Performance Evaluation Report

Health Plan of San Mateo

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 3.4 million beneficiaries (as of July 2008) 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. The 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. This report is specific to the MCMC Program's contracted plan, Health Plan of San Mateo ("HPSM" or "the plan").

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.

HSAG found that HPSM 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 performed best on its performance measure results but has opportunities to improve some aspects of its operational structure to better support quality care.

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.

Most of HPSM's performance measure rates fell between the established MPLs and HPLs. The plan exceeded the HPLs for *Comprehensive Diabetes Care—LDL-C Control (CDC–LC)* and *Childhood Immunization Status—Combination 3 (CIS–3)*. The plan did not have below-average performance measure rates in any area in 2009. The plan showed stable and increased rates for its diabetes measures and is close to achieving the HPLs for several of these rates.

HPSM had two measures with rates slightly above the MPLs for *Cervical Cancer Screening (CCS)* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* (*PPC–Pre*). These areas present opportunities for improvement and may point to issues with health care quality, access, and/or timeliness. Additionally, the *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* measure had a statistically significant decline between 2008 and 2009. To prevent further decline, the plan has an opportunity to address factors that contributed to the decreased rate.

During the review period, HPSM's QIP for cervical cancer screening showed an increase in performance between the baseline period and first remeasurement period and achieved its established goal. HPSM's efforts on its cervical cancer screening QIP may have resulted in the improvement of the plan's *Cervical Cancer Screening (CCS)* performance measure, which fell above the MPL in both 2008 and 2009.

HSAG noted that the plan has an opportunity to improve its documentation for 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.

A routine medical survey conducted by the DHCS's Audits and Investigations Division (A&I), which evaluated HPSM's compliance with federal and State standards related to quality management, showed that the plan's quality and provider oversight committees were not systematically assessing and monitoring quality of care. Although the plan's quality improvement work plan included objectives, the plan's committee minutes did not reflect any activities to achieve the established goals. The plan's organizational chart did not show the medical director overseeing all clinical activities. Additionally, the audit found some repeat deficiencies, indicating that the plan's quality management process did not adequately address previously identified areas of concern. Findings related to credentialing activities revealed that the plan lacked verification of professional licensure between recredentialing cycles and lacked oversight of its delegated entity. The *DHCS Medical Audit Close-Out Report, July 29, 2008*, noted that the plan's May 23, 2008, corrective action plan corrected these deficiencies.

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.

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

HPSM's 2009 performance measures that related to access fell primarily between the MPLs and HPLs. The plan was above the HPL for childhood immunizations and had no rates below the MPLs.

For access and availability standards, the routine medical survey found that the plan had policies that included standards for access to routine, preventive, emergency, and urgent care; however, it lacked a standard for specialty care. Additionally, the plan did not monitor wait times for appointments with specialists. The plan did not review access and availability of services through its quality committee structure. The Department's close-out report noted that the plan corrected these deficiencies.

The routine medical survey showed that HPSM had good policies, procedures, and systems in place to provide and monitor continuity and coordination of care for members. These procedures included a memorandum of understanding (MOU) with local agencies to ensure the identification and coordination of care for members eligible for California Children's Services and members with developmental disabilities.

Under cultural and linguistic service requirements, the Member Rights and Program Integrity Unit (MRPIU) noted several areas of deficiency with the plan's contracted providers. Not all offices were aware of the requirement to provide 24-hour language interpreter services or procedures for referring members to culturally and linguistically appropriate community service programs. Additionally, not all offices indicated that they documented requests for or refusals of interpreter services in the member's medical record, and not all offices discouraged the use of family, friends, or minors as interpreters.

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 for providing timely care and compliance review standards related to timeliness, HPSM demonstrated average performance in the timeliness domain of care.

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

For timeliness of care standards, the routine medical survey found that HPSM monitored under- and overutilization and showed evidence of acting upon inappropriate utilization. For prior authorizations, not all denials contained a clear description of the clinical rationale, and the plan did not meet the required time frames for sending the notice of action letter to the member. While the DHCS close-out report noted that the plan corrected these deficiencies, the more recent MPRIU review showed that the plan was not fully compliant with sending timely prior-authorization notifications.

