Medi-Cal Managed Care Program

QUALITY STRATEGY

December 2009

Department of Health Care Services
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Quality Strategy

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EXECUTIVE SUMMARY

The Medi-Cal managed care program currently provides health care services to approximately 3.8 million low-income Californians, including children, pregnant women, seniors, and persons with disabilities. As of December 2009, 20 managed health plans, contracted by the state, provide health care services to Med-Cal enrollees in 25 of the most populous counties in California. Work is underway to expand the program into five additional counties during calendar year 2010.

Each state that enters into one or more contracts with managed care organizations, prepaid ambulatory health plans, or pre-paid inpatient health plans must develop a written Quality Strategy per Code of Federal Regulations 438.202. The 2009 Medi-Cal Managed Care *Quality Strategy* is an updated revision of the initial Quality Strategy developed in 2004. The 2009 *Quality Strategy* describes the program history and structure, defines contractual standards, and outlines oversight and monitoring activities of the Medi-Cal managed care program. The *Quality Strategy* also addresses operational processes and procedures implemented by the Medi-Cal Managed Care Division of the California Department of Health Care Services to do the following:

- Assess the quality of care delivered through managed care health plan contracts,
- Make improvements, based on its assessment, in the quality of care delivered through the managed care health plan contracts,
- Obtain the input of recipients and other stakeholders,
- Ensure that contracted health plans comply with standards established by the State, and
- Conduct periodic effectiveness evaluation reviews and update the strategy, as needed.

Quality improvement processes and activities carried out within the Medi-Cal Managed Care Division strongly support the California Health and Human Services Agency's goal of ensuring that every Californian will have access to high quality health services. The MMCD *Quality Strategy* reflects the unique operational contributions that Medi-Cal managed care can make in furthering the Agency's goals. Because California is currently facing significant fiscal challenges, having an appropriate quality strategy in place becomes even more crucial to monitoring, assessing and improving the quality of healthcare services. The 2009 MMCD *Quality Strategy* will serve as a guide to the Division and the Department to monitor and assess the activities, interventions, and processes in place for providing quality health care and services to the Medi-Cal beneficiaries enrolled in the contracted managed care plans throughout California.

I. INTRODUCTION

Legislative and Program History

Managed care has been a part of the California Department of Health Care Services (DHCS) Medi-Cal program in a variety of forms since 1972. The DHCS initially contracted Medi-Cal managed care services through Prepaid Health Plans (PHPs) and Primary Care Case Management (PCCM) plans. These plans were largely individual clinic sites or small physician group practices that contracted with the state to provide primary care services to relatively small numbers of Medi-Cal members, with specialty care still being provided through the fee-for-service program. However, the majority of Medi-Cal beneficiaries were still receiving healthcare through the Medi-Cal fee-for-services program.

Medicaid Reform legislation (Title XIX, Social Security Act, Section 1115), passed in 1982, allowed the Medi-Cal program to contract with County Organized Health System (COHS) plans which are organized and operated by the county. Medi-Cal beneficiaries in COHS counties have a wide choice of managed care providers and do not have the option of getting services through the traditional Medi-Cal fee-for-service system unless authorized by the plan. The Santa Barbara Regional Health Authority (1983, now CenCal Health) and Health Plan of San Mateo (1987) became the first COHS plans in California. CalOptima in Orange County, Partnership Health Plan in Napa, Solano and Yolo Counties, and Central California Alliance for Health (formerly Central Coast Alliance for Health) in Santa Cruz and Monterey were added during the Medi-Cal managed care expansion in 1994-1995. Currently five COHS plans are operating in 11 counties (see Appendix A).

In 1991, legislation (Assembly Bill 337) amended various sections of the Welfare and Institutions Code to establish the California Managed Care Initiative which expanded managed care in the Medi-Cal program by requiring mandatory enrollment into managed care for designated aid codes. The Initiative resulted in the development of several competitive plan models for delivery of health care services to Medi-Cal managed care beneficiaries in targeted counties throughout California. For example, in 1994, the Geographic Managed Care (GMC) Pilot Project made enrollment mandatory primarily for low-income children and families in Sacramento County. This plan model allows beneficiaries the option of choosing from among multiple commercial plan alternatives. Expansion of the Medi-Cal managed care program was designed to improve timely access to preventive and primary health care services in a cost-effective manner for Medi-Cal beneficiaries enrolled in managed care health plans.

The principal model implemented during the Medi-Cal managed care expansion under the California Managed Care Initiative was the Two-Plan model. Medi-Cal beneficiaries in these counties had the option to select from two managed care plans, either a locally-operated “Local Initiative” plan or a traditional “mainstream” non-governmental commercial health plan. As in the COHS and GMC plan models, health plans provided services to beneficiaries in designated aid codes at a capitated reimbursement rate. In both the GMC and Two-Plan model counties, seniors and persons with disabilities who are eligible for Medi-Cal benefits under the Supplemental Security Income program have the option to voluntarily enroll in the Medi-Cal managed care program or to choose the Medi-Cal fee-for-service system. Currently, GMC models operate in Sacramento and San Diego Counties, and Two-Plan models operate in 12 counties.

Quality Strategy Development Process

Health plans contracted with the state to provide services to Medi-Cal beneficiaries must establish a comprehensive, structured quality improvement (QI) program, document monitoring activities, and maintain systems for performance measurement. The Medi-Cal Managed Care Division (MMCD) of DHCS is responsible for developing and implementing a comprehensive *Quality Strategy* to address the methods established for oversight, monitoring, quality assessment and performance improvement of the Medi-Cal managed care program, as required by Code of Federal Regulations (CFR), Title 42, Section 438.204(c). Steps for periodically revising *Quality Strategy* in the future include:

- MMCD staff will collaborate to draft a revised *Quality Strategy*.
- The revised draft will be reviewed internally by MMCD management, including Branch, Section and Unit Managers, the Division Chief and additional executives.
- During the revision process, MMCD will seek public input from various stakeholder groups, including the Medi-Cal Managed Care Advisory Group, health plan CEOs, the Medical Directors Workgroup, and the Quality Improvement Workgroup.
- The final revised *Quality Strategy* will be shared with stakeholder workgroups for public review and comment.
- Upon DHCS approval, the *Quality Strategy* will be submitted to CMS.
- The *Quality Strategy* will be made available to the public via the DHCS website.

Currently, the contracted External Quality Review Organization (EQRO) reviews the program objectives identified in Medi-Cal managed care *Quality Strategy* yearly when developing the annual Program Evaluation Report. MMCD has ongoing collaboration with stakeholders on initiatives identified in the *Quality Strategy* through regular workgroup meetings. However, with the release of this updated *Quality Strategy*, MMCD is committed to increasing regular opportunities for stakeholders to discuss the status of the MMCD *Quality Strategy*, address current issues, and make recommendations for needed improvement. Related to this commitment, MMCD has established an internal process for periodic division-wide review of the *Quality Strategy*.

Quality Strategy Objectives

Health plans contracted with DHCS currently provide health care services to approximately 3.8 million Medi-Cal beneficiaries in 25 of the most populous counties in California. The overall goal of the DHCS is to preserve and improve the health status of all Californians, with the supporting vision that quality health care will be accessible and affordable to all Californians. Since the expansion of the Medi-Cal managed care program during the mid-1990s, DHCS has made continuous strides in monitoring quality of care and evaluation of service delivery provided to the enrolled populations, largely low income children and families. However, because COHS plans cover the majority of Medi-Cal beneficiaries residing in their counties, including seniors and persons with disabilities (SPDs), and increasing numbers of voluntary SPD enrollees are covered in many GMC and Two-Plan model counties, DHCS is moving forward with strategies to ensure appropriate access, program monitoring and evaluation of services for these beneficiaries as well. The Medi-Cal managed care program objectives and quality strategies include:

Medi-Cal Managed Care Program Objectives:

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

Medi-Cal Managed Care Quality Improvement Strategies:

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

II. ASSESSMENT

States with Medicaid Managed Care Programs must assess how well the program is meeting its program objectives (CFR 42, Section 438.202 (d)). MMCD is responsible for oversight and monitoring of access to program services, quality of care delivered to enrollees, availability and timeliness of appropriate levels of care, and internal structural systems established by contracted health plans.

Quality and Appropriateness of Care and Services

Contracted plans must implement an effective QI system that monitors, evaluates performance measurement and implements strategies to improve the quality of care delivered by health care providers rendering services on its behalf, regardless of setting. Plans are also accountable for demonstrating evidence of an internal QI system that includes governing body participation in QI activities, designated QI committee(s) with oversight and performance responsibility, medical director supervision of QI activities, and inclusion of contracting physicians and other healthcare providers in the development and performance review of the QI system.

DHCS has established the following strategies to monitor access, appropriateness and quality of care provided by contracted health plans and their network providers:

Enrollee Race, Ethnicity and Primary Language Data
Information about the race, ethnicity and primary language information of enrollees is collected by eligibility workers at local county social services offices during the Medi-Cal enrollment process. The information is self-reported by the individual, but is sometimes determined by the eligibility worker. County staff enters the information into Medi-Cal Eligibility Data System (MEDS) along with the individual's other enrollment application information. However, recurrent problems in collecting race, ethnicity and primary language data indicate that MEDS data reports contain large numbers of incomplete or invalid responses in the data fields, at times resulting in approximately 23 percent of enrollees' languages not being available as well as data inaccuracies for persons of multi-racial backgrounds. Federal law also prohibits *requiring* enrollees to provide this information. Resolving the lack of accuracy and completeness in this area would require significant resources in order to work with the Department of Social Services and counties to develop a corrective action plan, provide initial and ongoing training for eligibility workers, and then perform periodic data audits to track progress in this area. Given California's budget limitations, DHCS and the counties are not likely to be able to implement corrective action in this area for some years.

