Medi-Cal Managed Care Division

state of california

Medi-Cal Managed Care External Quality Review Organization

Report of the

2005 Medi-Cal Managed Care Quality Strategy Annual Report

Submitted by

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Improving Health in the Communities We Serve

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Quality Strategy Annual Report

Introduction

The federal government has 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 requirement was a component of the Balanced Budget Act of 1997 (BBA) and is now contained in the Code of Federal Regulations, Title 42 CFR Section 438.200 Subpart D and Section 438.300 Subpart E and Section 1932 [42 U.S.C. 1396u–2] of the Social Security Act. Each Medicaid agency is required to produce an annual report that describes its progress toward meeting the stated quality strategy goals. As the agency responsible for oversight of the Medi-Cal Managed Care Program, the California Department of Health Care Services (DHCS) is responsible for development and implementation of the quality strategy.

This report provides an update of DHCS' progress during 2005 in meeting the goals set forth by its quality strategy and from the perspective of the federal quality requirements for Medicaid managed care. The quality strategy was initially scheduled to be reviewed and revised biannually by DHCS; however, the strategy was not revised for calendar year (CY) 2005 and, as of early 2008, still has not been updated. As a result, various findings of this report remain similar to those documented in the 2004 quality strategy report.

This Annual Report Updates DHCS' Progress in Meeting Its Quality Strategy Goals During 2005.

The final section of this document includes brief background information about the State's contracted managed care health plans and examples of specific types of monitoring conducted by MMCD to comply with the Federal requirements. For a detailed review of each specific monitoring activity conducted by MMCD, please refer to the Medi-Cal plan-specific reports, the Healthcare Effectiveness Data Information Set (HEDIS®) audit reports, and the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS®) report. The HEDIS® and CAHPS® reports are available at http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx. HEDIS® and CAHPS® reports for 2007 are scheduled for public release in 2008.

Due to a delay in the release of this report, it includes references to activities and program changes taking place after 2005 in order to provide the most current perspective of DHCS'

progress towards its quality goals. DHCS plans to issue a combined report for 2006 and 2007 before the end of 2008.

Overview of Quality Strategy Goals

The DHCS managed care quality goals are based on the Medi-Cal managed care program's mission and vision statements as of 2006:

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

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 DHCS' performance.

DHCS has further enhanced its core goals by integrating them with the Medicaid managed care rules contained within the Code of Federal Regulations, Title 42 CFR Section 438.204 Subpart D. The following requirements apply to all state Medicaid managed care 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.
- 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 Federal 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 Federal regulations 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 made or opportunities for further improvement.

Progress Towards Achievement of MMCD Strategic Goals

DHCS Strategic Plan Goal 1

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

Evidence of Compliance

The Medi-Cal Managed Care Division conducted five activities that showed compliance with Goal 1 of DHCS' Strategic Plan:

- Periodic MMCD teleconferences with health plans.
- Monitoring of contracted health plans' outcomes for DHCS required External Accountability Set (EAS) performance measures.
- Development of an initiative to increase the rigor and effectiveness of Quality Improvement Projects (QIPs).
- Implementation of the quarterly *Dashboard Report*.
- Annual plan-specific report development.

Each of these activities is discussed further below.

MMCD/Health Plan QI Teleconferences

MMCD/Health Plan Teleconferences Fostered Information Exchange and Collaboration

Throughout 2005, MMCD convened periodic teleconferences with contracted health plans to ascertain each plan's progress with implementation of its quality management programs. The teleconferences were an opportunity for DHCS and the health plans to engage in one-on-one dialogue to discuss state initiatives and operational challenges encountered by health plans to serve Medicaid recipients. An important component of this dialogue was a discussion of barriers to achievement that included:

- Health plan data issues such as variability in encounter data and the inability to determine race and ethnicity.
- Lack of health plan participation in the immunization registry (need for registry to be mandated).
- Low scores in some HEDIS® and CAHPS® rates (e.g., Adolescent Well Visit rate was low for the majority of health plans).
- Inaccurate medical and contact information for members.
- Emergency room (ER) over-utilization.
- Inconsistency of DHCS guidelines with American Academy of Pediatrics (AAP) guidelines.

Suggested recommendations and/or common elements discussed between the health plans and DHCS included:

- Recommendation for a decrease in the required number of Quality Improvement Projects (QIPs) from four to two.
- Success of provider and member incentives and as pay-for-performance initiatives in improving members' behavior and compliance with recommended care.
- Recommendation for a best practices forum to include all health plans to review and analyze HEDIS® and CAHPS® scores.
- Implementation of disease management programs.

Additionally, during these calls, MMCD reviewed the QIP activities and results from other initiatives performed by its external quality review organization (EQRO) with the health plans. These knowledge-sharing forums were beneficial in helping MMCD understand health plan progress toward quality improvement goals and the issues affecting goal achievement. Quarterly contract management meetings also address quality issues as appropriate.

External Accountability Set & CAHPS

Accountability for quality of care was further achieved through monitoring of each health plan's outcomes for the DHCS-required External Accountability Set (EAS) performance measures and CAHPS®. The required EAS consists of selected HEDIS® measures that are audited and reported each year by MMCD's EQRO. MMCD and its EQRO also reviewed findings from the medical review audits conducted by the DHCS Audits and Investigations Division (A & I) in conjunction with the Department of Managed Health Care (DMHC) related to plan quality improvement programs, systems, and processes.

Revamping of QIP Requirements

MMCD reduced the number of QIPs that health plans were required to submit from four to two. This reduction allows health plans to focus their resources on fewer quality improvement projects that are more relevant and meaningful based on their member populations. The reduction also permits MMCD to increase its level of collaboration and oversight regarding these projects with the EQRO. Although MMCD initially planned to implement this proposed change through a policy letter, it was later determined that this policy change must implemented through contract amendments. MMCD implemented this change in 2007.

Dashboard Report

Quarterly Dashboard Reports Provide Snapshots of Health Plans and Program Performance

The Dashboard Report was implemented in 2005 as a tool for MMCD management The quarterly report compiles data from various program areas in order to provide an overview of program status and performance. Specific areas covered include general demographics of the member population, enrollment and disenrollment trends, financial stability, service utilization (inpatient and outpatient care, prescriptions and ancillary services), quality and performance measurement results (HEDIS®/CAHPS®), encounter data timeliness and accuracy, and other monitoring results. The *Dashboard Report* provides the "big picture" of Medi-Cal managed care performance both at the health plan level and program-wide. The comprehensive report contains a variety of helpful graphics. In the future, more detailed performance summaries to supplement the tables and graphics may be a beneficial addition.