Under members' rights, the routine medical survey found that the plan's grievance procedures and oversight were deficient in several areas, including lack of identification and follow-up on quality of care issues, compliance with required information, and timely notifications. Similar to the timeliness of prior-authorization notifications, while the January 28, 2008, final medical survey report indicated that the plan corrected these deficiencies, the more recent MRPIU review showed that the plan had an ongoing opportunity to monitor whether member grievances were acknowledged within the required time frames. The plan also has an opportunity to improve its rate of initial health education behavioral assessment for new members. In addition, the plan needs to ensure primary care provider assignment within 40 days of enrollment for new members.

Conclusions and Recommendations

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

HPSM's performance measure rates were primarily between the established MPLs and HPLs. The plan exceeded the HPL for childhood immunizations and had no rates below the MPLs in 2009. The plan had statistically significant increases for four of its performance measures and is close to achieving the HPLs for two more of its diabetes measures.

The plan demonstrated an improvement between baseline and remeasurement rates for its cervical cancer screening QIP.

HPSM demonstrated compliance with the DHCS standards for structure and operations. Opportunities for improvement exist for utilization management, member rights, availability and accessibility, and the grievance system.

Based on the overall assessment of HPSM in the areas of quality and timeliness of and access to care, HSAG recommends the following:

- Focus performance measure improvement efforts on measures that fall just above the MPLs to ensure compliance in subsequent years.
- Explore factors that contributed to the statistically significant decline in the *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* measure to prevent further decline.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.
- Continue to monitor timeliness of notification for prior authorizations.
- Conduct a barrier analysis for the low rate of completed initial health education behavioral assessments within 120 days of enrollment for new members and develop strategies aimed at improving compliance.
- Continue to monitor the timeliness of grievance acknowledgements.
- Re-educate providers on cultural and linguistic service requirements and develop a process to monitor compliance.

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

Plan Overview

Health Plan of San Mateo (HPSM) is a full-scope Medi-Cal managed care plan operating in San Mateo County. HPSM delivers care to members as a County Organized Health System (COHS). HPSM began contracting with the MCMC Program in December 1987. As of June 30, 2009, HPSM had 54,925 MCMC members.[1]

In a COHS model, the DHCS contracts with a county-organized and county-operated plan to provide managed care services to all Medi-Cal beneficiaries in the county, except for those in a few select aid codes. These mandatory members do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the DHCS. Beneficiaries enrolled in the COHS plan can choose from a wide range of managed care providers in the plan's network.

[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 HPSM's performance in providing quality, accessible, and timely health care and 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, HPSM is not among those plans designated for a non-joint medical audit.

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. A joint audit for HPSM was conducted in August 2007 covering the review period of August 1, 2006, through July 31, 2007. The scope of the audit evaluated six areas of performance: utilization management, continuity of care, availability and accessibility, members' rights, quality management, and administrative and organizational capacity.

The plan was compliant with many standards reviewed; however, there were audit findings in all performance areas. All but two deficiencies were corrected through corrective action plans noted by the DHCS in the January 28, 2009, final medical audit/routine survey report and in the *DHCS Medical Audit Close-Out Report, July 29, 2008*.

Under the utilization management (UM) category, the plan showed evidence of implementing and maintaining a UM program; however, the plan lacked documentation to support that the governing body reviewed and approved the 2006 UM program. Organizational charts did not show key UM committees and the UM reporting structure. HPSM monitored under- and overutilization and showed evidence of acting upon inappropriate utilization. The Department's close-out report noted that HPSM's corrective action plan corrected these deficiencies.

A review of prior-authorization denials found that the plan exceeded the time frame for 4 of 38 denials. All four denials pertained to pharmaceutical prior-authorization requests, and the plan corrected its policy and procedure to include the appropriate timelines. Some closure procedures for medical requests resulted in members not receiving a notice of modification or denial. The plan's prior authorization policy referenced family planning services, for which prior authorization may not be required. The Department's close-out report noted that the plan corrected these deficiencies.

For continuity and coordination of care, the plan demonstrated procedures for providing case management to members through an HPSM case manager. Policies and procedures are in place for the coordination of services outside of the network. The plan established a memorandum of understanding with the local health department to identify and refer members eligible for California Children's Services and identify responsibilities for each party to ensure coordination of care. HPSM also had policies and procedures in place to identify both members at risk and those with developmental delay. The plan worked with a local agency to provide all medically necessary services for these members. The Continuity of Care Department tracked referrals using a computer program and conducted outreach to members for missed appointments.

