Performance Evaluation Report

Health Plan of San Joaquin

July 1, 2013–June 30, 2014

Managed Care Quality and Monitoring Division
California Department of Health Care Services

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Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)[1] in the State of California through a combination of contracted full-scope and specialty managed care health plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] 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 provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and state-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and operations,

[1] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2013–June 30, 2014). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Health Plan of San Joaquin ("HPSJ" or "the MCP"), for the review period July 1, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Health Plan Overview

HPSJ is a full-scope MCP delivering services to its MCMC members as a "Local Initiative" (LI) MCP under the Two-Plan Model (TPM). In TPM counties, MCMC beneficiaries may choose between two MCPs; typically, one MCP is an LI and the other a commercial plan (CP). DHCS contracts with both plans. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. MCMC beneficiaries may enroll in HPSJ, the LI MCP; or in Health Net Community Solutions, Inc., the alternative CP.

HPSJ became operational in San Joaquin County to provide MCMC services effective February 1996 and in Stanislaus County effective January 2013. As of June 30, 2014, HPSJ had 169,647 MCMC members in San Joaquin County and 77,064 in Stanislaus County—for a total of 246,711 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP'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. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to evaluate key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

Medical Audits and SPD Medical Surveys

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

DHCS received authorization "1115 Waiver" from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-County Organized Health System (COHS) counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

The most recent SPD medical survey for HPSJ was conducted February 21, 2012, through February 23, 2012, covering the review period of November 1, 2010, through October 31, 2011. HSAG included a summary of the review in HPSJ's 2012–13 MCP-specific evaluation report. DMHC identified two potential deficiencies in the area of Access and Availability and one potential deficiency in the area of Member Rights. HPSJ provided documentation to HSAG and DHCS of actions the MCP has taken to resolve each deficiency as part of the process for producing this MCP-specific evaluation report (see Appendix D).

Strengths

HPSJ provided documentation of actions the MCP has taken to address the potential deficiencies in the areas of Access and Availability and Member Rights that were identified during the February 2012 DMHC SPD medical survey (see Appendix D).

Opportunities for Improvement

HPSJ has the opportunity to ensure that the actions the MCP has taken to address the potential deficiencies identified during the February 2012 DMHC SPD medical survey in the areas of Access and Availability and Member Rights are acceptable to DHCS.

Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal Managed Care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

HSAG conducts validation of the External Accountability Set performance measures as required by DHCS to evaluate the accuracy of the MCPs' reported results. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[4] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[4] The CMS EQR Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Performance Measure Validation

DHCS's 2014 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 32. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[6] of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for Health Plan of San Joaquin* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that HPSJ followed the appropriate specifications to produce valid rates; however, there was an issue of concern that caused a minimal impact on the findings. A brief summary of the findings and opportunities for improvement is included below.

- HPSJ had sufficient practices in place to process medical services data.
- Although HPSJ expanded into Stanislaus County and experienced a large increase in its membership, in part due to the transition of the Healthy Families Program and Access for Infants and Mothers Program populations, the MCP had no issues with processing the additional data, and the expansion had no impact on member operations (i.e., processes related to enrollment, customer service, member outreach, etc.).
- HPSJ resolved the reporting issues noted in last year's audit and was encouraged to continue its oversight efforts moving forward.

[5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[6] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

- HSAG recommended that HPSJ formalize and document the steps for data extraction and file transfers to its software vendor to make these functions easier to track from year to year and to ensure these processes are well-documented.
- HPSJ experienced some backlogs in processing claims data during the measurement year; however, the backlogs resulted in minimal impact to the HEDIS rates.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 and Table 3.2 present a summary of HPSJ's performance measure results for 2011–14. Note that data may not be available for all four years.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 and Table 3.2 show the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

DHCS based the MPLs and HPLs on the NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *CDC–H9 (>9.0 percent)* measure. 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.

The reader should note the following regarding Table 3.1 and Table 3.2:

- Since 2013 was the first year HPSJ reported rates for Stanislaus County, DHCS did not hold the MCP accountable to meet the MPLs for any measures for this county in 2013. Although DHCS did not hold HPSJ accountable to meet the MPLs in Stanislaus County in 2013, HSAG provides an assessment of the measures' rates compared to the MPLs and HPLs.
- The *All-Cause Readmissions* measure is a non-HEDIS measure used for the ACR collaborative QIP; therefore, no MPL or HPL is established for this measure.
- For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- The *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures. No MPL or HPL is established for a utilization measure. Additionally, HSAG did not compare performance for these measures.

- Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for 2014:
  - All four *Children and Adolescents' Access to Primary Care* measures.
  - *Cervical Cancer Screening*. Note: MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008; however, due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014. Consequently, HSAG did not include or make comparisons to previous years' rates in this report.
  - *Comprehensive Diabetes Care—LDL-C Control.* (This measure is being eliminated for HEDIS 2015.)
  - *Comprehensive Diabetes Care—LDL-C Screening.* (This measure is being eliminated for HEDIS 2015.)