Plans must comply with 42 CFR 438.10 (c) and ensure that all monolingual, non-English-speaking, or limited proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpretation services at all key points of contact, either through interpreters or telephone language services. Each plan must provide translated informing materials to a population group of mandatory Medi-Cal beneficiaries residing in the plan's Service Area who indicate their primary language as other than English and who meet a numeric threshold of 3,000. Plans must also provide translated materials to a population group of mandatory Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

The enrollment contractor, Health Care Options (HCO), uses the information in MEDS to generate enrollment packets that it mails to newly eligible members in Two Plan or GMC counties. New members have 30 days to select one of the Medi-Cal managed care health plans available within their county. If a member residing in a Two-Plan or Geographic managed care county does not select a plan, they are defaulted into a plan in accordance with the auto assignment process. HCO enrollment packets are not sent out in counties where managed care is provided by a COHS plan, since all Medi-Cal members are enrolled in the plan. As required by CFR 438.204 (b)(2), race, ethnicity and language information for every enrollee is transmitted to the appropriate plan within the plans' enrollment files.

Threshold Language Determination
MMCD staff periodically run a threshold language report on all Medi-Cal managed care enrollees to help program management determine whether the threshold languages provided to HCO need to be updated for the Two-Plan and GMC counties. HCO uses this information to determine which languages are needed for translation of enrollment materials in each county and which languages must be available from HCO customer service representatives. HCO also conducts an annual Linguistic Study of enrollees in Two-Plan and GMC counties, which the contractor uses to further guide call center staffing and provisions for the on-site representatives in each county.

The health plans use the threshold language criteria specified in plan contracts and periodic policy and/or all-plan letters to determine the threshold languages for their Medi-Cal members in each specific service area. Plans use the criteria to determine the languages into which informing materials must be translated and to arrange for appropriate cultural and linguistics support to members with limited English proficiency.

External Quality Review Organization (EQRO) Technical Report
Through 2008, DHCS has fulfilled the federal requirement for an EQRO Technical Report with several focused reports.

- Annual aggregate report on the External Accountability Set (HEDIS) performance measurement results
- Summary report on the Member Satisfaction Survey (CAHPS) results
- Annual plan-specific performance reports
- Quarterly Quality Improvement Projects (QIPs) status reports.

These reports are released throughout each year on the MMCD website as they are prepared by the DHCS-contracted EQRO. Each report presents the results of the EQRO's independent evaluation and describes the methodology for collecting these results. These reports also present the EQRO's recommendations for more effectively integrating these results into program policy development and ongoing program and plan quality assurance and quality improvement activities.

Beginning in 2009, DHCS will fulfill the EQRO Technical Report requirement with a new two-volume Performance Evaluation Report. The first volume will present aggregate performance measurement results (e.g., HEDIS, CAHPS, QIPs and other monitoring results), describe data collection and analysis methods, discuss best practices and improvement strategies, and present the EQRO's overall assessment of plan and program strengths and weaknesses. The second volume will present more detailed plan-specific results for each contracted plan. (In previous years, plan-specific performance reports were issued as individual reports.)

Performance Measures and Improvement Projects

All plans must comply with the DHCS requirements for reporting performance measurement results, conducting Quality Improvement Projects (QIPs) and implementing the periodic Consumer Satisfaction Survey process as outlined in the annual "Quality and Performance Improvement Program Requirement" MMCD All Plan Letter (Appendix E). The most recent All Plan Letter 08-009 with the 2009 requirements is available on the DHCS website at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2008/APL08-009.pdf .

External Accountability Set (EAS) HEDIS Measures
Plans report audited results annually on all required *Healthcare Effectiveness Information and Data Set* (HEDIS) measures, which must adhere to the most current HEDIS reporting year specifications and to DHCS specified timelines. The DHCS-selected EQRO contractor conducts an annual on-site HEDIS Compliance Audit (See Appendix B). HEDIS rates are calculated and reported at the county level unless otherwise approved by DHCS. Currently, exceptions to the county level reporting requirement include the two plans (Inland Empire Health Plan and Molina Healthcare) operating in Riverside and San Bernardino counties, the COHS plan (Central Coast Alliance for Health) operating in Monterey and Santa Cruz counties, and the COHS plan (Partnership Health Plan) in Napa, Solano and Yolo counties.

Plans must meet or exceed the DHCS established Minimum Performance Level (MPL) for each required HEDIS measure. MMCD adjusts the MPL each year to reflect the national Medicaid averages reported in the most current version of NCQA *Audit Means, Percentiles and Ratios*. Currently, the MPL is the 25th percentile of the national Medicaid rates. For each measure that does not meet the established MPL or is reported as a "No Report" due to an audit failure, plans must submit an Improvement Plan (IP) to MMCD within the specified timeframe that describes steps to be taken for improvement during the subsequent year. Plans, with scores below the MPL for the same measure in more than one county, may submit a single IP which must separately address the targeted population(s) in each county. MMCD also establishes a High Performance Level (HPL) for each required EAS measure, which is currently at the 90th percentile of the national Medicaid average. DHCS publically reports audited HEDIS/EAS results for each contracted health plan as well as the program average for Medi-Cal managed care and national Medicaid and commercial plan averages for each measure. Plans meeting established MPLs are publically acknowledged by DHCS at the annual Medi-Cal Managed Care Quality Conference.

Under/Over-Utilization Monitoring
Plans report utilization rates for selected HEDIS Use of Services measures through the contracted EQRO. Beginning in 2010, MMCD clinical consultants will facilitate discussions of utilization data monitoring results at the quarterly Medical Directors meetings.

Quality Improvement Projects (QIPs)
Plans must conduct and/or participate in two QIPs, including the MMCD-led statewide collaborative project and either an internal QIP or a small group collaborative developed and led by two or more plans. As of 2009, two small group collaborative QIPs were currently underway.

Plans must submit a proposal for all QIPs for approval by MMCD and validation by the EQRO. Both the approval and validation processes focus on assuring QIPS are designed in accordance with federal requirements and appropriately targeting the needs of the plan's Medi-Cal members. As the result of the EQRO contract entered into with Health Services Advisory Group in September 2008, MMCD implemented an enhanced QIP reporting form in 2009 to further support plan compliance with CMS protocols for performance improvement projects.

After MMCD and the EQRO approve and validate the QIP proposals, plans must submit a status report on each project at least annually which includes remeasurement results and any changes to the planned interventions. Most QIPs run three years, allowing for at least two remeasurements to determine whether there is sustained improvement over the baseline. Once a QIP is complete, the plan must submit a new proposal within 60 days to remain in compliance with the requirement to have two QIPs underway at all times. DHCS adheres to Title 42, CFR, Section 428.240 (b)(1) in reviewing the significant improvement of QIPs sustained over time in clinical and non-clinical care areas that effect health outcomes and enrollee satisfaction. Plans are currently collaborating with MMCD on the following quality improvement projects:

- *Statewide Collaborative*

  Reduction in Avoidable Emergency Room Visits (2007-2010)

  All contracted plans, with the exception of specialty plans such as AIDS Healthcare Centers and one small Prepaid Health Plan, began a statewide collaborative in July 2007 to reduce avoidable emergency room visits. MMCD established the collaborative for several reasons. First, an Institute of Medicine (IOM) report in 2006 revealed that nationally many emergency rooms (ERs) are overburdened largely due to closure of many hospital ERs, shortage of hospital beds resulting from hospital closures, increase in patients with serious conditions seen in the ER, and use of the ER for non-urgent and non-emergent conditions. Additionally, Harris Interactive Inc., sponsored by the California HealthCare Foundation (CHCF), conducted a telephone survey of 1,402 California residents who had visited the ER for care. Almost half (46 percent) of the respondents said their problem could have been treated by their primary care physician. Although Medi-Cal fee-for-service and managed care participants were included in the CHCF survey, the exact number of Medi-Cal managed care members represented in the survey is unknown. However, the CHCF survey indicated that individuals covered by Medi-Cal, whether through fee-for-service or managed care, are twice as likely to have used the ER for care in comparison to privately insured individuals.

  In February 2007, MMCD administered an electronic survey to all contracted managed care plans to begin assessing the extent to which Medi-Cal managed care members visit the ER for care and why. Survey responses statewide revealed that members enrolled in Medi-Cal managed care made frequent ER visits, often viewed the ER as their usual source of care, and did not want to contact their primary care physician or wait for an appointment. These findings prompted MMCD and the health plans to select reducing avoidable emergency room visits as the focus for the statewide collaborative.

  MMCD convened a planning workgroup composed of medical directors and quality improvement managers from 17 health plans to identify the project focus, goals, measures and interventions. There was group consensus that overuse of the ER for avoidable visits contributed to high healthcare costs and affected the quality and continuity of care. Avoidable emergency room visits were defined by the collaborative

group as "a visit that could have been more appropriately managed and/or referred to a primary care provider in an office or clinic setting." The goal of the project is to reduce avoidable ER visits by 10 percent by the final rate remeasurement in October 2011.

The target population, determined by evaluation of encounter data, is enrolled Medi-Cal managed care members, 1-19 years of age, with diagnoses of upper respiratory infections (cold/flu), otitis media (ear infection), and pharyngitis (cough/sore throat). Plans will report the HEDIS® *Ambulatory Care Measure for Emergency Departments Visits* for rates of members seen in the ER and a HEDIS-like measure for the rate of members seen in the ER for an avoidable emergency room visit for the specified conditions. Baseline measurement occurred during fall 2007, after which some plans began plan-specific interventions. Plans began two statewide interventions in January 2009 – a member health education campaign and health plan collaboration with local hospital ERs.

Remeasurement of the rates for the HEDIS *Ambulatory Care Measure for Emergency Departments Visits* and the HEDIS-like avoidable visits measure of members seen in the ER for an avoidable emergency room visit occurred in November 2008. Subsequent remeasurements are scheduled for October 2009 (completed) and October 2010. MMCD released the EQRO's baseline report on this statewide collaborative on the DHCS website in October 2009. The EQRO will complete an interim report on the status of plan-specific and statewide interventions in January 2010. The first remeasurement report for the ER collaborative is scheduled for completion in 2010 and the second and final remeasurement report in 2011.

- *Small Group Collaborative*s

  Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD (2008-2011)
  In 2008, two plans in San Diego County, Care1st and Community Health Group, formed a small-group collaborative with the primary shared goal of improving performance in the NCQA® HEDIS® *Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease* (COPD) measure. The project supports the efforts of the American Lung Association of California to draft a strategic plan for addressing COPD within the state and the Assembly Concurrent Resolution 137 of 2008 on COPD. The collaborative is using the Global Initiative for Chronic Obstructive Lung Disease (GOLD) standards to determine appropriate health care delivery.

