Performance Evaluation Report

Health Plan of San Joaquin

July 1, 2009–June 30, 2010

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

February 2012

TABLE OF CONTENTS

1. INTRODUCTION 1
Purpose of Report 1
Plan Overview 2
2. ORGANIZATIONAL ASSESSMENT AND STRUCTURE 3
Conducting the Review 3
Findings 3
Medical Performance Review 3
Medi-Cal Managed Care Member Rights and Program Integrity Review 5
Strengths 6
Opportunities for Improvement 6
3. PERFORMANCE MEASURES 7
Conducting the Review 7
Findings 7
Performance Measure Validation 7
Performance Measure Results 8
HEDIS Improvement Plans 10
Strengths 10
Opportunities for Improvement 10
4. QUALITY IMPROVEMENT PROJECTS 11
Conducting the Review 11
Findings 11
Quality Improvement Projects Conducted 11
Quality Improvement Project Validation Findings 12
Quality Improvement Project Outcomes 14
Strengths 15
Opportunities for Improvement 15
5. MEMBER SATISFACTION SURVEY 16
Conducting the Review 16
Findings 16
National Comparisons 17
Strengths 18
Opportunities for Improvement 18
6. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS 19
Overall Findings Regarding Health Care Quality, Access, and Timeliness 19
Quality 19
Access 20
Timeliness 21
Follow-Up on Prior Year Recommendations 21
Conclusions and Recommendations 22
APPENDIX A. FOLLOW-UP ON THE PRIOR YEAR'S RECOMMENDATIONS GRID A-1

1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] 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 the 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. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Health Plan of San Joaquin ("HPSJ" or "the plan"), which delivers care in San Joaquin County, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

HPSJ is a full-scope managed care plan in San Joaquin County. HPSJ serves members as a local initiative (LI) under the Two-Plan Model. In a Two-Plan Model county, the DHCS contracts with two managed care plans in each county to provide medical services to members. Most counties offer an LI plan and a nongovernmental, commercial health plan.

HPSJ has been Knox-Keene licensed since January 1996. Knox-Keene licensure is granted by the Department of Managed Health Care (DMHC) to plans that meet minimum required standards according to the Knox-Keene Health Care Service Plan Act of 1975. The act includes a set of laws that regulate managed care organizations (MCOs).

Members of the MCMC Program in San Joaquin County may enroll in either the LI plan operated by HPSJ or in the alternative commercial plan. HPSJ became operational with the MCMC Program in February 1996, and, as of June 30, 2010, HPSJ had 74,450 MCMC members[2].

[2] *Medi-Cal Managed Care Enrollment Report—June 2010*. 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 that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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 and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division often work in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits are conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

HSAG reviewed the most current medical performance review reports available as of July 30, 2009, to assess the plans' compliance with State-specified standards. A&I and DMHC conducted a joint medical performance audit of HPSJ in January 2009, covering the review period of January 1, 2008, through December 31, 2008. The audit covered the areas of utilization management (UM), continuity of care, access and availability, member rights, quality management, and administrative and organizational capacity. Results from the audit showed strengths as well as opportunities for improvement.

In the area of utilization management, the review showed that HPSJ developed and implemented a UM program, and had mechanisms in place to detect both under- and overutilization. The plan also developed policies and procedures outlining the prior-authorization process. Audit findings related to utilization management revealed that HPSJ did not consistently send notification letters for prior authorization denial, deferral, or modification to members and providers. The plan also lacked a policy requiring prior authorization appeals to be resolved by a different physician than the one who made the initial denial.

In the continuity of care category, HPSJ was compliant with all the requirements. A comparison of prior audit findings in this category from the previous audit conducted in April 2005 for the period of April 1, 2004, through March 31, 2005, showed that HPSJ demonstrated strong success in improving its process to ensure the coordination of care for members receiving early intervention services through the California Children's Services program as well as the implementation and monitoring of initial health assessments for members.

For availability and accessibility, the plan had appointment access policies in place for routine care, periodic health assessments, urgent care, and specialty referral appointments. The review noted that HPSJ did not notify members of denied, adjusted, or deferred claims for emergency and family planning services. Additionally, a verification study revealed that family planning claims were incorrectly denied for lack of prior authorization.

