Performance Evaluation Report

Health Plan of San Mateo

July 1, 2013–June 30, 2014

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

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Performance Evaluation Report – Health Plan of San Mateo
July 1, 2013 – June 30, 2014

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 Mateo ("HPSM" 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

HPSM is a full-scope MCP delivering services to its MCMC members as a County Organized Health System (COHS). A COHS is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission.

HPSM became operational to provide MCMC services in San Mateo County in December 1987. As of June 30, 2014, HPSM had 110,411 MCMC members in San Mateo County.[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-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.

DHCS conducted no compliance reviews with HPSM during the review period for this report. The most recent routine monitoring review for HPSM was conducted November 7, 2011, through November 9, 2011, covering the review period of July 1, 2010, through October 21, 2011. DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit (MR/PIU) conducted a follow-up review in September 2012. As part of the follow-up review, MR/PIU evaluated HPSM's progress conducting SPD sensitivity training and facility site review assessments. HSAG included summaries of the reviews in HPSM's 2011–12 and 2012–13 MCP-specific evaluation reports.

Strengths

HPSM has no outstanding findings from the most recent reviews conducted by DHCS.

Opportunities for Improvement

Since HPSM has no outstanding deficiencies from the most recent reviews, HSAG has no recommendations for opportunities for improvement related to compliance reviews.

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 Mateo* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that HPSM followed the appropriate specifications to produce valid rates. Although the auditor identified multiple areas of concern during the audit, the identified issues had minimal impact on the audit findings. A brief summary of the opportunities for improvement is included below.

- The HSAG auditor recommended that HPSM implement a process to reconcile paid and reversed pharmacy claims to prevent over-reporting of rates for some measures that use pharmacy data.
- The HSAG auditor recommended that HPSM implement a process to reconcile its credentialing and claims processing databases to ensure that the MCP has accurate provider data.

[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).

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of HPSM'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 shows 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:

- 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
HPSM—San Mateo 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	—	—	14.52%	15.68%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	51.62	52.11	48.80	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	483.04	546.12	445.65	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	89.28%	89.51%	90.97%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	92.71%	94.95%	94.34%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	89.85%	90.57%	91.85%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	26.49%	34.06%	34.46%	37.13%	↔
Cervical Cancer Screening	Q,A	—	—	—	61.80%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	83.67%	80.29%	75.56%	82.11%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	95.89%	96.70%	97.13%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	88.34%	88.32%	90.40%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**87.75%**	89.36%	89.74%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**84.89%**	**85.61%**	**85.34%**	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	63.26%	66.18%	56.93%	**46.72%**	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	59.85%	61.07%	57.42%	60.83%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	86.62%	79.81%	83.70%	87.10%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	57.42%	55.72%	56.45%	54.01%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	46.96%	46.47%	46.96%	42.82%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	84.18%	82.00%	80.78%	80.78%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	86.62%	87.83%	82.97%	90.02%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	34.06%	37.96%	35.28%	38.69%	↔
Controlling High Blood Pressure	Q	—	—	51.34%	**29.93%**	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	68.49%	70.28%	78.45%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	48.51%	50.21%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	26.38%	27.69%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	61.84%	61.22%	59.18%	59.55%	↔

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	83.16%	81.89%	84.18%	82.66%	↔
Use of Imaging Studies for Low Back Pain	Q	84.62%	81.51%	80.07%	79.18%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	47.89%	66.67%	55.47%	67.32%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	75.43%	77.62%	70.05%	73.90%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	59.06%	63.99%	53.91%	63.66%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	75.44%	73.80%	77.13%	75.68%	↔

[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.

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 3.2 and Table 3.3, which present a summary of HPSM's 2014 SPD measure results. Table 3.2 presents 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 3.3 presents 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 3.2.