  The primary shared measure for the collaborative is the HEDIS COPD measure, which indicates the percentage of members 40 years of age and older with a new diagnosis or newly active chronic COPD who received appropriate spirometry testing to confirm the diagnosis. Plans also may use other measures or performance standards as well. The collaborative identified collaborative goals and objectives and plan-specific strategies and interventions such as member and provider education. The collaborative set quantitative objectives for Year 2 (2009-2010) after analysis of data from Year 1 (2008-2009). Improvement was evaluated using the 2009 results for the HEDIS measure and will again be evaluated in 2010. The timeline for project completion is mid-2010, but may be extended to mid-2011.

  Appropriate Treatment for Children with an Upper Respiratory Infection (2007-2009)
  In April 2007, CalOptima, Care 1st Health Plan, L.A. Care Health Plan, Health Net Community Solutions, and Molina Healthcare developed a collaborative project to decrease inappropriate use of antibiotics in children with upper respiratory infections

(URIs). Each year, children in the United States contract approximately 6 to 10 URIs/common colds (2006, *The State of Healthcare Quality*, National Committee for Quality Assurance at www.ncqa.org), which are often caused by viral infections. Although clinical practice guidelines do not support the use of antibiotics for treatment of the common cold, various studies indicate that as many as 22 percent of office visits for URIs for children less than 15 years of age result in a prescription for an antibiotic. Rationale for the project was that inappropriate prescribing of antibiotics for a diagnosis like the common cold increases drug resistance and decreases the effectiveness of drugs currently available to fight bacterial infections.

The primary measure for the project is the NCQA® HEDIS® *Appropriate Treatment for Children with an Upper Respiratory Infection* measure, with the participating plans allowed to develop additional measures and interventions relevant to their plan. Participating plans held quarterly teleconferences; developed barrier analysis processes interventions and best practices; and shared outcomes.

The baseline measurement occurred in HEDIS Reporting Year (RY) 2007, the first remeasurement in HEDIS RY 2008, and second remeasurement in HEDIS RY 2009. The project was completed in July 2009, and the URI Collaborative will submit will present project results and lessons learned to all plans at a Medical Directors meeting and/or a QI Workgroup meeting in 2010.

- *Internal Quality Improvement Projects*
  In addition to the statewide collaborative QIP on reducing avoidable emergency room visits and the two small group collaborative QIPs described above, most plans are also conducting at least one internal QIP (IQIP) focused on their Medi-Cal members. Appendix B lists the IQIPs underway as of October 2008.

Consumer Satisfaction Survey
The External Quality Review Organization (EQRO), contracted by DHCS, oversees administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to a sample of Medi-Cal managed care members, generally every two or three years. Separate surveys are administered in English and Spanish for adults and children. Parents or guardians complete the child surveys. MMCD and contracted plans use the consumer survey results to evaluate member satisfaction with the care they received from their providers and plans, to determine the need for further evaluation, and to highlight areas where specific quality improvement interventions by the MMCD and/or health plans are needed.

The CAHPS survey was most recently administered in 2007. The report, *Results of the 2007 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Medi-Cal Managed Care Health Plans*, was released on the DHCS website at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD Qual Rpts/CAHPS Reports/CAHPS2007.pdf . The report includes information about the survey methodology, the demographics of respondents, and results by plan and by Medi-Cal managed care delivery model (i.e., Geographic Managed Care, Two-Plan, and County Organized Health System).

In 2007, adult respondents gave generally high ratings to the care they received from their personal doctors and specialists, but expressed lower satisfaction with access to care at both the plan and provider level (“getting care quickly”). Parents and guardians of child members

gave high satisfaction ratings to their child's health plan, to both personal doctors and specialists, and to plan-level access to care, but lower ratings to access at the provider level.

MMCD management considered the 2007 survey results, particularly in areas indicating low member satisfaction and the plans identified as performing at the lowest levels in the adult and child survey. Due to competing priorities and resource challenges, MMCD is continuing to follow-up on the survey findings, including reviewing aggregate results with contracted plans as a group, convening individual meetings with plans with particularly poor results, and requesting corrective action plans from any plans determined not to be meeting minimum access standard in accordance with contract requirements.

The next CAHPS survey is scheduled for 2010, and the aggregate report is scheduled for release in early 2011.

DHCS is following the work underway at the Center for the Study of Chronic Illness and Disability at George Mason University to develop and field test a survey tool that would assess health plan and provider service from the perspective of members with activity limitations due to chronic illness or long-term disability. (The DHCS supported the Center's application for funding from the California Health Care Foundation.) Contingent on available resources, DHCS does hope in the future to incorporate approaches to member assessment and performance measurement that are tailored to the special needs of seniors and persons with disabilities.

Clinical Practice Guidelines

Plans provide or arrange for all medically necessary covered Medi-Cal services and other services covered under the DHCS contract, which includes all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury (Title 22, CCR, Section 51301). MMCD clinical staff develops healthcare policy, contract language and provide consultation for the program's standards for the covered scope of services. Registered nurses in MMCD review plans' scope of services protocols/policies, Evidence of Coverage deliverables, provider manuals, educational material, Memoranda of Understanding (MOUs) with public health agencies for compliance with contract requirements and adherence to acceptable practice standards. DHCS has established the following clinical guidelines as contract requirements:

- *Children's Services*
  Preventive health assessments for all members less than 21years of age are provided according to the most recent age-specific Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) assessments and services required by the California Child Health and Disability Prevention (CHDP) program for the lower age nearest to the current age of the child, and preventive health visits are provided according to the most recent age-specific periodicity schedule as specified by the American Academy of Pediatrics. Vaccines are provided according to the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). Blood lead screening tests are required at ages one and two in accordance with Title 17, California Code of Regulations (CCR), Division 1, Chapter 9, section 37000.

- *Pregnant Women*
  The most current standards/guidelines of American College of Obstetricians and Gynecologists (ACOG) are the minimum measure of quality for perinatal services. A comprehensive risk assessment is required for pregnant and postpartum members that is comparable to the Comprehensive Perinatal Services Program (CPSP) standards per Title 22, CCR, Section 51348.

- *Adult Services*
  The latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is the standard for providing clinical preventive services to asymptomatic, healthy adult members, aged 21 years or older. Vaccines are provided in accordance with the most current California Adult Immunization recommendations.

- *Tuberculosis (TB)*
  Screening, diagnosis treatment and follow-up for TB follows the guidelines recommended by the American Thoracic Society and the Centers for Disease Control and Prevention.

- *Pharmaceuticals Services*
  All prescribed drugs and medically necessary pharmaceutical services are provided in accordance with Federal and State laws and regulations, including the California State Board of Pharmacy Laws and Regulations, Title 22, CCR, Sections 53214 and 53854 and Title 16, CCR, Sections 1707.1-3.

Regulatory Requirements and Contract Compliance

Contract provisions established for Medi-Cal managed care health plans incorporate specific standards for the elements outlined in 42 CFR 438.204: access to care, structure and operations, and quality measurement and improvement. Plans are responsible for communicating established standards to network providers, monitoring provider compliance and enforcing corrective actions as needed.

Access to Care
Standards for access to care include availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services as required by 42 CFR 438.206. Medi-Cal managed care program standards promote early intervention at the appropriate level of care, and ensure that preventive and primary care services are available and accessible to enrollees. Plans must establish accessibility standards to ensure that each member has a primary care provider (PCP) and access to specialists for medically necessary services. Access standards must address availability of routine appointments and medically necessary specialty care services, appointment follow-up procedures and missed appointments, first prenatal visit, waiting times in provider offices, telephone medical advice, urgent care, after-hours calls availability for physicians or appropriate licensed professional under his/her supervision (Appendix C). The following activities and reports document DHCS and plan-specific endeavors to monitor access to care and status of available services:

- *Care Coordination/Case Management*
  Plans must maintain procedures for monitoring the coordination of care, determining whether targeted case management services are needed and establishing referral

processes, initiating and maintaining disease management services and processing authorizations for members receiving out-of-plan services.

MMCD works collaboratively with contracted plans to meet requirements in 42 CFR 438.208 for care coordination for individuals with special health care needs. In March 2008, the MMCD and Centers for Healthcare Strategy (CHCS) began collaboration on development of the Care Coordination/Case Management and Disease Management Activity Survey. CHCS distributed the survey to health plan chief executive officers and medical directors in August 2008 to gather plan-specific information about the established systems and processes currently being used for case management, care coordination and disease management. The survey covered topics such as definitions of care coordination/case management, identification of medical and social conditions of members for case management referral, clinical guidelines, and case management staff requirements, training and certification. CHCS released the final survey results report in November 2008.

- *Change in Provider Network Report*
  At startup, plans must submit a provider network report to MMCD to provide evidence of the required covered services for members in their service area. For example, documented evidence must demonstrate that primary care provider networks are continuously in compliance with the established provider and non-physician medical practitioner-to-member ratios, meet the established time and distance standards and have adequate numbers and types of certified (or eligible for certification) specialists available within the network to accommodate the specialty care needs of members. Plans submit Change in Provider Network Reports quarterly to MMCD, including a summary of provider network changes, the resulting impact of those changes, and information such as percentage of traditional and safety net providers, number of members assigned to each PCP, and network providers who are not accepting new patients.

- *Community Advisory Committee(s)*
  Plans must form local committees to maintain community partnerships with consumers, community advocates and traditional and Safety-Net providers. Plans must include and involve the Community Advisory Committee in policy decisions related to educational, operational and cultural competence issues.

- *Emergency Department Protocols*
  Plans must develop and maintain protocols that describe communication and interaction processes and distribute them to emergency departments. A health professional from the plan or a contracting physician must be available 24 hours per day, seven days per week to coordinate transfer of care in emergent care situations, authorize medically necessary post-stabilization services and communicate with emergency room personnel. Written protocols must include plan telephone triage and advice systems, contact person responsible for coordinating services and can be contacted 24 hours per day, instruction and referral procedures, and procedures ensuring continuity of care and handling assessment determined to have a non-emergent condition.

