Performance Evaluation Report

Health Plan of San Joaquin

July 1, 2008–June 30, 2009

Medi-Cal Managed Care Division
California Department of
Health Care Services

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1. Executive Summary

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.6 million beneficiaries (as of June 2009) in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review. Plan-specific reports are issued in tandem with the technical report.

Plan-specific reports include findings for each plan regarding its organizational assessment and structure, performance measures, and QIPs as they relate to the quality, access, and timeliness domains of care. This report is unique to the MCMC Program's contracted plan, Health Plan of San Joaquin ("HPSJ" or "the plan"), for the review period July 1, 2008, to June 30, 2009. Actions taken by the plan subsequent to June 30, 2009, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for Medi-Cal managed care members through the provision of health care services and the plan's structural and operational characteristics.

The DHCS uses performance measures and QIP results to assess care delivered to members by a plan in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, the DHCS monitors aspects of a plan's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems.

To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPLs indicate low performance, rates at or above the HPLs indicate high performance, and rates at the MPLs or between the MPLs and HPLs demonstrate average performance.

HSAG found that HPSJ demonstrated average performance for the quality domain of care. This was based on the plan's 2009 performance measure rates (which reflected 2008 measurement data), QIP outcomes, and compliance review standards related to measurement and improvement. The plan demonstrated good performance measure results but had opportunities to improve QIP outcomes and its compliance with some review standards.

Most of HPSJ's performance measure rates fell between the established MPLs and HPLs. The plan exceeded the HPLs for *Well-Child Visits in the First 15 Months of Life (W15)* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*. No measures fell below the MPLs in 2009. The plan showed statistically significant increases for four measures and had no statistically significant declines between 2008 and 2009. The plan had three performance measures with rates just above the MPLs. These present a potential opportunity for improvement.

During the review period, HPSJ's QIP for chlamydia screening showed a statistically significant decline in performance between the baseline period and first remeasurement period. The plan implemented a provider incentive intervention, although a lack of a provider incentive was not identified as a causal barrier. HPSJ has an opportunity to implement interventions that link to identified barriers to increase the likelihood of success.

HSAG noted that the plan has an opportunity to improve the documentation of both QIPs to meet compliance with federal requirements for conducting a QIP. Following the Centers for Medicare & Medicaid Services (CMS) protocol for conducting a QIP increases the likelihood that the plan will achieve real and sustained improvement of health outcomes.

Audit findings showed that the plan met most of the criteria for administrative and organizational capacity, which is necessary to support a quality improvement program. HPSJ has an opportunity to increase its compliance with some DHCS and federal requirements. The audit found that the plan lacked appropriate oversight of all quality monitoring activities, including the review and approval of the work plan and regular quality reports. The plan's work plan did not contain measureable performance goals for monitoring quality areas, including activities that address and monitor areas of noncompliance. A review of member grievances found that the medical director did not review all clinical grievances and that the clinical staff did not review the grievance logs to determine if clinical grievances were being referred appropriately for physician review. These findings impact quality of care delivered to members.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members.

The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess plans' compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Many performance measures fall under more than one domain. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HPSJ demonstrated average performance for the access domain of care based on its 2009 performance measure rates related to access, QIP outcomes addressing access, and compliance review standards related to the availability of and access to care.

HPSJ's 2009 performance measures related to access fell primarily between the MPLs and HPLs. The plan was above the HPLs for well-child visit measures and had no rates below the MPLs.

The plan had standards for access to care for routine, preventive, and prenatal care, as well as newborn, urgent, emergency, and routine specialty care. The audit showed that the plan lacked a

process to monitor primary care provider capacity to accept new members. In addition, the plan did not follow up on member grievances related to needed urgent care or office appointment wait times. The plan's policy and procedures related to in-office wait times were inconsistent with the plan's provider manual. The plan also lacked a process for overseeing and monitoring its contracted nurse advice line. Audit findings showed that not all plan provider offices were compliant with cultural and linguistic standards for providing appropriate language interpretation services, discouraging the use of family and friends as interpreters, and receiving cultural competency training.