Under the members' rights category, HPSJ had policies and procedures for processing and resolving member grievances. However, the plan acknowledged that some members did not receive grievance acknowledgement and resolution letters. Additionally, grievance resolution letters that were sent did not contain adequate explanation and detail of the grievance resolution, and these letters also did not include the grievance coordinator's contact information. Grievance files involving clinical issues did not include documentation of review by the medical director. Finally, the plan's policies lacked procedures for reporting health privacy breaches to DHCS. The grievance-related issues are similar in nature to audit findings noted in the prior review conducted in April 2005, covering the review period of April 1, 2004, through March 31, 2005. This indicates that HPSJ did not appropriately implement and monitor these areas of repeat deficiency.

In the quality management area, the plan had developed and implemented policies and procedures to assess, monitor, and take action to improve operations and deliver quality care to members. The review found that HPSJ did not complete an annual oversight audit of credentialing and recredentialing activities delegated to the pharmacy benefits manager; however, DHCS approved the plan's corrective action plan for this finding.

For administrative and organizational capacity, the plan did not maintain sign-in sheets for provider and staff attendance of in-service training sessions. Additionally, HPSJ's fraud and abuse policies also did not include a procedure to report suspected cases of fraud and abuse to DHCS within 10 working days from the start of the preliminary investigation.

The plan responded to these deficiencies in a corrective action plan. The DHCS responded to the plan's CAP on December 29, 2009, in the MMU Closeout Letter. The letter noted that many CAP issues remained unresolved. The plan failed to adequately show notification of prior authorization denial, deferral, or modification. Additionally, the plan did not demonstrate evidence to support the establishment of a grievance committee, a mechanism for tracking grievances and appeals, and approval from the State for grievance policies. Emergency services payment deficiencies remained unresolved; as did the finding that the plan was not sending NOA letters for family planning service claims denials, adjustments, or deferrals. The plan did not demonstrate DHCS approval for revised policies nor did it demonstrate implementation and monitoring. Although the Medical Audit Process is considered closed, HPSJ is expected to implement the necessary actions to achieve compliance.

In addition to the joint medical audit, the audit covered a review of MCMC Hyde contract requirements. The Hyde contract covers abortion services funded only with State funds, as these services do not qualify for federal funding. The review found that the plan did not include all State Supported Service codes as identified in the contract; however, the MMU Closeout Letter noted that that plan corrected this area of deficiency.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's 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 member rights reviews are conducted 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 member rights 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, 2010. The most current MRPIU review for HPSJ was conducted in November 2008, covering the review period of January 1, 2007, through June 30, 2008. The detailed findings from this review were included in the prior evaluation report.[3]

MRPIU's review showed that the plan had compliance findings in the following areas: grievances, prior authorization notifications, and cultural and linguistic services. Based on these findings, DHCS recommended specific actions to HPSJ to resolve each finding.

Strengths

HPSJ showed strength in the area of continuity and coordination of care. The plan addressed and resolved medical performance audit deficiencies noted in this area in 2005 as demonstrated by the plan's full compliance in this area during the 2009 review.

Opportunities for Improvement

There are several opportunities for HPSJ to improve its compliance performance. The plan has many repeat and unresolved deficiencies in the areas of grievances and appeals. Additionally, the plan has opportunities to correct its payment practices for emergency services and family planning services, privacy practices, and provider training. The plan needs to incorporate the areas of audit deficiency into its quality workplan to ensure the correction, implementation, and monitoring of these areas.

[3] California Department of Health Care Services. *Performance Evaluation Report, Health Plan of San Joaquin – July 1, 2008 through June 30, 2009*. December 2011.

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 provide 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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed a HEDIS Compliance Audit™ of HPSJ in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[4] Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

[4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. Table 3.1 displays a HEDIS performance measure name key.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
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*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of HPSJ's HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan's HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national Medicaid 25th percentile and 90th percentile, respectively. For the CDC–H9 (>9.0 percent) measure, 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.