- *Geographic Mapping Reports*
  Plans submit geographic mapping of their current provider network to MMCD quarterly using Geographic Information Software (GIS) maps to display and analyze the composition of their provider networks. Geographical mapping of provider networks

provides verification of the availability and location of primary care providers and specialists in relation to the needs of plan members. DHCS standards requires plans to meet the provider-to-member ratios of at least one full-time equivalent primary care physician to 2,000 enrollees and one full-time equivalent for total physicians to 1,200 enrollees. Plans monitor provider caseloads quarterly to ensure that providers remain within established provider/beneficiary ratios and capacity limits. Plans provide a copy of the provider caseload report to MMCD upon request. MMCD contract managers review submissions from plans and verify that plans are meeting their contractual obligations.

- *Provider Directory*
  Each plan issues a Provider Directory and periodic updates to provide information to members about primary care providers regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access and other special services. Plans submit revised provider directories to MMCD every six months for review and approval. To insure that Provider Directory submissions are current and accurate, MMCD conducts random phone calls on approximately 10 percent of the listed providers to validate the information (i.e., address, phone number, office hours and languages spoken). MMCD staff reports errors to the health plans for corrections.

- *Site Review Reports*
  Plans must conduct site reviews on all primary care provider sites in accord with MMCD Policy Letter 02-02. The Facility Site Review (FSR) is a system-wide process to assess the structure and capacity of provider sites to provide primary care services. Plan nurse reviewers conduct initial and tri-annual full scope reviews of provider sites and focused reviews as needed. All reviewers use the MMCD Full Scope Site Review Survey and Medical Record Review Survey forms to ensure that all contracting plans and subcontracting entities use MMCD survey standards, review criteria and scoring methodology.

  Site reviews ensure that all primary care sites within health plan provider networks meet established quality standards in areas such as physical plant access and safety, primary and preventative health services, continuity and coordination of care, and patient safety and infection control practices. Plans submit FSR scores electronically to MMCD every six months (January and July) for review and evaluation. MMCD staff analyzes scoring data and monitors for trends that may require implementing system-wide quality improvement strategies, including corrective actions and technical assistance.

Structure and Operations

DHCS has established contractual standards and processes for evaluating the operational structure and procedures plans use for internal and external communication, monitoring and the provision of consultation and technical assistance as required by 42 CFR 438.207. Structural operations also include the plan's internal operational systems and processes for monitoring and communicating with the MMCD and network providers. Contractual requirements include standards for provider selection, enrollee informing, confidentiality, enrollment disenrollment, grievance systems, and subcontracted and delegated relationships. MMCD and the plans use the following documentary evidence to demonstrate the establishment and monitoring of structural operations:

- *Evidence of Coverage Member Handbook*
  All contracted plans must submit an Evidence of Coverage (EOC) Member Handbook annually for approval prior to distribution to members. The EOC must meet state regulations regarding print size, readability, understandability of text and describe the full scope of Medi-Cal managed care covered benefits, all available services, procedures for accessing services and address/phone number for each service location. EOC Handbooks are reviewed by MMCD contract managers, nurses and staff from the Member Rights/ Program Integrity Unit (MR/PIU).

- *Facility Site Review Oversight*
  MMCD oversees and monitors the processes plans have established for implementing the primary care site review process, and consulting with and providing technical assistance to plans.

  - *On-site Primary Care Provider Monitoring Visits*
    MMCD performs oversight monitoring of the Facility Site Review (FSR) process by conducting on-site reviews of randomly chosen Medi-Cal primary care provider sites. The purpose of oversight visits is to validate the FSR process utilized by the health plan, monitor provider and member satisfaction of services provided by the health plan and to provide proactive technical assistance and educational consultation to plans and provider sites.

  - *Master Trainer and Reviewer Certification*
    Each plan has one or more certified FSR nurse master trainers who oversee the local site review process, train and certify new reviewers, and facilitate local collaboration with other plans and review programs. MMCD staff provides consultation and technical assistance to plans by conducting on-site certification for master trainers and collaborating with plans to implement annual inter-rater review (IRR) training days in Northern and Southern California for certified master trainers and site reviewers. MMCD staff also conducts periodic oversight FSR visits with plans in which randomly selected provider sites are reviewed to validate plan review procedures, to monitor provider satisfaction with services provided by the plan and to provide proactive consultation and technical assistance to both plan reviewers and providers.

    Occasionally, mandatory training days are implemented for all certified nurse trainers and reviewers on current topics that are relevant to the site and medical record reviews. In 2007, the MMCD coordinated a one-day training for over 100 nurse reviewers to present current information about immunizations, vaccine handling and storage, infection control for bloodborne pathogens and radiology equipment safety inspection regulations.

- *Fraud and Abuse Detection and Prevention*
  MMCD coordinates referral of fraud and abuse issues that occur within the Medi-Cal managed care program and contracted health plans. Member and provider complaints and cases submitted by plans are reviewed by MMCD staff and forwarded to the DHCS Audits and Investigations Division (A&I) for further investigation. The MMCD works collaboratively with A&I and the Department of Justice (DOJ) to provide technical assistance, to conduct educational trainings for plans about the prevention, detection, reporting and investigation of fraud and abuse and to facilitate opportunities for sharing best practices.

In August 2008, MMCD, A&I and DOJ collaborated with the California Pharmacist Association to provide training for the Pharmacy Directors at Medi-Cal managed care plans about the prevention, investigation and trends in pharmacy fraud.

- *Grievance Logs*

  Plans must establish and communicate to contracting and non-contracting providers a formal process for accepting, acknowledging and resolving provider grievances. Plans submit aggregated grievance data logs to MMCD quarterly, and MMCD staff analyzes them for trends and areas of concern. The MMCD also conducts on-site monitoring reviews with plans approximately every two years to verify compliance with state and federal requirements for member rights and program integrity. Monitoring reviews focus on the plans' processes for grievances, prior authorization notifications, marketing and cultural linguistics. Although corrective action plans are not required for review report findings, plans must correct findings within 30 days of receipt of report. Findings determined to be serious during the initial review will be followed up in six months on a subsequent review.

  MMCD received stakeholder input suggesting that the quarterly grievance logs should be made publicly available to help members make informed plan choices. It should be noted that quarterly grievance reports for all HMOs licensed in California are publicly available on the Department of Managed Health Care (DMHC) website at http://www.dmhc.ca.gov/healthplans/rep/rep_grievance.aspx. MMCD's focus when reviewing plans' quarterly grievance reports and conducting on-site monitoring review is determining whether plans are tracking and resolving grievances as required by state regulations and their contracts with DHCS and understanding the degree to which members are accessing the avenues available to them for resolving problems.

- *Joint Medical Reviews*

  Health plans undergo an on-site medical audit every three years conducted jointly by DHCS Audits and Investigations (A&I) and the CA Department of Managed Healthcare (DMHC). MMCD reviews the results, monitors and approves corrective action plans submitted by plans for audit deficiencies, makes on-site visits to plan and provider sites as needed to ensure compliance, and provides training or technical assistance to plan, A&I and DMHC staff.

- *Medical Exemptions*

  The Medical Exemption process allows Medi-Cal beneficiaries under treatment by a Fee-for-Service (FFS) Medi-Cal provider for specific medical conditions (e.g. cancer) to be exempted from enrollment in a Medi-Cal managed care plan until the treatment is completed (Title 22 CCR, Section 53887). Medical exemption assures continuity of care during the treatment of specific medical conditions.

  MMCD staff reviews medical exemption requests (MERs) within 72 hours and all Expedited Disenrollment Exemption Requests (EDERs) for medical conditions within 24 hours. EDERS are medical exemption requests that the primary care provider determines are urgent and include conditions requiring continuity of care such as late stage pregnancy or a member suddenly being placed on an organ transplant list. Upon completion of the specified treatment, the beneficiary is re-enrolled into a Medi-Cal managed care plan where their health care services are coordinated by a primary care

provider. In collaboration with DHCS Health Care Options and MAXIMUS, the enrollment contractor, all MERS and EDERS are processed electronically by MMCD staff.

- *Office of the Ombudsman*
  The MMCD Office of the Ombudsman has administrative responsibility for member complaint resolution and coordinating all State hearing requests submitted by Medi-Cal beneficiaries enrolled in managed care plans. The Office of the Ombudsman uses a contracted translation service to serve the needs of non-English speaking members and has bilingual-Spanish employees on staff. Monitoring of contract requirements include:

  - *Member Complaint Investigation*
    The Office of the Ombudsman investigates, consults with MMCD clinical staff, and works to resolve complaints made by enrolled plan members about Medi-Cal managed care health plans. Plan members may make complaints directly to the Office of the Ombudsman through a toll-free line (1-888-452-8609) and through a designated website at www.dhs.ca.gov/mcs/mcmcd/htm/OfficeoftheOmbudsman.htm. The Office of the Ombudsman serves as a resource for members in various ways, such as assisting with resolution of issues members have with their health plan, conducting impartial investigations of member complaints, assisting with urgent enrollment and disenrollment processes, providing education about effective navigation through the Medi-Cal managed care system, and offering referrals.

  - *State Hearing Request Coordination*
    The Office of the Ombudsman coordinates and processes all state hearing requests submitted by Medi-Cal managed care beneficiaries. Staff compiles medical and pharmacy information with assistance from MMCD clinical consultants and assists the California Department of Social Services (CDSS) administrative law judges with understanding critical member issues.

- *Utilization Management Reports*
  Plans must develop, implement, continuously update and improve their Utilization Management (UM) program to ensure that they consistently use appropriate processes to review and approve the provision of medically necessary covered services. Responsibilities include ensuring qualified staff for the UM program, separation of medical decisions from fiscal and administrative management, and established criteria for approving, modifying, deferring or denying requested services. Plans must have internal mechanisms to track and monitor prior authorization, timeliness of determination and a process to integrate reports on review of number and types of appeals, denials, deferrals and modifications.