While the plan demonstrated 80 percent compliance with an initial assessment within 120 days of enrollment for new members, the audit found the plan out of compliance with an initial health education behavioral assessment. This was a repeat finding from the previous audit.

The plan had policies that included standards for access to care; however, it lacked a standard for specialty care. The plan could not show evidence of reviewing access and availability of services through its Quality Assessment and Improvement Committee. The Department's close-out report noted that the plan corrected these deficiencies.

The plan's policy for emergency services claim payment did not include payment of a minimal screening fee or specify time limits for processing claims. A review of emergency service claims

denials found that physician review was not documented in all cases. In addition, the plan did not send notification letters to providers or members for denied claims. The plan also lacked a system to monitor family planning claims adjudication. Of the family planning claims reviewed, 2 of 11 were inappropriately denied. The Department's close-out report noted that the plan corrected this deficiency.

Under members' rights, the plan's grievance procedures and oversight were deficient in several areas:

- Potential quality of care issues were not identified by the plan and lacked clinical follow-up.
- Grievance notification was not compliant with requirements for acknowledgement and resolution.
- Grievance notification did not include the required information.
- Grievance reports were not reviewed by the plan's quality improvement committee.

The audit also found that the plan did not assign a primary care provider within 40 days of enrollment for all newly enrolled members. All deficiencies were addressed and corrected, as noted in the final medical report/routine survey report.

In the area of quality management standards, the plan's quality and provider oversight committees were not systematically assessing and monitoring quality of care. These committees lacked review of grievances and grievance reports, provider practice patterns, access, and member satisfaction. Although the plan's work plan included objectives, the committee minutes did not reflect any activities to achieve the established goals. The Department's close-out report noted that the plan corrected this deficiency.

Repeat deficiencies indicated that the plan's quality management process did not adequately address areas of concern. Findings related to credentialing activities revealed that the plan lacked verification of professional licensure between recredentialing cycles and that the plan lacked oversight of its delegated entity. HPSM's corrective action plans corrected these deficiencies.

Under administrative and organizational capacity, the plan's organizational chart did not show the medical director overseeing all clinical activities. The Department's close-out report noted that the plan corrected this deficiency.

Finally, the HPSM was missing documentation of Medi-Cal provider training for a few of its new providers during the review period.

Member Rights and Program Integrity Monitoring Review

The Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, 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, MRPIU conducts an on-site review of each plan approximately every two years and does 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 HPSM in November 2008, covering the period of January 1, 2007, through June 30, 2008.

MRPIU noted that 2 of the 50 grievance case files reviewed did not meet the required time frame for the required acknowledgement letters.

For prior-authorization notifications, 2 of the 50 files reviewed did not meet the required time frame for sending the notice of action letter to the member.

Under cultural and linguistic service requirements, MRPIU noted five areas of deficiency. Of the providers' offices reviewed, not all:

- Were aware of the requirement to provide 24-hour access to interpreter services.
- Indicated that they documented requests for or refusals of language interpreter services in the medical records of members with limited English proficiency.
- Were aware of procedures for referring members to culturally and linguistically appropriate community service programs.
- Discouraged the use of family, friends, or minors as interpreters.

One provider office refused to cooperate and allow staff to be interviewed.

Strengths

HPSM demonstrated compliance with many State and federal requirements. The plan met most of the criteria for administrative and organizational capacity. The plan had good policies, procedures, and systems in place to provide and monitor continuity and coordination of care for members. These procedures included MOUs with local agencies to ensure the identification and coordination of care for members eligible for California Children's Services and members with developmental disabilities.

Opportunities for Improvement

While the DHCS noted that the plan adequately addressed and corrected most deficiencies identified from the joint audit review, the more recent MRPIU review showed that the plan still had some opportunities for improvement. For prior-authorization notifications, the plan needs to continue to monitor the timeliness of member notifications to ensure that it complies with the required time frames. Similarly, the plan needs to monitor the timeliness of member grievance acknowledgment. The plan also has an opportunity to re-educate providers about the cultural and linguistic service requirements and develop a process to monitor compliance. Finally, the plan should conduct barrier analysis related to its low rate of completed initial health education behavioral assessments within 120 days of enrollment for new members and develop strategies aimed at improving compliance.

