Medi-Cal Managed Care Division

state of california

Medi-Cal Managed Care External Quality Review Organization

Report of the

2006-2007 Medi-Cal Managed Care Quality Strategy Annual Report

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Improving Health in the Communities We Serve

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2006-2007 Medi-Cal Managed Care Quality Strategy Annual Report

Introduction

In compliance with the external quality review regulations set forth by the Centers for Medicare and Medicaid Services for state Medicaid managed care programs (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), Delmarva Foundation for Medical Care, Inc. (Delmarva Foundation) has prepared this annual report to assess the California Department of Health Care Services' (DHCS) Medi-Cal Managed Care program's implementation of its quality assurance goals. Historically, this report has described the Medi-Cal Managed Care Division's (MMCD) performance in meeting the program's quality assurance goals, as described in the Medi-Cal Managed Care Quality Strategy. The discussion of the Division's activities relative to the formal Quality Strategy not only provided a context for assessing program performance, but also identified areas where the Division could best focus future efforts to meet its stated goals.

Although the Division's Quality Strategy, initially released in 2004, was scheduled for bi-annual review and revision, an updated document has not yet been released. (*Note: MMCD expects to release the final draft of an updated Quality Strategy in February 2009 to solicit stakeholder input.)* In order to avoid unnecessary focus on goals that may be outdated, this report will take an alternate approach to the annual review and focus on assessing the program's progress. Specifically, this report will focus on initiatives undertaken during calendar years 2006 and 2007 to support systemic improvements in the provision of care and management of the program. In addition, the report will identify current program challenges and opportunities for the development of updated quality strategies.

To provide a framework for discussion, the report is divided into four sections:

- Monitoring and Measurement
- Performance Improvement
- Reporting and Rewarding Performance
- Improvement through Collaboration.

This report does not present an overview of the program or its operations, but rather highlights Division-initiated activities that contribute to the advancement of the quality of care provided to Medi-Cal beneficiaries by the Medi-Cal Managed Care program. Where applicable, the goals and objectives set forth in the 2004 *Quality Strategy* will be referenced. More information about the program, including the 2004 *Quality Strategy* and reports on managed care health plan performance is available on the Division website at http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx.

Chapter 1: Monitoring and Measurement

In the 2001 report *Crossing the Quality Chasm*, the Institute of Medicine (IOM) called for improvement in six dimensions of health care performance: safety, timeliness, effectiveness, patient-centeredness, efficiency, and equity. In the 2004 Quality Strategy, the Division set forth a vision for the Medi-Cal managed care program that mirrors the IOM aims:

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

To drive the Medi-Cal managed care program toward this vision, the Department built an approach to quality monitoring that incorporates national performance measurement strategies and State-developed oversight activities.

External Benchmarking

Since 1998, the Medi-Cal Managed Care Division has required contracted managed care plans (MCOs) and health insuring organizations (HIOs) to report validated rates for select Healthcare Effectiveness Data Information Set (HEDIS®) and HEDIS-like measures. Identified as the "External Accountability Set," the number and focus of measures differed over time, and in some cases, were specified for designated plan models. For example, only the County Organized Health System (COHS) plans were required to report a rate for the Eye Exams for People with Diabetes measure through 2005. Beginning in 2006, all plans, whether Geographic Managed Care, Two-Plan, or County Organized Health System, were required to report on the renamed Eye Exam (Retinal) Performed measure.

Selection of the required measures has been based upon the Medi-Cal managed care population's needs with particular attention to care of children (e.g., well child care) and women of child-bearing age (e.g., prenatal and post-partum care), chronic disease management (e.g., treatment of asthma, diabetes) and public health concerns (e.g., breast cancer screening). In keeping with this strategy, the Division expanded the EAS in 2006 to include two new HEDIS® measures that assess treatment for child and adult respiratory illness (Appropriate Treatment of Children with Upper Respiratory Infection and Inappropriate Treatment of Adults with Acute Bronchitis). Additionally, all plans were required to report four indicators within the Comprehensive Diabetes Care measure set. (Note: In 2008, MMCD added three more Comprehensive Diabetes Care indicators to the required measures.) Department-developed measures for Blood Lead Testing in Children by 27 Months of Age and Use of Beta Agonist Inhalers (Rescue Medications) for People with Asthma were terminated.* With these modifications, the Division effectively standardized the requirements

for performance measurement reporting across contracted plans, thereby enhancing plan and model-level analyses of performance.

To complement the collection and assessment of HEDIS® rates, the Division conducted the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS®) in 2007. With the approval of the National Committee on Quality Assurance (NCQA), the Division added questions to gather information about member-reported use of emergency room services, levels of physical and mental impairment relative to daily functioning, frequency of engagement in physical activity, and experiences with provider counseling regarding diet and exercise. As borne out in the results, care of the Medi-Cal managed care population requires a significant commitment of resources, despite gains in the provision of preventive services.