Table 3.2—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for HPSM—San Mateo 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	11.52%	16.78%	▼	15.68%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.57%	91.58%	↑	90.97%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	94.84%	Not Comparable	94.34%
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.05%	92.65%	↑	91.85%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.15%	NA	Not Comparable	97.13%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.80%	77.57%	↓	90.40%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.92%	72.88%	↓	89.74%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	86.89%	68.15%	↓	85.34%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	52.31%	46.72%	↔	46.72%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.36%	63.99%	↑	60.83%
Comprehensive Diabetes Care—HbA1c Testing	81.75%	88.81%	↑	87.10%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	47.93%	56.93%	↑	54.01%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.50%	47.20%	↑	42.82%
Comprehensive Diabetes Care—LDL-C Screening	75.43%	84.91%	↑	80.78%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.00%	90.75%	↑	90.02%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	43.07%	36.01%	▲	38.69%

* 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 3.3—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
HPSM—San Mateo County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
326.37	44.87	797.31	60.39

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

Performance Measure Result Findings

The following measures had rates above the HPLs:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* for the third consecutive year
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

The following measures had rates that improved significantly from 2013 to 2014:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Children and Adolescents' Access to Primary Care Physicians—25 Months to 6 Years*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Immunization for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*

The rates for the following measures declined significantly from 2013 to 2014, resulting in the rates moving from above the MPLs in 2013 to below the MPLs in 2014:

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Controlling High Blood Pressure*

In addition to the two measures noted above with rates below the MPLs, the rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure was below the MPL for the third consecutive year.

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for nine measures. The better rates in the SPD population are likely a result of the SPD population often having more health

care needs, resulting in them being seen more regularly by providers and leading to more monitoring of care.

The SPD rates were significantly worse than the non-SPD rates for the following measures:

- *All-Cause Readmissions*
- *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*

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

HPSM was not required to submit any IPs in 2013. Based on 2014 performance measure rates, HPSM will be required to submit IPs for the following measures:

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Controlling High Blood Pressure*

Strengths

HPSM had three measures with rates above the HPLs and six measures with rates that improved significantly from 2013 to 2014.

Opportunities for Improvement

Although the HSAG auditor determined that HPSM produced valid performance measure rates, the auditor recommended the following to the MCP:

- Implement a process to reconcile paid and reversed pharmacy claims to prevent over-reporting of rates for some measures that use pharmacy data.
- Implement a process to reconcile credentialing and claims processing databases to ensure that the MCP has accurate provider data.

HPSM has the opportunity to assess the factors leading to three measures having rates below the MPLs and to identify strategies to improve performance. Additionally, for measures with SPD rates significantly worse than non-SPD rates, HPSM has the opportunity to assess the factors leading to the rates being significantly worse for the SPD population to ensure that the MCP is meeting this population's needs.

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 HPSM'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

HPSM 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 HPSM's QIPs and indicates whether the QIP is clinical or nonclinical, and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

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

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Increasing Timeliness of Prenatal Care	Clinical	Q, A, T

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.

HPSM's goal for the *Increasing Timeliness of Prenatal Care* QIP was to have women see a provider in their first trimester and then maintain a prenatal "home" throughout the pregnancy. At the initiation of the QIP, HPSM reported that 85.3 percent of eligible members received a prenatal visit within the appropriate time frame. The lack of timely prenatal care is associated with poorer pregnancy outcomes, including preterm birth.

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
HPSM—San Mateo 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	69%	86%	*Partially Met*
	Annual Resubmission 1	94%	100%	*Met*
Internal QIPs				
Increasing Timeliness of Prenatal Care	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 HPSM'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, HPSM resubmitted the QIP and achieved an overall *Met* validation status, with 94 percent of the evaluation elements and 100 percent of the critical elements receiving a met score. The *Increasing Timeliness of Prenatal Care* QIP annual submission received an overall validation status of *Partially Met*. HPSM 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 HPSM's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
HPSM—San Mateo County
(Number = 4 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	90%	5%	5%
Design Total		**96%**	**2%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	77%	12%	12%
	VIII: Appropriate Improvement Strategies	50%	33%	17%
Implementation Total**		**68%**	**18%**	**13%**
Outcomes	IX: Real Improvement Achieved	50%	0%	50%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**50%**	**0%**	**50%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

HSAG validated Activities I through VIII for HPSM's *All-Cause Readmissions* QIP annual submission and Activities I through IX for the MCP's *Increasing Timeliness of Prenatal Care* QIP annual submission.

HPSM demonstrated a strong application of the Design stage, meeting 96 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP did not describe the data analysis plan for the *All-Cause Readmissions* QIP, resulting in a lower score for Activity VI. HPSM met all requirements for all applicable evaluation elements within the Design stage for its *Increasing Timeliness of Prenatal Care* QIP.