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

Conducting the Review

The DHCS annually selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. 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 of 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 HPSM'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 HPSM in 2009. HSAG found all measures to be reportable except for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)* measure. This measure had significant methodology revisions, resulting in challenges for the plan in achieving the required sample size because of a high number of unexpected exclusions. The plan chose not to report this measure due to the added cost to resample and abstract medical records needed to produce a valid rate. Since the plan chose not to report the *Comprehensive Diabetes Care—HbA1c Control (<7.0 Percent)* measure, Table 4.1 shows the 2009 rate as a *Not Report* audit result.

[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.

HPSM's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

Recommendations from the audit included:

- Implementing a formal claims audit program that incorporates validation of manual data entry randomly across all examiners and claims types.
- Exploring ways to improve the control of paper batches from the point of receipt to the scanning vendor to reduce the potential for lost claims.
- Implementing a formal process to oversee the functions performed by the plan's clearinghouse to help ensure that no data are lost.
- Exploring mechanisms to capture the dates of service for prenatal care visits on global bills.

These actions will help the plan to ensure more complete and accurate data for performance measures reporting.

Performance Measure Results

The table below presents a summary of HPSM'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 National Committee for Quality Assurance (NCQA) 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.

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 Mateo—San Mateo 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	28.2%	26.4%	★★	↔	20.6%	35.4%
ASM	Q	89.7%	90.1%	★★	↔	86.1%	91.9%
AWC	Q,A,T	34.8%	41.6%	★★	↑	35.9%	56.7%
BCS	Q,A	56.2%	55.9%	★★	↔	44.4%	61.2%
CCS	Q,A	60.4%	58.7%	★★	↔	56.5%	77.5%
CDC–E	Q,A	53.1%	59.7%	★★	↑	39.7%	67.6%
CDC–H7 (<7.0%)	Q	28.9%	NR	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	49.1%	43.1%	★★	↔	52.5%	32.4%
CDC–HT	Q,A	80.9%	83.9%	★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	31.3%	42.7%	★★★	↑	25.1%	42.6%
CDC–LS	Q,A	74.8%	79.4%	★★	↔	66.7%	81.8%
CDC–N	Q,A	80.0%	85.2%	★★	↑	67.9%	85.4%
CIS–3	Q,A,T	76.6%	79.1%	★★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	78.0%	77.5%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	54.3%	60.1%	★★	↔	54.0%	70.6%
URI	Q	91.4%	89.0%	★★	↓	79.6%	94.1%
W15	Q,A,T	58.4%	61.1%	★★	↔	44.5%	73.7%
W34	Q,A,T	71.4%	72.8%	★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for 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.
NR = Not Report. The plan chose not to report the rate or the rate could not be reported due to material bias.

Performance Measure Result Findings

Overall, HPSM demonstrated average performance, falling between the HPLs and MPLs for most of its reported performance measures in 2009. The plan exceeded the MCMC goal, which represented the national Medicaid 90th percentile, for *Comprehensive Diabetes Care—LDL-C Control (CDC–LC)* and *Childhood Immunization Status—Combination 3 (CIS–3)*. The plan did not have below-average performance in any area.

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 HPSM to submit one improvement plan for *Adolescent Well-Care Visits (AWC)*. HPSM had statistically significant improvement for this measure's rate in 2009, which increased above the MPL; therefore, no improvement plan was required. The plan implemented incentives for both members and providers as strategies for improving performance.

Based on its 2009 performance, the DHCS did not require HPSM to submit improvement plans for any of its measures.

Strengths

HPSM performed above the MCMC Program goal on the *Comprehensive Diabetes Care—LDL-C Control (CDC–LC)* and *Childhood Immunization Status—Combination 3(CIS–3)* measures, and it showed a statistically significant increase over the prior year for *Comprehensive Diabetes Care—LDL-C Control (CDC–LC)*.

The plan also demonstrated statistically significant improvement for adolescent well-child visits and for eye exam rates and nephropathy rates among members with diabetes. The plan showed stable and increased rates for its diabetes measures and was close to achieving the HPLs for two additional diabetes measures pertaining to screening and nephropathy. This suggests that the plan provides quality care for its MCMC members with diabetes.

Opportunities for Improvement

HPSM had stable rates for the *Cervical Cancer Screening (CCS)* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* (*PPC–Pre*) measures; however, these rates were only slightly above the MPLs (2.2 and 0.9 percentage points, respectively). These areas present an opportunity for improvement and may point to issues with health care quality, access, and/or timeliness.

HPSM had a statistically significant decrease from the 2008 to 2009 HEDIS rate for *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*. The plan has an opportunity to address factors that contributed to the decreased rate to prevent further decline.