In addition to the expansion of performance measurement requirements for the MCOs and HIOs, the Division initiated new requirements for specialty and prepaid health plans under contract to Medi-Cal managed care. Beginning in 2007, the AIDS Healthcare Centers and Kaiser Permanente Prepaid Health Plan in Marin and Sonoma counties were each required to report HEDIS® rates for two Department-selected measures. The Division has also required these plans to conduct two quality improvement projects and to report the findings of a plan-initiated consumer satisfaction survey for Medi-Cal managed care beneficiaries. Findings of the initial analyses of performance will be published in plan-specific reports in 2008. It is also worth noting that, while the Division had not yet finalized the reporting specifications for Family Mosaic and SCAN Health Plan as of 2007, these two specialty plans will be subject to the same requirements for reporting of HEDIS® rates, as well as the conduct of QI projects and a consumer survey by 2008 and 2009.

Recommendation: To measure the quality of services provided by contracted plans, the Division has employed nationally recognized measurement tools developed by leading health care accreditation and health research organizations. Undoubtedly, the use of HEDIS® and CAHPS® has enabled the Division to assess performance within the context of national benchmarks that provide both the gauge and goals against which to measure health plan operations.

If, however, the Division desires to facilitate systemic change to meet the aims set forth by the IOM, alternate strategies for monitoring and measurement may be required. For example, in the Quality Chasm report, ten rules are proposed as a framework for system improvement. Under the current system, care is based primarily on face-to-face visits; under the proposed system, care is based upon continuous healing relationships in which patients receive care "whenever they need it and in many forms (e.g., telephonic; internet), not just face-to-face." Unfortunately, neither HEDIS® nor CAHPS® is designed to measure the ability or effectiveness of a health plan in supporting continuous healing relationships between practitioners and patients.

The IOM proposes that an effective system of care should prioritize the "active collaboration" of the institution and its clinicians, rather than giving preference to professionals. Once again, neither HEDIS® nor CAHPS® provides a measurement of the extent to which a health plan collaborates with its providers to ensure an appropriate level of information exchange.

The value of measurement is not only in assessing levels of performance, but more importantly, in identifying opportunities for improvement. If the improvements desired require system redesign, as proposed by the IOM, the tools for measurement must reflect the goals of the new system.

Internal Benchmarking and Monitoring

With a variety of resources from which data is drawn and reported, the Division implemented a number of mechanisms to improve the tracking and trending of data. Among these initiatives were the:

- Expansion of the Division's quarterly Dashboard Report to include trending for HEDIS® rates and measures of performance relative to encounter data submission and quality;
- Creation of the Facility Site Review (FSR) database to document site review results; and
- Implementation of a system to track and trend issues brought to the Medi-Cal Managed Care Office of the Ombudsman.

With each initiative, the Division not only realized improved efficiencies in reporting significant trends and/or changes to management, but these efforts fostered improvements in documentation and management of the monitoring quality within the Medi-Cal managed care program.

In a similar vein, the Division developed boilerplate contract language in 2006 which was first presented to the County Organized Health Systems (COHS) plans. With the goal of creating consistent contractual requirements, the Division successfully reduced the duplication of efforts previously spent on development and negotiation of contract language. This uniformity of requirements has also led to greater efficiencies in development of all-plan letters and audit tools which set forth and monitor the plans' performance relative to the stated set of expectations.

Recommendation: Pursuant to the goals set forth in the 2004 Quality Strategy, the Division has "increased accountability for the quality of care" by adding to the requirements for quality measurement reporting. With the expansion of the EAS and CAHPS® survey, the Division is not only able to assess plan performance across a broader spectrum of services, but is positioned to analyze performance at the systemic level to assess which service delivery systems better meet the needs of particular cohorts within the served population.

The challenge, however, is to utilize the wealth of information in a manner that facilitates objective analyses in support of plan and systemic quality improvement, strategic planning, and the promotion of efficacious practices. While collection of HEDIS® and CAHPS® rates allow for a comparative assessment of health plans, health plan models, and system performance, each are only a set of proxy measures that provide much greater information when integrated with data from alternate sources including analyses of quality improvement initiatives, grievance documentation, enrollment statistics, and financial profiles. To that end, Delmarva recommends that the Division develop a strategic plan for data integration and assessment to better utilize existing data in management of the Medi-Cal managed care program. Just as the information technology industry has transitioned from a focus on "real time" data to "right time" data, the Division would benefit by identifying a strategy to collect and use the *right* data at the *right* time to obtain the *right* results. Given all the information available to and within the Division, which measures/monitoring activities help to identify successful practices and in turn, 'spread' systemic improvements? What information is needed to signal sentinel events in health plan operations and prevent declining performance? How can the information be used to tactically prepare for the addition of seniors and persons with disabilities within managed care? For example, the Division could achieve greater benefit from its quarterly *Dashboard Reports* if management agreed to specific corrective actions that would be triggered if a certain number of key indicators in the report for any plan fell below agreed-upon minimum performance levels.

