Performance Evaluation Report

Health Plan of San Mateo

July 1, 2009–June 30, 2010

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

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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 Mateo ("HPSM" or "the plan"), which delivers care in San Mateo 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

HPSM is a full-scope managed care plan in San Mateo County. HPSM serves members as a County Organized Health System (COHS) model type. HPSM has been Knox-Keene licensed since 1998. 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).

In a COHS model county, the DHCS initiates contracts with county-organized and operated plans to provide managed care services to beneficiaries with designated, mandatory aid codes. In a COHS plan, beneficiaries can choose from a wide network of managed care providers. These beneficiaries do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the plan.

HPSM became operational with the MCMC Program in San Mateo County in December 1987. As of June 30, 2010, HPSM had 58,115 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 HPSM'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 June 30, 2010, to assess plans' compliance with State-specified standards. HSAG reported the results of the 2007 review in the previous plan evaluation report. The results from the most recent medical performance review were not yet available and will be reported in the next annual plan evaluation report. The 2010 review will include an evaluation of plan actions on deficiencies that remained unresolved as of the *DHCS Medical Audit Close-Out Report, July 29, 2008*. Unresolved deficiencies were noted in the areas of delegated utilization management, the process for approving the use of alternative forms for initial health assessments and initial health education behavioral assessments, and provider training requirements.

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 recent MRPIU review was conducted in November 2008 and was reported in the prior plan evaluation report. The MRPIU noted deficiencies in the areas of grievance acknowledgement letters, prior authorization denial or modification notification letters, procedures for notification of suspected fraud and abuse, and cultural and linguistic requirements. The subsequent MRPIU review results were not available and will be reported in the next plan evaluation report. This review will include an evaluation of HPSM's resolution of all open deficiencies.

Strengths

HPSM was able to resolve most deficiencies prior to the close-out of the most recent medical performance review.

Opportunities for Improvement

HPSM has additional opportunities for improvement related to unresolved deficiencies identified by the medical performance and MRPIU reviews. Resolution and plan actions taken will be addressed in the next plan evaluation report.

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 HPSM's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed an NCQA HEDIS Compliance Audit™ of HPSM in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[3] Based on the results of the compliance audit, HSAG found all measures to be reportable. The auditors noted minimal issues related to information systems standards that did not impact the measure results. The auditors made recommendations regarding formalizing oversight of the optical character recognition (OCR) vendor within the claims department and capturing lab value results within the supplemental pay-for-performance database.

[3] *HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). NCQA HEDIS Compliance Audit™ is a trademark of the 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 HPSM'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 Mateo–San Mateo 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	26.4%	33.5%	★★★	↔	20.2%	33.4%
AWC	Q,A,T	41.6%	43.8%	★★	↔	37.9%	59.4%
BCS	Q,A	55.9%	57.0%	★★	↔	45.0%	63.0%
CCS	Q,A	58.7%	62.6%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	62.3%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	59.7%	60.3%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	56.9%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	43.1%	35.8%	★★	↑	50.6%	29.2%
CDC–HT	Q,A	83.9%	86.6%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	42.7%	45.0%	★★★	↔	27.2%	44.7%
CDC–LS	Q,A	79.4%	80.5%	★★	↔	71.5%	82.5%
CDC–N	Q,A	85.2%	85.4%	★★★	↔	73.4%	85.4%
CIS–3	Q,A,T	79.1%	87.3%	★★★	↑	62.4%	80.6%
LBP	Q	‡	86.5%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	77.5%	85.3%	★★	↑	78.5%	92.2%
PPC–Pst	Q,A,T	60.1%	63.5%	★★	↔	57.9%	72.7%
URI	Q	89.0%	89.7%	★★	↔	81.1%	94.5%
W34	Q,A,T	72.8%	70.7%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	59.6%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	67.9%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	56.7%	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, HPSM had average to above-average performance with noted steady improvement over the prior year's results. The plan achieved the HPL for four measures, had three measures with statistically significant improvement, no measures with a statistically significant decline, and no measures 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.

HPSM had no 2009 performance measure rates that required an improvement plan.

Strengths

While achieving notable improvement in some measures, HPSM had no significant declines and increased the number of measures reaching the HPL to four (the plan had two measures reach the HPL in 2009).

Opportunities for Improvement

HPSM should continue internal improvement efforts and evaluate lower-performing measures to identify those which can be impacted by targeted interventions.

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 HPSM's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Projects Conducted

HPSM had two clinical QIPs and one QIP proposal 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. HPSM's second project, an internal QIP, aimed to increase cervical cancer screening in women 21 to 64 years of age. The third project sought to increase the timeliness of prenatal care. All three QIPs fell under the quality and access domains of care, and the prenatal care QIP also fell under the timeliness domain of care.

