SEPTEMBER 2019

CHCF Issue Brief

A Close Look at Medi-Cal Managed Care:
Stories of Quality Improvement Success

With more than 80% of Medi-Cal beneficiaries enrolled in managed care, assessing and monitoring the quality of care delivered by managed care plans (MCPs) is critical to ensuring all Medi-Cal members receive high-quality, timely care. Among other oversight activities, the California Department of Health Care Services (DHCS) monitors Medi-Cal MCPs' annual scores on Healthcare Effectiveness Data and Information Set (HEDIS) measures, which assess quality of care, including rates for preventive screening, control of chronic conditions, and access to primary care.

A 2019 study conducted by the University of California, San Francisco analyzed HEDIS scores and trends in Medi-Cal managed care from 2009 to 2018. The study found that quality varied significantly across MCPs and regions and that, over this ten-year period, quality did not improve or declined for more than half of the measures.[1] However, there are many examples of significant progress by individual MCPs on specific measures. In light of these findings, the California Health Care Foundation (CHCF) commissioned Chapman Consulting to examine the experiences of a subset of successful MCPs to answer two questions: First, how did the selected MCPs make real, sustained improvements in quality and achieve those gains? Second, what lessons do these experiences provide to policymakers, Medi-Cal program officials, and MCPs seeking to broaden and accelerate quality improvement in Medi-Cal managed care?

The experiences of the selected MCPs point to several, interconnected strategies: leadership commitment; effective data analysis; real-time data exchange; collaborating with providers at the point of service; increasing member access to care and education; and targeted financial incentives. Shared experiences also surfaced several impediments to be addressed: carve-out services; poor data exchange; and inadequate provider supply and participation. These lists are intended not to be comprehensive but rather to shed light on what must be done to ensure all Medi-Cal enrollees receive high-quality care.

Approach

Chapman Consulting and CHCF established multiple criteria to identify which MCP improvements to include in this study. Among the most important criteria, the MCP had to have improved its HEDIS quality score by at least ten percentage points between 2009 and 2018; the MCP's most recent score (2018) had to be at or above the statewide average; and the MCP had to have demonstrated significant improvement across a minimum of three HEDIS measures in a given service area. Also, measures had to have been reported on for at least five years to qualify.

Several MCPs met these criteria on one or more quality measures. The six MCPs selected to study reflect the diversity of MCPs by ownership, plan type, and geographic service area (Table 1, page 2). These MCPs were not selected because they scored higher than other MCPs.

Chapman Consulting conducted structured interviews with each MCP to understand what actions were taken to improve HEDIS scores. This issue brief summarizes the common themes that emerged from these discussions. The information and findings presented in this issue brief are based on the information shared during the structured interviews, and no additional independent verification of the quality improvement activities and strategies was conducted as part of this analysis.

Table 1. Characteristics of Featured Managed Care Plans

	OWNERSHIP	TYPE	COUNTIES SERVED
Anthem Blue Cross	Commercial	For-profit	Multiple/statewide
CalViva Health	Public	Local initiative	Fresno, Kings, Madera
Community Health Group	Commercial	Nonprofit	San Diego
Health Plan of San Mateo	Public	County-organized health system	San Mateo
L.A. Care Health Plan	Public	Local initiative	Los Angeles
Molina Healthcare of California	Commercial	For-profit	Multiple/statewide

Findings: Common Themes in Quality Improvement

Quality Improvement Starts with Plan Leadership

Each of the MCPs interviewed emphasized the important role senior leadership played in the development of effective solutions to improve quality scores. Leadership involvement not only signaled that quality monitoring and improvement were priorities for all MCP staff but also ensured that necessary resources (staff, infrastructure, and funding) were available to support the MCP's quality improvement efforts. Several MCPs commented that leadership's involvement allowed quality staff to pilot different strategies to improve quality scores with the understanding that, although some strategies would be unsuccessful, trial and error would ultimately identify the most effective way to improve the MCP's quality scores and member outcomes. Examples include the following:

- Molina indicated the leadership team made significant investments in both staff and financial resources to drive improvements in quality. Molina shared that a "top-down" approach fostered shifts in the organizational culture to emphasize collaboration. For example, a framework that created connections and communication across departments within the MCP was implemented. This framework resulted in the development of a data analytics team, practice facilitation teams, and care connections teams that worked together to develop strategies to improve Molina's quality scores.
- In 2014, Anthem reported it was below the minimum performance levels (MPLs) established by DHCS.[2] In response, Anthem's leadership made an explicit commitment to implement targeted quality improvement efforts. This process began with an analysis of data and internal processes to revamp the MCP's quality approach, which led to the development of a comprehensive plan to focus on quality across the MCP with a clear message that the plan was an organizational priority. Anthem's quality scores have improved significantly as a result, with 91% of measures above the MPL, and the MCP has been recognized as "Most Improved Plan" by DHCS for the past four years.
- The leadership team of L.A. Care Health Plan (LA Care) implemented regular meetings with the leadership of clinics with which the MCP contracts to discuss quality improvement goals and progress. Signaling the importance of these meetings, LA Care participants include the chief executive officer, chief medical officer, and quality team leadership.

Data Analysis Is Key

Every MCP interviewed referenced the importance of data analysis and improvements in data collection as a critical component to improving quality performance. For example, all the MCPs discussed the importance of data analysis for identifying both high-volume provider sites with low HEDIS scores (i.e., "high-volume/low-performing" providers) and member gaps in care to develop specific interventions. Identifying the high-volume/low-performing providers helped the MCPs target specific quality improvement efforts initially before extending successful transformation efforts to larger networks. Other examples include the following:

- When CalViva Health (CalViva) launched in 2011, MCP staff reviewed the data on quality metrics in its service area. This analysis revealed low HEDIS scores for eye exams and blood pressure control for diabetic patients among a few high-volume/low-performing clinics. MCP staff used this information to conduct outreach to the clinics and identified a need for staff training on the use of the retinal camera, how to measure a patient's blood pressure correctly, and proper documentation of results to meet the HEDIS requirements as well as to ensure proper follow-up by the provider. For the diabetic eye exams, CalViva learned one clinic was referring patients to an optometrist to complete the test rather than conducting the test on-site, and patients were not following through with the referral. Once the clinic began completing the test on-site, the related HEDIS score increased, and patients were more likely to complete the exam, resulting in better care. Similarly, once clinic staff learned how to measure a patient's blood pressure correctly and document the results, the clinics' quality scores increased, and the clinics were able to better identify and implement appropriate interventions. CalViva improved the rate at which members' blood pressure is under control, a component of the "Comprehensive Diabetes Care" HEDIS measure, from 53% in 2013 to 68% in 2018. During this same period, CalViva also improved its rate of eye exams (retinal screening) from 49% to 59%.[3]
- In 2014, DHCS put a corrective action plan (CAP) in place with LA Care as a result of the MCP's low scores for two measures related to monitoring use of persistent medications for the treatment of high blood pressure: angiotensin-converting enzymes (ACE) inhibitors and angiostensin receptor blockers (ARB). This action led the MCP to evaluate its data and determine which clinics and providers were performing poorly on these measures. LA Care also evaluated pharmacy data to identify the members filling prescriptions for ACE inhibitors and diuretics and shared that data with pharmacies and providers. In addition, the MCP sent letters to members reminding them to schedule appointments and suggesting members bring the letter to their appointment to provoke conversations about necessary labs and other follow-up appointments related to the members' persistent medications. LA Care's score on monitoring patients using ACE inhibitors or ARB improved from 73% in 2012 to 89% in 2018. Similarly, the MCP's score on monitoring patients using diuretics improved from 72% to 88% during this period.