With increased demand on administrative resources, the addition of new requirements and evaluation activities may place an unnecessary strain on an already burdened system. Identification of key indicators to measure and assess performance, using existing data, will provide for both an economy of scale and balance in monitoring performance and supporting operations.

Chapter 2: Performance Improvement

Central to the Division's Quality Strategy is the goal to improve the quality of care for Medi-Cal managed care enrollees. According to the 2004 *Quality Strategy*, the Division will meet this goal, in part, by:

- Improving the monitoring of plan QI projects (QIPs);
- Developing and implementing mechanisms to increase collaboration for quality; and
- Working with plans to initiate quality improvement projects which specifically seek to implement the care model at the practice level.

Monitoring Quality Improvement Activities

Since 2005, MMCD has employed a series of strategies to improve the monitoring of QI projects. In 2006, the Division determined that a reduction in the number of required projects (from four to two) would not only enable the plans to focus their QI efforts and resources, but would permit Delmarva to conduct more intensive evaluations by reducing the excessive number of proposals and status reports submitted for validation. Accordingly, the Division directed Delmarva Foundation to increase the rigor of review to 'stretch' plans' thinking around the selection and design of QI projects, development and application of interventions, analysis of data, and promotion of change. As a result of this direction, Delmarva applied more stringent standards for QIP approval that require identification of specific goals and completion of statistical analyses. Although the reduction in QIPs could not be realized until 2007 when the change was incorporated into contract language, there is evidence to suggest that this modification has in fact led to more thorough analysis and documentation. In particular, Delmarva has noted increased assessment of health services disparities as measured by differences in utilization among different cohorts (e.g., analysis by ethnicity, gender, language, age).

To further support advancements in the quality improvement process itself, the Division modified the requirements set forth in the annual "Quality and Performance Improvement Program" all-plan letter so as to define the parameters for acceptable performance of QIPs. Specifically, the November 2006 letter which identified requirements for calendar year 2007, described the requirements for demonstration of "significant and sustained improvement." In doing so, the Division provided both clarity and consistency for conduct and evaluation of performance.

Increasing Collaboration and Practice-Level Change

Beginning in 2003, the Division required that all health plans participate in a statewide collaborative quality improvement project. Throughout 2006 and early 2007, the Division continued the statewide collaborative on Adolescent Health which focused on improving the quality of service provided to adolescents during well

visits, as measured by surveys, and the HEDIS rate for the Adolescent Well-Care Visits measure. According to the interim status report published in August 2006, several key interventions were identified that contributed to the achievement of the first objective. The analysis indicated that the provision of *practical tools* for providers was beneficial to improvement in the comprehensiveness of the well visit. This finding mirrors the literature that identifies skills-based training as a "best practice strategy" to support practice improvements. Through the application of evidence-based interventions aimed at practice-level change in this statewide collaborative QIP, the Division successfully contributed to improvements in the quality of care. Statistically significant improvements in the screening rates for behavioral health risk indicators are documented in the June 2008 *Adolescent Collaborative Remeasurement Report*.

Unfortunately, the gains achieved in the quality of service were not evidenced in the rate of well-care visits. According to the 2007 HEDIS results, the average rate for Medi-Cal Managed Care was only 37.0 percent, a slight increase from the 2006 rate of 36.3 percent. The system-wide average was also below the HEDIS 2006 national Medicaid average (40.6 percent), the HEDIS 2006 national Commercial average (38.7 percent) and the California Healthy Families 2004 average (37.0 percent). Despite continuation of the collaborative which began in 2003, the Division saw little systemic improvement in the rate of adolescent well visits during the four-year study period.

With the conclusion of this first collaborative in July 2007, the Division launched a new statewide project aimed at reduction in the use of emergency rooms (ER) for non-emergent care. Once again, the Division selected two measures:

- The HEDIS rate of members seen in the ER; and
- The rate of members seen in the ER with MMCD-designated avoidable visits.

Unlike the first statewide collaborative in which plans implemented only individual interventions, the ER collaborative requires that all participating managed care plans apply a common statewide intervention, in addition to those designed to meet plan-specific barriers. This strategy, derived from the Institute for Healthcare Improvement (IHI) model for collaborative QI efforts, is intended to effect systemic change through the application of systemic interventions. While the impact of the uniform intervention(s) will not be measured for several years, this approach is expected to produce greater systemic changes than realized in the Adolescent Health collaborative.