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

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

The lack of timely prenatal care is associated with poorer pregnancy outcomes including prematurity of the fetus. The plan's goal is to have women seen by a provider in their first trimester and maintain a prenatal "home" throughout their pregnancy.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for Health Plan of San Mateo—San Mateo 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	84%	100%	*Met*
Internal QIPs				
Cervical Cancer Screening	Annual Submission	90%	100%	*Met*
Increasing Timeliness of Prenatal Care	Proposal	87%	67%	*Partially Met*
	Proposal Resubmission 1	100%	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*.

*Not Applicable—Percentage scores were not applied for a small number of QIPs still in the process of final QIP submission/closeout, for which new scoring methodology had not yet been implemented.

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 HPSM of its *Reducing Avoidable Emergency Room Visits* QIP received an overall

validation status of *Met* with 84 percent of all evaluation elements and 100 percent of critical elements receiving a *Met* score. Additionally, HPSM received a *Met* validation status for its *Cervical Cancer Screening* QIP submission. Ninety percent of all elements and 100 percent of critical elements received a *Met* validation score. Neither QIP required a resubmission. Because HPSM completed two remeasurement periods for its *Cervical Cancer Screening* QIP, the plan opted to retire the QIP. HPSM submitted a new QIP proposal in February 2010. The *Increasing Timeliness of Prenatal Care* QIP proposal received a *Partially Met* validation result upon initial review. Lower validation scores were related to the study question and its lack of alignment with the study indicator. The plan revised the study question, resubmitted the QIP proposal, and received a *Met* validation result.

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

Table 4.2—Quality Improvement Project Average Rates* for Health Plan of San Mateo—San Mateo County (Number = 3 QIP Submissions, 3 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	94%	6%	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		**99%**	**1%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	76%	24%	0%
	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**62%**	**15%**	**23%**

*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.

HPSM accurately documented the activities for the design and implementation stages, scoring 100 percent for six of the seven activities. The *Increasing Timeliness of Prenatal Care* QIP did not progress to the outcomes stage. For the other two QIPS, HPSM scored lower in Activity VIII for the plan's lack of statistical testing between the most recent measurement periods in the *Cervical Cancer Screening* QIP, and not reporting accurate *p* values in the *Reducing Avoidable Emergency Room Visits* QIP. Neither QIP demonstrated improvement; therefore, HPSM received a score of 25 percent for Activity IX. The *Cervical Cancer Screening* QIP progressed through Activity X and was assessed

for and achieved sustained improvement. 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.

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 Mateo—San Mateo County (Number = 3 QIP Submissions, 3 QIP Topics) 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	15.0%	16.2%*	‡	‡
QIP #2—Cervical Cancer 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 21–64 years of age who received one or more Pap tests during the measurement year or the two years prior	55.0%	60.4%	58.7%	Yes
QIP #3—Increasing Timeliness of Prenatal Care				
Percentage of members who had a prenatal care visit in the first trimester or within 42 days of enrollment	‡	‡	‡	‡

¥ 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.

*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.

HPSM reported a decline in performance for both QIP study indicators during the review period. The increase in the avoidable ER visits indicator rate was statistically significant and denoted a decline in performance. The decrease in the cervical cancer screening rate was not statistically significant. The *Increasing Timeliness of Prenatal Care* QIP had not progressed to the point of reporting study indicator outcomes.

For the *Reducing Avoidable Emergency Room Visits* QIP, the plan implemented the statewide collaborative work group interventions following Remeasurement 1. Additionally, the plan offered pay-for-performance to providers that offered extended office hours. Since these interventions were not initiated until 2009, HSAG cannot evaluate the effectiveness of those interventions until the next reporting cycle (July 2010 through July 2011).

While the *Cervical Cancer Screening* QIP rate did not improve over the last measurement period, the plan was able to demonstrate sustained improvement. The plan stated that there were still members who did not understand the need for a Pap test. The plan felt that members were confused because the recommendations of the American College of Gynecologists (ACOG) changed while the NCQA/state requirements continued to recommend a Pap test every one to three years. Due to a very low member demand to have the health promotion specialist accompany them to Pap testing appointments, the plan eliminated this service from the program, which allowed the health promotion specialist to focus on other program outreach activities. Additionally, the incentive was changed from a gift from Bath and Body Works to a Target gift card, which had more universal appeal and lower mailing costs.

Strengths

HPSM accurately documented the activities for the design and implementation stages. The plan's interventions to address identified causes/barriers and system interventions are likely to induce permanent change.