Quality Measurement and Improvement

Plan contracts require an ongoing program for quality assessment and performance improvement of the services provided to enrollees as required in 42 CFR 438.240. Quality measurement and improvement standards include clinical practice guidelines, quality assessment and performance improvement program, and health information systems. The clinical practice guidelines used by plans and providers are nationally recognized and accepted, based on valid and reliable clinical evidence and applicable to the populations served within the Medi-Cal managed care program. Quality improvement projects are designed to achieve, through ongoing measurement and intervention, significant

improvement sustained over time in clinical and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

- *Clinical Practice Guidelines*
  For all health services delivery areas where DHCS has not specified standards of practice guidelines, health plans may adopt nationally recognized standards, best practices guidelines and/or recommendations from appropriate professional organizations of proven methods that are time-tested, research supported and accepted by peer professionals as reasonable practices. Practice guidelines adopted for the Medi-Cal managed care program are administered and/or promoted by other state agencies/programs and widely used throughout the state (See Clinical Practice Guidelines section). Plans must establish Memorandum of Understanding agreements with local county public health programs, such as Women, Infants and Children (WIC), Comprehensive Perinatal Services Program (CPSP), and California Children's Services (CCS) to address practice and quality of care issues, referral and communication systems, and ongoing collaborative processes. Health plan nurse reviewers assess content elements of clinical practice guidelines for preventive and primary care every three years as part of the Site Medical Record Review.

- *HEDIS External Accountability Set*
  To assess the quality of care provided to Medi-Cal managed care plan members, as federally required, MMCD requires contracted plans to annually report the results of selected Healthcare Effectiveness Data and Information Set (HEDIS) performance measures – referred to as the "External Accountability Set" (EAS). HEDIS measures are established by the National Committee for Quality Assurance and are the "gold standard" performance measures used nationally to assess the quality of care provided by commercial, Medicaid and Medicare plans.

  The HEDIS measures that make up the EAS for Medi-Cal managed care plans currently focus on access to care provided to women and children, ambulatory care services provided to members of all ages, screening for diseases such as breast and cervical cancer, and care provided to members with chronic diseases such diabetes and asthma and serious conditions such as upper respiratory infection in children and acute bronchitis in adults. Plans submit data annually for the EAS. Any plan that scores below the Department-established Minimum Performance Level (MPL) on any required EAS measure must submit an Improvement Plan indicating how they will work to improve plan performance in the measures below the MPL. (See Appendix D for list of required HEDIS measures since 2007.)

  MMCD shares plan-specific and aggregate results with the plans and publicly releases them on an annual basis. MMCD also incorporates plan results into the *Consumer Guides* provided to potential enrollees, both mandatory and voluntary, in the GMC and Two-Plan model counties. These *Consumer Guides* are designed to encourage members to choose a Plan based on the quality of care provided in areas particularly relevant to each member -- such as prenatal and postpartum care, timely childhood immunization, treatment for chronic conditions, and the plan's customer service. MMCD also uses HEDIS scores for six selected measures in the Auto Assignment Performance Incentive Program, which awards more defaulted enrollment to plans with higher scores in these measures.

Plans indicate that the public release of HEDIS scores, both in the annual summary report and the *Consumer Guides*, is a strong incentive for plans to improve quality particularly because these materials are reviewed not only by members, but also by legislators, advocates and other potential purchasers.

- *Quality Improvement Projects*
  All individual QIP proposals submitted by plans are reviewed and approved by MMCD clinical staff prior to implementation by plans. MMCD medical and/or nurse consultants serve as project leads for the statewide collaborative quality improvement and for some small group collaborative projects. The EQRO contractor validates submitted proposals and subsequent status reports for all QIPs. The MMCD and EQRO reviewers use the ten-step process defined in "Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities" (Final Version, May 2002, Department of Health and Human Services Centers for Medicare and Medicaid Services) to review and validate QIP proposals and status reports (available on the CMS website at http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/07).

- *Health Information Systems*
  DHCS has determined minimum Management Information System (MIS) requirements it expects of its contracted managed care health plans and periodically reviews documentation from the plans to ensure that these minimum requirements are met. The MIS shall have the capability to capture, edit, and utilize various data elements for internal management use as well as to meet the data quality and timeliness requirements of DHCS's encounter data submission. The MIS shall provide, at a minimum:
  - All Medi-Cal eligibility data
  - Information of members enrolled in the plan
  - Provider claims status and payment data
  - Health care services delivery encounter data
  - Provider network information
  - Financial information

  On execution of new or renewed contracts, the plan must submit a baseline assessment of its MIS as well as policies and procedures to MMCD. This provides the DHCS with a high-level understanding of how the plan collects and maintains claims/encounters, enrollment information and data on ancillary services such a prescription drugs and whether the system has sufficient capacity to accommodate all activities associated with the anticipated enrollment level.

  The DHCS maintains managed care data element dictionaries, which specify the form and manner in which the contracted health plans must submit encounter data on a monthly basis. Health plans must have in place mechanisms, including edits and reporting systems sufficient to assure encounter data is complete and accurate prior to submission to DHCS. The submitted encounter data undergoes rigorous quality control checks, which are continually enhanced to catch data problems early in the process before data is entered into DHCS's Management Information Systems/Decision Support System (MIS/DSS) database. Should encounter data be found insufficient or inaccurate, DHCS has established timeframes for the submission of corrected data.

  Multiple reports generated during the processing of submitted encounter data enable DHCS to monitor the plans' level of compliance with contract requirements and the quality, accuracy and timeliness of the data. Key performance indicators related to plan

performance are tracked and reported to program management quarterly to allow for comparison from plan to plan and with national benchmarks.

An ongoing Encounter Data Workgroup meets quarterly to ensure appropriate coordination between interested parties from various Divisions within DHCS, its contracted data intermediary, and the Management Information Systems/Decision Support System (MIS/DSS) contractor regarding encounter data issues. This workgroup determines the most efficient process for communicating with health plans regarding non-compliance of encounter data submission, assures that the *Data Dictionary* provided to plans is accurate and updated when necessary, and collaborates regarding the appropriate methods for storage and retrieval from the MIS/DSS database.

- *Stakeholder Input*

  MMCD has organized various on-going collaborative workgroups to ensure that stakeholders have ample opportunity to advise, provide input and make recommendations regarding program services, operational issues and areas for quality improvement. MMCD currently conducts the following Stakeholder Workgroups:

  - *Medi-Cal Managed Care Advisory Group*
    MMCD facilitates quarterly meetings with plan representatives and consumer advocacy representatives to discuss a wide array of issues, including quality of care. Meetings provide an opportunity for MMCD staff to provide program updates and for stakeholders to raise concerns about issues that affect enrolled members.

  - *DHCS/DMHC Medical Audits Committee*
    MMCD organizes quarterly multi-agency in-person meetings to plan and discuss issues related to collaborative joint audits of health plans. These meetings, jointly held by the DHCS and the Medical Audits Committee (DMAC) of the Department of Managed Health Care (DMHC), include participants from the agencies (DHCS and DMHC) that conduct the joint medical audits and other stakeholders (Managed Risk Medical Insurance Board's Healthy Families Program and DHCS's Office of Long Term Care). MMCD clinical staff and DHCS's Audits and Investigations clinical and audit staff meet as a subgroup for in-depth discussions of specific medical issues.

  - *Facility Site Review (FSR) Workgroup*
    Plans must complete initial full scope site reviews on all primary care provider sites that have not been previously reviewed and then every three years on an ongoing basis. Registered nurses serving as FSR Master Trainers from each plan and MMCD meet in person quarterly to address FSR issues, such as policy revision, interrater reliability methods for medical record and physical site scoring, problem solving strategies related to oversight and monitoring and reviewer training and certification needs. Since May 2008, the FSR Policy Revision Task Force, a subcommittee of the FSR Workgroup which is composed of plan master trainers, medical directors and MMCD clinical professionals, has held periodic teleconferences to update the FSR policy, review tools and reviewer guidelines. The workgroup expects to complete this work in June or July 2010.

  - *Health Education Workgroup*
    Health educators from each plan meet in person quarterly with MMCD health education staff to address issues related to health education, behavioral risk assessments, group needs assessment, and other topics related to improving the

quality of health education services provided to enrolled members. Since May 2008, the workgroup has established several task force groups to revise the Staying Healthy Behavioral Risk Assessment Tool and implement provider and member surveys regarding use of the tool.

- *Medical Directors Workgroup*
  Plan medical directors are responsible for overseeing and rendering decisions related to clinical services, provision of medical care, and healthcare quality improvement. Medical directors meet quarterly with MMCD's Chief Medical Consultant and other clinical staff to address and problem solve a wide range of health care topics including clinical services, specific health conditions, program benefits, coordination of services, provider issues, health care policy and legislation, and budgetary constraints. These meetings have included presentations by representatives from various state and private programs and agencies including the California Department of Public Health; the Medi-Cal Fee-for-Service program; the California Children's Services; the Women, Infant and Children's Supplemental Food Program; researchers and clinicians from learning institutions; the California Medical Association; and plan medical directors.

- *Pharmacy Directors Workgroup*
  Plan pharmacy directors meet quarterly with the MMCD pharmacy consultant to discuss pharmacy issues. One responsibility of plan pharmacy directors is oversight of plan formularies to assure medication access meets all medically necessary needs of Medi-Cal managed care members and that access is comparable to and consistent with the Medi-Cal FFS pharmacy services benefit.

- *Quality Improvement Workgroup*
  Managers in the areas of quality improvement and performance measurement and medical directors from Medi-Cal managed care plans participate in periodic teleconferences, generally held quarterly. Participants, including MMCD staff, discuss issues specifically related to current and future quality improvement strategies, required and proposed performance measures, plan-specific and collaborative QIPs, and other activities related to quality improvement within the Medi-Cal managed care program.

- *State Hearings Quality Circle*
  The MMCD Office of the Ombudsman and the California Department of Social Services (CDSS) state hearings staff hold quarterly meetings, chaired by the presiding judge of the CDSS State Hearing Division Sacramento Region, to improve the quality and efficiency of the state hearing process. This is a forum for MMCD and CDSS to support open communication, address state hearing problems, and resolve member issues.