Recommendation: In an early discussion on health systems improvement, IHI President and CEO Don Berwick stated that the "central law of improvement (is that) every system is perfectly designed to achieve the results it achieves." Rather than viewing performance as a matter of effort, Berwick proposed that performance is a matter of design in which health care results or outcomes are properties of the system of care. "Mere effort can achieve some improvements. But such improvement is not fundamental; it does not often represent a new level of capability." He concluded that significant improvement will only occur with the creation of new systems, rather than within existing systems.

Berwick continued his discussion on systems improvement by noting that *effective* leaders insist that the current system cannot remain, offering clear alternatives and aims. Unfortunately, many health care leaders permit the "change" to be no more than the familiar – educating people and providing different incentives. Both, he says, rely on the existing system, rather than creating a new one. "Teaching people facts so as to change their behavior is a long, slow road. We have known for years that to reduce the use of an overused laboratory test, removing its name from a preprinted laboratory form (requiring a doctor who wants it to write it in) works far better than any number of educational sessions about the proper use of the test."

Since Berwick published his paper on systems improvement in 1996, much more has been written about facilitation of performance improvement. In many respects, the Division has promulgated much of the current thinking on quality improvement by cultivating the principles of collaborative learning, rapid-cycle measurement and analysis, practice-level change, and the application of evidence-based interventions. Where the Division might lend greater support is in continuing to nurture systemic change, rather than incremental change within existing systems. Specifically, Delmarva recommends that MMCD explore the feasibility of coordinating and/or sponsoring leadership training for health plan management, such as plan QI managers or medical directors, to foster increased dialogue and support for transformative change. By equipping health plan management with knowledge, tools, and resources to develop new systems, MMCD will bolster health care improvement efforts aimed at innovative design.

Chapter 3: Reporting and Rewarding Performance

Numerous studies point to the value of public reporting in stimulating and reinforcing quality improvement activities, facilitating informed decision-making among consumers in the selection of health plans, and promoting value-based purchasing. As stated by Julie Lewis, Quality Affairs Consultant with the American College of Surgeons, "The concept of public reporting is now embedded in the current health care culture of accountability and transparency."

Public Reporting

Since the Medi-Cal Managed Care Division first required contracted health plans to report HEDIS rates for selected performance measures and participate in the CAHPS survey in 1999, results of the selected performance measures have been made available to the public. Initially, copies of the statewide HEDIS and CAHPS reports, as prepared by the External Quality Review Organization, were mailed to individuals and organizations identified as "interested parties," including health plan management, representatives of patient advocacy groups, State policy makers, and legislative staff. With the expansion of the Division's website in early 2006, MMCD began posting all reports prepared by the first two EQROs (Health Services Advisory Group and Delmarva Foundation for Medical Care), including analyses of the health plan quality improvement projects and the statewide Annual Report. The website also provides access to financial reports, managed care statistical reports, and copies of the Division's reports to the legislature. Efforts are also underway with the Office of the Patient Advocate to develop a more effective way of presenting and comparing plan-specific performance measurement and member satisfaction survey results. (*Note:* The first phase of these enhancements was implemented in November 2008 and will be discussed in the next Annual Report.)

*Recommendatio*n: As noted by the Commonwealth Fund in the February 2007 report on Public Reporting and Transparency, "an emerging body of research indicates that the way information is presented affects how it is interpreted and weighed in decisions." Reports that are either too technical to be considered "user-friendly" or that provide benchmarks of questionable comparability (e.g., not relevant across diverse populations) may not lend support to performance improvement or consumer education.

The Division's efforts to publicly report health plan performance demonstrate a commitment to accountability and transparency. However, Delmarva recommends that the Division evaluate publicly released materials to assess how well they communicate with specific stakeholders, such as health plan members, policy makers, health plan management, and providers. For example, the annual HEDIS summary reports are quite technical and could benefit from a more user-friendly presentation of results with more technical information presented in appendices. While detailed information is necessary to facilitate increased understanding, it may not drive desired changes if the presentation of the information fails to resonate with the targeted readers.

Reporting to Rewarding

In addition to distributing quality improvement and performance measurement reports written for the broad healthcare audience, the Division began publishing a Consumer Guide specifically intended for newly eligible Medi-Cal recipients enrolling in managed care plans in both Geographic Managed Care and Two-Plan model counties. As noted in the 2005 Annual Report, the Guide utilizes select HEDIS and CAHPS results to display plan performance for competing Medi-Cal health plans relative to statewide Medi-Cal health plan averages. Since the fall of 2005, county-specific Guides have been distributed as part of the enrollment packet and have also been available on the Department's website. This initiative not only marked the Division's introduction of consumer-targeted quality reporting, but anchored the use of performance measures to reward "better" performing plans by strategically guiding enrollment toward those with stronger documented results. In 2007, the Office of Patient Advocate added a link on their website to connect site visitors with county-specific versions of the Medi-Cal Managed Care Consumer Guide.