Data analysis also is critical to evaluating interventions. While most MCPs did not cite "plan-do-study-act" (PDSA) cycles specifically, all mentioned that interventions must be assessed frequently and, if an effort is not having the intended result, the MCP must be able to pivot quickly to a different strategy. Data analysis helped the MCPs realize the importance of emphasizing to providers the correct data to capture so providers receive credit for providing comprehensive, quality care. The MCPs interviewed discussed the importance of developing a comprehensive "plain language" HEDIS guide to crosswalk quality measures with the corresponding data necessary for collection, so all staff in the provider's office can easily understand HEDIS measures and specifications. Consistent data capture, although not the only element critical to improving the delivery of high-quality care, is one of the most important aspects of the HEDIS process and was a starting point to identify the root causes of low HEDIS scores. Once the MCP identifies the underlying causes of poor quality scores (e.g., data collection, quality of care delivered, member education and outreach), the appropriate interventions can be implemented.

Real-Time Data Exchange with Providers Is Critical

The MCPs interviewed noted the importance of exchanging data with in-network providers on a real-time basis to drive immediate action when issues are identified. Examples include the following:

- CalViva developed provider profiles to identify and track members with gaps in care. These profiles are shared with providers to encourage follow-up with their patients. CalViva also sends information about individual providers' HEDIS scores based on the raw data providers submit to the MCP. CalViva found that successful quality improvement interventions require provider champions who can lead practice transformation and provide the MCP with data. Provider profiles were created to support clinic staff engaged in this work.

- Community Health Group (CHG) provides monthly reports to its providers identifying members who have not followed medical recommendations or taken their medications. As the end of the HEDIS measurement year approaches, reports are sent out biweekly and then weekly, and CHG's providers use this information to work with their patients to close gaps in care. CHG provides countywide dashboards so each clinic can compare its scores with other clinics in the county. The MCP believes this level of comparison spurs "friendly competition" among the clinics and fosters improvements.

- For several years, the Health Plan of San Mateo's (HPSM) score on the HEDIS "Prenatal and Postpartum Care — Postpartum Care" measure fell below the MPL. This measure reflects the percentage of women giving birth who had a postpartum visit within the first eight weeks after delivery. To improve the quality score, HPSM implemented several strategies, including the revision of an existing report tracking recent deliveries by members. Originally, this report was produced monthly, but the report is now produced weekly. Health promotion coordinators at the MCP use this report to identify postpartum members for telephonic outreach to encourage them to schedule an appointment with their provider between 21 and 56 days after delivery. By producing the report on a weekly basis, the health promotion coordinators have virtually real-time information about deliveries, which increases the likelihood the member will see her provider within the HEDIS required time frame. HPSM's score on the postpartum care measure improved from 60% in 2009 to 75% in 2018, which is 11 percentage points above the statewide average (64%).

Quality Improvement Efforts Are Most Effective at the Point of Service

Sending health plan staff on-site with providers. The MCPs interviewed identified the importance of having staff on-site with providers to observe best practices and identify areas for improvement. Being on-site allows the MCPs to develop targeted interventions that reflect the local landscape and needs of both members and providers. The MCPs then use this information to scale up the interventions, when feasible, and identify best practices for other provider sites. This process also allows the MCPs the opportunity to identify other issues at the provider sites that otherwise might not have been uncovered, often leading to additional quality improvement efforts. For example:

- Anthem implemented on-site patient-centered care consultants, leading to the development of its "clinic days" initiative. Anthem invites members with diabetes to attend a clinic day for a comprehensive diabetes care visit, initially targeting clinics with a high volume of diabetes patients. Anthem staff are on-site during the clinic day to assess current practices and identify additional steps the MCP can take to support in-network health care providers. While at the clinic, members also can complete other lab work and address unrelated gaps in care (e.g., if a member is overdue for another preventive service such as a mammogram, the member can complete it during the same visit). Anthem noted significant improvements in several measures of diabetes care, including the "Comprehensive Diabetes Care — Eye Exam (Retinal) Performed" measure, which improved from 49% in 2009 to 90% in 2018.[4] Anthem found the initial diabetes-focused clinic days were so successful that it replicated the model to address care

needs specific to women's health. The MCP also implemented the model at nonclinic locations, such as homeless shelters, to increase the ability to reach members.