HPSM's efforts on its cervical cancer screening QIP may have resulted in the plan's improvement of its cervical cancer screening rate, which improved significantly from baseline to the second remeasurement period.

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

Opportunities for Improvement

For its *Increasing Timeliness of Prenatal Care* QIP, the plan has an opportunity to explore its access-related barriers for members seeking prenatal care and implement targeted interventions that may increase the concept of a prenatal "home." Additionally, the plan should continue to conduct subgroup analysis for its *Reducing Avoidable Emergency Room Visits* QIP, evaluating the efficacy of the interventions that have been implemented and developing new interventions to address any barriers identified.

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.[4]

The administration of the CAHPS surveys 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 HPSM'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*

[4] 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 Mateo—San Mateo 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 Mateo—San Mateo County
Medi-Cal Managed Care County-Level Composite Measures

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

Strengths

HPSM performed exceptionally well across the global ratings, particularly in the child survey results. The plan achieved the highest performance for the child *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*. The plan also showed strong performance in the child *Rating of Health Plan* and *Rating of All Health Care*, as well as *Rating of Personal Doctor* for adults. Within the composite ratings, the plan also achieved the highest performance for both children and adults in *Shared Decision Making*.

Opportunities for Improvement

HPSM's CAHPS results showed poor performance for all child composite rating categories with the exception of *Shared Decision Making*. Low performance was also observed for most composite measures for adult surveys, except for *Shared Decision Making* (achieved the highest performance) and *How Well Doctors Communicate* (results exceeded the 50th percentile). While HPSM showed a need for improvement in several areas of member satisfaction across both adult and child populations, HSAG conducted a key drivers of satisfaction analysis 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 HPSM's highest priority: *Customer Service,* and *Getting Care Quickly*. *Getting Needed Care* was identified as an area of moderate priority. 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 Mateo CAHPS Plan-Specific Report*. 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.

HPSM showed average to above-average performance in the quality domain. This assessment was based on HPSM's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, and member satisfaction survey results. Since there were no new results available from the medical performance and member rights review, HSAG did not use this activity as a part of the evaluation.

The plan reported four measures that reached the HPL and no results below the MPL. The plan also achieved statistically significant improvement in three performance measures. All of the performance measures reflect quality of care, indicating HPSM performs above average in this area. Notably, two of the measures that reached the HPL and one of the measures with a statistically significant increase were diabetes care indicators, indicating that HPSM provides a high quality of care to its diabetic members.

QIP results showed that the plan did well with documenting the QIP study design and implementation phases; however, the plan had some challenges with achieving improved outcomes. Both QIPs showed a decline in performance during the review period. The plan did achieve sustained improvement, however, in its *Cervical Cancer Screening* QIP. The plan has an

opportunity to further analyze factors that may be preventing the plan from achieving improved outcomes in its *Reducing Avoidable Emergency Room Visits* QIP.

HPSM had strong performance in member satisfaction with respect to quality. The plan had high performance in the *Rating of Personal Doctor* global rating and *Shared Decision Making* composite rating for both children and adults. The plan performed well in all child global ratings, while the results for adults were average.

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 to below-average performance in the access domain. This assessment was based on a review of 2010 performance measure rates that related to access, QIP outcomes, and member satisfaction results.

Two performance measures that indicate access to care showed statistically significant improvements (children's immunizations and timeliness of prenatal care) with one achieving the HPL. The remainder of the performance measures that address access to care showed average performance, with no measures below the MPL.

HPSM had a decline in the first remeasurement of its *Reducing Avoidable Emergency Room Visits* QIP, which impacts access. The interventions, however, were not implemented in time to affect the remeasurement; therefore, the second remeasurement will be more indicative of the plan's success.

HPSM has an opportunity to improve member satisfaction results that involve access to care. Results showed poor performance for both adults and children in *Getting Needed Care* and *Customer Service* composites, a stark contrast to the plan's high performance in most global ratings that reflect quality and access to care.

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.

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

Performance measure rates related to timeliness showed that the plan had statistically significant improvements in two measures (childhood immunizations and timeliness of prenatal care), with the childhood immunization rate exceeding the HPL. All of the remaining performance measure rates that involve timeliness were above the MPL.

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 timely care.

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. HPSM's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, HPSM had average to above-average success in providing quality health care services to its MCMC measures, and below-average to average performance in providing accessible and timely services.

HPSM had some improvements in performance measure results, with average to above-average rates and no rates below the MPL. The plan was generally compliant with documentation

requirements across performance measures and QIPs; however, the plan experienced preliminary challenges with improving actual health outcomes for members for one of its QIPs. Member satisfaction was strong in global ratings, which cross the domains of quality, access, and timeliness; however, the plan had lower performance in composite measures of access to and timeliness of services.