In 2006 and 2007, the Division continued presenting annual Quality Awards to publicly acknowledge plans with outstanding results in the required HEDIS performance measures and CAHPS survey. Beginning in 2007, a "Most Improved" category was added to the Quality Awards. The next Annual Report will discuss additional award categories added in 2008.

As another way of rewarding high performing plans, the Division launched the Auto Assignment Incentive Program in late 2005. As discussed in the 2005 Annual Report, newly eligible Medi-Cal beneficiaries residing in either a Geographic Managed Care or Two-Plan model county who do not select a health plan within the required timeframe are "defaulted" into a plan. Using a default algorithm based upon selected HEDIS measures, as well as measures related to the utilization of safety net providers, the Division strategically steers enrollment towards health plans with superior performance measure scores. In 2006, the algorithm was further refined to factor in "change over time" – adding points if a plan's HEDIS scores improved over the prior year and subtracting points if a plan's performance declined. This approach has enabled the MMCD to promote quality improvement by capitalizing on the plan competition for market share.

During 2006 and 2007, no further changes were made in the Division's approach to reporting or rewarding performance. Rather, these years were regarded as an incubation period for market testing of the Auto Assignment Incentive Program and the Consumer Guide. (An additional HEDIS measure was added to the default algorithm for 2008, which will be discussed in the 2008 Annual Report.) Although the California HealthCare Foundation published a preliminary report on the Auto Assignment Incentive Program in April 2006, too little time had passed to conduct a full-scale longitudinal analysis of the impact of this non-financial reward strategy.

Recommendation: Delmarva understands that the Division intends to conduct comprehensive evaluations of the Consumer Guide and Auto Assignment Incentive Strategy during 2008. As part of the analyses, Delmarva recommends that the Division not only examine the impact of the Consumer Guide and incentive program in the initial selection or enrollment of the beneficiaries, but also the *net* impact of these strategies in retaining a stable health plan membership. For those individuals enrolled in a plan by default, what percent remain with that plan during the course of their eligibility with Medi-Cal managed care? Have beneficiaries enrolled in the "better" plans, i.e., plans with superior performance measure results, remained with those managed care organizations or is the rate at which they change similar to those initially enrolled in plans with poorer performance? Strategies which guide beneficiaries toward select organizations should seek to reduce health plan "churning" and foster stable consumer/provider relationships to achieve long-term success.

Delmarva also recommends that the Division prepare a cost/benefit analysis of the Consumer Guide to fully evaluate the efficacy of this tool. Current research indicates that consumers are less influenced by health plan report cards than by word-of-mouth recommendations from family and friends. Moreover, the availability of specific providers may be a greater factor in the decision-making process than the overall performance of a health plan. Given the multiplicity of health plan report cards published by California organizations, including the Office of the Patient Advocate, MMCD might investigate the potential for a collaborative effort with other agencies that consolidates information about health plan performance into one (or a few) user-friendly documents. Alternatively, the Division may want to consider production of a consumer decision-aid tool to guide beneficiaries through a series of value-based questions to help identify individuals' key concerns in selection of a health plan.

Delmarva fully supports the Division's intent to promote health quality care by rewarding top performing plans. Understanding how consumers define performance, as measured by initial and sustained enrollment, will better enable MMCD to ensure that the care and services delivered meet the Medi-Cal managed care population's needs.

Chapter 4: Improvement through Collaboration

"Collaboration is the new frontier of human creativity."

> Michael O. Leavitt, Secretary of Health and Human Services,
> U.S. Department of Health and Human Services
> June 5, 2005, HIMSS Summit: Achieving National Healthcare Transformation

The premise that systemic improvements are best achieved through collaborative efforts is a core principle in the Division's strategy for improving the quality, access, and timeliness of services provided to Medi-Cal managed care beneficiaries. This principle is reflected in the 2004 *Quality Strategy*:

- MMCD will develop and implement mechanisms to increase collaboration for quality;
- MMCD will work to develop a partnership with stakeholders to improve the quality of care.