Table 3.2––2009–2010 Performance Measure Results for Health Plan of San Joaquin–San Joaquin County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	23.3%	24.6%	★★	↔	20.2%	33.4%
AWC	Q,A,T	53.8%	51.1%	★★	↔	37.9%	59.4%
BCS	Q,A	55.4%	58.0%	★★	↔	45.0%	63.0%
CCS	Q,A	67.6%	65.5%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	66.2%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	58.9%	52.1%	★★	↓	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	46.7%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	42.7%	44.5%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	79.0%	77.6%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	30.7%	30.2%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	77.2%	77.6%	★★	↔	71.5%	82.5%
CDC–N	Q,A	77.4%	74.9%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	74.7%	74.0%	★★	↔	62.4%	80.6%
LBP	Q	‡	74.5%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	83.2%	81.0%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	60.8%	62.8%	★★	↔	57.9%	72.7%
URI	Q	82.5%	85.5%	★★	↑	81.1%	94.5%
W34	Q,A,T	83.9%	82.2%	★★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	62.3%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	60.6%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	41.8%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[5] Performance comparisons are based on the Chi-square 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 DHCS did not require plans to report this measure in 2009.
NA = The DHCS does not establish an MPL/HPL for first year measures.
★ = 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 to either significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, HPSJ had average performance results across the spectrum of HEDIS measures. One measure had a statistically significant increase from 2009 to 2010, while one measure had a statistically significant decrease. One measure, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life,* scored above the HPL, while the remaining measures fell between the 25th and 90th Medicaid national percentiles. The plan had no performance measure rates below the MPL.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline the steps it will take to improve care.

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing towards the MPL. In addition, HSAG assessed the plan's need for continuing existing improvement plans and/or developing new improvement plans.

In 2009, HPSJ did not have any measures finish below the MPL. Therefore there were no improvement plans in place for 2010.

Strengths

HPSJ scored above the HPL on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. Additionally, there were no measures that scored below the MPL.

Opportunities for Improvement

HPSJ should focus on *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed,* as it was the only measure that had a statistically significant decrease from 2009 to 2010.

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 clinical and nonclinical areas.

HSAG reviews each QIP using the Centers for Medicare & Medicaid Services' (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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Quality Improvement Projects Conducted

HPSJ had two clinical QIPs in progress during the review period of July 1, 2009, through June 30, 2010. 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 table below summarizes the validation results for both of HPSJ's QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Health Plan of San Joaquin—San Joaquin County July 1, 2009, through June 30, 2010

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	97%	100%	*Met*
Internal QIPs				
Chlamydia Screening	Annual Submission	97%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a new proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met, Partially Met,* or *Not Met*. In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that the annual submission by HPSJ of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met* with 97 percent of all evaluation elements and 100 percent of critical elements receiving a *Met* score. Additionally, HPSJ received a *Met* validation status for its *Chlamydia Screening* QIP submission. 97 percent of all elements and 100 percent of critical elements received a *Met* validation score. Neither QIP required a resubmission.

Table 4.2 summarizes the validation results for both of HPSJ's QIPs across the CMS protocol activities during the review period.

Table 4.2––Quality Improvement Project Average Rates*
for Health Plan of San Joaquin—San Joaquin County
(N = 2 QIPs, 2 QIP Topics)
July 1, 2009, through June 30, 2010

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	67%	33%	0%
Implementation Total†		**88%**	**13%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		**100%**	**0%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.
† The sum of an activity or stage may not equal 100 percent due to rounding.
‡ The QIP did not progress to this activity during the review period and could not be assessed.

HPSJ submitted Remeasurement 1 data for the *Reducing Avoidable Emergency Room Visits* QIP; therefore, HSAG validated Activity I through Activity IX. For the *Chlamydia Screening* QIP, the plan submitted Remeasurement 2 data, however since Remeasurement 1 demonstrated a statistically significant decline in performance, sustained improvement could not be assessed. Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

HPSJ accurately applied the QIP process for the Design stage, scoring 100 percent for the four activities. For the Implementation stage, the plan successfully documented the data collection process; however, for both QIPs, the plan did not discuss which interventions were considered successful or how it would monitor and/or standardize successful interventions as part of its improvement strategy. Therefore, the score for Activity VII was lowered to 67 percent. For the Outcomes stage, HPSJ conducted the appropriate analyses, interpreted the results, and more

importantly, achieved statistically significant improvement (considered "real improvement" or improvement that is unlikely due to chance) for the study indicator outcomes.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3––Quality Improvement Project Outcomes for Health Plan of San Joaquin—San Joaquin County July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement**
Percentage of ER visits that were avoidable	21.3%	16.7%*	‡	‡
QIP #2—Chlamydia Screening				
QIP Study Indicator	**Baseline Period 1/1/06–12/31/06**	**Remeasurement 1 1/1/07–12/31/07**	**Remeasurement 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%*	57.9%*	‡

*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05)
‡The QIP did not progress to this phase during the review period and could not be assessed.