Table 3.1—Performance Measure Results
HPSJ—San Joaquin County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	7.07%	11.06%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	38.16	46.68	45.89	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	283.73	274.87	249.11	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	85.56%	**83.69%**	**83.80%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	92.11%	94.12%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	85.05%	84.58%	84.29%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	27.13%	25.42%	29.24%	25.10%	↓
Cervical Cancer Screening	Q,A	—	—	—	61.12%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	74.45%	77.13%	76.40%	75.91%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.66%	97.49%	97.04%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	86.82%	87.59%	87.79%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**84.17%**	**85.71%**	**86.70%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**83.53%**	**84.94%**	**83.23%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	75.18%	77.62%	78.28%	65.69%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	52.31%	53.28%	45.62%	44.77%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Comprehensive Diabetes Care—HbA1c Testing	Q,A	80.54%	81.51%	80.66%	**79.08%**	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	51.82%	55.96%	52.37%	51.82%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	31.39%	39.17%	35.22%	41.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	75.91%	78.59%	75.55%	75.18%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	76.16%	80.29%	82.12%	79.08%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	41.36%	36.74%	39.60%	40.15%	↔
Controlling High Blood Pressure	Q	—	—	66.42%	65.45%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	63.99%	67.15%	72.02%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**40.72%**	**43.45%**	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**21.82%**	23.04%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	65.21%	68.61%	64.48%	60.83%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	87.83%	88.08%	85.64%	82.24%	↔
Use of Imaging Studies for Low Back Pain	Q	82.45%	80.67%	81.80%	84.03%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	67.15%	73.48%	69.10%	70.32%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	69.59%	72.51%	72.75%	68.37%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	58.15%	65.69%	61.80%	55.96%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	81.27%	80.54%	76.16%	76.89%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.2—Performance Measure Results
HPSJ—Stanislaus County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	13.11%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	56.07	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	272.99	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	84.64%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	87.39%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	**16.95%**	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	**41.08%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	**64.96%**	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	97.23%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	88.43%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	88.90%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	86.60%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	67.88%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	**37.23%**	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	85.40%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	52.31%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	—	40.63%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	—	74.94%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	80.29%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	36.98%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	56.20%	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	58.15%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	51.65%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	**21.98%**	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	**54.99%**	Not Comparable

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	**73.24%**	Not Comparable
Use of Imaging Studies for Low Back Pain	Q	—	—	—	76.51%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	—	54.01%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	—	**41.85%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	—	39.17%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	—	68.61%	Not Comparable

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
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↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[7] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

[7] Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. Managed care health plan performance measures may include measures from HEDIS; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Table 3.3 through Table 3.6, which present a summary of HPSJ's 2014 SPD measure results. Table 3.3 and Table 3.4 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[8] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.5 and Table 3.6 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[8] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.3 and Table 3.4.

Table 3.3—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for HPSJ—San Joaquin County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	6.86%	13.65%	▼	11.06%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.28%	85.07%	↑	83.80%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	93.18%	Not Comparable	94.12%
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.14%	86.24%	↑	84.29%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.00%	100.0%	↔	97.04%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.86%	86.09%	↔	87.79%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	86.67%	87.37%	↔	86.70%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	83.07%	85.91%	↑	83.23%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.61%	69.10%	↑	65.69%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.85%	42.34%	↔	44.77%
Comprehensive Diabetes Care—HbA1c Testing	72.02%	81.75%	↑	79.08%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	43.80%	56.45%	↑	51.82%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.12%	46.72%	↑	41.12%
Comprehensive Diabetes Care—LDL-C Screening	68.86%	78.10%	↑	75.18%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.37%	84.18%	↑	79.08%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	47.69%	36.25%	▲	40.15%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

▲▼ are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.4—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for HPSJ—Stanislaus County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.67%	15.88%	▼	13.11%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.48%	87.72%	↑	84.64%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.05%	89.27%	↔	87.39%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.21%	NA	Not Comparable	97.23%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.33%	93.20%	↔	88.43%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.87%	NA	Not Comparable	88.90%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	86.62%	NA	Not Comparable	86.60%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	66.58%	66.42%	↔	67.88%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	31.78%	39.17%	↑	37.23%
Comprehensive Diabetes Care—HbA1c Testing	83.01%	88.56%	↑	85.40%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.22%	59.37%	↑	52.31%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	39.73%	43.55%	↔	40.63%
Comprehensive Diabetes Care—LDL-C Screening	72.33%	81.75%	↑	74.94%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.16%	83.70%	↑	80.29%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.37%	31.14%	▲	36.98%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

▲▼ are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.5—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
HPSJ—San Joaquin County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
223.43	42.34	438.00	71.99

*Member months are a member's "contribution" to the total yearly membership.

Table 3.6—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
HPSJ—Stanislaus County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
244.19	51.51	585.69	105.58

*Member months are a member's "contribution" to the total yearly membership.

Performance Measure Result Findings

The rate for the *Use of Imaging Studies for Low Back Pain* measure was above the HPL for San Joaquin County in 2014. Across both counties, 13 rates were below the MPLs. The rate for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure for San Joaquin County improved significantly from 2013 to 2014; however, the rate remained below the MPL in 2014 for the third consecutive year. The rate for the *Medication Management for People with Asthma—Medication Compliance 75% Total* measure for San Joaquin County improved from 2013 to 2014; although not statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014.

The rates for the following measures for San Joaquin County were significantly worse in 2014 when compared to 2013:

- *All-Cause Readmissions*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* (Note: The rate for this measure remained below the MPL for the third consecutive year.)
- *Comprehensive Diabetes Care—Blood Pressure control (<140/90 mm Hg)*

Seniors and Persons with Disabilities Findings

The SPD rates for 10 measures for San Joaquin County were significantly better than the non-SPD rates, and the SPD rates for seven measures for Stanislaus County were significantly better than the non-SPD rates. In both counties, the SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however, rates should be interpreted with caution as high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures, and HSAG does not provide comparative analysis.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act cycle. DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates (measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid cycle approach (including the Plan-Do-Study-Act cycle) to strengthen these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

Assessment of MCP's Improvement Plans

HPSJ had five measures with rates below the MPLs for San Joaquin County in 2013. The MCP was not required to submit IPs for four of the measures (the *Children and Adolescents' Access to Primary Care—7 to 11 Years* and *12 to 19 Years* measures and both *Medication Management for People with Asthma—Medication Compliance* measures). DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years to prioritize DHCS and MCP efforts in other areas of poor performance that have clear improvement paths and direct population health impact. DHCS did not hold the MCPs accountable to meet the MPLs for the *Medication Management for People with Asthma* measures in 2013 since 2013 was the first year the measures were reported.