Timeliness

The timeliness domain of care relates to a plan's ability to make timely utilization decisions based on the clinical urgency of the situation, minimize any disruptions to care, and provide a health care service quickly after a need is identified.

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

Based on 2009 performance measure rates related to providing timely care and compliance review results related to timeliness, HPSJ demonstrated average performance in the timeliness domain of care.

The plan performed within the MCMC-established thresholds for prenatal and postpartum visits and for childhood immunizations. HPSJ performed above the HPLs for well-child visits in the timeliness domain of care.

The plan monitors for under- and over-utilization. Additionally, the plan monitors member referrals through facility site reviews. The plan's providers had 99 percent compliance for physician review of consult/referral reports, demonstrating good continuity and coordination of care for members at the provider level. The plan also demonstrated provider follow-up with members for missed appointments through outreach that helped members follow through with needed care. The plan has an opportunity to improve care coordination for persons with developmental disabilities and for new members by ensuring that they receive an initial health assessment.

For prior authorizations, findings indicated that not all denials contained a clear description of the clinical rationale and met required time frames for submission. The member Evidence of Coverage document, which provides members with information about covered services under the

plan, did not list preventive services as a covered benefit that does not require prior authorization. Under member rights, the audit noted a lack of documentation of a discussion of grievances; analysis, tracking, and trending of grievance data; and corrective actions related to grievances. The plan also did not send grievance acknowledgment and resolution letters within the required time frames.

Conclusions and Recommendations

Overall, HPSJ demonstrated average performance in providing quality, accessible, and timely health care services to its MCMC members.

HPSJ's 2009 performance measure rates fell primarily between the established MPLs and HPLs. The plan exceeded the HPL for well-child visits and had no rates below the MPLs.

The plan had a decline in QIP performance between the baseline and remeasurement periods, indicating that HPSJ has an opportunity to better align intervention strategies with barriers to increase the likelihood of success.

HPSJ demonstrated compliance with the DHCS standards for structure and operations. Opportunities for improvement exist for quality improvement, member rights, availability and accessibility, cultural and linguistic service requirements, marketing, prior authorization, and the grievance system.

Based on the overall assessment of HPSJ in the areas of quality and timeliness of and access to care, HSAG recommends that the plan do the following:

- Focus performance measure improvement efforts on the three measures that fall just above the MPLs to ensure compliance in subsequent years.
- Realign QIP intervention strategies to target identified barriers and explore evidence-based interventions that may increase the likelihood of improvement.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance toward increasing compliance with the CMS protocol for conducting QIPs.
- Enhance the quality management program to include effective oversight of all monitoring activities, including the review and approval of the work plan and all quality-related reports.
- Incorporate measurement performance goals for monitoring quality areas into the work plan and include activities that address and monitor areas of noncompliance.
- Implement a process to monitor the provision of all medically necessary services for persons with developmental disabilities.

- Implement a process to monitor primary care providers' capacity to accept new enrollment.
- Develop a process to follow up on member grievances regarding access and availability.
- Develop a process to oversee and monitor the nurse advice line.
- Document discussions of grievance data and ensure that the plan takes action, as appropriate, after discussion of these data.
- Incorporate a process to ensure appropriate physician review of all clinical grievances.
- Implement a process to assure that grievance acknowledgment and resolution letters are sent within the required time frames to members and that compliance is monitored.
- Revise grievance policies and procedures to include the process for written notification to members for grievances not resolved within 30 days.
- Implement a process to monitor prior-authorization notifications to ensure that required information is contained in the notifications and to ensure that plan policies and procedures in this area are consistent with contract requirements.
- Reeducate providers on cultural and linguistic service requirements and update marketing policies and procedures.

In the next annual review, HSAG will evaluate HPSJ's progress with these recommendations along with its continued successes.

Plan Overview

Health Plan of San Joaquin ("HPSJ") is a full-scope managed care plan in San Joaquin County. HPSJ became operational with the MCMC Program in February 1996, and as of June 30, 2009, the plan had 68,089 MCMC members[1]. HPSJ serves members as a local initiative plan under the Two-Plan model.