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 HPSM'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

HPSM 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. HPSM's second project, an internal QIP, aimed to increase cervical cancer screening in women 21 to 64 years of age. 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.

Low cervical cancer screening rates are an indicator of reduced preventive services and suboptimal care. The lack of screening may also indicate limited access to PCPs. HPSM's cervical cancer screening QIP 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.

The table below summarizes the validation results for both of HPSM's QIPs across CMS protocol activities during the review period.

Table 5.1—Quality improvement Project Validation Results for Health Plan of San Mateo—San Mateo County (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	92%	8%	0%
II.	Clearly Defined, Answerable Study Question(s)	50%	0%	50%
III.	Clearly Defined Study Indicator(s)	77%	15%	8%
IV.	Correctly Identified Study Population	50%	17%	33%
V.	Valid Sampling Techniques (if sampling was used)	100%	0%	0%
VI.	Accurate/Complete Data Collection	75%†	13%†	13%†
VII.	Appropriate Improvement Strategies	83%	17%	0%
VIII.	Sufficient Data Analysis and Interpretation	76%	6%	18%
IX.	Real Improvement Achieved	75%	0%	25%
X.	Sustained Improvement Achieved	‡		
Percentage Score of Applicable Evaluation Elements *Met*		**77%**		
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.
† The sum may not equal 100 percent due to rounding.

HPSM submitted baseline data for the ER project and remeasurement data for the cervical cancer screening project during the review period; therefore, the QIPs had not progressed to the point of a second remeasurement period, and 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 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 HPSM's QIPs, neither of which fully met the new validation criteria. As directed by DHCS, HSAG provided HPSM, 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 HPSM's data for its QIPs. For the ER collaborative QIP, HPSM's goal was to reduce the overall rate of members who used the emergency room by five percent from the baseline rate in its avoidable ER visits. The plan's first remeasurement year data will be submitted 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 *Cervical Cancer Screening* QIP, HPSM's initial goal for both baseline and remeasurement was to increase to 58.6 percent the percentage of women 21 to 64 years of age who received one or more Pap tests during the measurement year or the two years prior.

Table 5.2—Quality Improvement Project Outcomes for Health Plan of San Mateo—San Mateo 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	15.0%	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Cervical Cancer 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 21–64 years of age who received one or more Pap tests during the measurement year or the two years prior	55.0%	60.4%	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

The plan had an increase between the baseline and remeasurement period for its *Cervical Cancer Screening* QIP. Although the increase was not statistically significant, the plan achieved its goal of 58.6 percent. The plan established a new goal of 63.4 percent for the second remeasurement period.

The plan identified that its previous reporting of the cervical cancer screening rate used only administrative data. The plan suspected that physicians may not have been submitting data for the Pap test since it was included in their capitation payment. To address this issue, the plan used hybrid methodology to collect data from the medical record to identify Pap tests performed but

not reported in the administrative data. This may have contributed to the increased performance. The plan used both reminders and member incentives to encourage cervical cancer screening.

The plan also conducted data analysis and noted that 80 percent of women without evidence of a Pap test had disabled aid codes. The plan indicated that in many of these cases, a Pap test was contraindicated since these women would need to go under sedation to receive the test and/or had no history of sexual activity.

Strengths

HPSM demonstrated a good understanding of documenting support for its QIP topic selections and for providing plan-specific data. In addition, HPSM used sound sampling methodology. The plan's interventions to address identified causes/barriers and system interventions are likely to induce permanent change.

HPSM's efforts on its cervical cancer screening QIP may have resulted in the plan's improvement of its *Cervical Cancer Screening (CCS)* performance measure, which fell above the MPL in both 2008 and 2009.

HPSM implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits. After analyzing the member and provider surveys, the plan implemented a nurse advice line as well as several member education initiatives. Additionally, to address provider barriers, the plan highlighted a pay-for-performance measure for extended provider hours, which may have an impact on the plan's avoidable ER visits rate.

Opportunities for Improvement

HPSM 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.

The plan has an opportunity to explore its access-related barriers for members seeking cervical cancer screening and implement targeted interventions that may increase evening and weekend access. Despite the plan's challenges with its population of disabled members, the plan still has an opportunity to continue to monitor and improve its screening rate for its nondisabled member population, which the plan indicates is roughly 73.4 percent.

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*