Following is a summary of HPSJ's IP for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure, which had a rate below the MPL for San Joaquin County in 2013.

HPSJ identified the following barriers to the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure being above the MPL:

- Provider lack of knowledge.
- The MCP not tracking members needing medication monitoring.
- The MCP not identifying low-performing providers for required monitoring.
- Member lack of knowledge of monitoring requirements.
- Member lack of transportation for required laboratory tests.

The MCP implemented the following interventions to address the barriers:

- Implemented provider education through a fax-blast, followed by ongoing provider outreach and education on medication monitoring requirements and best practices.
- Had the pharmacy generate reports identifying members in need of monitoring and sent the reports to providers.

- Had pharmacy staff members assist quality improvement staff members to develop an educational program for providers.
- Provided outreach, education, and assistance to members who needed medication monitoring.

HPSJ's efforts did not result in the rate for this measure improving, and the MCP will be required to continue the IP in 2014. Additionally, HPSJ will be required to submit IPs for the following measures for San Joaquin County in 2014:

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Medication Management for People with Asthma—Medication Compliance 50% Total*

Although the rates for eight measures for Stanislaus County were below the MPLs in 2014, the MCP will not be required to submit IPs for the measures since 2014 was the first year the MCP reported rates for Stanislaus County.

Strengths

Although HPSJ expanded into Stanislaus County and experienced a large increase in its membership due in part to the transition of the Healthy Families Program and Access for Infants and Mothers Program populations, the MCP had no issues with processing the additional data, and the expansion had no impact on member operations.

For San Joaquin County, the rate for one measure was above the HPL in 2014, and one measure's rate improved significantly from 2013 to 2014. Additionally, the rate for one measure moved from below the MPL in 2013 to above the MPL in 2014.

Opportunities for Improvement

HSAG recommends that HPSJ formalize and document the steps for data extraction to and file transfers to its software vendor to make tracking these functions easier from year to year and to ensure these processes are well-documented.

HPSJ has the opportunity to assess the factors leading to poor performance on several measures and to identify improvement strategies that have the potential to result in positive outcomes. Based on priorities established by DHCS, HSAG recommends that for San Joaquin County, the MCP focus on the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Comprehensive Diabetes Care—HbA1c Testing*, and *Medication Management for People with Asthma—Medication Compliance 50% Total* measures. Although DHCS did not hold the MCP accountable to meet the MPLs for Stanislaus County in 2014, the MCP has the opportunity to assess the factors leading to eight measures having rates below the MPLs and identify strategies with the potential to result in improvement so that the rates are above the MPLs in 2015.

HPSJ also has the opportunity to assess the factors leading to a significantly higher rate of readmissions for the SPD population for San Joaquin and Stanislaus counties to ensure the needs of the SPD population are being met. While the MCP provided a summary of actions the MCP has taken to address the significantly higher rate of readmissions for the SPD population for San Joaquin County (see Appendix D), since the SPD readmissions continued to be significantly higher than the non-SPD readmissions in 2014, HSAG recommends that the MCP assess if processes are in place to ensure the SPD population's health care needs are being met.

Conducting the EQRO 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 CMS validation protocol[9] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

HSAG organized, aggregated, and analyzed HPSJ's validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[9] The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Quality Improvement Project Objectives

HPSJ participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2013–June 30, 2014.

Table 4.1 below lists HPSJ's QIPs and indicates the county in which the QIP is being conducted, whether the QIP is clinical or nonclinical, and the domains of care (i.e., quality, access, timeliness) the QIP addresses. Although HPSJ delivered services in Stanislaus County during the review period, the MCP was not required to have QIPs in place for this county during the review period. The MCP will be required to initiate QIPs for Stanislaus County in 2014, and HSAG will report on these QIPs in the MCP's 2014–15 MCP-specific evaluation report.

Table 4.1—Quality Improvement Projects for HPSJ
July 1, 2013, through June 30, 2014

QIP	Counties	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	San Joaquin	Clinical	Q, A
Improving the Percentage Rate of HbA1c Testing	San Joaquin	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members, leading to improved health outcomes.

HPSJ's internal QIP, *Improving the Percentage Rate of HbA1c Testing,* attempted to increase HbA1c testing to minimize the development of diabetes complications. At the start of the QIP, 80.5 percent of the MCP's members with diabetes had received an HbA1c test within the measurement year. Blood glucose monitoring assists in the development of appropriate treatment plans to decrease the risk of diabetes complications. Lack of appropriate testing in people with diabetes may indicate suboptimal care and case management.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Validation Activity
HPSJ—San Joaquin County
July 1, 2013, through June 30, 2014

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				
All-Cause Readmissions	Annual Submission	75%	86%	*Partially Met*
	Annual Resubmission 1	88%	86%	*Partially Met*
	Annual Resubmission 2	100%	100%	*Met*
Internal QIPs				
Improving the Percentage Rate of HbA1c Testing	Annual Submission	74%	90%	*Partially Met*
	Annual Resubmission 1	91%	100%	*Met*

[1] **Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP 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 noncritical) 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*.