Both QIPs progressed to the Implementation stage during the reporting period. The MCP struggled with its application of the Implementation stage, meeting 68 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The *All-Cause Readmissions* and *Increasing Timeliness of Prenatal Care* QIPs had multiple implementation issues, resulting in lower scores for Activities VII and VIII. HPSM corrected the deficiencies in the resubmissions, resulting in both QIPs achieving an overall *Met* validation status.

Only the *Increasing Timeliness of Prenatal Care* QIP progressed to the Outcomes stage during the reporting period. The QIP study indicator did not achieve statistically significant improvement over baseline, resulting in only 50 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:

- Sent notifications by mail to non-SPD members within two weeks of discharge that highlight the need for them to contact their primary care physician (PCP) for follow-up and include contact information for the MCP's care coordination department.
- Implemented a process to send quarterly reports to PCPs with the highest readmission rates.

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

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

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

QIP #1—Increasing Timeliness of Prenatal Care				
Study Indicator: Percentage of members who had a prenatal care visit in the first trimester or within 42 days of enrollment				
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
85.3%	83.2%	81.9%	84.2%	‡

¥ 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.

Increasing Timeliness of Prenatal Care QIP

The *Increasing Timeliness of Prenatal Care* QIP project goal was to increase by 5 percent the number of eligible members having a prenatal visit in the first trimester or within 42 days of enrollment in the MCP, which the QIP did not achieve. At Remeasurement 3, the indicator 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:

- HPSM did not provide complete or accurate data analysis documentation in the initial QIP submission.
- Initially, HPSM did not thoroughly document its causal/barrier analysis or how barriers were identified and prioritized nor provide an evaluation plan for each intervention. The MCP provided this documentation in its resubmission.
- HPSM should develop system-wide interventions strictly based on the root cause analysis of the problem this QIP is addressing and likely to induce permanent change, since the past interventions have been shown to be ineffective.
- Although the interventions were not successful producing the desired QIP outcomes, following is a brief description of the interventions implemented by HPSM:
  - Conducted outbound calls to eligible members.
  - Maintained and catalogued records and forms from the pay-for-performance (P4P) program for use as leads during the HEDIS process.
  - Redesigned reminder forms to be more meaningful to members.
  - Reached out to providers who could benefit from the P4P program, and investigated why the providers are not participating.
  - Researched ways to conduct outreach to members younger than 21 years of age to identify effective strategies to engage these members in the MCP's incentive programs.
  - Reestablished community partnerships.

Strengths

HPSM 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 *Increasing Timeliness of Prenatal Care* QIP.

Opportunities for Improvement

In response to HSAG's recommendations in HPSM's 2012–13 MCP-specific evaluation report, HPSM implemented a process to ensure that all documents undergo quality checks for completeness (see Appendix D). Since the MCP had to resubmit both QIPs due to incomplete or inaccurate documentation, the MCP demonstrates continued opportunities for improving its QIP documentation. The MCP should continue to implement strategies to ensure that all required

documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

Since HPSM's *Increasing Timeliness of Prenatal Care* QIP has not been successful in improving the indicators' rate, the MCP should conduct a new causal/barrier analysis and assess if it needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.

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 HPSM's quality improvement system description and found detailed documentation of processes the MCP uses to ensure that quality care is provided to MCMC members. Additionally, goals and objectives include monitoring and evaluation of the quality of care provided to members.

The rates for the following quality performance measures were above the HPLs:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* for the third consecutive year
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

The rates for the following quality measures improved significantly from 2013 to 2014:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Immunization for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*

The rates for the following quality measures declined significantly from 2013 to 2014, resulting in the rates moving from above the MPLs in 2013 to below the MPLs in 2014:

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Controlling High Blood Pressure*

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and the SPD rates were significantly better than the non-SPD rates for nine measures. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to more monitoring of care. The SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care.

Both of HPSM's QIPs fell into the quality domain of care. Only the *Increasing Timeliness of Prenatal Care* QIP progressed to the Outcomes stage. At Remeasurement 3, the QIP study indicator had not yet achieved statistically significant improvement over baseline, suggesting that the MCP has

continued opportunities for improvement related to the quality of care being provided for pregnant members.

Overall, HPSM showed 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.

As part of the process for producing this report, HSAG reviewed HPSM's quality improvement program documents and found that the MCP has processes in place to assess and monitor member access to needed health care services.

The rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure, which falls into the access domain of care, was above the HPL. The rates for the following access measures improved significantly from 2013 to 2014:

- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Immunization for Adolescents—Combination 1*

The rate for one access measure, *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*, was below the MPL for the third consecutive year.

Nine of the performance measures stratified for the SPD population fall into the access domain of care. The SPD rates were significantly better than the non-SPD rates for four measures which, as indicated above, is likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to more monitoring of care. The SPD rates were significantly worse than the non-SPD rates for the following access measures:

- *All-Cause Readmissions*

- *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*

Both of HPSM's QIPs fell into the access domain of care. As indicated above, only the *Increasing Timeliness of Prenatal Care* QIP progressed to the Outcomes stage, and at Remeasurement 3 the QIP study indicator had not yet achieved statistically significant improvement over baseline. The results suggest that the MCP has continued opportunities for improvement related to ensuring access to care for pregnant members.

Overall, HPSM showed 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.

HPSM's quality documents include information related to member rights and responsibilities, grievances and appeals, continuity of care, and utilization management. Additionally, the documents provide details about the MCP's efforts to improve the timeliness of prenatal care delivered to members, since this is a priority area in the timeliness domain of care.

The rates for all measures falling into the timeliness domain of care were between the MPLs and HPLs. The rate for the *Immunizations for Adolescents—Combination 1* measure, which falls into the timeliness domain of care, improved significantly from 2013 to 2014.

The MCP's *Increasing Timeliness of Prenatal Care* QIP fell into the timeliness domain of care. As indicated above, the QIP progressed to the Outcomes stage, and at Remeasurement 3 the QIP study indicator had not yet achieved statistically significant improvement over baseline. The lack of positive outcomes suggest that the MCP has continued opportunities for improvement related to ensuring timeliness of care for pregnant members.

Overall, HPSM showed 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. HPSM's self-reported responses are included in Appendix D.

Recommendations

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

- Implement a process to reconcile paid and reversed pharmacy claims to prevent over-reporting of rates for some measures that use pharmacy data.
- Implement a process to reconcile credentialing and claims processing databases to ensure that the MCP has accurate provider data.
- Assess the factors leading to the rates being below the MPLs for the following measures, and identify strategies to improve performance:
  - *Children and Adolescents' Access to Primary Care practitioners—12 to 19 Years*
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
  - *Controlling High Blood Pressure*
- For measures with SPD rates significantly worse than non-SPD rates, assess the factors leading to the rates being significantly worse for the SPD population to ensure that the MCP is meeting this population's needs.
- Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.
- Conduct a new causal/barrier analysis for the *Increasing Timeliness of Prenatal Care* QIP and assess if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.

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

Table A.1 provides 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
HPSM—San Mateo County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	13.28%	16.78%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	58.21	60.39	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	924.90	797.31	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.95%	91.58%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	94.79%	94.84%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.23%	92.65%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	79.41%	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	74.72%	77.57%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	72.19%	72.88%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	65.03%	68.15%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	48.18%	46.72%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.42%	63.99%	↔
Comprehensive Diabetes Care—HbA1c Testing	83.94%	88.81%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	55.72%	56.93%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	48.18%	47.20%	↔
Comprehensive Diabetes Care—LDL-C Screening	83.21%	84.91%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.16%	90.75%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	46.72%	36.01%	▲

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

Table B.1 provides 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
HPSM—San Mateo County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	19.24%	11.52%	▲
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	49.86	44.87	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	405.92	326.37	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.52%	83.57%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.70%	82.05%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.98%	97.15%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.77%	90.80%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.72%	90.92%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.60%	86.89%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	13.38%	52.31%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	32.36%	50.36%	↑
Comprehensive Diabetes Care—HbA1c Testing	78.35%	81.75%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.47%	47.93%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	30.90%	36.50%	↔
Comprehensive Diabetes Care—LDL-C Screening	69.34%	75.43%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.97%	82.00%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	35.52%	43.07%	▼

*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 3.1)