During the reporting period covered by this evaluation (July 1, 2009–June 30, 2010), HPSJ submitted Remeasurement 1 data for the *Reducing Avoidable Emergency Room Visits* QIP. For the *Chlamydia Screening* QIP, HPSJ submitted Remeasurement 2 data.

For the *Reducing Avoidable Emergency Room Visits* QIP, avoidable ER visits decreased, indicating an increase in performance. This increase was statistically significant. The plan implemented the statewide collaborative work group interventions following Remeasurement 1. Since collaborative interventions were not initiated until 2009, HSAG cannot evaluate the effectiveness of those interventions until the next reporting cycle (July 2010 through June 2011).

The *Chlamydia Screening* QIP was effective, with a statistically significant increase in the percentage of women screened for Chlamydia from Remeasurement 1 to Remeasurement 2. However, since the performance had initially decreased from baseline to Remeasurement 1, this was the first measurement period demonstrating improvement in the outcome. HPSJ will need to submit an additional measurement period to determine if it is able to sustain the improvement achieved thus

far. The plan implemented several interventions including assisting with member outreach by provider offices and conducting on-site provider office visits. Additionally, the plan was able to access all lab data beginning with CY 2008, which was directly loaded into the HEDIS data warehouse.

Strengths

HPSJ demonstrated a strong application of the QIP process for the Design and Outcome stages. The plan documented statistically significant improvement in the outcomes for both QIPs. To increase Chlamydia screening, the plan implemented several interventions including a system intervention that may have a greater likelihood of achieving sustained improvement.

Opportunities for Improvement

The plan should include a method to evaluate the efficacy of the interventions that are implemented. This type of evaluation facilitates decisions as to which interventions should be continued based on their success. The intervention evaluation plan should include subgroup analyses to determine the effects of the intervention across the population.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan surveys.[5]

The administration of the CAHPS survey is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS surveys be administered to both adult members and the parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

The Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about HPSJ's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures as follows:

CAHPS Global Rating Measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

[5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CAHPS Composite Measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance (NCQA)'s HEDIS® benchmarks and thresholds or NCQA's national Medicaid data, when applicable. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 5.1.

Table 5.1—Star Ratings Crosswalk

Stars	Adult Percentiles	Child Percentiles
★★★★★	≥ 90th percentile	≥ 80th percentile
★★★★	75th percentile–89th percentile	60th percentile–79th percentile
★★★	50th percentile–74th percentile	40th percentile–59th percentile
★★	25th percentile–49th percentile	20th percentile–39th percentile
★	< 25th percentile	< 20th percentile

Table 5.2—Health Plan of San Joaquin—San Joaquin County Medi-Cal Managed Care County-Level Global Ratings

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★	★★
Child	★★	★	★★	★+

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Table 5.3—Health Plan of San Joaquin—San Joaquin County Medi-Cal Managed Care County-Level Composite Ratings

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Adult	★	★	★	★★★+	★
Child	★	★	★	★★+	★★★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Strengths

At the composite rating level in the adult category, *Customer Service* scored above the 50th percentile. Also in the composite ratings, the *Shared Decision Making* rating in the child category scored above the 40th percentile.

Opportunities for Improvement

At the global ratings level, HPSJ's CAHPS results showed the opportunity for the most improvement in the *Rating of All Health Care* category as it received a single star in both the adult and child segments. At the composite rating level, three categories received single star scores in both the adult and child segments, these are: *Getting Needed Care*, *Getting Care Quickly, and How Well Doctors Communicate.*

HSAG conducted a key driver analysis of satisfaction that focused on the top three highest priorities based on the plan's CAHPS results. The purpose of the key drivers of satisfaction analysis was to help decision makers identify specific aspects of care most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as HPSJ's highest priority: *Rating of All Health Care, Getting Needed Care, and How Well Doctors Communicate*. The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 Health Plan of San Joaquin*. Areas for improvement spanned the quality, access, and timeliness domains of care.