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that HPSJ's annual submission of its *All-Cause Readmissions* QIP received an overall validation status of *Partially Met*. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, HPSJ resubmitted the QIP and, after the second resubmission, achieved an overall *Met* validation status with 100 percent of evaluation elements (critical and noncritical) receiving a met score. The *Improving the Percentage Rate of HbA1c Testing* QIP annual submission received an overall validation status of *Partially Met*. HPSJ resubmitted its QIP and achieved an overall *Met* validation status with 91 percent of the evaluation elements and 100 percent of the critical elements receiving a met score.

Table 4.3 summarizes the aggregated validation results for HPSJ's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
HPSJ—San Joaquin County
(Number = 5 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	96%	0%	4%
Design Total		**98%**	**0%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	90%	7%	3%
	VIII: Appropriate Improvement Strategies	43%	57%	0%
Implementation Total		**75%**	**23%**	**2%**
Outcomes	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**25%**	**0%**	**75%**

*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.

HSAG validated Activities I through VIII for HPSJ's *All-Cause Readmissions* QIP annual submission and Activities I through IX for the MCP's *Improving the Percentage Rate of HbA1c Testing* QIP annual submission.

HPSJ demonstrated a strong application of the Design stage, meeting 98 percent of the requirements for all applicable evaluation elements within the stage for both QIPs. The MCP did not describe its data analysis plan for the *All-Cause Readmissions* QIP, resulting in a lower score for Activity VI. HPSJ met all requirements for all applicable evaluation elements within the Design stage for its *Improving the Percentage Rate of HbA1c Testing* QIP.

Both QIPs progressed to the Implementation stage during the reporting period. The MCP demonstrated an adequate application of the Implementation stage, meeting 75 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. In the initial submission of the *All-Cause Readmissions* QIP, HSAG could not determine if HPSJ followed the data analysis plan since the MCP did not provide this information, resulting in a lower score

for Activity VII. Also, for this QIP, HPSJ did not provide all the necessary documentation regarding the process used to identify barriers and develop interventions, and how the MCP planned to measure the effectiveness of the implemented interventions, resulting in a lower score for Activity VIII. HPSJ corrected the deficiencies in its resubmissions, resulting in the QIP achieving an overall *Met* validation status. In the initial submission of the *Improving the Percentage Rate of HbA1c Testing* QIP, HPSJ did not provide a comparison between the Remeasurement 2 rate and the goal, inaccurately calculated the statistical testing, and had multiple issues regarding the casual barrier analysis and intervention implementation and evaluation, resulting in lower scores for Activities VII and VIII. The MCP corrected the deficiencies in its resubmission, resulting in the QIP achieving an overall *Met* validation status.

Only the *Improving the Percentage Rate of HbA1c Testing* QIP progressed to the Outcomes stage during the reporting period. The QIP did not achieve statistically significant improvement over baseline for the study indicator, resulting in only 25 percent of the requirements for all applicable elements being met for Activity IX. Activity X was not assessed since sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved.

Quality Improvement Project Outcomes and Interventions

The *All-Cause Readmissions* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP's interventions for the *All-Cause Readmissions* QIP:

- Implemented a transitional care behavioral health intervention program that includes a mental health specialist seeing the members while they are in the acute care setting. Additionally, the mental health specialist joins the nurse practitioner on home visits to follow up with recently discharged members.

- Implemented a pilot biometric outreach program which allows for in-home monitoring of high-risk members.

Outcome information for the *All-Cause Readmissions* QIP will be included in HPSJ's 2014–15 MCP-specific evaluation report.

Table 4.4 summarizes the *Improving the Percentage of HbA1c Testing* QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

Table 4.4—Quality Improvement Project Outcomes for HPSJ—San Joaquin County
July 1, 2013, through June 30, 2014

QIP #1—*Improving the Percentage of HbA1c Testing*			
Study Indicator: Percentage of diabetic members with at least one HbA1c test			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
80.5%	81.5%	80.7%	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Improving the Percentage of HbA1c Testing QIP

The *Improving the Percentage of HbA1c Testing* QIP project goal for Remeasurement 2 was a 5 percent increase from the baseline rate, which the QIP did not achieve. At Remeasurement 2, the QIP still had not achieved statistically significant improvement over baseline. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- In HPSJ's 2012–13 MCP-specific evaluation report, HSAG noted that the MCP did not select the type of administrative data used in this QIP. In HPSJ's 2013 QIP submission, the MCP corrected this oversight and provided the proper documentation.
- As discussed in the previous year's report, HPSJ continues to struggle with the influx of the SPD population's effect on the outcomes of this QIP. Two of the leading providers partnered with HPSJ on its Patient Centered Medical Home Program intervention and demonstrated an increase in HbA1c testing; however, the MCP believes this increase was not systemwide due to the increase in the SPD population.
- HPSJ did not provide complete or accurate data analysis documentation in the initial submission of this QIP.
- Initially, HPSJ did not thoroughly document its casual barrier analysis, describe how barriers were identified and prioritized, or provide an evaluation plan for each of the interventions to determine the efficacy of the interventions. The MCP provided this documentation in its resubmissions.
- HPSJ should develop systemwide interventions that are strictly based on the root cause analysis of the problem this QIP is addressing and that will likely induce permanent change since the past interventions have been shown to be ineffective.
- Although the interventions were not successful in improving the QIP outcomes, following is a brief description of the interventions implemented by HPSJ:
  - Hired a full-time HEDIS coordinator to help improve processes and rates.

- Continued outreach programs and expanded to the Patient Centered Medical Home Program.
- Continued outreach and support programs to providers.

Strengths

HPSJ demonstrated an excellent application of the QIP Design stage for the *All-Cause Readmissions* and *Improving the Percentage Rate of HbA1c Testing* QIPs. The MCP met all requirements for all applicable evaluation elements within the Design stage for its *Improving the Percentage Rate of HbA1c Testing* QIP. Additionally, HPSJ documented actions the MCP will take to ensure all comments from the QIP Validation Tool are addressed when completing the QIP Summary Form for all QIPs (see Appendix D).

