Performance Evaluation Report

San Francisco Health Plan

July 1, 2008–June 30, 2009

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

December 2010

TABLE OF CONTENTS

Performance Evaluation Report – San Francisco Health Plan
July 1, 2008 – June 30, 2009

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.

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, San Francisco Health Plan ("SFHP" or "the plan"), for the review period of July 1, 2008, to June 30, 2009. Actions taken by the plan subsequent to June 30, 2009, regarding findings identified within 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 MPL indicate low performance, rates at or above the HPL indicate high performance, and rates at the MPL or between the MPL and HPL demonstrate average performance.

HSAG found that San Francisco Health Plan demonstrated above-average performance for the quality of care domain. 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 as follows:

- SFHP performed above the HPLs on 11 of 17 measures in 2009. Additionally, the plan had four statistically significant increases in performance measure rates between 2008 and 2009 with no statistically significant declines. Three performance measures that were below the HPLs were within approximately one percentage point of the HPLs. The plan had no below-average performance on any measures.
- The plan's *Diabetes Care Management* QIP demonstrated sustained improvement for all four of its study indicators and statistically significant improvement for three of the four indicators. The project improved the rates of HbA1c testing, LDL-C screening, retinal eye exams, and monitoring for nephropathy for its members with diabetes. Despite the improvement, HSAG noted that the plan has an opportunity to improve its documentation of the *Diabetes Care Management* QIP and the statewide QIP on reducing avoidable emergency room visits to comply with federal requirements for conducting a QIP.

- Findings from the 2005 joint audit showed that the plan lacked sufficient mechanisms to address ongoing deficiencies within the quality management program and lacked a process for tracking, monitoring, and taking action related to all areas of quality management. A more recent quality improvement evaluation showed that the plan took action to address these areas of concern.

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.

SFHP demonstrated above-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 as follows:

- All of SFHP's 2009 performance measures were above the MPLs, with many exceeding the HPLs.
- The plan's diabetes QIP demonstrated improvement for diabetic screening and monitoring, which suggests the plan has adequate access to providers to manage diabetes.
- SFHP was fully compliant with cultural and linguistic service requirements and demonstrated an ongoing commitment to provide culturally responsive care to the plan's diverse MCMC membership. The plan's efforts to take effective action to minimize any access-related cultural and linguistic barriers may be one factor that contributed to its overall performance measure success.
- SFHP has an opportunity to continue to improve access to care for members within its network capacity. The plan has taken action to measure referrals; however, these data suggest substantial wait times for many specialty providers. Additionally, the highest percentage of member grievances relate to access issues.

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, SFHP demonstrated above-average performance in the timeliness domain of care as follows:

- The plan performed within the MCMC-established thresholds for adolescent well-child visits and postpartum visits and above the HPLs for childhood immunizations, timeliness of prenatal care, and both well-child visit measures in the timeliness domain of care. None of the plan's measures had below average performance.
- Joint audit review findings noted that non-delegated denials were resolved timely and appropriately. Additionally, the plan resolved grievances and appeals within the required time frames. At the time of the audit, the plan lacked adequate monitoring of prior authorization procedures for its delegated entities to ensure the reporting of denials and compliance with notification requirements. Many notification letters did not include the criteria used for the denial or modification of a requested service.
- Within its internal 2008 program evaluation, the plan showed evidence of providing good oversight and monitoring of delegated entities, which included taking corrective action when appropriate. SFHP initiated a project to track referrals, which resulted in improvement with providing timely care. The plan has an opportunity to continue to address members' wait times to specialty providers.
- SFHP has substantially improved the identification of members eligible for the California Children's Services program and referrals. Additionally, the plan has improved care coordination for early intervention services and for members with disabilities, an area that showed as a repeat audit finding in 2005.

Conclusions and Recommendations

Overall, SFHP demonstrated above-average performance in providing quality, accessible, and timely health care services to its MCMC members based on several factors:

- The plan shared the spot of top performer with another plan for its 2009 performance measures rates, of which 11 of 17 exceeded the HPLs.[1] The plan had no performance measures below the MPLs.
- The plan achieved sustained improvement for all of its study indicators for its *Diabetes Care Management* QIP.
- The plan was fully compliant with cultural and linguistic service requirements and demonstrated its ability to provide culturally responsive care.
- While the plan had many joint audit findings in 2005 across compliance standards areas, it has demonstrated substantial improvement in these areas.