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 the results of performance measures and quality improvement projects (QIPs) 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.

The plan showed average performance in the quality domain. This assessment was based on HPSJ's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

The HPSJ plan was able to report valid rates for all 2010 performance measures, and no measures fell below the MPL. The plan had one measure above the HPL. One performance measure rate had a statistically significant decline between 2009 and 2010, and one measure had a statistically significant increase in performance measure rates. One indicator of steady performance is that the plan was not required to submit improvement plans based on 2009 and 2010 HEDIS results.

QIP results showed that the plan did well at documenting the QIP study design and outcome phases. The plan did achieve statistically significant improvement in both QIPs, leading to a decrease in avoidable ER visits and improved Chlamydia screening rates. In future QIP submissions, the plan should include a method to evaluate the efficacy of the interventions that are implemented.

Despite overall success with performance measure rates and QIPs, the plan had several repeat audit deficiencies noted in the medical performance reviews. This suggests a lack of implementation and monitoring of areas to fully address audit deficiencies. The plan has an opportunity to improve its internal quality improvement process to ensure greater attention to areas that require correction. Member grievances that lack review of a physician for potential quality-of-care issues could have a negative impact on the overall health care quality received by 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 a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. 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.

The plan demonstrated average performance in the access domain. This assessment was based on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance, member rights reviews related to the availability and accessibility of care, and member satisfaction results.

For access-related compliance standards, the plan was able to close out its CAP related to access to prenatal care by revising its policy. However CAPs related to emergency room and family planning Notice of Action Letters were not adequately addressed in the plan's response. Member satisfaction results for adults and children demonstrated poor performance for *Getting Needed Care*. This composite assesses members' satisfaction with accessing care once a need is identified and presents an area for improvement.

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, to minimize any disruptions to care, and to 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.

HPSJ demonstrated below average performance in the timeliness domain of care. This assessment was based on 2010 performance measure rates for providing timely care, medical performance, member rights reviews related to timeliness, and member satisfaction results related to timeliness.

While performance measure rates related to timeliness showed that the plan performed above the MPL for all timeliness related HEDIS measures, the plan was unable to fully address repeat deficiencies related to the grievance system as well as adequately resolve the issue prior to the medical audit close-out.

Member satisfaction results showed that the plan demonstrated poor performance in the *Getting Care Quickly* category for both adult and child populations. This suggests that members perceive that they do not always receive care in a timely manner.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. HPSJ's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, HPSJ had average performance in providing quality and accessible health care services to its MCMC members. HPSJ's performance in the area of timeliness of health care services was below average due to medical performance audit findings related to prior authorization notifications as well as grievance and appeals.

HPSJ remained consistent in its performance measures rates in 2010 compared with 2009 rates. The plan demonstrated a statistically significant decline in its avoidable ER visits rates and a statistically significant increase in its Chlamydia screening rates. The plan's greatest opportunity for improvement is related to improving compliance with State and federal requirements as part of the medical performance reviews. The plan must ensure that audit deficiencies are adequately addressed and monitored as part of the quality improvement program.

Based on the overall assessment of HPSJ in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following:

- Review the DHCS close-out reports for Medical Performance Report and MRPIU to identify all open CAP items and incorporate a mechanism to include the implementation and monitoring of these areas within the quality improvement program to ensure that deficiencies are fully resolved.
- Conduct periodic, internal, prior-authorization file audits to ensure compliance with required documentation.
- Explore factors that may have contributed to decline in the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure.
- Re-educate providers on the cultural and linguistic service requirements, including the grievance process and language interpreter services.
- Review the detailed recommendations for improving member satisfaction, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 Health Plan of San Joaquin.*
- Include subgroup analyses in the plan's QIP evaluation plan to determine the effects of the intervention across the population.