Opportunities for Improvement

HPSJ has the opportunity to implement the actions described in Appendix D to ensure all required documentation is included in the QIP Summary Form since the MCP continued to have difficulty meeting the validation requirements. The MCP should reference the QIP Completion Instructions and previous QIP Validation Tools to ensure that all documentation requirements for each activity have been addressed prior to submission to avoid incomplete or inaccurate documentation of the various elements.

For the *Improving the Percentage Rate of HbA1c Testing* QIP, HPSJ has the opportunity to assess if the MCP should discontinue or modify existing interventions or identify new interventions to better address the large influx of SPD members.

Conducting the EQRO Review

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each MCP in the three domains of care—quality, access, and timeliness. A numerical score is calculated for each domain of care for performance measure rates, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care and converted to a rating of above average, average, or below average. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the MCPs' medical audit/SPD medical survey reviews and assessment of the accuracy and completeness of encounter data to determine overall performance within each domain of care, as applicable. A more detailed description of HSAG's scoring process is included in Appendix C.

Please note that when a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[10]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP 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, DHCS monitors aspects of an MCP'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. DHCS also uses the results

[10] This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

HSAG reviewed HPSJ's Quality Management and Improvement Program Description and found detailed documentation of goals, objectives, and processes designed to ensure quality health care services are provided to MCMC members.

The rate for the *Use of Imaging Studies for Low Back Pain* measure, which falls into the quality domain of care, was above the HPL for San Joaquin County. The rate for the *Medication Management for People with Asthma—Medication Compliance 75% Total* measure for San Joaquin County, which falls into the quality domain of care, improved from 2013 to 2014; although not statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014.

The rates for the following quality measures for San Joaquin County were below the MPLs:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Medication Management for People with Asthma—Medication Compliance 50% Total*

The rates for eight quality measures for Stanislaus County were below the MPLs, although DHCS did not hold HPSJ accountable to meet the MPLs in Stanislaus County since 2014 was the first year the MCP reported rates for this county.

The rates for the following quality measures for San Joaquin County were significantly worse in 2014 when compared to 2013:

- *All-Cause Readmissions*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

Twelve of the measures stratified for the SPD population fall into the quality domain of care. The SPD rates for nine of the measures in San Joaquin County and seven measures in Stanislaus County were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in these members being seen more regularly by providers and leading to more monitoring of care. The SPD rates for the *All-Cause Readmissions* measure, which falls into the quality domain of care, were significantly worse than the non-SPD rates for both counties, meaning that significantly more members in the SPD population (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than members in the non-SPD population.

Both of HPSJ's QIPs fell into the quality domain of care. Only the *Improving the Percentage Rate of HbA1c Testing* QIP progressed to the Outcomes stage during the reporting period. The QIP did not show improvement, suggesting that the MCP has opportunities for improvement in the quality of care being provided to members with diabetes.

Overall, HPSJ showed below-average performance related to the quality domain of care.

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP'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. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HPSJ's Quality Management and Improvement Program Description and work plan include goals and objectives designed to ensure member access to needed health care services. The MCP's annual evaluation document provides information on barriers to member access to care, opportunities for improvement, and plans for addressing the barriers and opportunities for improvement.

The rate for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure, which falls into the access domain of care, improved significantly from 2013 to 2014 for San Joaquin County. The rates for the following access measures for San Joaquin County were below the MPLs:

- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*—Note: Although below the MPL, the rate for this measure improved significantly from 2013 to 2014.
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—HbA1c Testing*

The rates for five access measures for Stanislaus County were below the MPLs, although, as stated above, DHCS did not hold HPSJ accountable to meet the MPLs in Stanislaus County since 2014 was the first year the MCP reported rates for this county.

The rates for the following access measures for San Joaquin County were significantly worse in 2014 when compared to 2013:

- *All-Cause Readmissions*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Nine of the performance measures stratified for the SPD population fall into the access domain of care. The SPD rates for four of the measures in each county were significantly better than the non-SPD rates. The SPD rates for the *All-Cause Readmissions* measure, which falls into the access domain of care, were significantly worse than the non-SPD rates for both counties. As indicated above, this means that significantly more members in the SPD population (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than members in the non-SPD population.

Both of HPSJ's QIPs fell into the access domain of care. Only the *Improving the Percentage Rate of HbA1c Testing* QIP progressed to the Outcomes stage during the reporting period. The QIP did not show improvement, suggesting that the MCP has opportunities for improvement in ensuring access to care for members with diabetes.

Overall, HPSJ showed below-average performance related to the access domain of care.

Timeliness

The timeliness domain of care relates to an MCP'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.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' 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. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

HSAG reviewed HPSJ's Quality Management and Improvement Program Description and found that the MCP has a structure that supports assessment of timely care to members. Additionally, the MCP's work plan includes goals related to timeliness of utilization management decisions.

The rates for all timeliness performance measures for San Joaquin County were above the MPLs. The rates for three timeliness measures for Stanislaus County were below the MPLs, although, as

stated above, DHCS did not hold HPSJ accountable to meet the MPLs in Stanislaus County since 2014 was the first year the MCP reported rates for this county.

Overall, HPSJ showed below-average performance related to the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2012–13 MCP-specific evaluation report. HPSJ's self-reported responses are included in Appendix D.

Recommendations

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

- Ensure that the actions the MCP has taken to address the potential deficiencies identified during the February 2012 DMHC SPD medical survey in the areas of Access and Availability and Member Rights are acceptable to DHCS.
- Formalize and document the MCP's steps for data extraction and file transfers to its software vendor to make tracking these functions easier from year to year and to ensure these processes are well-documented.
- Assess the factors leading to poor performance on several measures and identify improvement strategies that have the potential to result in positive outcomes. Based on priorities established by DHCS, HSAG recommends that for San Joaquin County, the MCP focus on the following measures:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
  - *Comprehensive Diabetes Care—HbA1c Testing*
  - *Medication Management for People with Asthma—Medication Compliance 50% Total*
- Assess the factors leading to eight measures having rates below the MPLs for Stanislaus County and identify strategies with the potential to result in improvement so that the rates are above the MPLs in 2015 when DHCS will hold HPSJ accountable to meet the MPLs in this county.
- Assess the factors leading to a significantly higher rate of readmissions for the SPD population for San Joaquin and Stanislaus counties to ensure the needs of the SPD population are being met.
- Implement the actions described in Appendix D to ensure all required documentation is included in the QIP Summary Form since the MCP continued to have difficulty meeting the validation requirements. The MCP should reference the QIP Completion Instructions and

previous QIP Validation Tools to ensure that all documentation requirements for each activity have been addressed prior to submission to avoid incomplete or inaccurate documentation of the various elements.

- For the *Improving the Percentage Rate of HbA1c Testing* QIP, assess if the MCP should discontinue or modify existing interventions or identify new interventions to better address the large influx of SPD members.

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

Table A.1 and Table A.2 provide two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table A.1—HEDIS 2014 SPD Trend Table
HPSJ—San Joaquin County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	13.75%	13.65%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	72.22	71.99	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	474.21	438.00	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.44%	85.07%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	90.91%	93.18%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.39%	86.24%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.30%	100.0%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.90%	86.09%	↓
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.53%	87.37%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.69%	85.91%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.26%	69.10%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	45.01%	42.34%	↔
Comprehensive Diabetes Care—HbA1c Testing	82.00%	81.75%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	51.09%	56.45%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.79%	46.72%	↑
Comprehensive Diabetes Care—LDL-C Screening	77.86%	78.10%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.24%	84.18%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	43.55%	36.25%	▲

*Member months are a member's "contribution" to the total yearly membership.

Table A.2—HEDIS 2014 SPD Trend Table
HPSJ—Stanislaus County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	—	15.88%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	105.58	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	585.69	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	87.72%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	89.27%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	—	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	—	93.20%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	—	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	66.42%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	39.17%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	88.56%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	59.37%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	43.55%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	81.75%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	83.70%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	—	31.14%	Not Comparable

*Member months are a member's "contribution" to the total yearly membership.

Table B.1 and Table B.2 provide two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table B.1—HEDIS 2014 Non-SPD Trend Table
HPSJ—San Joaquin County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	6.27%	6.86%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	43.01	42.34	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	246.24	223.43	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.70%	81.28%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.44%	80.14%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.51%	97.00%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.52%	87.86%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.55%	86.67%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.77%	83.07%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	60.34%	59.61%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	42.58%	41.85%	↔
Comprehensive Diabetes Care—HbA1c Testing	77.62%	72.02%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.99%	43.80%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	27.74%	32.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	71.29%	68.86%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.40%	68.37%	↓
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	47.20%	47.69%	↔

*Member months are a member's "contribution" to the total yearly membership.

Table B.2—HEDIS 2014 Non-SPD Trend Table
HPSJ—Stanislaus County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	—	8.67%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	51.51	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	244.19	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	80.48%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	84.05%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	—	97.21%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	—	88.33%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	—	88.87%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	—	86.62%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	66.58%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	31.78%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	83.01%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	48.22%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	39.73%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	72.33%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	76.16%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	—	41.37%	Not Comparable

*Member months are a member's "contribution" to the total yearly membership.

Quality, Access, and Timeliness Scoring Process

Scale
2.5–3.0 = Above Average
1.5–2.4 = Average
1.0–1.4 = Below Average

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[11] This process allows HSAG to evaluate each MCP's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.1and Table 3.2)

Quality Domain

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.
   - If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.
3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

[11] The CMS protocols specify that the EQRO must include an assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Access and Timeliness Domains

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.
   - If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

Validation *(Table 4.2)*: For each QIP submission and subsequent resubmission(s), if applicable.

1. **Above Average** is not applicable.
2. **Average** = *Met* validation status.
3. **Below Average** = *Partially Met* or *Not Met* validation status.

Outcomes *(Table 4.4)*: Activity IX, Element 4—Real Improvement

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

Sustained Improvement *(Table 4.4)*: Activity X—Achieved Sustained Improvement

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Some, but not all, study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

Appendix D. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

for Health Plan of San Joaquin

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with HPSJ's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table D.1—HPSJ's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