In a Two-Plan model type, the DHCS contracts with two managed care plans in each county to provide medical services to members. Most Two-Plan model counties offer members a choice between a local initiative plan and a nongovernmental commercial health plan.

[1] *Medi-Cal Managed Care Enrollment Report -June 2009*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process to assess plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about HPSJ's performance in providing quality, accessible, and timely health care services to its MCMC members. Compliance monitoring standards primarily fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Joint Audit Review

The DHCS's Audits and Investigations Division (A&I) works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A joint audit is conducted for each MCMC plan approximately once every three years. In addition, A&I periodically conducts non-joint medical audits of five MCMC plans; however, HPSJ is not among those plans designated for a non-joint medical audit.

HSAG reviews the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. The most recent joint audit of HPSJ was conducted in January 2009, covering the audit period of January 1, 2008, through December 31, 2008; however, the audit report was not issued until July 2009, and the close-out report was not issued until

December 2009. Therefore, the 2009 audit results are not reflected in this report and will be included in the next plan-specific evaluation report.

The previous joint audit was conducted in April 2005, covering the review period of April 1, 2004, through March 31, 2005. The audit showed that while HPSJ was compliant with many standards under the scope of the review, areas for corrective action were identified.

HPSJ demonstrated that it had a utilization management (UM) program incorporated into its quality program and that the quality program was continually updated by the plan. The plan's medical director is responsible for overseeing the program, and UM decisions are made based on established medical guidelines. The plan has an operational structure that supports ongoing reporting, monitoring, and analysis of under- and over-utilization.

For prior authorizations, HPSJ's medical director or physician designee is responsible for all denials and authorizations. The review of prior-authorization notifications showed that not all denials included a clear description of the clinical rationale. Denial letters related to pharmacy services lacked the reviewing physician's telephone number, signature, and date. The plan missed the required time frame for one submission. These findings were repeat deficiencies noted in the previous audit.

In the area of continuity and coordination of care, HPSJ had procedures for providing case management to members. The plan monitored member care and referrals through facility site reviews. Results from the plan's facility site reviews showed 99 percent compliance for physician review of consult/referral reports. Provider follow-up and outreach to members regarding missed appointments had an 85 percent compliance rating. Audit findings showed that HPSJ was not monitoring the provision of all medically necessary services and care coordination for members receiving early intervention services through the California Children's Services (CCS) program and for persons with developmental disabilities. Additionally, the plan lacked a process for monitoring providers' attempts to contact members to schedule an initial health assessment and lacked a process for documenting that new members received the assessment.

A DHCS communication letter to the plan dated February 14, 2006, noted that the plan had adequately addressed deficiencies related to coordination of care for members receiving early intervention services through CCS. However, the report also noted that HPSJ's corrective action plan did not adequately address efforts made by the plan to coordinate care for persons with developmental disabilities who were receiving care through the regional center.

The plan had standards related to access to care for routine, preventive, and prenatal care, as well as newborn, urgent, emergency, and routine specialty care. The audit revealed that HPSJ lacked a process for collecting, analyzing, trending, and monitoring primary care providers' capacity to accept new enrollment. In addition, the plan did not follow up on member grievances related to

access to urgent care or concerns with office appointment wait times. The plan's policy and procedures related to in-office wait times were inconsistent with HPSJ's provider manual. Additionally, the plan lacked a process for overseeing and monitoring its contracted nurse advice line. HPSJ also did not demonstrate monitoring to ensure members' access to medications in emergency situations.

Under members' rights, the plan's grievance system had several deficiencies. The plan lacked documentation of a discussion of grievances; analysis, tracking, and trending of grievance data; and corrective actions in this area. The medical director did not review all clinical grievances, and the clinical staff did not review the grievance logs to determine if clinical grievances were appropriately referred for physician review. The audit also showed that the plan did not send grievance acknowledgment and resolution letters within the required time frames.