Annual Plan-Specific Report Development

The EQRO develops plan-specific reports annually for each MMCD health plan to meet state and federal reporting requirements. These reports include information on each health plan's HEDIS® and CAHPS® results, QIPs, and audit findings. These various data sets are utilized to assess each health plan's performance in the areas of quality, access, and timeliness and to provide MMCD with a comprehensive evaluation of each health plan's strengths and weaknesses. Additionally, the EQRO provides specific recommendations for improving the overall quality of care provided to Medi-Cal members to each health plan and by extension to MMCD.

Compliance with Federal Requirements

The MMCD shows compliance with federal requirements through several activities. These activities include the following:

- Health plan evaluation processes.
- EAS annual measurement, CAHPS®, and QIP review processes.
- Implementation of MMCD *Consumer Guides* to encourage consumer engagement in healthcare choices.

These activities are discussed below.

Health Plan Evaluation

The health plan evaluation processes are conducted jointly by the DHCS Audits and Investigations (A& I) Division and the DMHC. Onsite reviews of health plans are conducted approximately every three years to assess the quality and appropriateness of care provided to plan members as demonstrated by compliance with DHCS contract

requirements and with state laws and regulations for licensed plans. The evaluation process includes, but is not limited to, assessments of the following:

- Member rights
- Credentialing
- Utilization management policies and procedures
- Continuity of care
- 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 these onsite audits. MMCD reviews and approves these CAPs and notes areas of concern for continued monitoring.

EAS, CAHPS®, & QIPs

The EAS annual measurement (through the DHCS-required HEDIS® measures) and QIP review processes are integral components of the quality strategy 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 its contracted health plans to one another in each participating county, by model type, and against national averages for Medicaid plans.

The HEDIS® results often 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 evident in improved measurement outcomes during subsequent HEDIS® measurement cycles. The required HEDIS® measures are detailed in the appendix of this report.

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 an Improvement Plan (IP) describing how the health plan will work to raise its score to or above the MPL. Each contracted health plan is required to develop IPs using the same Quality Improvement Activity (QIA) form that they also use to submit QIPs. The IPs are an essential part of the QI process and are subject to the same scrutiny as the QIPs.

MMCD uses the CAHPS® surveys to measure member satisfaction as another approach to ensure accountability for the services and care provided to members. The CAHPS® surveys are standardized surveys developed by the Agency for Healthcare Research and Quality. These surveys contain questions that address member satisfaction in such areas as the coverage provided; their access and utilization of health care; their communication and

interaction with providers, provider staff and health plan staff; self-perceived health status; and demographics. Separate surveys are conducted for adults and children, and surveys are administered in both English and Spanish. The CAHPS® results help MMCD assess the rate of member satisfaction for each health plan relative to the calculated average Medi-Cal satisfaction level. The MMCD specifically questions health 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.

MMCD Consumer Guide

Consumer Guides Enhance Member Choice

A county-specific *Consumer Guide* is placed in the enrollment packets of newly eligible Medi-Cal recipients to provide information to help members choose the best Medi-Cal plan for their healthcare needs. These *Guides* are available for all two-plan model or Geographic Managed Care (GMC) model counties. The *Guide* helps members learn about the quality of care and the services provided by each health plan in relation to other Medi-Cal plans and where to get answers to their questions. These *Consumer Guides* are also available on the DHCS website at www.dhcs.ca.gov/individuals/Pages/MMCDConsumerGuide.aspx.

In September 2005, MMCD began including plan performance and member satisfaction information in the *Consumer Guide* for each county to provide members with better information to assess and choose from the health plans in their areas. Subtitled "My Medi-Cal Choice for Healthy Care", the *Consumer Guide* includes selected HEDIS® and CAHPS® results for the plans available in each county indicating how each 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 EQRO offers the following recommendations related to Goal 1:

- **Develop interim annual updates.** This recommendation was also made in the 2004 Quality Strategy Report. In addition to the onsite audits of health plans conducted every three years by DHCS and DMHC, it is recommended that MMCD develop an interim annual update process between on-site 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 CAPs. 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 request an interim on-site visit from DHCS and/or DMHC auditors.

These interim updates would keep MMCD informed on a more timely basis regarding each plan's progress toward improved quality of care, timeliness, and access to providers.

- **Integrate audit findings with other health plan data.** It is recommended that the MMCD integrate findings from the joint DHCS/DMHC audits with other sources of health plan data, such as the performance and member services indicators, financial stability measures, utilization and quality measures, and the encounter data contained in the internal MMCD quarterly *Dashboard Report*. This recommendation was also made in the 2004 Quality Strategy Report.

  Although the *Dashboard Report* is not publicly released, MMCD could consider including relevant information from the report in audit reports when it is helpful and not proprietary. This strategy would give audit findings a more comprehensive view of health plan operational performance and support more substantive judgments regarding the healthcare quality provided to members by health plans. Integrated data review is more likely to unveil systemic issues and lead to the identification of root causes and barriers to improvement. Health plans are more likely to find intervention planning and monitoring easier to implement if they have a greater understanding of the issues identified from the integrated data approach.

- **Provide full reporting relative to audit findings.** This recommendation was also made in the 2004 Quality Strategy Report. Currently, MMCD receives only "exception" results as feedback from the DHCS A&I Division 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. MMCD's ability to link problems identified in one area with problems in another area would be greatly enhanced by receiving the full audit report from A&I.

  Previously, A&I could not legally share audit findings until the findings were finalized and made public. However, the Memorandum of Understanding (MOU)

now in place between DHCS and DMHC has successfully improved the receipt of and access to the audit findings and relevant reports in real-time. The purpose of entering into the MOU cooperative agreement between DHCS and DMHC was to improve efficiency, limit duplication of efforts, maximize resources, and reduce the disruptive effect upon health plans of having multiple reviews focused on the same procedures. Additionally, the MOU applies to the sharing of health plan grievance data.