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

- Ensure all review deficiencies are fully resolved.
- Monitor performance measure results and prioritize what measures will be targeted for future improvement efforts.
- Conduct annual causal-barrier and subgroup analyses to determine why and for what groups current QIP interventions did not produce improvement between measurement periods for the *Reducing Avoidable Emergency Room Visits* QIP.
- Review the 2010 plan-specific CAHPS results report and develop strategies to address the following priority areas: *Customer Service, Getting Care Quickly* and *Getting Needed Care.*

In the next annual review, HSAG will evaluate HPSM'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	Comments
Focus performance measure improvement efforts on measures that fall just above the MPLs to ensure compliance in subsequent years.	The Quality Department meets monthly to discuss and focus on all quality improvement projects, which are based on the HEDIS rates. We focus on measures that fall short to develop interventions for improvements.	
Explore factors that contributed to the statistically significant decline in the Appropriate Treatment for Children With Upper Respiratory Infection (URI) measure to prevent further decline.	Our rate has increased in the last couple of years, and we will continue to monitor our claims data to identify providers who are treating URI inappropriately and/or billing for incorrect diagnosis codes and follow up with them. Once we identify these providers, we contact them and conduct educational outreach based on our findings to improve our rates.	
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.	HPSM currently uses the HSAG QIP Summary Form for the projects whose HEDIS rates are below the minimum performance level. We follow their guidance to produce the best quality results that we can for each project.	
Continue to monitor timeliness of notification for prior authorizations.	The health services clinical manager holds primary accountability for ensuring all treatment authorization requests processing time frames are compliant with appropriate regulatory, contract requirement and policy and procedure standards. The health services clinical manager is also responsible for the day-to-day monitoring of treatment authorization requests (TARs) to ensure that member and provider notifications for all modified, deferred and denied TARs for all product lines for all members are in compliance with appropriate regulatory contract requirements and standards outlined in the plan's Health Services policies (specifically HS-03 and UM 03.02). Plan policy and procedure UM 03.02 outlines the monitoring of member and provider notification of deferred, denied or modified TARS. To comply with this policy, the health services clinical manager will review daily every deferred, denied and	

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

EQR Recommendation	Plan Actions That Address Recommendation	Comments
	modified TAR for appropriate member and provider written notification timelines and criteria and/or reference citations. This review also includes: ◆ Ensuring correct completion of TARs, including dates, signatures and inclusion of the appropriate, clear and concise denial, deferral, or modification reason and for ensuring the appropriate criteria/guideline used in the decision is cited. ◆ Ensuring the correct letters are included for the specific line of business. ◆ Ensuring the inclusion of the "Your Rights" statement notifying members of their appeal rights. ◆ Statement of applicable criteria used in making a decision to deny, modify or defer is to be included in the letters. The plan continues to maintain daily, monthly and quarterly authorization reports. Daily reports include: (1) incoming medical and pharmaceutical TARs, (2) outstanding TARS with processing times exceeding three business days without a decision, and (3) deferred TAR reports awaiting additional documentation exceeding 14 days. These reports are accessed daily by the clinical management team and clinicians to ensure contract and SB 59 compliance. Additionally, monthly TAR authorization processing timeline reports are analyzed by the plan's clinical management team to identify opportunities for continuous quality improvement (CQI) interventions. These monthly reports include TARS outliers that do not meet plan timeline standards outlined in the Health Services policies and procedure. Lastly, quarterly authorization timeline notification reports are reported to and reviewed by the plan's senior management team and its governing board, The San Mateo Health Care Commission.	

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

EQR Recommendation	Plan Actions That Address Recommendation	Comments
Conduct a barrier analysis for the low rate of completed initial health education behavioral assessments (IHEBA) within 120 days of enrollment for new members and develop strategies aimed at improving compliance.	We have included a $90 incentive for timely IHEBAs for our PCPs in our pay-for-performance (P4P) program. In addition to highlighting new members by placing an asterisk (*) next to their names on monthly case-management lists, PCPs also receive quarterly P4P reports which list the new members who are still in need of an IHEBA.	
Continue to monitor the timeliness of grievance acknowledgements.	A compliance auditor conducts quarterly audits of HPSM's two grievance and appeals coordinators. As part of the ongoing audits, the compliance auditor assesses whether acknowledgement letters for both grievances and appeals are sent within the mandated time frame.	
Re-educate providers on cultural and linguistic service requirements and develop a process to monitor compliance.	Providers receive information about cultural and linguistic services through periodic provider visits from staff and through the provider newsletter articles. Their compliance with these requirements is monitored through Facility Site Review.	