The Medi-Cal managed care program has had a long history of engaging in dialogue with contracted health plans, representatives from the advocacy community and community health councils, and staff from the Centers for Medicare and Medicaid Services to assist in the development of policies and practices that improve the care and services delivered by the health plans and Medi-Cal administration. Examples of such efforts, including coordination of the Medi-Cal Managed Care Advisory Group, Medical Directors' Meetings, Pharmacy Directors' Meetings, and the Quality Improvement Workgroup have been cited in previous annual reports. After the Auto Assignment Program was implemented in 2005, the Division has convened an Auto Assignment Workgroup on an annual basis to provide plan input to proposed changes to the quality measures used in the program and to the calculation methodology.

Collaboration with External Partners

To expand upon the successful collaboration experienced to date, the Division identified a series of opportunities for both new and improved partnerships. Beginning in 2006, the Division modified the structure of the Medical Directors' meetings to shift from a presentation-based format to agendas that support discussion of policy and operational concerns. In modifying the organization of these meetings from didactic or "reporting out" to interactive, i.e., sharing among, MMCD leveraged this venue to enable an increased exchange of information and consensus building. Similar tactics were applied in coordination and facilitation of meetings held with the Pharmacy Directors, the Health Education Workgroup, and the Quality Improvement Workgroup. Informal feedback from meeting participants indicates support for these changes.

Recommendation: With increased demands on time and resources, it is essential that individuals perceive their participation in committees or workgroups and/or attendance at on-going meetings as a valuable use of time for themselves and the organization which they represent. While the Division has received some feedback suggesting that these modified forums are beneficial, Delmarva recommends that the Division implement a routine, periodic process for soliciting feedback about the perceived effectiveness and efficiency of Departmental meetings. By doing so, the Division will be better able to gauge the support for these venues and in turn, maximize opportunities for improved communication and partnering.

In late 2005, the California HealthCare Foundation (CHCF), in collaboration with key stakeholders including the Western University of the Health Sciences, the Center for Health Care Strategies, and the Lewin Group, sponsored a project to develop recommendations for the Department concerning Medi-Cal managed care performance standards specific to persons with disabilities and chronic conditions. The Division provided support in this process, providing information about current policies, procedures, and practices in administration of the program. In May 2007, the Division published its response to the 53 recommendations set forth in the CHCF report. By assisting CHCF in their analysis of the current state of care for persons with chronic health needs, the Division played a critical role in the development of a comprehensive gap analysis that led to the identification of proposed system changes.

MMCD engaged in a new partnership in 2006 to support increased voluntary enrollment of seniors and persons with disabilities (SPDs) into managed care. In collaboration with the School of Public Health at the University of California at Berkeley, the Division launched the Medi-Cal Access Project to provide the SPD population with information about their enrollment options and the benefits of managed care versus the fee-for-service model of health care delivery. While the project seeks to educate the SPD population about health care options, improved access and coordination of care have also been identified as project goals. To date, the project has produced a Guidebook which will be piloted in three counties, with a full project evaluation to be conducted in 2010.

Recommendation: Historically, the Division has sought partnerships with entities that either engage in the delivery of health care or oversee/monitor the services provided to beneficiaries of publicly-funded programs. In working with the University of California to develop, implement, and evaluate strategies for improved access and care, the Division has secured valuable resources for the conduct of health services research. Delmarva recommends that the Division explore future projects with the UC system as a means to obtain the human capital needed to perform the quantitative and qualitative analyses to support strategic planning and system improvements. With the execution of the master contract between the Department of Health Care Services and the University of California and the creation of the California Medi-Cal Research Institute (CaMRI), administrative processes are now in place to support the collaborative enterprise.

Internal Partnerships

In contrast to the long-term partnerships MMCD has maintained with external stakeholders, intra-departmental collaborations have been intermittent and project-based. Historically, there have been fewer opportunities for on-going inter-divisional coordination and/or communication. This has been due, in part, to the enormity of the Department's scope of responsibility and complexity of the organization's structure that administers the Medi-Cal program (i.e. fee-for-service and managed care) alongside a host of public health programs that serve residents across California.

To overcome the "silo effect," MMCD launched several new quarterly meetings to facilitate discussion of plan performance, identify plan-specific and systemic issues, and develop coordinated action plans. Working with the Department's Audits and Investigations Division (A&I), personnel from MMCD's Medical Monitoring Unit, Medical Policy Section, and Member Rights/Program Integrity Unit hold routine meetings to review concerns regarding plan and/or provider non-compliance. Beginning in 2006, these meetings have helped to educate audit staff regarding the subtleties of contract requirements and medical practice which supports appropriate contract compliance audits. In addition, discussions with audit staff have enabled the Division to identify the need for new or revised contract language to help prevent inappropriate audit findings.

In 2007, MMCD initiated quarterly internal plan update meetings attended by representatives from every program area – finance, rate development, plan management, medical monitoring, Office of the Ombudsman, and performance measurement - during which information about selected health plans is shared and discussed. Both sets of meetings not only serve as opportunities for exchange of information, but also are used to encourage coordination of efforts and development of program knowledge across administrative units. These internal briefing sessions have fostered more efficient and efficient sharing of information across operational lines, which in turn enhances the Division's partnerships with all stakeholders.