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

- **Provide timely approval of annual plan-specific reports.** As set forth in Section 1932 **[**42 U.S.C. 1396u–2**]** of the Social Security Act, the EQRO conducts an annual external independent review of managed care activities to include "the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract." Delays in MMCD review and approval of the annual plan-specific reports compiled by the EQRO impacts the implementation and effectiveness of the recommendations provided in those reports for each health plan. The recommendations in these reports pertain to a specific time period when the report is written. If release of the reports is delayed, the recommendations may become outdated. The EQRO also recommends that these annual plan-specific reports be released before the annual HEDIS Aggregate Report.

- **Reinstate health plan teleconferences.** Although the health plan teleconferences were not held in 2006 and 2007, MMCD staff agrees that the teleconferences successfully provided a forum for MMCD to meet with the leadership from each health plan and learn the nuances of each health plan's quality improvement program. This is particularly important given variability in each health plan's size,

scope, area, and demographics. During 2008, MMCD intends to resume regularly scheduled and structured meetings with individual health plans focused on quality improvement and performance measurement. The EQRO agrees that resuming the health plan teleconferences would provide an effective mechanism for open communication and would help prevent barriers to collaboration between the health plans and MMCD in the areas of quality improvement and performance measurement.

DHCS Strategic Plan Goal 2

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

Evidence of Compliance

Several strategies to improve quality through better communication and collaboration among health plans were undertaken by MMCD in support of Goal 2. Strategies include the following:

- Development of collaborative QIPs.
- Restructuring of QIP requirements.
- Enhanced collaboration in Medical Directors meetings.
- Co-sponsorship of annual Quality Conference.
- Establishment of minimum and high performance levels for required HEDIS® measures.
- Development of a default enrollment incentive program.
- Establishment of additional Quality Awards based on performance.
- Implementation of MMCD Advisory Group for stakeholder input.

Further discussion of these innovative activities and some current trends in performance incentives follows.

Collaborative QIPs

Collaborative statewide and small group QIPs have been developed and implemented to address chronic conditions prevalent among Medi-Cal managed care plan members (e.g., asthma and diabetes) and identified barriers in providing services to specific populations (e.g., children and adolescents). Beginning in 2003 and ending in 2007, MMCD conducted a statewide collaborative QIP in the area of adolescent well-care. All contracted plans participated in this statewide collaborative QIP. The remeasurement phase concluded in 2007, and improvements in the indicators measured have been documented over the baseline measurement.

This statewide collaborative QIP focused on improving each health plan's HEDIS® Adolescent Well Visit measure rate and improved results from a survey of adolescents regarding the quality of their well-care visit. The Adolescent Report of Health Visit Survey was designed to query adolescents about what they experienced during their healthcare visit and included questions related to confidentiality, comprehensive health risk screening, health counseling, and education. The improvements documented in these indicators during the period covered by the QIP are in part attributable to the involvement of experts in adolescent healthcare who consulted with MMCD and the health plans.

During 2005 small group collaborative QIPs were being conducted by groups of Medi-Cal managed care plans in the areas of childhood immunization, asthma management, and diabetes management and documented improvement in selected indicators measured. The childhood immunization and diabetes collaboratives concluded as of 2007. The asthma collaborative is continuing with a smaller number of health plans participating than those involved in the original project. Though this collaborative is no longer being directed by MMCD, the division continues upon request to provide technical assistance to the participating health plans.

DHCS has continued to take steps to improve the quality and efficacy of the QIPs, both the internal QIPs and small group collaborative QIPs conducted by plans and the statewide collaborative QIPs directed by MMCD. These improvements are generally the result of enhanced monitoring and technical assistance provided by both MMCD and EQRO staff and of more detailed QIP specifications released to plans by MMCD in annual All Plan Letters regarding the division's quality and performance improvement program requirements.

QIP Restructuring

QIP Restructuring: Prescription for Improved Performance and Results

A second strategy MMCD employed in 2005 to improve the quality of care provided to managed care enrollees was restructuring its QIP requirements for health plans. To initiate this process, MMCD staff spent several sessions with the EQRO reviewing health plan QIPs. During these meetings, MMCD and the EQRO jointly decided whether specific QIPs should be continued or retired after multiple measurement periods were conducted. 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 the recommended 36 months.

MMCD also advocated that health plans utilize the rapid cycle improvement methodology to achieve improvement within the QIPs' targeted timeframes. Rapid cycle improvement methodology involves defining the scope of the project, developing the interventions thought to obtain the desired change, implementing the changes, assessing the impact on what is being measured, and spreading the new processes that led to positive changes – all in a condensed timeframe rather than the 12-month cycle organizations generally use to assess change.

As part of its restructuring of QIP requirements, MMCD decided (as discussed above in Goal 1) that health plans should be required to participate in only two QIPs each year, one

internal quality improvement project (IQIP) or small group collaborative and the statewide collaborative, rather than the four QIPs previously required (the statewide collaborative, one small group collaborative, one internal IQIP and a fourth QIP, which could be either an IQIP or another small group collaborative). The rationale for proposing this change was to allow health plans to devote more time and resources to implementing more meaningful, rigorous, and effective QIPs. Because this change had to be implemented through contract amendments, MMCD required health plans to participate in four QIPS each year until 2007.

Medical Directors Meetings

From the outset of the Medi-Cal Managed Care program, MMCD implemented quarterly meetings with the health plan medical directors. These meetings, which are chaired by MMCD's Chief of Medical Policy, provide a forum for MMCD staff, as well as staff from other DHCS departments, to share information about state-sponsored programs and initiatives and Medi-Cal policies with the medical directors. This dialogue with the health plan Medical Directors provides MMCD with feedback on the impact of these state-sponsored programs, initiatives and policies on plan operations and service provisions. In addition, health plan Medical Directors have the opportunity to share information about how plans are working to improve the quality of care and service provided to their Medi-Cal members.

To further enhance ongoing communication with health plan medical directors, in 2005 MMCD established a website for the medical directors. The site is used as a venue for sharing information regarding upcoming meetings and related handouts as well as other information of interest to medical directors and pertinent to Medi-Cal managed care. MMCD hoped that this website would help spur exchange of information about new quality improvement strategies and initiatives among plans and with MMCD and foster a "best practices model" for quality improvement.