Health Information Technology

Data collection systems, such as registries, pay-for-performance tracking or profiling systems, electronic record information exchange, regional Health Information Technology (HIT) collaborative activities, and telemedicine initiatives largely occur at the health plan level. Some health plans have developed very sophisticated internal and external health information systems, whereas other plans continue to struggle with basic systems.

Despite California's budgetary constraints, opportunities still exist for making improvement in data collection systems within DHCS, as required by CFR 438.204 (f)). For example, one key goal identified in the October 2008 *DHCS Strategic Plan* is to expand and promote the use of information technology within the department. The objectives for this important goal, outlined in the strategic plan, include identifying the top priority systems for modernization and improvement and establishing areas of governance for shared information technology infrastructure services between DHCS and the California Department of Public Health (CDPH).

MMCD will continue to be a collaborative partner with other DHCS programs and with providers and stakeholder groups to develop policies to support the adoption of HIT and health information exchange solutions to improve access and health care quality.

III. IMPROVEMENT

The Medi-Cal managed care *Quality Strategy* not only serves as a descriptive guide for current quality improvement activities, but also as a roadmap for planning and initiating meaningful future strategies. Although California is experiencing a difficult budget crisis, updating the quality strategy will help focus MMCD on how best to use available resources to advance the DHCS mission and respond to the healthcare needs of California residents. Future quality improvement strategies include collaboration with both state and private agencies, ensuring access to the appropriate level of care and evaluating the utilization and effectiveness of care and medical services. In this section, the interventions describe how DHCS will meet strategic objectives and the initial and/or ongoing steps it has taken to foster improvement.

Interventions, Meeting Objectives, Steps to Improvement

- *Collaboration with California HealthCare Foundation*
  The California HealthCare Foundation (CHCF) led a project to develop enhanced performance standards for Medi-Cal managed care health plans for services for persons with disabilities and chronic illnesses. DHCS, one of several key partners in this project, received CHCF recommendations in a report titled, "Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions" in November 2005. DHCS requested comments and input from its contracting health plans regarding these recommendations. DHCS completed an analysis of the 53 recommendations to determine the applicability of the recommendations to the target population, and to assess the feasibility of each recommendation. The CHCF report and DHCS response are available on the Medi-Cal Managed Care website at http://www.dhcs.ca.gov/dataandstats/reports/Pages/CHCFRpt_DHCSRspns.aspx .

  DHCS is currently working with the Center for Health Care Strategies (CHCS) on two major areas highlighted in the CHCF recommendations: developing a member evaluation tool and developing and implementing policy for care coordination for seniors and persons with disabilities.

- *Medical Home*
  One of the key goals identified in the 2008-2009 DHCS *Strategic Plan* is to organize care to promote improved health outcomes. In this goal, the primary objective is to ensure that every Medi-Cal beneficiary has a medical home. MMCD has a major role in meeting this Departmental goal. The following strategies are currently underway within MMCD:

  - *Medical Home Workgroup*
    To ensure that enrollees in Medi-Cal managed care plans have an established medical home, clinical consultants in Medi-Cal managed care established a multi-agency workgroup to assist MMCD with planning and developing a Medical Home project. The workgroup began meeting in early 2009. Initial discussions focused on establishing a definition of medical home within the Medi-Cal managed care framework.

- *Guide for Seniors and Persons with Disabilities*
  In 2006, MMCD executed a four-year contract with the University of California Berkeley (UCB), School of Public Health, *Health Research for Action*, to develop a comprehensive consumer guide to promote Medi-Cal managed care and increase voluntary enrollment of seniors and persons with disabilities (SPDs). The contract includes development of a consumer guide, an evaluation of the outcome and impact of the consumer guide, follow-up research on factors that inhibit or promote voluntary enrollment of SPDs, and research and evaluation on the usability of the Health Care Options web site for SPDs.

  As part of the development of the guide, an advisory group was convened with representation from health plans, advocates, and consumers. The advisory group provided vital information and feedback during the development of the pilot guide.

  The pilot study was conducted in Alameda, Riverside and Sacramento counties. In early 2008, a phone survey was conducted in English, Spanish, Cantonese and Mandarin, and in mid-2008 the guide was mailed to approximately 61,500 seniors and persons with disabilities. After completion of the pilot study, the guide was edited and revised per the findings of the phone survey, mailed evaluations, and input from the advisory group. Additional revisions were made to reflect the changes in Medi-Cal optional benefits.

  UCB analyzed enrollment change data for the six months following the mailing of the guide. UCB is currently conducting a phone survey, based on this data, to identify additional modalities that will facilitate the voluntary enrollment of SPDs into Medi-Cal managed care. The translations of the Guide and accompanying county-specific inserts into all appropriate threshold languages should be completed and posted on the DHCS website by February 2010.

- *Geographic Expansion*
  Geographic expansion of the Medi-Cal managed care program increases access to a medical home for Medi-Cal enrollees. In 2008, San Luis Obispo County became the first county to complete the Medi-Cal managed care expansion process by becoming part of CenCal Health Plan (formerly Santa Barbara Regional Health Authority). In 2009, Medi-Cal managed care expanded into Merced and Sonoma counties. Further expansion into Kings, Lake, Madera, Mendocino, and Ventura counties is planned for 2010.

- *Member Evaluation Tool*
  MMCD initiated the Member Evaluation Tool (MET) project in 2007 to develop a non-clinical, initial health evaluation tool for newly enrolled members in response to the California Healthcare Foundation's (CHCF) recommendations in the November 2005 report, *Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Disabilities*. The goal in implementing the MET is to identify members of any age with chronic diseases and disabilities that may need expedited appointments with their primary care physicians to initiate care or avoid disruption of services. A collaborative workgroup was established to develop a preliminary tool which will be implemented as a pilot program during 2010.

- *Policy Development and Contract Revision*
  MMCD is currently in the process of developing new clinical policy letters as well as updating and revising several existing policy letters. Clinical policy letters clarify contractual and regulatory requirements, and provide a standard that allows plans and DHCS to establish monitoring and quality improvement activities. The following policies letters are currently under development or undergoing revision by MMCD:

  - *Enhanced Care Coordination Requirements*
    DHCS is taking a proactive approach towards clarifying and enhancing current plan requirements related to care coordination. DHCS and the Center for Health Care Strategies (CHCS) administered an electronic survey to Medi-Cal managed care plans to determine the current types of medical care coordination activities for seniors and persons with disabilities. In January 2009, MMCD convened a collaborative workgroup with contracted plans to identify best practices and to clarify performance standards and contract language appropriate for all plans. An updated Policy Letter is planned for release in 2010. Implementation of contract language will vary depending on the contracting cycle for each plan.

  - *Emergency Room*
    All previous policy and all-plan letters related to emergency room services are under review for their current applicability and will be condensed into one single policy letter. This will provide the necessary clarity for effectively auditing plans based upon current policy letters.

  - *Individual Health Education Behavioral Assessment*
    Providers have expressed concerns about the usefulness of the MMCD-developed "Staying Healthy" tool, which may be used for the contractual requirement to complete an Individual Health Education Behavioral Assessment. MMCD is working currently with the Health Education Workgroup and the DHCS Office of Clinical Preventive Medicine to complete revision of the tool and policy letter by mid-2010.

  - *Facility Site Review*
    Site Review nurses from Medi-Cal managed care plans requested that MMCD update the Site (physical plant) and Medical Record Review tools (MMCD Policy Letter 02-02) to include pertinent new review criteria for areas such as electronic medical records. As part of the policy revision process, MMCD is working with the Facility Site Review (FSR) Revision Task Force, a subgroup of the Site Review Workgroup, which is composed of FSR Master Trainer nurses, medical directors and MMCD clinical consultants. MMCD's goal is to complete the revision process in 2010.

  - *Group Needs Assessment*
    Plans must demonstrate, upon request of the State, how they use the Group Needs Assessment (GNA) to provide contractually required cultural and linguistic services for members. MMCD is working with the Health Education Workgroup to discuss proposals and recommendations for updating the GNA Policy Letter. The new Policy Letter is scheduled for release in 2010.

  - *Non-Monetary Member Incentives*
    With the passage of AB 915 in October 2007, DHCS began development of policy guidelines for non-monetary member incentives used by Medi-Cal managed care plans. In March 2009, MMCD issued the Policy Letter 09-005, "Non-Monetary

Member Incentive Guidelines," available on the DHCS website at http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx.

- *Cultural and Linguistic Policy Guidelines*
  MMCD began development of policy guidelines for the readability and suitability of informing and health education materials in 2006 and has recently been discussing proposals and recommendations with the Health Education Workgroup. MMCD plans to release new guidelines during 2010.

IV. REVIEW OF QUALTY STRATEGY

Performance Assessment

DHCS released its first formal *Quality Strategy* in 2004, but at that time did not implement a formal schedule or protocol for periodic review and updating. MMCD began an update process in 2007, which included several rounds of stakeholder input and which resulted in this final updated *Medi-Cal Managed Care Program Quality Strategy* (December 2009).

MMCD will now implement the following ongoing review and updating process to assure timely release of *Quality Strategy* updates whenever appropriate:

- Each year when the annual *Performance Evaluation Report*, prepared by MMCD's External Quality Review Organization (EQRO), is released, MMCD will schedule a management discussion of any EQRO findings and recommendations related to the current *Quality Strategy* within 60 days of the report's release. Any action items that result from this meeting will be shared with the EQRO and tracked by MMCD's staff.

- The EQRO will report on the results of any action items related to the *Quality Strategy* in the following year's Performance Evaluation Report until such time that the *Quality Strategy* is again updated. *Note:* The next Performance Evaluation Report will be prepared by the Health Services Advisory Group, the current EQRO, and is scheduled to be released in early 2010. This report is also referred to as the annual Technical Report and is discussed earlier in this report on page 6.

- Every three years MMCD will coordinate a comprehensive review and updating of the *Quality Strategy*. The target date for release of the next update is December 2012.

Frequency of Reporting

As described above, MMCD is establishing an annual review of any findings and recommendations related to the *Quality Strategy* that are included in the EQRO's annual *Performance Evaluation Report*. This annual review process will include tracking and follow up on any recommended action items. In addition, every three years MMCD will conduct a comprehensive review of the *Quality Strategy* and release an updated strategy. The "Performance Assessment" section above provides target dates for these activities.