Data-Driven Collaboration

The Division's increased use of data, and resulting desire to improve the quality of that data, has served as a catalyst for additional inter-departmental collaborations. Initiated in 2005, MMCD established the Internal Encounter Data Workgroup (IEDWG) for the purpose of remediating data submission issues identified by the Division. The workgroup was tasked with improving the quality, timeliness, and completeness of claims and encounter data submitted by the managed care plans. Attended by personnel in MMCD's Performance Measurement and Plan Management areas, the Information Technology Services Division (ITSD), and EDS, the Department's fiscal intermediary vendor, the workgroup focused initial efforts on updating the data dictionary for encounter data submission. During 2006 and 2007, the scope of the workgroup expanded to provide a forum for discussion of plan performance relative to data submission, the impact of the National Provider Identification implementation on managed care data, data efforts associated with managed care expansion, and changes in data processing, storage, and/or reporting activities. Now called the Encounter Data Coordination Group, this workgroup has not only provided a forum to explore and address data issues of concern to the Department, but also encouraged more consistent communication of policies and practices to health plans across division lines.

A second effort undertaken by MMCD, in collaboration with the Divisions of Information Technology Services, Fiscal Intermediary and Contracts Oversight, and Pharmacy Benefits, centered on improvement of pharmacy data submitted by the county organized health plans (COHS). Specifically, the COHS Pharmacy Data and Rebate Improvement project was tasked with identification and remediation of COHS' reporting errors that resulted in the Department's inability to invoice for rebates. During 2006 and 2007, project personnel developed and implemented claim-level edits, claim-level feedback reports, and claims reporting performance standards which were incorporated into the COHS contract. Recent statistics for calendar year 2006 through third quarter 2007 indicate a 75 percent decrease in labeler (i.e., drug manufacturer) disputes related to the quality of the claims data. These improvements are not only expected to be reflected in increased rebate revenue, but also in the quality of reports prepared from the data warehouse for utilization management, quality improvement, rate development and forecasting. Progress to date on this project underscores that collaboration between all stakeholders (internal and external) will continue to be critical to the success of the next phase of this initiative, implementation of physician-administered drug (PAD) claims reporting with national drug codes (NDCs).

As noted in the 2004 Quality Strategy, MMCD strives to "increase staff expertise on monitoring, measurement, and improvement of quality of health care." Through the establishment and conduct of routine, cross-divisional and intra-departmental activities, MMCD is now better positioned to improve programmatic performance and in turn, improve the quality of care for Medi-Cal managed care enrollees.

Recommendation: Whether partnering with external stakeholders or collaborating with internal parties, effective time management and communication is essential if these partnerships are to achieve meaningful results. Through routine, periodic participant evaluation of meetings, workgroups and/or joint efforts, the Division can obtain insight as to the perceived value of the activities undertaken and/or issues addressed in such forums. Accordingly, Delmarva recommends that MMCD implement a formal process staff can use to periodically assess how useful these venues are in achieving their respective organizational goals and objectives. Delmarva also recommends that MMCD identify and document specific goals, objectives, responsibilities, and activities for each workgroup, committee and on-going forum in order to provide a set of anticipated results against which to measure the effectiveness and value of the time spent.

Chapter 5: Additional Recommendations

As noted in the introduction, this report is not intended to identify all activities undertaken by the Medi-Cal Managed Care Division during calendar years 2006 and 2007. Many of the efforts noted within this report are discussed in much greater detail in other publicly-released reports or internal documents. Delmarva believes that one key value of the Annual Report is that it provides a vehicle for examination and discussion of Division-initiated actions within the context of the Quality Strategy, as well as the programmatic environment in which Medi-Cal managed care operates.

Over the course of the past five years, Delmarva Foundation has had the opportunity to work alongside the Division to monitor and evaluate the contracted health plans, as well as the managed care program as a whole. Undoubtedly, the Division has made great strides in moving from a program that simply reports performance, to one that incents and rewards quality of care. Significant efforts have been made to address areas of service requiring improvement – from adolescent well-care and avoidable emergency room usage at the systemic level to the performance of specific health plans with HEDIS rates that fall below the minimum performance level. With increased rigor of review for individual quality improvement projects, coupled with facilitation of State-wide collaboratives, the Division has fostered continuous improvement and systemic support over baseline quality assurance and individual plan gain.

Many of the efforts discussed in this report point to increased efficiencies within the Division, including improved communication with internal and external stakeholders and development of databases to track and trend statistics. In each example provided, the Division responded to an identified need in a manner that speaks to the commitment to improve the quality of care and services provided to the program's beneficiaries.