Despite the overall above-average performance, the plan still has opportunities for improvement. Based on the overall assessment of SFHP in the areas of quality and timeliness of and access to care, HSAG recommends that the plan do the following:

- Explore factors that led to the decrease of the *Breast Cancer Screening* (BCS) rate 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.
- Formally retire the *Diabetes Care Management* QIP, given the multiple remeasurement periods and sustained improvement.
- Focus on a nonclinical, actionable area in need of improvement for the next QIP, given the plan's above-average performance measures rates in clinical areas.
- Increase network capacity for specialty providers to reduce member grievances and appointment wait times.
- Continue to monitor and address noncompliance in audit areas.
- Continue to monitor compliance with the DHCS standards for access to care, structure and operations, and quality measurement and improvement.

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

[1] California Department of Health Care Services. *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program. July 2010.*

Plan Overview

The San Francisco Health Authority, doing business as San Francisco Health Plan (SFHP), is a full-scope managed care plan in San Francisco County. SFHP became operational with the MCMC Program in January 1997, and as of June 30, 2009, SFHP had 34,738 MCMC members.[2] SFHP delivers care to members as a Two-Plan model local initiative (LI) plan.

In a Two-Plan model county, the DHCS contracts with two managed care plans to provide health care services to members. In most Two-Plan model counties, Medi-Cal beneficiaries in both mandatory and voluntary aid codes can choose between a local initiative plan and a nongovernmental commercial health plan.

[2] *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 SFHP'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, SFHP was 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. A joint audit for SFHP was conducted in March 2009; however, because SFHP's corrective action plan and the report that closed the audit were not issued until early 2010, the 2009 audit results will be included in the next plan-specific evaluation report.

The prior joint audit occurred in August 2005 covering the review period August 1, 2004, through July 31, 2005. The audit covered the areas of utilization management (UM), continuity of care, access and availability, member's rights, quality management, and administrative and organizational capacity.[3]

Results from this audit identified many strengths as well as areas that required improvement.

Under the UM category of review, SFHP demonstrated a UM program that used written criteria to determine medical necessity. The UM program measured indicators for under- and over-utilization of services, timeliness of UM decisions, member and provider satisfaction, and interrater reliability. A review of non-delegated denials showed the denials were timely and appropriate.

Findings under this category showed that the plan did not have adequate monitoring of prior authorization procedures for its delegated entities to ensure compliance with the reporting of denials and notification requirements. Additionally, many notification letters did not include the criteria used for the denial or modification of a requested service. SFHP did not have a system to track referrals requiring prior authorization or to track follow-up on specialty referrals, a repeat finding.

For continuity of care, the plan did not monitor the provision of all medically necessary services and care coordination for members receiving Early Intervention Services or monitor services for members with disabilities. SFHP did not have a mechanism to track completion rates for initial health assessments and initial health education behavioral assessments.

Under the availability and accessibility of services category, SFHP had policies and procedures for access and availability of PCPs and specialists, including benchmarks for appointments and wait times. Standards were in place for routine care, urgent care, emergency care, routine specialty care, prenatal care, and initial health assessments. The audit noted that the plan's policy for standing referrals to specialists lacked the definition of HIV/AIDS and credentialing requirements. The plan did not monitor the process of providers to ensure members' access to medications in an emergency situation.

Under the grievance system, a review of 40 grievance and appeals files found the plan compliant with the required time frames. However, SFHP did not demonstrate review and evaluation of grievance issues, and it had not filed its grievance policy with DMHC or the DHCS. The plan's acknowledgement letters, resolution letters, and Web site grievance form were not in an approved format. The plan was compliant with cultural and linguistic service requirements, including access to interpreters and having printed materials available to members in all languages that met the required threshold.

[3] *California Department of Health Services. Medical Review – Northern Section, Audits and Investigations. San Francisco Health Plan*, December 28, 2005.

Under the quality management category, the plan lacked sufficient mechanisms to address ongoing deficiencies. The plan also lacked a process for tracking, monitoring, and taking action related to all areas of quality management.

For administrative and organizational capacity, the plan's organizational chart did not accurately reflect the medical director's responsibilities, including oversight of the quality management program and supervision of the clinical staff.