Under the quality management area, the audit showed that HPSJ's governing body did not document the approval of the Quality Improvement Workplan or review regular quality reports. Additionally, the work plan did not contain measureable performance goals for monitoring quality areas. The audit found no evidence that the plan had addressed deficient areas noted in the previous audit related to its quality improvement program and work plan.

HPSJ met most of the criteria for administrative and organizational capacity. The audit noted one finding that the plan did not have a mechanism for monitoring whether it conducted training for all network providers before putting them on active status.

As a result of the audit findings, HPSJ submitted a corrective action plan to the DHCS in January 2007. The Department's joint response to the corrective action plan, dated February 2006, indicated that the plan had not sufficiently corrected all areas of deficiency. It should be noted that HPSJ has indicated that most, if not all, of the negative findings from the April 2005 audit reflected in this evaluation report have been resolved, and HPSJ expressed concern that readers would not realize that deficiencies had been corrected. Because documentation from the most recent audit conducted in 2008 was not completed during the period covered by this report, the EQRO could not determine if the plan completed corrective actions.. The next evaluation report will reflect the deficiencies that have been corrected and any outstanding negative findings.

Member Rights and Program Integrity Monitoring Review

The Member Rights/Program Integrity Unit (MRPIU) in DHCS's Medi-Cal Managed Care Division is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, the MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and

detection). These reviews are done before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, the MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2009.

The MRPIU conducted an on-site review of HPSJ in November 2008, covering the review period of January 1, 2007, through June 30, 2008. The audit noted findings related to grievances, prior-authorization notifications, cultural and linguistic services, marketing, and program integrity. The review showed that HPSJ was fully compliant in the area of program integrity, while audit findings were noted in the other areas of review.

The review showed three findings in the area of grievances. The plan lacked information within its policy and procedure regarding written notification to the member when a grievance was not resolved within 30 days. A file review of grievances showed that acknowledgment letters in 9 of 55 files reviewed lacked the name of the plan representative. None of the grievance files reviewed contained required information regarding circumstances in which medical services may be continued.

Findings related to prior authorization showed that the plan's Evidence of Coverage did not list preventive services as care that does not require prior authorization. The plan did not include in its denial, deferral, and modification letters the required updated member rights attachment, the form for filing a request for a State hearing, nor the independent medical review form. The review noted an inconsistency in the time frame to notify a member of the decision to deny or modify a prior-authorization request. The required time frame included in plan contracts was 28 days, but the plan's process provided 30 days. Of the 55 prior-authorization files reviewed, 7 lacked a specific citation to support the action taken by the plan.

The review of standards related to cultural and linguistic services showed that not all plan provider offices discouraged the use of family and friends as translators, not all offices had 24-hour access to interpreter services, and not all offices had received cultural competency training from the plan.

MRPIU noted that HPSJ's marketing policies and procedures lacked prohibitions against door-to-door marketing and cold calling to potential enrollees. Additionally, the plan's policies lacked requirements for obtaining prior approval from the DHCS for any in-home marketing.

Strengths

HPSJ demonstrated compliance with many State and federal requirements. MRPIU noted full compliance with standards related to program integrity, including reporting suspected fraud and abuse cases. The plan met most of the criteria for administrative and organizational capacity.

The plan effectively monitored member referrals, and its providers showed 99 percent compliance with the required physician review of consult/referral reports. This demonstrates good continuity and coordination of care for members at the provider level. The plan also monitored its providers for follow-up and outreach to members regarding missed appointments to help encourage members to follow through with needed care.

Opportunities for Improvement

HPSJ has an opportunity to increase its compliance with both DHCS and federal requirements. The plan needs to ensure a greater degree of oversight and review of ongoing quality activities. This includes monitoring of access and availability of services through analysis of its provider network to ensure adequate provider-to-member ratios, access-related grievances, in-office wait times, and oversight of the nurse advice line.