Going forward, the Division faces many challenges. News reports concerning Medicaid continue to point to deepening financial difficulties fueled by rising health care costs and increasing numbers of beneficiaries, many of whom present with multiple co-morbidities. As with Medicaid programs across the nation, the Medi-Cal managed care program will have to continue its focus on how best to use limited resources to assure that Medi-Cal plan members continue to receive quality care in accordance with both federal and state requirements.

To advance the Medi-Cal managed care agenda, Delmarva recommends that the Division consider the following recommendations within its goal-setting processes for 2009:

- *Develop the Quality Strategy as a guiding document for the Division*

The Division is in the process of updating the Quality Strategy to reflect new goals and initiatives to be undertaken in the advancement of the program. Delmarva recommends that in development of the new strategy, the document reflect an approach to quality improvement that is incorporated into every aspect of the Division's operation. That is, improvement in services and care delivered by contracted health plans and the Medi-Cal managed care program should be the responsibility of the entire organization, not just those areas of the Division overtly focused on quality improvement. All branches of the Division contribute to the success of the program and should be engaged in the development of the strategy to ensure that all available resources are utilized for the improvement of the program. The Quality Strategy should be a guiding document for the entire Division, not just those organizational sections or units associated with the work performed by the EQRO.

- *Continue to break down State silo walls*

Arguably, California has one of the most complex programs for Medicaid managed care. With three primary model types and more than 22 separate plan contracts (excluding specialty plans), the number of enrollees alone surpasses the population of some States. With that in mind, however, Delmarva recommends that the Division seek greater communication and collaboration with other State Medicaid programs, just as it has with other DHCS Divisions. While the policies and practices of other programs may not have direct application, the learnings of other States can be of use to the Division in development and/or enhancement of pay for performance programs, quality improvement projects, internal monitoring activities, employee training, and data analysis. Management at *all* levels of the Division should be encouraged to identify peers in other States and participate in multi-State teleconferences for the purpose of exchanging ideas, information, and support. Not only are such efforts expected to result in an increased awareness of approaches undertaken elsewhere, but they may foster improvements in employee satisfaction as personnel experience more opportunities for peer support and knowledge-based development.

- *Adopt the philosophy of continuous quality improvement as a business strategy for internal development*

In many organizations, activities are initiated in reaction to a perceived or identified need. The activity may be mandated by another party or seen by internal stakeholders as a solution to a problem for which the organization either has a responsibility or some stake in the outcome. Proactive efforts are often difficult to launch, particularly in an environment with increasing demands and depleting resources. Whether undertaken as a preventive measure or in response to a recognized problem, all activities should undergo periodic review

to assess their utility in meeting the Division's objectives and goals. Does the activity produce actionable results? Are all engaged parties benefitting from the interaction? Are there alternative methods to reach the same goal(s)? Are environmental and/or policy changes used to inform the practices? Has the practice/activity/procedure outlived its purpose? Just as the health plans are required to demonstrate continuous quality improvement, so too should the Division aim for advancements in the operation of the program through improved procedures and practices.

- *Leverage existing resources to advance the understanding and future direction of Medi-Cal managed care*

The Medi-Cal managed care program has a wealth of information that can be accessed to evaluate the quality of care provided to beneficiaries. In all operational areas of the Division, information is collected, analyzed, summarized, reported, and stored. Some of this information is publicly released, such as performance measurement results. Other data is confidential, such as plan financial reports, and used only for internal analysis. Certain data qualities – such as incomplete data, reporting inconsistencies from plan to plan, and time lags to final reporting – do limit the usefulness of some of this information. Even still, the amount and type of information available to the Division over the past decade has produced incomparable resources for studying and evaluating the state of publicly-funded health care in California.

Delmarva strongly encourages the Division to identify means to use available data to prepare analyses which shed light on the successes and challenges of the Medi-Cal managed care program. As a starting point, the Division might begin by collating a series of questions based upon published findings. Why have certain performance measure rates flattened over time when others have continued to improve and exceed national averages? What are the unique characteristics of the model types and/or plans that have demonstrated improvements in delivery of services? What is the relationship between consumer satisfaction scores and HEDIS rates, as measures of quality? How do the results of the Facility Site Reviews compare to performance measure results? How do the three-year audits performed by Audits and Investigations compare to results of quality performance measures?

In the face of limited resources, the Division will have to find the right balance between analysis of existing data and collection of new data to support operations and policy development. While there is no clear answer as to where that balance lies, it is incumbent upon the Division to use the data which is reported, at a cost to the health plans and the State, to meet its responsibility to the health care consumers of the State.

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