A DHCS medical audit letter was issued to the plan on December 28, 2005, in response to SFHP's corrective action plan to address audit deficiencies identified in the joint audit. The DHCS noted that the plan fully addressed deficiencies in the administrative and organizational capacity areas. Additionally, the plan addressed both grievance and UM policy and procedures. The DHCS outlined the remaining areas of deficiency, which were in the areas of UM, continuity of care, availability and accessibility, and member rights.

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, 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 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.

MRPIU conducted an on-site review of SFHP in March 2010 covering the review period of January 1, 2009, through December 31, 2009. These results will be included in the next annual evaluation report.

Strengths

Despite the multiple areas of deficiency from the joint audit report in 2005, the plan demonstrated evidence in its 2008 program evaluation that it had addressed many of the areas of concern.[4] The plan showed reporting, monitoring, analysis, and corrective action within the quality improvement program.

SFHP monitors both internal and external grievance and prior authorization notification time frames. There was evidence of corrective action with one of the plan's delegated entities that was not fully compliant.

The plan showed significant improvement beginning in 2007 with coordination of care for members with community agencies. SFHP accomplished this by serving as a pilot site in collaboration with the DHCS and Golden Gate Regional Center, San Francisco County's provider of early-start services. This pilot increased communication between SFHP and the regional center to ensure that members were receiving medically necessary services. In addition, the plan worked with its providers to improve the identification and referral of eligible members to the California Children's Services program.

The plan demonstrated full compliance with cultural and linguistic service requirements and showed ongoing monitoring and quality improvement efforts to provide culturally responsive care to its members.

Opportunities for Improvement

Access-related issues accounted for the highest percentage of member grievances reported by the plan in the 2008 program evaluation. While the plan has implemented a system to track specialty referrals through its *eReferral Spread Project* and has reduced wait times and improved access to care, wait times for many specialty providers still range between 50 and 150 days. The plan has an opportunity to continue to improve access to care for members.

[4] San Francisco Health Plan. Quality Improvement Program Evaluation 2008.

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 SFHP'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™ [5] of SFHP in 2009. HSAG found all measures to be reportable with the exception of 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.

[5] 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.

SFHP'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 performing internal audits of its scanning data to ensure data accuracy. Additionally, the plan should continue to identify methods to address the data lag in incoming electronic data interchange files from claims/encounter vendors. The plan may consider automating checks for clinical reasonableness following measure calculations, which currently is done manually by the plan.

Performance Measure Results

The table below presents a summary of SFHP'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 San Francisco Health Plan—San Francisco 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	31.4%	32.2%	★★	↔	20.6%	35.4%
ASM	Q	90.1%	90.6%	★★	↔	86.1%	91.9%
AWC	Q,A,T	52.8%	52.4%	★★	↔	35.9%	56.7%
BCS	Q,A	58.3%	55.7%	★★	↔	44.4%	61.2%
CCS	Q,A	74.2%	80.6%	★★★	↑	56.5%	77.5%
CDC–E	Q,A	66.5%	73.1%	★★★	↑	39.7%	67.6%
CDC–H7 (<7.0%)	Q	39.3%	NR	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	27.7%	25.9%	★★★	↔	52.5%	32.4%
CDC–HT	Q,A	86.4%	89.5%	★★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	46.0%	47.4%	★★★	↔	25.1%	42.6%
CDC–LS	Q,A	79.4%	80.8%	★★	↔	66.7%	81.8%
CDC–N	Q,A	82.2%	87.1%	★★★	↑	67.9%	85.4%
CIS–3	Q,A,T	90.7%	90.3%	★★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	87.7%	92.3%	★★★	↑	76.6%	91.4%
PPC–Pst	Q,A,T	64.2%	69.5%	★★	↔	54.0%	70.6%
URI	Q	94.4%	95.3%	★★★	↔	79.6%	94.1%
W15	Q,A,T	75.4%	80.1%	★★★	↔	44.5%	73.7%
W34	Q,A,T	81.3%	82.4%	★★★	↔	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.

↔ = 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, SFHP demonstrated above-average performance, exceeding the HPLs for 11 of its 17 reported performance measures in 2009. 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.

SFHP did not have any measures in 2008 or 2009 that were below the MPLs. Therefore, the DHCS did not require SFHP to submit improvement plans for any measure for either year.

Strengths

SFHP performed above the MCMC Program goal on eleven measures:

- *Cervical Cancer Screening (CCS)*
- *Comprehensive Diabetes Care* (five measures)
- *Childhood Immunization Status—Combination 3 (CIS–3)*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)*
- *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*
- *Well-Child Visits in the First 15 Months of Life (W15)*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*

Additionally, four of these measures showed statistically significant improvement:

- *Cervical Cancer Screening (CCS)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC–E)*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N)*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)*

SFHP had an additional three performance measures with rates within approximately one percentage point of the HPL:

- *Use of Appropriate Medications for People With Asthma (ASM)*

- *Comprehensive Diabetes Care—LDL-C Screening (CDC–LS)*
- *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)*

The measures listed above spanned the domains of quality, access, and timeliness. The plan had no statistically significant declines, which demonstrated both stable and in some cases improved performance.

Opportunities for Improvement

While not a statistically significant decrease, the plan has an opportunity to improve its *Breast Cancer Screening (BCS)* rate to ensure there is no 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 SFHP'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

SFHP 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. SFHP's second project, an internal QIP, aimed to improve diabetes management. 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.

Regular blood sugar tests, cholesterol tests, retinal eye exams, and monitoring for nephropathy are indicators of quality care for diabetics. SFHP's *Diabetes Care Management* QIP focused on improving the rates of these indicators and thus improving the management of diabetes.

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 SFHP's QIPs across CMS protocol activities during the review period.

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

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	100%	0%	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	69%†	13%†	19%†
VII.	Appropriate Improvement Strategies	40%	40%	20%
VIII.	Sufficient Data Analysis and Interpretation	71%†	18%†	12%†
IX.	Real Improvement Achieved	50%†	13%†	38%†
X.	Sustained Improvement Achieved	100%	0%	0%
Percentage Score of Applicable Evaluation Elements *Met*		**72%**		
Validation Status		***Not Applicable****		

* QIPs were not given an overall validation status during the review period.

† The sum may not equal 100 percent due to rounding.

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 SFHP's QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided SFHP, 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 SFHP's data for its QIPs. For the ER QIP, 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.

Table 5.2—QIP Outcomes for San Francisco Health Plan—San Francisco 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	16.3%	‡	‡	‡
‡The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Diabetes Care Management					
		Remeasurement Period			
QIP Study Indicator	Baseline Period 1/1/05–12/31/05	1 1/1/06–12/31/06	2 1/1/07–12/31/07	3 1/1/08–12/31/08	Sustained Improvement
1) Percentage of total members 18–75 years of age with type 1 or 2 diabetes who had at least one HbA1c test during the measurement year	71.3%	86.0%*	86.4%	‡	Yes
2) Percentage of total members 18–75 years with type 1 or 2 diabetes who had at least one LDL screening during the measurement year	65.2%	77.9%*	79.4%	‡	Yes
3) Percentage of total members 18–75 years with type 1 or 2 diabetes who had at least one eye exam during the measurement year	58.9%	64.8%	66.5%	‡	Yes
4) Percentage of total members 18–75 years with type 1 or 2 diabetes who had at least one nephropathy screening test or evidence of nephropathy during the measurement year	52.6%	74.9%*	82.2%*	‡	Yes
* Designates statistically significant improvement over the prior measurement period. ‡ The QIP did not progress to this phase during the review period and could not be assessed.					

For the diabetes QIP, the plan focused on both member and provider interventions. One intervention implemented was a $50 member incentive for high-risk diabetic members who underwent all required screening. The plan appropriately evaluated the success of this intervention and, based on the results, expanded the intervention to include all diabetic members with a reduced incentive of $25.

Strengths

SFHP demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data. In addition, SFHP used appropriate sampling techniques, ensuring study results would be generalizable to the plan's population.

The plan's diabetes QIP demonstrated sustained improvement for all four study indicators and statistically significant improvement for three of the four indicators.

SFHP's success with its diabetes QIP was reflected in the plan's improved diabetic performance measure rates. The HEDIS 2009 rates for three of the four *Comprehensive Diabetes Care* measures included in the QIP—*Eye Exam (Retinal) Performed (CDC–E), HbA1c Testing (CDC–HT),* and *Medical Attention for Nephropathy (CDC–N)*—were above the HPLs and demonstrated the plan's ability to sustain the improvement documented in the QIP.

Opportunities for Improvement

SFHP 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 should retire its diabetes QIP and focus on an area that is actionable and in need of improvement. The plan may consider a nonclinical QIP since it has demonstrated consistent above-average performance for most of its clinical indicators.

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*