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 Mateo

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with HPSM'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—HPSM'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 HPSM	Actions Taken by HPSM During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. To ensure accurate and complete data reporting:	
a. Implement editing processes that require valid coding specificity on claims.	HPSM developed a request for proposal in 2013 for a more robust claims editing software. Verisk was chosen, and we are in final testing stages. Full implementation is planned for Fall 2014.
b. Explore options to reconcile pharmacy reversals to ensure that the reported data are accurate.	We evaluated this issue and determined that it does not affect HEDIS reporting. 1. The matter does not concern reversals, but rather denied claims. 2. We do receive reversals from our pharmacy benefit manager (PBM), and reversing and reversed claims were excluded from HEDIS reporting. 3. We do not receive denied prescription (RX) claims. We have monitored the HEDIS rates for the measures utilizing RX claims data, and the rates are consistent with previous years' rates. Therefore, we believe that excluding denied RX claims does not have significant impact on our HEDIS reporting.
c. Require billing providers to populate the *Rendering Provider* field rather than having it be optional.	The Rendering Provider field is a required field effective July 2013.
d. Reconcile the data in the MCP's credentialing and claims processing databases at least annually.	HPSM has developed a process to compare our credentialing database known as "Prime" with our claims encounters contained within our claims processing system, HEALTHsuite, annually during the 3rd quarter of every year. The comparison identifies providers that appear in our credentialing database but that do not appear as contracted within our claims processing database. The reverse of this also occurs—where a provider is listed as contracted in our claims system but does not appear as contracted in our credentialing database. These exceptions are identified and reconciled.

2012–13 External Quality Review Recommendation Directed to HPSM	Actions Taken by HPSM During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	Additionally, an evaluation of providers that are not in our credentialing database and that are not contracted is performed, and a list of noncontracted providers is created. HPSM monitors noncontracted providers to ensure appropriateness of noncontracted providers within our network. The first report will be created and evaluated in August 2014.
2. Assess the factors leading to the rate for the *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* measure being below the MPL in 2013 and identify improvement strategies that will result in an improvement on performance.	There are significant barriers to affecting rates of *Adolescent Well-Care Visits* (*AWC*), as demonstrated by the overall performance of the Medi-Cal managed care health plans. HPSM's score for this measure was 85.61 and the Medi-Cal Managed Care weighted average was 85.62, below the MPL. As such, most MCPs rates fell below the MPL. The measure was eventually retired because the MCPs were not showing improvement in their *AWC* compliance rates over time. We looked to best practices to determine if there were areas for opportunity. To address this issue we have identified several factors: 1) Within the community there is only a single school-based clinic. 2) Within the community there is limited access to walk-in, weekend, and after-hours clinics. 3) Lack of ability to perform interim rate monitoring. Improvement strategies include: 1) Outreach to school-based clinics at Sequoia Teen Health Center to increase awareness and offered incentives when appropriate. 2) Working with providers to expand weekend/after-hours access. In 2013, a new federally qualified health centers (FQHCs) system (Gardner) expanded its pediatric clinics to San Mateo County, providing expanded access. 3) The MCP purchased certified HEDIS software and will be doing interim monitoring throughout the year. Our Q1 2014 run will be done in the month of July. This will give us a list of noncompliant members to target for intervention. Previously contracted through a vendor, the MCP did not have the ability to do interim HEDIS monitoring. The plan of increasing compliance rates will be multi-tiered. Based on the noncompliance lists from the HEDIS certified software, the quality improvement (QI) department will work with network providers as well as provider services department to see if the barriers to care are member oriented or provider access oriented. 4) The MCP will look at effectiveness of interactive voice response (IVR) calls for this population.

2012–13 External Quality Review Recommendation Directed to HPSM	Actions Taken by HPSM During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
3. Assess the factors that caused the rates for the following measures to decline significantly from 2012 to 2013 and identify interventions to be implemented to prevent further decline on the rates:	
a. *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*	We identified that the main driver of the decline in this measure was related to data collection: The standard of practice for all primary care visits in the region is to take a blood pressure (BP) reading every time the member is in for a visit. Diabetes members receive care at specialty and hospital sites in addition to primary care physician (PCP) offices. The focus is on the following: 1) Data collection and chart pursuit logic. 2) Outreach to members with diabetes to ensure that PCP assigned in HEALTHsuite is PCP that they see regularly. 3) If members with diabetes have not seen PCP, per claims, members are contacted and educated re PCP and need for preventive care. 4) Provider-specific lists of diabetes members who can be targeted for outreach for P4P at the same time that BP monitoring is done.
b. *Comprehensive Diabetes Care—Medical Attention for Nephropathy*	We identified that the main reason for the change in this measure was that those PCPs who participated in pay-for-performance (P4P) programs for other diabetes measures (HbA1C and LDL-C) did not always participate in macro and micro albumin testing. We use provider-specific lists of diabetes members to identify areas of gaps in diabetes care as part of our P4P outreach.
c. All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures	Body mass index (BMI) is a P4P measure, and our previous process for P4P for these measures relied on supplemental data collection—providers submitted an HPSM "BMI and Weight Assessment/Counseling" form. Since the switch to claims-based billing, providers have low utilization of standard codes to bill these interventions. We are targeting those providers with low utilization of these codes and doing targeted education and outreach.
4. For the following measures with SPD rates that were significantly worse than the non-SPD rates, assess the factors leading to the rates being significantly worse for the SPD population and identify strategies to ensure the MCP is meeting this population's needs:	
a. All four *Children and Adolescents' Access to Primary Care Practitioners* measures	Issue identified: Children with SPD aid codes frequently have high/specialized health care needs and are served by alternative programs including: (1) California Children's Services, and (2) Regional Center—Golden Gate Regional Center (GGRC) in San Mateo County. Many of these children receive the majority of their care in specialized centers. Planned approach: We will identify those children in special needs programs and partner with these programs to identify potential gaps in primary care services.