- To improve its HEDIS scores for the comprehensive diabetes care measures, CHG staff visited several provider sites where the MCP determined providers were unable to complete the required eye exams because the providers lacked retinal cameras. As a result, members were referred to another provider to complete the exam, and compliance rates were low, which negatively impacted both quality scores and outcomes. CHG purchased retinal cameras for several providers and trained staff on their use. Additionally, CHG provided cameras for clinical staff who perform in-home visits, which increased the ability to reach members and ensure the test was completed. Data from the cameras is sent to specialists who analyze, interpret, and send feedback within 24 to 48 hours so appropriate action can be taken and monitored by the MCP. CHG's score on the "Comprehensive Diabetes Care — Eye Exam (Retinal) Performed" measure improved from 47% in 2009 to 67% in 2018.

Educating providers and front-line office staff on HEDIS specifications and documentation. Most MCPs noted challenges with ensuring provider staff are following the HEDIS specifications for each measure and reported that problems recording the correct information were a significant barrier leading to low quality scores. To address this problem, CHG, for example, developed a HEDIS quick reference guide that includes every measure and the corresponding ICD-9 or ICD-10 codes, common procedure codes, and information on co-testing. The HEDIS guide is updated every year and designed to be easy to understand, so providers, as well as front-line staff, can familiarize themselves with the specifications. Additionally, CHG provides voluntary HEDIS training sessions throughout the year, which low-scoring clinics and providers are encouraged to attend. HEDIS trainings also are available on the MCP's website for providers and clinics to review.

Small and local interventions. Several of the MCPs highlighted the importance of piloting interventions that are small and locally focused. Nationally, Anthem has found it beneficial to create local quality teams that include clinical staff focused entirely on ensuring the MCP improves its quality scores and outcomes for members. Anthem has made significant investments in provider incentives and data analytics, which allow for root-cause analysis to determine how best to structure an intervention (e.g., with a focus on provider education, member outreach, data improvements) and have led to implementation of interventions specific to the local service area and population needs.

Increasing Access to Care and Member Education

The MCPs interviewed noted that impediments to member access are often major barriers to quality improvement efforts. The MCPs shared that quality scores improved when interventions made it easy for members to address several needs at the same time — for example, to receive care for multiple complex needs and obtain preventive care in a single visit rather than across several appointments in different locations. Anthem's "clinic days," described earlier, are one example of an MCP taking steps to make it easier for members to get the care they need. Other examples include the following:

- Molina created care connection teams comprised of in-home nurse practitioners. The teams were initially deployed to work with members with diabetes to assist them in connecting with the right resources and help them understand how to obtain assistance to avoid delays in care. This initiative was quickly expanded to conduct outreach to members, identified through data analysis, who had not seen their primary care practitioners within a specified time frame. While in the home, the nurse practitioners can conduct thorough examinations that would otherwise require several trips to provider's office and the lab. Nurse practitioners also identify barriers to care and improved health, such as transportation needs and food insecurity. Once an unmet need is identified, the MCP can link members to both internal and external resources for social services and supports

to address social determinants of health. Molina has seen improvements in its HEDIS diabetes scores. For example, its score for the "Comprehensive Diabetes Care — HbA1c Control" measure improved from 41% in 2010 to 89% in 2018.[5]

- HPSM's health promotion coordinators connect postpartum members to community resources (e.g., the Black Infant Health Program or the county home visiting program). The health promotion coordinators also can help members access appropriate care by connecting them to a provider and helping to schedule appointments. In addition, HPSM noted it sends text messages to postpartum members regarding the importance of scheduling timely appointments with their providers. Given the sensitive nature of postpartum care, successful member engagement requires the health program coordinators to have strong customer service skills, and bilingual staff have been critical to the success of the postpartum program at the MCP. As noted earlier, HPSM's score on the postpartum care measure is now well above the statewide average.