2012–13 External Quality Review Recommendation Directed to HPSJ	Actions Taken by HPSJ During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Ensure all potential deficiencies from the February 21, 2012, through February 23, 2012, SPD medical survey are resolved. Specifically:	
a. Ensure that the level of access met per provider site is documented in the MCP's Medi-Cal Provider Directory.	HPSJ inserts definitions and symbols on whether or not a provider location provides access and the type of access provided.
b. Ensure that HPSJ's Monitoring Provider to Member Ratios Policy includes the required information about the ratio for full-time physicians.	HPSJ produces a quarterly member-to-physician ratio report to ensure set forth guidelines are met. HPSJ's Appointment Availability and Access Standards, Quality Assurance 04 has the information regarding the ratio for full-time providers.
c. Ensure that the Mail Stop information for the Department of Social Services is corrected on the MCP's grievance resolution letters.	Resolution letters were corrected with address as noted below: Information about the State Fair Hearing process is also available by writing the California Department of Social Services (CDSS), State Hearing Division, PO Box 944243, MS 19-17-37, Sacramento, CA, 94244-2430, or by calling 1-800-952-5253. The TDD number is 1-800-952-8349.
2. Assess the factors that have led to the rates on the *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*, *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*, and *Annual Monitoring for Patients on Persistent Medications—ACE* measures falling below the MPLs and identify interventions to be implemented that will result in an improvement on performance.	Health Plan of San Joaquin stakeholders met to review rates for the measures of Access to Primary Care for practitioners ages 7–11 years and 12–19 years to assess the factors that led to the rates and identify actions/interventions for both providers and members. For provider intervention it was determined to categorize HEDIS measures in buckets with the intention of providing clarity to providers for children's health measures. Within the "Children's Health" bucket, measures included Well-Child Visits, Children's and Adolescents' Immunizations, as well as Weight Assessment with counsel for nutrition and physical activity. Utilizing this approach, HPSJ's intention was to increase the rates for each of these measures along with Access to Primary Care. Provider in-services were completed in both San Joaquin and Stanislaus counties in August and September 2013. Provider attendees included pediatrics, family medicine, and primary care physicians. HPSJ meets quarterly with California Health and Disability Prevention (CHDP) liaison and collaborative activities, one of which includes joint Facility Site Reviews (FSRs) where provider education

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	takes place for CHDP periodicity versus HPSJ's periodicity for annual well-child visits. During FSRs HPSJ's Preventive Health Guidelines are distributed to providers. The Provider Services department also distributes the Preventive Health Guidelines to providers during their monthly meetings or as requested. Health Plan of San Joaquin also provides quality incentives for practitioners through the "2013 Primary Care Provider Shared Risk Payment Program." For member interventions, HPSJ reaches out to new members to receive an Initial Health Assessment (IHA) through new member welcome packets which include HPSJ's Preventive Health Guidelines. HPSJ uses on-hold messages for members which includes obtaining an IHA. HPSJ completed analysis of encounter data of IHAs completed for members >18 months between 1/13–12/13 which indicated a 33 percent increase in San Joaquin county. Member education is promoted through HPSJ health education and member newsletters about important information on health care services. ***Annual Monitoring for Patients on Persistent Medications* (*MPM-ACE*):** This was a new measure for HEDIS 2012. HPSJ had a rate of 85.6 percent; the MPL was 83.06. Since HPSJ was above the MPL, no specific improvement actions were conducted. HEDIS RY [reporting year] 2013 results placed HPSJ 0.03 percentage points below the MPL. An improvement plan was required; HPSJ stakeholders met to conduct quantitative and qualitative analysis of data, identify barriers, and develop an improvement plan (IP). Factors identified by the HPSJ stakeholders were: providers not aware of annual lab monitoring, members not getting the ordered lab testing drawn/completed, and members getting to an approved lab for testing. HPSJ will continue to assess access to lab services. HPSJ's interventions: A provider alert was issued to HPSJ providers with evidence-based guideline reference from http://www.kidney.org/professionals/KDOQI/guidelines_bp/guide_11.htm regarding the need to conduct annual lab monitoring of members on specific medications, namely ACE/ ARB's, diuretics, and digoxin. An information sheet was developed for distribution to providers during provider service monthly visits and QM nurse visits during HEDIS and FSRs to increase awareness regarding the indication for annual lab monitoring of persons on this category of medications. HPSJ ran a midyear report to identify members who are on these medications, who have NOT had the annual lab testing for this year (2014). HPSJ QM and provider services staff have outreached practitioners to educate and share the identified gaps in care and advise them regarding the need for annual monitoring of potassium and creatinine levels of patients on ACE/ARB medications and diuretics. Suggestions were provided regarding ways to reach out to members and accomplish the needed lab testing. HPSJ will follow up on this outreach to identify members who remain in the gap as of November 2014, and a letter will be mailed to these members advising them of the need to obtain lab work and communicate with their doctor's office. An MPM-ACE fact sheet was developed and shared with practitioners to

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	clearly identify best practice and requirements of HEDIS. HPSJ case management (CM) and disease management (DM) staff to assist with member issues to get indicated lab work. See attached IP from 12/9/13. HSAG note: The IP referenced above was submitted to DHCS. DHCS sent a summary of the IP to HSAG, and the summary was reviewed and incorporated into this report in the Performance Measures section.
3. Assess the factors that led to a statistically significant decline in the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure from 2012 to 2013 to prevent further decline on the rate.	Health Plan of San Joaquin stakeholders met to conduct qualitative and quantitative analysis on the data related to the decline in the rate for *CDC—E* for RY 2013. Upon review, the stakeholders' assumption was that the decline was in part due to change in member incentive from retinal eye exam to A1C testing. Stakeholders also attributed the *CDC—E* rate decline to provider confusion as a covered benefit for MCMC members' versus Fee-for-Service (FFS) members. HPSJ will continue to validate our assumptions by collecting claims data to compare FFS providers versus capitated providers for qualitative and quantitative analysis of next steps. For provider intervention it was determined to categorize HEDIS measures into buckets with the intention of providing clarity and enhance provider awareness of the effectiveness of care measures for *Comprehensive Diabetes Care* (CDC). Within the "General Medicine "bucket, components of the measure Comprehensive Diabetes included A1C testing and control, eye exams, LDL testing and control, attention to nephropathy and blood pressure control. Utilizing this approach, provider in-services were completed in both San Joaquin and Stanislaus counties in August and September 2013. Health Plan of San Joaquin's Health Education department also sponsored a provider forum in July 2013, "Strategies to Address Diabetes in Diverse Communities" as a collaborative effort with invitations to practitioners, schools, and community-based organizations. Health Plan of San Joaquin also provided quality incentives for practitioners through the "2013 Primary Care Provider Shared Risk Payment Program" to encourage best practice within the provider community. HPSJ member interventions included continuing the A1C testing incentive with additional documentation on the incentive flyer to include other diabetic care recommendations that encourage best practice within our community. HPSJ also collaborated with community-based organizations to hold member-focused classes on Chronic Disease Self Management, with a focus on diabetes.
4. Assess the factors leading to a significantly higher rate of readmissions for the SPD population and identify strategies to ensure the MCP is meeting the needs of the SPD population.	HPSJ is currently part of the Statewide Quality Improvement Plan regarding All Cause Hospital Readmissions. This QIP started in CY 2013 with baseline data; the next submission will be due in September 2014. HPSJ stakeholders met in August 2013 to conduct qualitative and quantitative analysis of readmission data focusing on the SPD population results. Data regarding readmissions is part of the monthly dashboard review. Readmission data indicated that the SPD readmission rate was 13.65 percent, and the non-SPD rate for readmission is 6.86 percent. Analysis indicates that HPSJ's SPD members tend to be more ill and have more frequent acute hospital admissions and readmissions, with admissions being longer than the general Medi-Cal population. SPD population tends to have more complex social issues as well as behavioral

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	health issues that impact the transition of care and recovery as well as their general health. HPSJ conducts an initial risk assessment based on key medical and medication factors. A risk factor is assigned to each SPD member who has had a hospital admission in the recent past, who has health issues that may benefit from more aggressive care management. The Medical Management team has complex case managers, care managers, concurrent review nurses and disease management as well as pharmacy staff, health navigators, and social workers all working together to promote transition of care and care coordination to minimize the likelihood of readmission. HPSJ applied and was awarded a grant from Blue Cross regarding Transition of Care. Planning and program development has been completed with implementation to start 7/21/14 at the safety net hospital—San Joaquin General Hospital. This program will focus on the initial admission and 2 weeks post discharge to decrease the risk of readmission. HPSJ staff works with hospital staff and network providers to promote timely and efficient transition of care. HPSJ Medical Management staff coordinates care to promote recovery, thus reducing the risk for readmission. HPSJ has numerous programs offered to all HPSJ members, but a majority of participants are SPD members. 1) IDEAL life is a biometric monitoring program with scales, glucose meters, blood pressure monitoring, pulse oximeters, and medication dispensers placed in the member's home. There is an active interface with the data and the case manager in HPSJ and the member's PCP. 2) Nurse Practitioner Follow-up—Members recently discharged from acute care may be referred to this program for an in-home visit and assessment; noting that physically getting to a doctor's appointment may be difficult to accomplish. This program works with the PCP and member to decrease the risk of readmission.
5. Ensure that all comments from the QIP Validation Tool are responded to when completing the QIP Summary Form for all QIPs.	The Validation Tool is a vital part of ongoing improvement planning. The tools and resources will be used to build all improvement plans. The Validation Tool will be referred to ongoing; and when the QIP submissions are being written and reviewed for submission, the Validation Tool and comments will be reviewed to ensure they are used as a resource and guide. Use of notes from technical assistance (TA) calls will be incorporated into the QIP process. The content of the performance evaluation is used as our action plan for QIPs. HPSJ uses this document in all phases of the QIP process and will review all QIP submissions closely to ensure all recommendations and areas of question have been clearly addressed. Specifically on the HbA1c QIP, HPSJ will clearly define the type of administrative data used and will address these data in the 2013 QIP submission. HPSJ will also update and clarify the incentive programs as they relate to the HbA1c testing and the membership.

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	HPSJ is in the process of identifying subgroups of the population that would benefit from greater attention, thus moving HPSJ toward the improvement goals of the QIP. The goal is to identify and use specific interventions that will improve HbA1c testing and allow HPSJ to reflect a sustained improvement in the next two years. Recommendations regarding HEDIS measures are reviewed with medical management and HPSJ stakeholders to determine next steps. The stakeholders meet as well as the Medical Management team to address programs and impacts being seem from programs. HPSJ applies the Plan–Do–Study–Act (PDSA) process and in order to have the greatest impact will apply the rapid cycle process with modifications being made as indicated during the measurement year to have greater impact. A barrier analysis is conducted as part of the annual QIP process to keep the QIP current and meaningful. Qualitative and quantitative analysis is conducted on data HPSJ obtains from the HEDIS process as well as the summer and fall reviews and internal HPSJ data. This allows more comprehensive monitoring of data.
6. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the *Rating of Personal Doctor, Rating of All Health Care,* and *Getting Care Quickly* priority areas.	Health Plan of San Joaquin stakeholders met on April 29, 2014, to conduct qualitative and quantitative analysis for the 2013 CAHPS member satisfaction survey and develop a performance improvement plan as noted below: • Collaboration with providers to decrease no-show appointments. • Develop electronic communication and nurse advice help line to promote increased member access. • Collaborate with providers for open access scheduling and patient flow analysis. • Community Advisory Committee focused groups to solicit member feedback. • Member newsletter to include how to prepare patients for enhanced communication exchange between member and provider. Health Plan of San Joaquin participated in the Association for Community Affiliated Plans (ACAP) CAHPS network call on April 24′ 2014, where the participants agreed that the priority should be member focused.
7. Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.	Health Plan of San Joaquin is reviewing the findings from the "Performance Evaluation Report" and will use the recommendations as an outline to address the identified data quality issues.

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