Quality Conference

Quality Conference Showcases Best Practices

The goal of improved quality of care for Medi-Cal enrollees is further enhanced by the annual Quality Conference sponsored by MMCD. First held in 2002, the conference 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*. Speakers from California and around the country shared their expertise in developing and implementing strategies and mechanisms geared toward enhancing the quality of services provided to Medicaid consumers. Conference participants, including health plan representatives, DHCS staff, and staff from other state and federal agencies, learned how quality tools such as disease registries, small group collaboratives, and

community advocacy activities can be used as adjunct strategies to assist in monitoring the quality of care provided to consumers. Approximately 175 participants attend these conferences annually, and the conference evaluations generally indicated that the attendees thought the information shared was helpful and useful to them within their work environments.

Establishment of Minimum and High Performance Levels

To further support Goal 2, MMCD also established minimum performance levels and high performance levels (MPLs and HPLs) to be used in the assessment of the HEDIS® 2006 rates (based on services provided in 2005). Health plans that score below the MPL in any of the targeted HEDIS® measures are required to submit an Improvement Plan (IP) for that measure. The EQRO fully supported this change because health plans with performance below the MPL need to conduct root cause and barrier analyses in order to determine how to effectively address the issues related to the low score. Root cause and barrier analyses are a critical component of an effective IP; thus, the likelihood of a plan successfully addressing an identified issue is enhanced when substantive root cause and barrier analyses have been conducted.

Although MMCD currently uses Minimum Performance Levels (MPLs) to determine the need for corrective action related to the required HEDIS® measures, as plan performance expectations are increased over time, more complex methodologies may be helpful to more fully engage 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 methodology used to determine minimum and high performance levels. Adjustment strategies, such as developing regional thresholds for the MPLs and HPLs, could allow some health plans to become more competitive with high performing health plans. 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.

Default Enrollment Incentive Program

Default Enrollment: MMCD Tool for Performance-Based Incentive

An innovative strategy in support of Goal 2 was started in 2005 when MMCD began using a default enrollment strategy as an incentive to health plans to improve the quality of care offered to enrollees. This strategy assigns more default enrollment in the geographic managed care (GMC) and two-plan model counties to health plans that have demonstrated high quality performance for selected HEDIS® measures and for two measures related to

the utilization of safety net providers. The members subject to default enrollment are Medi-Cal beneficiaries who are required to enroll in a managed care plan but who do not select a health plan within the required timeframe established by the DHCS. The five HEDIS® measures used for the first three years of the default enrollment incentive program were:

- Childhood immunizations (Combination 2)
- Well-child visits (3rd-6th years of life)
- Adolescent well-visits
- Timeliness of prenatal care
- Appropriate medications for people with asthma

The two safety net provider utilization measures were created through collaboration between DHCS and affected GMC and two-plan model plans:

- Number of members assigned to safety net provider PCPs
- Discharges at disproportionate share hospital (DSH) facilities

Although this strategy directly benefits Medi-Cal plan members through improved quality of care in the targeted areas, 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.

Quality Awards

Another strategy that MMCD uses in relation to quality and performance improvement requirements is the conferring of annual Quality Awards. Health plans with no HEDIS® scores below the MPLs (which are 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 Conference. In 2005, three health plans received quality awards based on HEDIS® performance:

- Gold award -- Santa Barbara Regional Health Authority
- Silver award -- Central Coast Alliance for Health (Monterey and Santa Cruz Counties)
- Bronze awards -- Blue Cross of California (Fresno County), Inland Empire Health Plan (Riverside and San Bernardino Counties) and San Francisco Health Plan.

Additional awards were given in 2005 to health plans that performed significantly above the Medi-Cal managed care average in overall CAHPS® ratings:

- Gold -- Kaiser Foundation Health Plan (North and South)
- Silver -- Health Plan of San Mateo

In addition, three plans received special acknowledgement for their voluntary participation in the Pilot Survey for the statewide Adolescent Health Collaborative: Blue Cross of California, Health Plan of San Joaquin, and Partnership Health Plan.

MMCD has continued to confer Quality Awards during the annual Quality Conferences and developed additional award categories for the 2008 Quality Conference in response to plan input.

Medi-Cal Managed Care Advisory Group

MMCD Advisory Group Recognizes Importance of Stakeholder Involvement

The Medi-Cal Managed Care Advisory Group was created as another venue for sharing information and soliciting input from consumers and other interested stakeholders, including persons with disabilities and chronic medical conditions, about the Medi-Cal managed care program. During 2005, the Advisory Group met every few months. Attendees included DHCS and health plan representatives and representatives from other organizations such as the Centers for Medicare and Medicaid Services, Community Health Councils, Maternal and Child Health Access, and the Health Rights Hotline. Discussions at these meetings focused on budget and program updates, such as elements of the Medi-Cal redesign and managed care expansion, Health Care Options enrollment program updates, *Consumer Guide* and *Dashboard Report* updates, health plan updates, and other issues affecting Medi-Cal. These meetings promoted positive exchange of ideas and information between MMCD, stakeholders and other interested parties and successful follow-up on action items.

In the opinion of the EQRO, enhancement of the advisory group membership should be a continued goal at MMCD. 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.

Compliance with Federal Requirements

DHCS' approaches to complying with Strategic Goal 2 have focused on improving the quality of care through the sharing of health plan information. Some of this information, such as chlamydia screening in women results, is used by other programs within DHCS and the California Department of Public Health, as well as by MMCD.

Recommendations

In addition to the recommendations presented earlier in this report related to performance incentives (DHCS Strategic Goal 2), the EQRO has the following additional recommendations regarding Goal 2:

- **Conduct semi-annual review of utilization data stratified by ethnicity and regional factors, as well as by demographic information, such as age and sex.** This recommendation was also made in the 2004 Quality Strategy Report. This level of information could provide MMCD with focused data identifying which population segments, if any, should be targeted for quality improvement. Such data analysis would help health plans focus limited resources on 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. Some of the difficulties and concerns related to the collection of valid data are discussed below.

- **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 to 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 was less successful in meeting its quality improvement goals in 2005 were activities that depend heavily on data analysis. Since 2005, MMCD has expanded its staff resources in the areas of research and data analysis and implemented more robust utilization monitoring, making use of both encounter data from the DHCS data warehouse and the utilization data from the HEDIS Use of Services measures. These developments will be discussed in subsequent annual reports.

- **Establish a protocol for changing MPLs and HPLs.** This recommendation was also made in the 2004 Quality Strategy Report. To improve the quality of care, MMCD must clearly define thresholds for adequate care. MMCD currently does this by establishing Minimum Performance Levels and High Performance Levels (MPLs and HPLs) for the required HEDIS® measures using the 25th and 90th

national percentile for Medicaid plans established by the National Committee for Quality Assurance. 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 focusing only on improvement over the baseline year is not a successful long-term strategy and that a goal of sustained improvement is likely to produce more meaningful improvement over time. For calendar year 2006 and thereafter, MMCD 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 using the same baseline percentiles for more than one year. However, NCQA does not release the updated Medicaid averages for the current year until very late each year (e.g., 2006 national averages based on 2005 services were not available until approximately November 2006). To allow contracted plans time to understand areas where improvement is most needed and to prepare IPs and to allow annual adjustment of the default enrollment algorithm, MMCD has chosen to use the most currently available national averages (e.g., 2005 averages for 2004 services) to establish the MPLs and 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.

- **Institute trending and statistical significance testing of HEDIS® rate decreases and increases between years for the state as a whole as well as at the plan level.** Trending performance measures and statistical significance testing would more accurately measure improvement and/or decline in HEDIS® rates. These activities would also provide MMCD with additional plan performance information and a deeper look into the quality of care as well as the bigger performance picture. The performance information obtained from these activities could be used in state and plan reports and as a tool for establishment of performance-based incentives. *Note:* MMCD began trending HEDIS® rates for the program as whole in 2006 and doing statistical significance testing of plan scores in 2007.

- **Require the implementation of effective interventions for QIPs.** Passive interventions, such as one-time mailings to members or providers, are insufficient to initiate successful and long-term improvement. The EQRO recommends that

MMCD encourage plans to emphasize more active interventions in their QIPs. In the 2006 and 2007 annual *All Plan Letters* addressing quality and performance improvement requirements, MMCD has been focusing on goal setting and statistical significance testing.

Holding health plans more accountable for implementing targeted and effective interventions should continue to be a focus for MMCD. Interventions should target both the members and providers because both populations are equally important to attaining meaningful improvement for QIPs. Additionally, the timing of interventions is critical to the success of a QIP. A health plan cannot implement interventions in the fourth quarter of the measurement year and expect substantial improvements by the end of that measurement year. Finally, interventions also should be conducted at a system level to address underlying program or statewide problems and/or issues.

DHCS Strategic Plan Goal 3

MMCD will develop and implement programs to reduce health disparities.

Evidence of Compliance

Three identified activities support Goal 3 -- the development and implementation of programs to reduce health disparities -- and are discussed below:

- Implementation of a racial/ethnic disparities project.
- Expansion of managed care by DHCS to increase access to care and improve health outcomes for targeted populations and in additional counties.
- Requirement of increased cultural sensitivity by contracted health plans and providers.

Focusing on Racial/Ethnic Disparities

Tackling Cultural Barriers to Quality Care

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 are often more successful in having targeted population seek recommended care. Understanding health disparities among particular ethnic groups within the Medi-Cal population is an important goal, and MMCD has developed one workable approach to achieving this.

It should be noted that, although the Medi-Cal Eligibility Data System (MEDS) contains an ethnicity identifier, this information is self-reported to county staff during the application process for Medi-Cal assistance and is not validated. The EQRO recommends that validation of the ethnicity data be pursued, but also acknowledges that budget limitations may preclude this in the near term.

Since 2005, a number of contracted plans have implemented Quality Improvement Projects (QIPs) focused on addressing identified racial/ethnic disparities in healthcare delivery, such as lower levels of childhood immunization among African American and Hispanic members in some areas. MMCD also has considered racial/ethnic disparities in statewide collaborative QIPs on improving adolescent well-care (completed in 2007) and reducing avoidable emergency room use (currently underway). This work will be discussed in subsequent reports.

Expansion of Managed Care

Widening Medi-Cal's Reach

The expansion of managed care by DHCS, a second activity in support of goal 3, is facilitating a multitude of initiatives focused on increasing access to care and improvement of health outcomes. The expansion of managed care will not only expand Medi-Cal

managed care into additional counties, but also focus on increasing the voluntary enrollment of seniors and persons with disabilities (SPDs) in Medi-Cal managed care plans.
DHCS in partnership with the University of California, Berkeley, School of Public Health, is in the process of developing outreach and education strategies to increase enrollment of voluntary populations in all managed care counties with a focus on seniors and persons with disabilities. This pilot project will target English, Spanish, and Chinese-speaking seniors and persons with disabilities in Alameda, Riverside, and Sacramento counties.

Cultural Sensitivity and Health Plans

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 of 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 threshold languages. In support of Goal 3, plans must assure that their provider networks include PCPs and/or their office staff 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. The Medi-Cal managed care program has been acknowledged as a national leader in the area of plan requirements related to cultural sensitivity.

Compliance with Federal Requirements

The pertinent federal requirement to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee is discussed in immediately above and in the section of compliance with Goal 2. The same evidence offered for DHCS Strategic Goal 3 applies for evidence of compliance with federal requirements.

Recommendations

The EQRO's recommendations related to Goal 3 are discussed below:

- **Conduct semi-annual review of utilization data stratified by ethnicity and regional factors, as well as by demographic information, such as age and sex.**

This recommendation was also made in the 2004 Quality Strategy Report and was also recommended in this report for Goal 2. Due to the difficulties already discussed in this section and in the recommendations section for Goal 2, reducing health disparities is likely to be difficult for MMCD, as well as other states, to completely achieve. In spite of anticipated difficulties, efforts should be made to conduct these reviews and collect information in support of this goal. A potential option is to measure performance in decreasing health disparities would be to consider using the demographic component of the CAHPS® satisfaction data by and/or to consider using the HEDIS® health plan descriptive measures Language Diversity of Membership (LDM) and Race/Ethnicity Diversity of Membership (RDM).

In the Prevention Institute's 2006 report, *The Imperative of Reducing Health Disparities through Prevention: Challenges, Implications, and Opportunities,* one recommendation for reducing health disparities is community-based participatory efforts. This approach focuses on empowering ethnic communities by partnering with coalitions, practitioners, decision-makers, and health plans. Focus groups also can help make progress in this area at the community level. Other ways to engage community participation include: public hearings/meetings, media stories, and demonstrations. Farmers' markets and youth programs are other specific examples of piloted community activities. These and other initiatives presented in related research may lead to additional success in reducing health disparities by focusing on community partnership interventions and collaborative models.

The Agency for Healthcare Quality and Research's (AHRQ) 2006 report, *The National Healthcare Disparities Report*, also suggests that a potential solution for moving forward in reducing disparities in health care is a focus on neighborhoods and/or "focused community-based projects that are supported by detailed local data". This option to promote positive change appears to be similar to those presented in other research in this area.

As reflected in some of the more recent QIPs conducted by Medi-Cal managed care plans, community-based participation has been used to achieve improvement in the quality of care and access to care, with some specific focus on reducing healthcare disparities in particular ethnic groups. MMCD should consider holding a forum for their plans for the specific purpose of sharing work underway in this area and emerging "best practices."

- **Collaborate with the DHCS Office of Multicultural Health to explore other avenues for collecting ethnicity data or conducting focus groups.** This recommendation was also made in the 2004 Quality Strategy Report. The Office of Multicultural Health could be used as a resource for technical expertise and assistance by MMCD in the effort to reduce health disparities. The EQRO is not aware of any efforts conducted by MMCD in 2005 in this area.

DHCS 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 Federal 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. During 2005 and ongoing, DHCS has continued to promote 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.
- MMCD sponsored training, some including the EQRO contractor, to increase staff understanding of federal external quality review requirements, MMCD contract requirements in the area of quality improvement and performance measurement, quality and performance measurement results, and how these results can be used in ongoing auditing and monitoring activities.
- Using quarterly meetings of the Medical Directors, the QI Workgroup, and the Encounter Date Coordination Group as opportunity for ongoing training and development in the area of quality improvement and performance measurement.

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.

Recommendations

Perform annual assessments and inventory of staff knowledge and skills. Being aware of the knowledge and skills that staff members possess related to quality improvement and performance measurement is important in order for MMCD to maximize its staff resources in support of its Quality Strategy. Implementing a structured process for tracking and updating staff qualifications in quality improvement and performance measurement could help MMCD more effectively use staff resources. This could also help MMCD identify gaps in staff knowledge and training that need to be addressed and prioritize the use of limited training funds.

Final Thoughts

As reflected in this report, during 2005 and ongoing, MMCD has made progress toward achieving its quality improvement objectives. Unfortunately, MMCD's Quality Strategy has not been revised in a timely manner to reflect current realities within the Medi-Cal program that may result in the establishment of new MMCD priorities and the revision of goals and objectives to meet them. Updating the quality strategy more frequently, such as every two years, would allow MMCD to better evaluate its true progress toward achieving its quality goals, formulate updated or new goals consistent with the program's current direction, and avoid duplication of efforts from previous years that are no longer as relevant to the current state of Medi-Cal. More frequent updating of the Quality Strategy also would facilitate a more meaningful evaluation by the EQRO of MMCD's progress towards its current quality goals.

Although resource constraints are a primary reason for delayed progress toward some objectives, MMCD is compliant with each federal requirement. However, the EQRO believes that it could render a more accurate and substantiated assessment of MMCD's program quality if the suggested recommendations were implemented.

Appendix

Table 1. Background Information: Medi-Cal Managed Care Plans (as of December 31, 2005).

County	Health Plan	Membership	Health Plan Model			
			Two Plan	Local Initiative	County Organized	Geographic Managed
Alameda	Alameda Alliance for Health	76,227		√		
	Blue Cross	28,657	√			
Contra Costa	Contra Costa Health Plan	42,909	√			
	Blue Cross	10,576	√			
Fresno	Blue Cross	140,609	√			
	Health Net	27,053	√			
Kern	Kern Family Health Care	90,842	√			
	Health Net	22,980				
Los Angeles	L.A. Care Health Plan	734,587		√		
	Health Net	471,042	√			
Monterey	Central Coast Alliance for Health	54,127			√	
Napa	Partnership Health Plan of California	10,166			√	
Orange	CalOptima	296,030			√	
Riverside	Inland Empire Health Plan	115,270		√		
	Molina Healthcare of California	36,258	√			

County	Health Plan	Membership	Health Plan Model			
			Two Plan	Local Initiative	County Organized	Geographic Managed
Sacramento	Blue Cross	33,187				√
	Health Net	30,935				√
	Kaiser Permanente	20,155				√
	Molina Healthcare of California	18,773				√
	Western Health Advantage	13,502				√
San Bernardino	Inland Empire Health Plan	132,868	√			
	Molina Healthcare of California	55,512	√			
San Diego	Blue Cross	20,602				√
	Community Health Group	70,370				√
	Health Net	13,414				√
	Kaiser Permanente	9,740				√
San Francisco	San Francisco Health Plan	32,080	√			
	Blue Cross	13,156	√			
San Joaquin	Health Plan of San Joaquin	55,660	√			
	Blue Cross	26,599	√			
San Mateo	Health Plan of San Mateo	47,847			√	
Santa Barbara	Santa Barbara Regional Health Authority	54,295			√	

County	Health Plan	Membership	Health Plan Model			
			Two Plan	Local Initiative	County Organized	Geographic Managed
Santa Clara	Santa Clara Family Health Plan	69,432		√		
	Blue Cross	33,187	√			
Santa Cruz	Central Coast Alliance for Health	29,248			√	
Solano	Partnership Health Plan of California	50,061			√	
Stanislaus	Blue Cross	48,452		√		
Tulare	Blue Cross	69,444		√		
	Health Net	15,379	√			
Yolo	Partnership Health Plan of California	24,037			√	

Membership as of December 2005. *Note: Current plan listing and enrollment numbers are available on the DHCS website at http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx*

Table 2. Monitoring of Quality of Care Indicators: 2006 Scores for 2005 Measurement Year