Financial Incentives Can Spur Quality Improvement

Most of the MCPs interviewed found both member and provider incentives are useful tools to help prioritize improvements in specific quality metrics. For example:

- HPSM includes the HEDIS postpartum measure in the MCP's provider pay-for-performance (P4P) program, and payments are intended to encourage providers to see postpartum members and schedule timely appointments. Because labor and delivery are typically reimbursed globally (i.e., providers receive a single payment for the entire set of services), it was difficult to identify the postpartum component provided to the member. HPSM instituted a specific code to capture this visit, which triggers an incentive payment of $50 per postpartum visit completed.

- Molina used grant funding to pay provider office staff to prioritize and participate in weekly meetings on quality initiatives and to monitor improvement. Molina found that providing incentives for practices to utilize nonphysician staff to work to the "top of their licenses" also was key to closing gaps in care, as well as creating an internal champion who would engage in constant monitoring and reporting related to quality. Further, Molina's P4P incentives are aligned with the targeted interventions at the provider level.

Challenges to Health Plan Quality Improvement Efforts

While an exhaustive review of impediments to successful and sustained quality improvement was beyond the scope of this study, a few common challenges emerged from the MCP interviews:

Carve-out services. MCPs noted that the Medi-Cal "carve-outs," which are covered services not provided under the health plan contract (such as dental and specialty mental health services), can have a negative impact on quality scores and care provided. Without the ability to coordinate a member's care across the continuum of services, the MCPs have less ability to impact the overall health outcomes for a member.

Data exchange. Many MCPs struggle to obtain complete utilization data for members. Problems occur in data exchange from within the network (e.g., from contracted providers and groups) and in obtaining timely data from DHCS on carve-out services. Consistent data regarding services provided outside the MCP's contract or by noncontracting providers also could help MCPs identify gaps in care and could lead to better care coordination.

Provider supply and participation. Access to care requires an extensive provider network, and the MCPs shared that finding providers willing to see Medi-Cal patients can impede efforts to improve quality. For example, the MCPs reported increasing difficulty with finding specialty provider types such as obstetricians/gynecologists and cardiologists willing to accept Medi-Cal payment rates.

Conclusion

California's Medi-Cal managed care program provides coverage to more than 10 million Californians. The examples of quality improvement success stories included in this report demonstrate that state officials and MCP leaders can deploy strategies to significantly improve the quality of care provided to Medi-Cal beneficiaries. Most Medi-Cal MCPs still have room to improve on many HEDIS measures. By shining a light on where progress is occurring and what made it possible, this brief provides lessons for accelerating quality improvement and extending it program-wide.

Endnotes

1. Andrew B. Bindman, Denis Hulett, Isabel Ostrer, and Taewoon Kang, *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade*, California Health Care Foundation, September 2019, www.chcf.org.
2. Until 2019, DHCS set the MPLs at the 25th percentile of all Medicaid MCPs nationwide. MCPs that did not meet the MPL were subject to increased oversight by DHCS and potentially put on a corrective action plan (CAP).
3. Authors' calculation of the average HEDIS scores across Fresno, Kings, and Madera Counties.
4. Authors' calculation of the average HEDIS scores across Alameda, Contra Costa, Fresno, Sacramento, San Francisco, Santa Clara, and Tulare Counties.
5. Authors' calculation of the average HEDIS scores across Sacramento, San Diego, and Riverside/San Bernardino Counties.

About the Authors

Athena Chapman, MPP, is president and Elizabeth Evenson is policy director of Chapman Consulting, which provides strategic planning, meeting facilitation, organizational support, and regulatory and statutory analysis to organizations in the health care field. Caroline Davis, MPP, is president of Davis Health Strategies, which provides strategic and analytical services, including government/public policy strategy, managed care program development and implementation, regulatory analysis, and meeting facilitation to health care organizations focused on improving care for vulnerable and safety-net populations.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For other reports in the "A Close Look at Medi-Cal Managed Care" series, visit **www.chcf.org**.