2012–13 External Quality Review Recommendation Directed to HPSM	Actions Taken by HPSM During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
b. *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*	The MCP continues to develop ways to decrease the proportion of members who have diabetes with HbA1c that is out of control (greater than 9 percent). The MCP recognizes that the efforts will need to be coordinated with the PCP to ensure this is done in a safe way with no negative impact to the health of the member. With the use of HEDIS certified software and the ability to do interim measurements throughout the year, we will be targeting members for either getting their HbA1c test done, or collaborating with the member's PCP to get the member's blood sugar levels below 9 percent. Based on previous experiences aimed at improving diabetic control, the initial focus for this measure will be getting members with diabetes in for their HbA1c screening. (Specifications identify members who have no test/level reported as noncompliant or having blood sugar levels above 9 percent.)
5. Reference the QIP Completion Instructions to ensure that all required information is documented in the QIP Summary Form.	Part of the quality assurance (QA) process is that all documents produced by the department undergo checks for completeness based on the information requested in the QIP Summary Form.
6. For the *Increasing Timeliness of Prenatal Care* QIP:	
a. Continue to explore access-related barriers for beneficiaries seeking prenatal care. Specifically, the MCP should implement targeted interventions that may promote providers accepting new Medi-Cal beneficiaries.	The greatest barrier continues to be the MCP's timely access to knowledge of pregnancy status of members. We have developed a program to receive consistent data feeds of newly eligible Medi-Cal members who are in pregnancy-related aid codes. The relationships with the county partners have created mechanisms for members to be aware of all the resources available to them for pregnancy care. Part of the MCP staff's duties is working with providers to get the provider participating in the Comprehensive Perinatal Services Program (CPSP). The combination of these partnerships should increase access to MCP members who are pregnant.
b. Consider conducting a new barrier analysis and assessing if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers. While the MCP reports that some interventions are making a positive impact on members' prenatal care, the improvements are not showing in the study indicator rate, which is declining rather than improving.	We are using the HEDIS certified software to track our progress and make changes more frequently to determine if our current interventions are not effective (i.e., rapid cycle quality improvement).

2012–13 External Quality Review Recommendation Directed to HPSM	Actions Taken by HPSM During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
7. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the *Getting Care Quickly, Getting Needed Care,* and *How Well Doctors Communicate* priority areas.	The director of Provider Network Development and Services and the director of Member Services have met with the medical director of the Ambulatory Care Clinics at the San Mateo Medical Center (SMMC); SMMC is HPSM's largest PCP provider. Discussions will be ongoing regarding establishing appropriate PCP clinic capacity and the impact of capacity on appointment availability and timely access to PCP appointments. In addition, the director of Provider Network Development and Services is in the process of engaging Palo Alto Medical Foundation on various aspect of timely access to care and will formalize a corrective action plan in the second quarter of 2014. In the first quarter of 2014, a system-wide 24/7 nurse advice line was implemented to support all HPSM members in conjunction with their primary care providers.
8. 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.	HPSM has developed IT resources for our CMS Encounter Data Processing System (EDPS) and continues to expand those resources as we prepare for the DHCS 837 rollout in October of 2014. We have formed an interdepartmental work group to develop processes to monitor and correct encounter error reports.

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