Health Plan	Treatment of Adults with Acute Bronchitis	Medication Used for Asthma	Cervical Cancer Screening	CDC Eye Exams	CDC Hb1Ac	CDC LDL	CDC Neph.	Chlamydia Screening	URI Treatment of Children
AAH – Alameda	76.3%	90.4%	73.7%	22.2%	75.9%	85.4%	44.9%	47.6%	93.8%
BC of CA – Alameda	57.5%	85.5%	65.1%	44.0%	62.1%	76.1%	76.3%	54.1%	91.7%
BC of CA – Contra Costa	NA	88.3%	52.1%	43.8%	50.0%	71.9%	74.0%	48.9%	88.0%
BC of CA – Fresno	64.4%	91.1%	71.7%	52.0%	74.3%	83.2%	85.9%	59.1%	85.2%
BC of CA – Sacramento	72.2%	83.0%	69.4%	49.4%	66.8%	78.4%	79.2%	47.4%	90.9%
BC of CA – San Diego	NA	82.5%	66.1%	51.7%	63.9%	85.9%	76.1%	43.9%	90.8%
BC of CA – San Francisco	38.5%	80.8%	72.0%	54.0%	77.4%	84.1%	77.4%	55.7%	94.5%
BC of CA – San Joaquin	83.3%	87.8%	65.1%	40.7%	66.2%	78.4%	76.8%	50.5%	81.2%
BC of CA – Santa Clara	76.7%	83.6%	69.2%	55.8%	81.7%	90.0%	87.7%	46.2%	84.9%
BC of CA Stanislaus	76.3%	85.4%	66.9%	43.7%	67.3%	81.9%	81.4%	52.2%	85.5%
BC of CA – Tulare	72.8%	92.0%	78.4%	48.7%	70.8%	85.6%	83.7%	54.8%	80.2%
CalOptima – Orange	73.4%	88.0%	69.1%	71.6%	80.0%	89.4%	50.8%	37.4%	79.4%

Health Plan	Treatment of Adults with Acute Bronchitis	Medication Used for Asthma	Cervical Cancer Screening	CDC Eye Exams	CDC Hb1Ac	CDC LDL	CDC Neph.	Chlamydia Screening	URI Treatment of Children
CCAH – Monterey and Santa Cruz	64.8%	87.9%	72.5%	67.2%	81.5%	83.5%	55.2%	51.5%	91.1%
CCHP – Contra Costa	68.8%	82.4%	63.8%	52.6%	77.5%	82.9%	39.9%	66.8%	92.2%
CHG – San Diego	NA	81.1%	63.3%	49.9%	66.9%	82.0%	42.8%	25.6%	84.4%
Health Net – Fresno	34.6%	89.0%	72.5%	50.9%	75.2%	84.2%	41.1%	59.1%	85.1%
Health Net- Kern	37.7%	NA	45.7%	42.0%	70.0%	70.9%	35.6%	36.9%	79.2%
Health Net – Los Angeles	53.8%	75.3%	65.7%	48.4%	74.2%	83.9%	47.9%	40.2%	75.1%
Health Net – Sacramento	38.5%	75.9%	51.8%	46.5%	70.3%	80.3%	35.0%	33.6%	86.0%
Health Net – San Diego	42.0%	75.5%	64.7%	44.7%	77.7%	81.9%	42.6%	51.0%	90.7%
Health Net – Tulare	48.2%	78.3%	75.1%	47.6%	81.1%	90.6%	49.5%	52.7%	86.6%
HPSJ – San Joaquin	72.6%	84.5%	62.6%	42.3%	70.6%	81.3%	42.1%	48.3%	75.8%
HPSM – San Mateo	26.9%	78.4%	49.6%	66.3%	68.9%	72.6%	47.3%	54.5%	91.3%
IEHP – San Bernardino and Riverside	35.6%	87.0%	74.5%	64.7%	79.1%	88.8%	63.5%	53.1%	58.7%

Health Plan	Treatment of Adults with Acute Bronchitis	Medication Used for Asthma	Cervical Cancer Screening	CDC Eye Exams	CDC Hb1Ac	CDC LDL	CDC Neph.	Chlamydia Screening	URI Treatment of Children
Kaiser (N) – Sacramento	78.8%	89.8%	74.8%	70.5%	81.3%	91.9%	69.0%	75.6%	96.8%
Kaiser (S) – San Diego	52.1%	90.2%	74.1%	71.9%	87.7%	89.7%	83.2%	74.5%	90.4%
KFHC – Kern	73.6%	84.1%	60.2%	41.4%	73.7%	89.5%	54.3%	56.9%	79.8%
LA Care – Los Angeles	56.7%	82.4%	68.5%	32.9%	69.0%	84.0%	43.8%	44.1%	76.3%
Molina – Sacramento	71.6%	82.8%	64.7%	61.3%	77.9%	83.8%	49.4%	62.5%	86.4%
Molina – San Bernardino and Riverside	72.8%	80.0%	60.1%	61.7%	75.4%	87.1%	52.6%	40.3%	74.1%
PHP of CA – Solano, Yolo, and Napa	72.9%	86.7%	67.8%	65.8%	83.2%	85.2%	65.6%	50.4%	89.1%
SBRHA – Santa Barbara	70.2%	87.5%	74.3%	83.3%	90.6%	97.3%	82.5%	57.9%	75.0%
SCFHP – Santa Clara	77.5%	84.9%	69.9%	49.1%	72.3%	74.7%	51.2%	50.0%	89.7%
SFHP – San Francisco	62.4%	93.8%	74.7%	58.9%	71.3%	65.2%	52.6%	62.5%	95.5%
WHA –Sac.	67.3%	85.0%	63.0%	48.2%	82.5%	89.3%	56.0%	59.4%	92.6%
Total	62.8%	84.5%	63.2%	53.6%	74.8%	83.5%	58.7%	48.1%	19.9%

Health Plan	Treatment of Adults with Acute Bronchitis		Medication Used for Asthma		Cervical Cancer Screening		CDC Eye Exams		CDC Hb1Ac		CDC LDL		CDC Neph.		Chlamydia Screening		URI Treatment of Children	
Weighted Average All	62.7%		84.5%		68.0%		51.1%		74.3%		84.4%		56.4%		48.1%		80.1%	
MPL and HPL	NA	NA	60.5%	74.1%	58.9%	76.6%	35.3%	60.9%	70.0%	88.8%	74.0%	91.6%	37.9%	63.0%	38.2%	63.5%	76.9%	89.0%

Table 3. Measure Indicators of Access to Care: 2006 Scores for 2005 Measurement Year

Health Plan	Adolescent Well Care		Postpartum Care	
AAH – Alameda	44.8%		61.9%	
BC of CA – Alameda	35.0%		54.5%	
BC of CA – Contra Costa	26.2%		54.6%	
BC of CA – Fresno	41.2%		60.4%	
BC of CA – Sacramento	30.1%		51.6%	
BC of CA – San Diego	27.1%		50.2%	
BC of CA – San Francisco	47.0%		54.2%	
BC of CA – San Joaquin	37.5%		51.4%	
BC of CA – Santa Clara	32.9%		58.1%	
BC of CA – Stanislaus	29.6%		51.6%	
BC of CA – Tulare	34.5%		64.6%	
CalOptima – Orange	55.1%		65.6%	
CCAH – Monterey and Santa Cruz	41.6%		73.2%	
CCHP – Contra Costa	34.3%		55.1%	
CHG – San Diego	24.6%		44.8%	
Health Net – Fresno	36.4%		64.3%	
Health Net- Kern	21.2%		58.4%	
Health Net – Los Angeles	29.1%		56.7%	
Health Net – Sacramento	30.7%		51.3%	
Health Net – San Diego	27.5%		58.2%	
Health Net – Tulare	28.7%		60.3%	
HPSJ – San Joaquin	34.8%		56.9%	
HPSM – San Mateo	32.2%		54.3%	
IEHP – San Bernardino and Riverside	59.3%		66.0%	
Kaiser (N) – Sacramento	24.5%		60.6%	
Kaiser (S) – San Diego	24.4%		52.6%	
KFHC – Kern	35.5%		61.6%	
LA Care – Los Angeles	37.0%		48.7%	
Molina – Sacramento	46.3%		47.9%	
Molina – San Bernardino and Riverside	40.7%		48.4%	
PHP of CA – Solano, Yolo, and Napa	43.5%		63.5%	
SBRHA – Santa Barbara	31.7%		74.9%	
SCFHP – Santa Clara	35.0%		59.9%	
SFHP – San Francisco	49.1%		64.3%	
WHA – Sacramento	38.2%		50.0%	
Total	32.8%		57.7%	
Weighted Average All	37.9%		57.3%	
MPL and HPL	33.1%	55.3%	50.8%	69.8%

Table 4. Measurement Indicators for Timeliness of Care: 2006 Scores for 2005 Measurement Year

Health Plan	Breast Cancer Screening	Childhood Immunizations (Combo. 2)	Timeliness of Prenatal Care	Well Child Visits in 1st 15 Month of Life	Well Child Visits in Ages 3-6 years
AAH – Alameda	62.3%	75.7%	82.8%	56.2%	76.6%
BC of CA – Alameda	48.5%	74.5%	81.7%	59.1%	68.8%
BC of CA – Contra Costa	44.8%	65.3%	83.3%	51.9%	63.9%
BC of CA – Fresno	48.4%	78.0%	88.0%	57.2%	77.1%
BC of CA – Sacramento	46.3%	71.5%	81.9%	57.6%	67.4%
BC of CA – San Diego	53.7%	77.1%	84.1%	47.5%	60.2%
BC of CA – San Francisco	67.2%	77.6%	86.6%	62.9%	78.9%
BC of CA – San Joaquin	51.4%	70.8%	82.2%	53.6%	74.1%
BC of CA – Santa Clara	69.8%	75.2%	74.3%	53.6%	60.2%
BC of CA – Stanislaus	53.2%	80.3%	87.0%	33.9%	65.1%
BC of CA – Tulare	47.7%	77.6%	86.3%	53.9%	75.9%
CalOptima – Orange	61.4%	85.9%	85.2%	60.4%	78.9%
CCAH – Monterey and Santa Cruz	61.9%	86.6%	88.8%	68.4%	74.9%
CCHP – Contra Costa	55.9%	79.0%	78.1%	54.0%	68.3%
CHG – San Diego	56.3%	78.8%	77.4%	31.9%	65.5%
Health Net – Fresno	55.9%	73.7%	84.7%	51.9%	80.7%
Health Net- Kern	NA	64.6%	76.3%	NA	64.2%
Health Net – Los Angeles	46.3%	69.5%	77.4%	35.9%	68.9%
Health Net – Sacramento	53.8%	71.3%	78.5%	54.2%	76.5%
Health Net – San Diego	42.2%	80.9%	85.0%	41.9%	64.4%
Health Net – Tulare	40.9%	71.8%	84.0%	40.5%	72.7%
HPSJ – San Joaquin	44.9%	71.8%	79.8%	53.8%	73.2%
HPSM – San Mateo	56.0%	78.7%	74.7%	59.2%	66.7%
IEHP – San Bernardino and Riverside	52.1%	77.4%	87.3%	81.8%	81.8%
Kaiser (N) – Sacramento	66.6%	77.5%	78.3%	65.6%	59.4%
Kaiser (S) – San Diego	82.9%	77.7%	80.7%	12.5%	47.4%
KFHC – Kern	49.7%	69.8%	77.4%	51.1%	70.4%
LA Care – Los Angeles	51.9%	77.2%	70.7%	44.2%	73.0%
Molina – Sacramento	44.8%	69.6%	70.2%	44.2%	73.1%

Molina – San Bernardino and Riverside	46.3%		70.6%		77.4%		46.1%		71.8%	
PHP of CA – Solano, Yolo, and Napa	58.7%		78.5%		88.1%		75.1%		70.8%	
SBRHA – Santa Barbara	57.8%		85.0%		83.4%		60.8%		67.1%	
SCFHP – Santa Clara	59.0%		86.8%		82.4%		52.8%		69.4%	
SFHP – San Francisco	68.1%		76.9%		88.6%		73.9%		74.1%	
WHA – Sacramento	59.2%		64.2%		66.7%		49.2%		67.9%	
Total	55.0%		75.8%		81.1%		55.5%		68.4%	
Weighted Average All	55.0%		76.6%		79.5%		55.8%		72.7%	
MPL and HPL	48.0%	67.8%	56.7%	75.7	73.7%	89.5%	40.1%	67.7%	56.0%	77.5%

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