Strategy Effectiveness

In preparing the annual Performance Evaluation Report, which includes an evaluation of MMCD's implementation of its most recent *Quality* Strategy, the EQRO considers the following documentation:

- Plans' annual HEDIS scores (reported to EQRO in June)
- Plans' QIP proposals and annual status reports (reported periodically throughout each year as determined by each QIP's schedule)
- Baseline and remeasurement reports released on the statewide collaborative. (*Note:* The baseline report on the statewide collaborative QIP on avoidable ER use was

released in October 2009. The interim report is scheduled for release by January 2010, the first remeasurement report for mid-2010, and the second and final remeasurement report in mid-20111.)

- Plans CAHPS survey results in year when the survey is administered (next scheduled for 2010)
- Other QI activities conducted by MMCD throughout each year (e.g., annual Quality Conference and quarterly meetings of the plan Medical Directors and the QI Workgroup)
- Plan audit reports (conducted jointly by DHCS and DMHC)
- MMCD Office of the Ombudsman calls, cases and State Fair Hearing request statistics
- Plans' quarterly grievance reports
- Results of Facility Site Review and Medical Record Reviews conducted by plans and MMCD's Medical Monitoring Unit
- Other relevant documentation

These documents and activities each have specific schedules and performance targets, which are discussed throughout this document.

To periodically update the *Quality Strategy* document, MMCD will convene a workgroup representing all program areas and also include the EQRO as appropriate.

V. ACHIEVEMENTS AND OPPORTUNITIES

Successes and Challenges

Since Medi-Cal managed care's major expansion began in the mid-1990s, the program has achieved many successes. MMCD has conducted extensive activities in areas such as community education, public informing, testing systems, meeting with stakeholders, identifying practice standards and performance measures, negotiating contracts, developing policies to clarify contract requirements, and writing and reviewing contract deliverables, informing and educational materials, and policies and procedures. As a result of these ongoing activities, a successful, well-organized program has been established, maintained, and further expanded.

Another major success has been a greater degree of transparency for the public release of quality improvement and performance measurement reports on the DHCS website. These reports are used by members, plans, legislators, advocacy groups and other stakeholders, researchers, other state Medicaid programs and government entities. Publicly sharing quality improvement and performance information not only promotes a more comprehensive presentation of the Medi-Cal managed care program, but also encourages more informed dialogue among stakeholders.

Comprehensive best practices have greatly contributed to program success and include:

- Program activities emphasize access to comprehensive health services and prevention-oriented health care that promotes health, well-being and individual choice.
- Consistent collaboration with stakeholder workgroups has enabled MMCD to identify key program issues and to plan meaningful improvement strategies.
- Access issues are addressed by MMCD both with plans and other stakeholders to assure ongoing basic access to the appropriate level of health care services for both current and future enrollee populations.
- Public sharing of quality improvement and performance measurement results supports both program transparency and better informed dialogue among stakeholders.

California is currently facing significant fiscal challenges, which have required difficult policy and programmatic decisions about service levels and staff resources. In addition, other limiting trends that threaten access to care for vulnerable populations include a continuing undersupply of nurses, declining numbers of physicians opting to practice adult medicine and family practice, declining provider participation in the Medi-Cal program in both managed care and fee-for-service, and increasing hospital and emergency room closures.

Recommendations

During these times of limited budgetary resources, it is especially important that the DHCS have a *Quality Strategy* focused on the best use of available resources to advance the quality of health care and services provided to the low-income families, children, pregnant women, seniors and persons with disabilities enrolled in the Medi-Cal managed care program. Improving the quality and efficiency of health care and preserving and improving every enrollee's health status are the desired outcomes of the program.

Quality improvement activities recommended in the future for the Medi-Cal managed care program will emphasize the following:

- Providing person-centered care tailored to meet the needs of the individual.
- Eliminating unnecessary barriers in accessing health care from appropriate professional and institutional networks, with consideration for improved reimbursement for providers and efficient business processes such as provider enrollment, treatment authorization and claims processing.
- Reducing and eliminating disparities in health outcomes from selected populations and groups.

Strategies Recommended by Stakeholders

An important part of developing this updated *Quality Strategy* for Medi-Cal managed care was soliciting input and strategic recommendations from various stakeholder groups, including advocates, enrolled members, medical directors and quality improvement managers from the plans. Over a two-month period in 2008, MMCD held discussion sessions and solicited written recommendations from plan representatives and the Medi-Cal managed care Advisory Group. In general, the majority of recommendations from these stakeholders were addressed by one or more current or proposed activities in the updated *Quality Strategy*.

In February 2009, MMCD distributed the final draft of this *Quality Strategy* to various stakeholders to solicit input. Again, the majority of recommendations received were addressed by current or proposed activities already included in the final draft *Quality Strategy*, although some further changes were made to appropriately reflect and respond to the last round of stakeholder input.

The following list represents an overview of recommendations received from stakeholders during the development process of this updated *Quality Strategy:*

Recommendations included in 2009 Quality Strategy

- Evaluate the successes/relevance of the current MMCD *Quality Strategy* before identifying and designing new strategies.
- Revise contract language and coordinate efforts with DHCS Audits and Investigations to assure that plans are audited to appropriate standards.
- Expand the core goals to go beyond quality of care and to make improvements in quality of service and patient safety.

Recommendations for future consideration

- Work with other agencies to develop a written matrix of state agency roles and responsibilities, especially with respect to coordination for carved out services and children with special health care needs.
- Investigate the feasibility of “deeming” (accepting) audits conducted by other regulatory agencies, especially for plans that have gone above and beyond contractual requirements by achieving National Committee for Quality Assurance (NCQA) accreditation.
- Keep measurement strategies in line with current HEDIS measures and NCQA standards. Assessing health outcomes via chart review requires extensive resources currently unavailable to most plans and providers. (MMCD currently consults each year with plan medical directors and staff involved in HEDIS reporting regarding the impact on plan resources of any proposed changes to required HEDIS measures. It should be

noted that NCQA is considering reducing or eliminating the medical record review requirement for a number of HEDIS measures for 2010 and beyond.)

- Consider contracting with an external vendor, such as the Center for Health Care Strategies, to administer the statewide collaborative QIP. The statewide collaborative can be a cost effective and beneficial means of reviewing and analyzing best practices and lessons learned from various interventions.
- Make developing and implementing programs to reduce racial disparities a priority, with a closer look at ethnicity, language and cultural issues. Evaluating the make-up of a population regionally should be an important part of the overall quality of care provided to members by a health plan.
- Work with plans to (1) urge NCQA to develop HEDIS measures appropriate to the disabled population, especially those who are cognitively impaired; (2) develop quality projects that address the needs of these members; and (3) work with NCQA to develop measures that assess the results of these efforts.
- Support statewide adoption of a fully interoperable Health Information Technology system (such as electronic medical records and e-prescribing) that would allow comprehensive management of medical information and secure exchange between members, providers, and plans. For example, the capacity could be developed to accept CHDP PM 160 forms electronically, provide aggregate feedback to plans, and accept proxy formats generated by electronic medical records.
- Work with agencies such as the California Department of Social Services or county human services agencies to explore how more accurate information on beneficiaries' race, ethnicity and language can be provided to health plans.
- Work with the California Department of Public Health to expand upon efforts already initiated by MMCD to address such issues as childhood obesity, diabetes education and prevention, pregnancy/prenatal care of young women, and breastfeeding informing materials.

VI. APPENDICES

A. Medi-Cal Managed Care Health Plan Demographics (as of November 2009)

B. Internal Quality Improvement Projects (as of December 2009)

C. Access to Care Contract Requirements

D. HEDIS External Accountability Set (EAS) Measures: 2007-2009

E. MMCD All Plan Letter 08-009: *Quality and Performance Improvement Requirements for 2009*

APPENDIX A: HEALTH PLAN DEMOGRAPHICS (as of November 2009)

Model	Health Plan	Federal Waiver	County/Start up Year	Current Enrollment (November 2009)
County Operated Health Systems	CalOptima	1915 (b)	Orange (1995)	348,725
	CenCal Health Plan (formerly Santa Barbara RHA)	1915 (b)	San Luis Obispo (2008) Santa Barbara (1983)	27,245 61,475
	Central California Alliance for Health	1915 (b)	Merced (2009) Monterey (1996) Santa Cruz (1996)	67,553 67,927 34,176
	Partnership Health Plan	1915 (b)	Napa (1998) Solano (1994) Sonoma (2009) Yolo (2001)	12,890 60,514 47,439 26,171
	Health Plan of San Mateo	1915 (b)	San Mateo (1987)	57,351
Geographic Managed Care Plans	Anthem Blue Cross	1915 (b)	Sacramento (1994)	87,033
	Care First	1915 (b)	San Diego (2006)	10,007
	Community Health Group	1915 (b)	San Diego (1998)	89,120
	Health Net	1915 (b)	Sacramento (1994) San Diego (1998)	37,384 34,323
	Kaiser Permanente	1915 (b)	Sacramento (1994) San Diego (1998)	25,753 13,608
	Molina Healthcare of CA	1915 (b)	Sacramento (2000) San Diego (2008)	22,935 55,440
	Western Health Advantage	1915 (b)	Sacramento (1994)	16,186
Two-Plan Model Commercial Plans	Anthem Blue Cross	1915 (b)	Alameda (1996) Contra Costa (1996) Fresno (1996) San Francisco (1996) San Joaquin (1997) Santa Clara (1996)	26,514 11,200 103,751 12,034 28,251 34,312
	Health Net	1915 (b)	Fresno (1997) Kern (2004) Los Angeles (1997) Stanislaus (2005) Tulare (1999)	93,268 29,999 439,077 18,969 23,884
	Molina Healthcare Of CA	1915 (b)	Riverside (1997) San Bernardino (1997)	38,478 53,695
Two-Plan Model Local Initiative Plans	Alameda Alliance for Health	1915 (b)	Alameda (1996)	92,411
	Anthem Blue Cross	1915(b)	Stanislaus (1997)	48,840
	Anthem Blue Cross	1915(b)	Tulare (1999)	77,064
	Contra Costa Health Plan	1915 (b)	Contra Costa (1997)	55,225
	Health Plan of San Joaquin	1915 (b)	San Joaquin (1996)	70,609
	Inland Empire Health Plan	1915 (b)	Riverside (1996) San Bernardino (1996)	170,982 189,849
	Kern Family Health Care	1915 (b)	Kern (1996)	102,599
	LA Care Health Plan	1915 (b)	Los Angeles (1997)	781,422
	San Francisco Health Plan	1915 (b)	San Francisco (1997)	35,597
	Santa Clara Family Health Plan	1915 (b)	Santa Clara (1997)	93,712
			Total Enrollment	3,834,997