The plan needs to improve its grievance process to ensure that grievance data are analyzed, tracked, and trended. In addition, the plan has opportunities to provide timely grievance acknowledgment and resolution to members and ensure that the required language is included in the notifications. Grievances that involve a potential quality-of-care issue must be reviewed by a physician.

The plan has an opportunity to monitor prior-authorization notifications to ensure that required information is contained in the notification letters and that policies and procedures for these notifications are consistent with contract requirements. The plan should reeducate providers on cultural and linguistic service requirements and update its marketing policies and procedures. The plan can improve its care coordination for members with developmental disabilities by monitoring the provision of all medically necessary services, an area noted as a corrective action.

HPSJ's opportunities for improvement span across quality, access, and timeliness domains of care.

Conducting the Review

The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provides a standardized method for objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its EAS-specific performance measures when calculating rates.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about HPSJ's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Performance Measure Validation

HSAG performed a HEDIS® Compliance Audit™[2] of HPSJ in 2009. HSAG found all measures to be reportable and that HPSJ's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

The auditors did note some suggestions for the future. The plan should look for methods to identify whether data from clearinghouses are accurate and complete. This pertains to data exchanged between vendors/provider groups and clearinghouses. The plan should obtain documentation from vendors, providers, and/or clearinghouses as to how interrater reliability is performed for data entry and how file counts are reconciled. HPSJ also may want to consider

[2] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS Compliance Audit™ is a trademark of the NCQA.

adding a medical record review component as part of the supplemental database audit process. The plan may want to consider working with its data collection vendor, Qmark, to ensure that the electronic tools have the capacity to capture all immunizations provided beyond the National Committee for Quality Assurance (NCQA)-required antigens. This would allow abstractors to capture all immunization information documented in the medical records without having to determine whether the specific immunization is required and whether the date of the vaccination falls within the specified time frames.

Performance Measure Results

The table below presents a summary of HPSJ's county-level HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measures results (based on calendar year 2007 data). In addition, the table shows the plan's HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the NCQA's national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

Due to significant methodology changes for the *Comprehensive Diabetes Care—HbA1c Control (<7.0 Percent)* measure for 2009, the MCMC Program was unable to compare 2008 and 2009 performance results for this measure.

Appendix A includes a performance measure name key with abbreviations contained in the following table.

Table 4.1—2008–2009 Performance Measure Results for Health Plan of San Joaquin—San Joaquin County

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	26.3%	23.3%	★★	↔	20.6%	35.4%
ASM	Q	86.7%	86.8%	★★	↔	86.1%	91.9%
AWC	Q,A,T	44.8%	53.8%	★★	↑	35.9%	56.7%
BCS	Q,A	55.8%	55.4%	★★	↔	44.4%	61.2%
CCS	Q,A	68.1%	67.6%	★★	↔	56.5%	77.5%
CDC–E	Q,A	47.4%	58.9%	★★	↑	39.7%	67.6%
CDC–H7 (<7.0%)	Q	28.5%	34.1%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	47.2%	42.7%	★★	↔	52.5%	32.4%
CDC–HT	Q,A	80.8%	79.0%	★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	32.8%	30.7%	★★	↔	25.1%	42.6%
CDC–LS	Q,A	78.1%	77.2%	★★	↔	66.7%	81.8%
CDC–N	Q,A	72.3%	77.4%	★★	↔	67.9%	85.4%
CIS–3	Q,A,T	72.0%	74.7%	★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	83.5%	83.2%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	63.7%	60.8%	★★	↔	54.0%	70.6%
URI	Q	77.0%	82.5%	★★	↑	79.6%	94.1%
W15	Q,A,T	67.6%	76.2%	★★★	↑	44.5%	73.7%
W34	Q,A,T	82.0%	83.9%	★★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the full name of each HEDIS measure.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.
[4] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[5] Performance comparisons are based on the *z* test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
†The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.
Not Comparable = Performance could not be compared due either to significant methodology changes between years or because the rate was not reported.