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

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address Recommendation
Focus performance measure improvement efforts on the three measures that fall just above the MPLs to ensure compliance in subsequent years.	Provider and member incentives incorporated with ongoing educational outreach through member and provider newsletters. Office managers' in-service completed regarding HEDIS measures and using the Health plans HEDIS Projector for member out reach.
Realign QIP intervention strategies to target identified barriers and explore evidence-based interventions that may increase the likelihood of improvement.	Identified barriers for one of the QIPs involved providers requiring education on completing urinalysis testing for Chlamydia screening. Post-implementation HEDIS scores were improved along with QIP approval. Per AER/ER QIP, the QI department—along with Disease Manager and Health Educator—participated in the State Wide ER collaborative that identified barriers. Implementation activities within the Health Plan include sending monthly reports to providers and education outreach with members as well.
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance toward increasing compliance with the CMS protocol for conducting QIPs.	The QI department is utilizing the most recent format of the QIP summary form and, as such, all QIPs completed for submission have been accepted.
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.	The QI Workplan is completed annually along with reporting to the QI/UM Committee the key findings and analysis of the prior year's activity results. All activities requiring annual reporting are presented to QI/UM, including, but not limited to, Quality Reviews, Annual Access Survey, HEDIS, QIP's, IHA's, Delegated oversight activities, FSR/MRR DHCS reporting, and advisory/liaison activities. Please note this was not a finding in the 2009 Joint Medical Audit.
Incorporate measurement performance goals for monitoring quality areas into the work plan and include activities that address and monitor areas of noncompliance.	QI Work plan clinical improvements have measurable goals and work plan activities with activity reporting to QI/UM on an annual basis.
Implement a process to monitor the provision of all medically necessary services for persons with developmental disabilities.	The QI Workplan addresses the provision of a liaison who meets quarterly with Valley Mountain Regional Center. Coordination-of-care issues can be addressed in this forum. Also, DHCS sends a monthly file noting all members who have dual eligibility. Currently the Health Plan has in place an SPD project that is on task for triage care management. Please that was not a finding in the 2009 Joint Medical Survey Audit.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address Recommendation
Implement a process to monitor primary care providers' capacity to accept new enrollment.	The Provider Services Department monitors physician/patient ratios by verifying on an ongoing basis the PCP's extenders (NPs and PAs) and updates the PCP's capacity as needed.
Develop a process to follow up on member grievances regarding access and availability.	Providers who receive three member grievances regarding access and availability are audited for access by QI. Results are reported to the QIUM Committee and if corrective actions are required, deficiencies must be corrected. Please note this was not a finding in the 2009 Joint Medical Audit.
Develop a process to oversee and monitor the nurse advice line.	Advice nurse calls are reviewed daily, triaged, and referred to care management as needed. All calls are saved and archived in DRE. Monthly reports and statistics are forwarded to the QIUM Committee. Please note this was not a finding in the 2009 Joint Medical Audit.
Document discussions of grievance data and ensure that the plan takes action, as appropriate, after discussion of these data.	HPSJ implemented a Grievance Committee to review grievance data, which is then reported to the QIUM Committee which may recommend plans of action if needed.
Incorporate a process to ensure appropriate physician review of all clinical grievances.	All call logs referred to the Quality Improvement department are reviewed to substantiate quality of care. Once indentified by a clinician (RN) regarding quality and deemed relevant to quality of care, the medical director reviews the case. Quality-of-care issues can be further reviewed via Clinical Potential Quality Investigations (CPQIs) which are reviewed by MDs at HPSJ and considered for reporting to QI/UM.
Implement a process to ensure that grievance acknowledgment and resolution letters are sent within the required time frames to members and that compliance is monitored.	The plan reviewed the grievance process and revised policies and procedures as necessary to ensure that acknowledgement and resolution letters are timely. Timelines for acknowledging and responding to grievances are closely monitored by the Grievance Committee.
Revise grievance policies and procedures to include the process for written notification to members for grievances not resolved within 30 days.	The plan reviewed the grievance process and revised policies and procedures as necessary to ensure written notification to members for grievances not resolved within 30 days. This data is closely monitored by the Grievance Committee. Please note this was not a finding in the December 2010 MRPUI onsite review.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address Recommendation
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.	The plan has revised policies and procedures to ensure Notice of Action letters contain all required information, consistent with contract requirements. NOAs are monitored for accurate information and turnaround time.
Reeducate providers on cultural and linguistic service requirements and update marketing policies and procedures.	HPSJ hosted provider training relating to cultural disparities and sensitivity issues. Providers are educated about access to interpreter services for members during provider in-service trainings. HPSJ also produces a provider newsletter specific to cultural and linguistic issues. Marketing policies have been updated. Please note this was not a finding in the December 2010 MRPUI onsite review.