Source:
MMCD Claims Payment Unit "Enrollment by Type-County Detail"

APPENDIX B: CURRENT INTERNAL QUALITY IMPROVEMENT PROJECTS (as of December 2009)

Health Plan	Internal QIP Title	Objective	Current Phase
AHF Healthcare Centers (IQIP 1)	Controlling High Blood Pressure	Increase the percentage of hypertensive patients meeting HEDIS standards for controlling blood pressure (systolic pressure <140 mmHg & diastolic pressure <90 mmHg).	Remeasurement 1
AHF Healthcare Centers (IQIP 2)	Reducing Adverse Reactions to Coumadin for Patients with HIV/AIDS K6	Reduce hospitalizations for GI bleeds related to interaction of Warfarin (Coumadin) with triple drug therapies of patients with HIV/AIDS.	Remeasurement 2
Alameda Alliance for Health	Decrease return ER visits for asthmatic exacerbations in children 2-18	Reduce number of children ages 2-18 who visited the ER with asthma from returning to the ER with additional asthmatic events.	Remeasurement 2
Central California Alliance for Health	Improving Effective Case Management	Increase the effectiveness of complex case mgmt & reduce avoidable ER visits.	Remeasurement 1
Community Health Group Partnership Plan	Increasing Follow-up to Positive Post-Partum Screens	Increase percentage of members with a live birth who receive a post-partum visit within 6 months of delivery & percentage of members screened for post-partum depression using a screening tool.	Remeasurement 2
Contra Costa Health Plan	Reducing Health Disparities Pediatric Obesity	Reduce health disparities in childhood obesity age 3-11 for African Americans, Hispanics & Whites.	Baseline
Health Plan of San Joaquin	Chlamydia Screening	Increase the rate in Chlamydia screening in sexually active women age 16-25.	Remeasurement 2
Kaiser Permanente: North	Childhood Obesity	Identify and decrease the number of children age 3-11 with BMI in the at-risk for overweight and overweight category.	Baseline
Kaiser Prepaid Health Plan (IQIP 1)	Cervical Cancer	Reduce the incidence, morbidity and mortality related to cervical cancer.	Remeasurement 4
Kaiser Prepaid Health Plan (IQIP 2)	Smoking Prevention	Increase the percentage of members receiving advice to quit smoking.	Remeasurement 5
Santa Clara Family Health Plan	Adolescent Health & Obesity Prevention	Increase screening for adolescent obesity & timeliness of appropriate health education interventions.	Remeasurement 1
SCAN Health Plan (IQIP 1)	Chronic Obstructive Pulmonary Disease (COPD) Management	Increase the rate of Spirometry Testing for COPD diagnosis & increase the percentage of patients who receive a prescription for bronchodilator.	Remeasurement 2
SCAN Health Plan (IQIP 2)	Prevention of Stroke and Transient Ischemic Attack (TIA)	To prevent new incidence of stroke or TIA by implementing interventions to target risk factors.	Remeasurement 1

APPENDIX C: ACCESS TO CARE CONTRACT REQUIREMENTS

Domain	Contract Requirements	Compliance Documentation, Monitoring and Evaluation
Provider Network	Plans are required to provide access to the following services: ♦ Adequate Capacity Primary Care Network ♦ Board certified or eligible Specialists ♦ Non-physician medical practitioners (e.g., midwives, nurse practitioners) ♦ Federally Qualified Health Center services ♦ Traditional and Safety-Net Providers	☐ Change in Provider Network Quarterly Report ☐ Geographic Mapping Reports ☐ Joint Medical Reviews ☐ Plan Subcontractors Quarterly Report ☐ Provider Directory (updated annually) ☐ Subcontractors' Agreements/Records
Access and Availability	Plans communicate, enforce and monitor provider compliance with the following standards: ♦ Appointments (per contract criteria) ♦ Emergency Services facility within service area with at least one physician and one nurse on duty at all times ♦ Urgent care within 24 hours ♦ After Hours Calls ♦ Linguistic/Interpreter Services available 24 hrs/7days/week ♦ Access for Disabled Members ♦ Services with Special Arrangements (e.g., family planning) ♦ Community Advisory Committee(s)	☐ Consumer Satisfaction Survey ☐ Emergency Department Protocols ☐ Evidence of Coverage Member Handbook ☐ Inpatient Days Information ☐ Joint Medical Reviews ☐ Policies and Procedures ☐ Quality Improvement Projects
Care Coordination	Plans and contracted provider provide the following care coordination services: ♦ Comprehensive Medical Case Management ♦ Targeted Case Management ♦ Disease Management Services ♦ Out-of-Plan Case Management and Coordination of Care ♦ Children with Special Health Care Needs services ♦ California Children's Services ♦ Services to Persons with Developmental Disabilities ♦ Plan health professional or contracted physician available 24 hrs/7 days/week to coordinate transfers, authorizations	☐ Consumer Satisfaction Survey ☐ Memorandums of Understanding with Local Health Departments ☐ Policies and Procedures
Providers	Plans monitor provider compliance in the following areas: ♦ Preoperational and periodic Facility Site Reviews (FSR) ♦ Full-time equivalent Provider to Member ratios ♦ Regulatory physician supervision ratios for non-physician medical practitioners ♦ Time and distance standard	☐ Geographic Mapping Reports ☐ FSR Master Trainer and Reviewer Certification ☐ FSR Oversight by Medical Monitoring Unit ☐ Joint Medical Reviews ☐ Site Review Reports
Scope of Services	Plans assure that the following services are provided: ♦ Medically Necessary Covered Services ♦ Initial Health Assessment ♦ CHDP Preventive and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services ♦ Adult Preventive, diagnostic and treatment ♦ Comprehensive Perinatal Services ♦ Pediatric and Adult Immunizations ♦ Vision Care ♦ Pharmaceutical Services ♦ Health Education ♦ Hospice Care	☐ Consumer Satisfaction Survey ☐ HEDIS External Accountability Set ☐ Joint Medical Reviews ☐ Over/Under Utilization Monitoring ☐ Quality Improvement Projects
Member Services	Plans and providers must comply with standards re: ♦ Member Rights/Responsibilities ♦ Rights to Advance Directives ♦ Notification of Changes to Access to Covered Service ♦ Primary Care Provider Selection/Assignment ♦ Member Grievance System ♦ Expedited State Hearings	☐ Call Center Reports Quarterly ☐ Consumer Satisfaction Survey ☐ Grievance Log ☐ Joint Medical Reviews ☐ Member Services Guide ☐ Oversight by Member Rights/Program Integrity ☐ Policies and Procedures ☐ Quality Improvement Projects ☐ Quarterly Grievance Report

APPENDIX D: EXTERNAL ACCOUNTABILITY SET (EAS) MEASURES: 2007-2009[1]

Calendar Year 2007	Calendar Year 2008	Calendar Year 2009
Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the First 15 Months of Life
Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life*	Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life*	Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life*
Adolescent Well-Care Visits*	Adolescent Well-Care Visits*	Adolescent Well-Care Visits*
Childhood Immunization Status – Combo 2*	Childhood Immunization Status – Combo 2*[2] & Combo 3	Childhood Immunization Status –Combo 3*
Appropriate Treatment for Children with Upper Respiratory Infection	Appropriate Treatment for Children with Upper Respiratory Infection	Appropriate Treatment for Children with Upper Respiratory Infection
Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care* • Postpartum Care	Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care* • Postpartum Care	Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care* • Postpartum Care
Chlamydia Screening in Women	Ambulatory Care (4 indicators): • Ambulatory Surgery/Procedures • ED Visits • Observation Room Stays • Outpatient Visits	Ambulatory Care (4 indicators): • Ambulatory Surgery/Procedures • ED Visits • Observation Room Stays • Outpatient Visits
Breast Cancer Screening	Breast Cancer Screening	Breast Cancer Screening
Cervical Cancer Screening	Cervical Cancer Screening*	Cervical Cancer Screening*
Use of Appropriate Medications for People with Asthma*	Use of Appropriate Medications for People with Asthma*	Use of Appropriate Medications for People with Asthma*
Comprehensive Diabetes Care (4 indicators): • Eye Exam (Retinal) Performed • LDL-C Screening • HbA1c Testing • Medical Attn. for Nephropathy	Comprehensive Diabetes Care (7 indicators): • Eye Exam (Retinal) Performed • LDL-C Screening Performed • LDL-C Control (<100 mg/dL) • HbA1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Good Control (<7.0%) • Medical Attn. for Nephropathy	Comprehensive Diabetes Care (7 indicators): • Eye Exam (Retinal) Performed • LDL-C Screening Performed • LDL-C Control (<100 mg/dL) • Hemoglobin A1c Testing • HbA1c Poor Control (>9.0%) • HbA1c Control (<7.0%) • Medical Attn. for Nephropathy
Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis[3]	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

*Measures used for the default algorithm.[1] Since 2006, the EAS has included only HEDIS measures and no Department-developed measures.

[2] In 2008, NCQA indicated that the Child Immunization Status Combo 2 indicator might be retired in 2009. Although, it remained an active measure in 2009, MMCD chose to require only Combo 3.

[3] For 2008, NCQA renamed this measure and removed the inverse nature of the measure's rate, so starting in 2008 a higher rate is better for the AAB measure, as it has been for the other measures.

APPENDIX E: ALL PLAN LETTER 08-009

All Plan Letter 08-009, *Quality and Performance Improvement Requirements for 2009* is available on the DHCS website at http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx .