%		NR		32.5%	
SBRHA – Santa Barbara	53.9%		NR		32.4%	
SCFHP – Santa Clara	56.5%		65.5%		33.1%	
SFHP – San Francisco	56.3%		79.7%		45.1%	
WHA – Sacramento	51.2%		62.3%		31.1%	
Total	53.1%		67.0%		32.5%	
Weighted Average All	50.7%		68.9%		37.0%	
MPL and HPL	38.0%	63.0%	54.4%	74.8%	29.2%	52.3%

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