Findings from Performance Measure Results

Overall, HPSJ demonstrated average performance measure results, with rates falling between the MPLs and HPLs for most of its reported measures in 2009. The plan exceeded the Medi-Cal managed care goal (HPL) for *Well-Child Visits in the First 15 Months of Life (W15)* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*. The plan did not have below-average performance in any areas.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. Plans that have rates below these minimum levels must submit an improvement plan to the DHCS for each area of deficiency, outlining the steps they will take to improve care.

In 2008, the DHCS required HPSJ to submit an improvement plan for *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*. The plan collaborated with the California Medical Association's Alliance Working for Antibiotic Resistance Education (AWARE) and other health plans to develop and disseminate an antibiotic awareness provider tool kit. In 2008, the plan implemented targeted provider interventions, sending alerts and letters to providers with their URI rates and links and phone numbers for resources. HPSJ had statistically significant improvement of its 2009 URI rate. The plan's rate increased above the MPL for HEDIS 2009, and HPSJ was not required to submit an improvement plan for this measure.

Strengths

HPSJ performed above the MPLs for all measures in 2009. The plan exceeded the HPLs for both well-child visit measures and showed a statistically significant increase over the previous year for *Well-Child Visits in the First 15 Months of Life (W15)*. Well-child visits span the domains of quality, access, and timeliness of care.

In addition, the *Adolescent Well-Care Visits (AWC)*, *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed (CDC-E),* and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* measures all showed statistically significant improvement, which demonstrated HPSJ's efforts to improve the quality of care delivered to MCMC members. The plan had no statistically significant declines in performance between 2008 and 2009.

Opportunities for Improvement

HPSJ had three measures that were less than 3 percentage points above the MPLs. Two of these measures, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)* and *Use of Appropriate Medications for People With Asthma (ASM),* did not demonstrate statistically significant change between HEDIS 2008 rates and HEDIS 2009 rates and were only slightly above the MPLs (2.7and 0.7 percentage points, respectively). The plan's AAB rate decreased between 2008 and 2009. Despite the plan's statistically significant improvement for *Appropriate Treatment for Children With Upper Respiratory Infection (URI),* the measure still presented an opportunity for improvement.

HPSJ's performance in these areas may point to issues with health care providers not providing care consistent with practice guidelines.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas.

HSAG reviews each QIP using CMS' validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about HPSJ's performance in providing quality, accessible, and timely care and services to its MCMC members. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Quality Improvement Projects Conducted

HPSJ had two clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP project. HPSJ's second project, an internal QIP, aimed to increase chlamydia screening. Both QIPs fell under the quality and access domains of care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

For the *Chlamydia Screening* QIP, low screening rates may indicate suboptimal care or limited access to PCPs. HPSJ's project attempted to improve the quality of care delivered to women in this area.

Quality Improvement Project Validation Findings

The DHCS contracted with HSAG as its new EQRO in the second half of 2008. HSAG began validation for QIPs submitted by the plans after July 1, 2008.

Table 5.1 summarizes the validation results for both of HPSJ's QIPs across CMS protocol activities during the review period.

Table 5.1—QIP Validation Results for Health Plan of San Joaquin (N=2 QIPs)—San Joaquin County

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	100%	0%	0%
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	69%	15%	15%
IV.	Correctly Identified Study Population	0%	33%	67%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	33%	33%	33%
VII.	Appropriate Improvement Strategies	83%	17%	0%
VIII.	Sufficient Data Analysis and Interpretation	31%	13%	56%
IX.	Real Improvement Achieved	25%	0%	75%
X.	Sustained Improvement Achieved	‡		
Percentage Score of Applicable Evaluation Elements *Met*		**48%**		
Validation Status		***Not Applicable****		

‡ The QIP did not progress to this activity during the review period and could not be assessed.
* QIPs were not given an overall validation status during the review period.

HPSJ submitted baseline data for the ER collaborative QIP, and the QIP had not progressed to the point of remeasurement during the period covered by this report. Therefore, HSAG could not assess for real and sustained improvement during the review period. The plan submitted Remeasurement 1 data for its *Chlamydia Screening* QIP, which HSAG assessed for real improvement. Since the QIP had not progressed to a second remeasurement period, HSAG could not assess for sustained improvement.

During the period covered by this report, HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the MCMC plans. As a result, many plans had difficulty complying fully with these requirements during the first cycle of QIP validations by HSAG. This was the case with the plan's QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided HPSJ, as well as other plans, with an overall validation status of "Not Applicable" for both QIPs. This allowed time for plans to receive technical assistance and training with HSAG's validation requirements without holding up the ongoing progress of QIPs that were already underway.

Quality Improvement Project Outcomes

Table 5.2 shows HPSJ's data for its QIPs. For the ER collaborative QIP, HPSJ's goal was to reduce the overall rate of members who used the emergency room by 10 percent over the duration of the QIP in its avoidable ER visit rate. The plan will have submitted its first remeasurement year data in time to be included in the next performance evaluation report (July 1, 2009, through June 30, 2010), at which time HSAG will assess for real improvement.

For the *Chlamydia Screening* QIP, HPSJ set a goal to increase its rate of screening to 49.3 percent for the percentage of women 16 to 25 years of age who were identified as sexually active and who had at least one test for chlamydia.

Table 5.2—QIP Outcomes for Health Plan of San Joaquin—San Joaquin County

QIP #1—Reducing Avoidable Emergency Room Visits				
		Remeasurement Period		
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	1 1/1/08–12/31/08	2 1/1/09–12/31/09	Sustained Improvement
Percentage of ER visits that were avoidable	21.3%	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Chlamydia Screening				
		Remeasurement Period		
QIP Study Indicator	Baseline Period 1/1/06–12/31/06	1 1/1/07–12/31/07	2 1/1/08–12/31/08	Sustained Improvement
Percentage of women 16–25 years of age who were identified as sexually active and who had at least one test for chlamydia	39.2%	29.0%¥	‡	‡
¥ Designates statistically significant decline in performance over the prior measurement period. ‡The QIP did not progress to this phase during the review period or did not meet the criteria for assessment and therefore could not be assessed.				

The plan showed a statistically significant decline from its baseline results to its first remeasurement period. The plan's primary intervention was to reinstitute a provider incentive that the plan had terminated in 2005. While the plan had success with this incentive in the past, its barrier analysis did not identify a lack of physician financial incentive as a barrier to the low screening rate. The plan needs to target intervention strategies that align with identified barriers to increase the likelihood of success.

Moving forward, the plan noted the addition of several interventions aimed at sharing individual performance results with providers, which target an identified barrier of lack of feedback to providers. The plan is using its quality improvement nurses and provider services representatives to provide feedback and education to providers in this area. Since these interventions align with identified barriers, the plan may have a greater likelihood of successfully improving its rates.

Strengths

HPSJ demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data. To reduce avoidable ER visits, the plan implemented its own specific interventions in addition to the statewide collaborative interventions. Several of these interventions are system interventions that have a greater likelihood of achieving sustained improvement.

Opportunities for Improvement

HPSJ has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with the DHCS requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

HPSJ has an opportunity to implement interventions that link to identified barriers to increase the likelihood of success. While the plan is modifying and implementing many new interventions as a result of the declining performance, HPSJ indicated the potential for using at-risk dollars to increase screening rates in lieu of the provider incentive. The plan needs to determine if a lack of a financial incentive is a factor contributing to the low screening rates before it implements an intervention that may not be effective. HPSJ should conduct a more detailed barrier analysis and align its intervention strategies appropriately. The plan also should explore whether financial incentives for chlamydia screening are supported as an evidenced-based intervention.

The table below provides abbreviations of HEDIS performance measures used throughout this report.

Table A.1—HEDIS® Performance Measures Name Key

Abbreviation	Full Name of HEDIS® Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ASM	*Use of Appropriate Medications for People With Asthma*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–E	*Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed*
CDC–H7	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)*
CDC–H9	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC	*Comprehensive Diabetes Care—LDL-C Control*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W15	*Well-Child Visits in the First 15 Months of Life (Six or More Visits)*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*