Performance Evaluation Report

Santa Clara Family Health Plan

July 1, 2013–June 30, 2014

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

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TABLE OF CONTENTS

Performance Evaluation Report – Santa Clara Family Health Plan 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, performance measures, QIPs, and optional activities, including member satisfaction survey and

[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.

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, Santa Clara Family Health Plan ("SCFHP" 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

SCFHP 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 SCFHP, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative CP.

SCFHP became operational in Santa Clara County to provide MCMC services effective February 1997. As of June 30, 2014, SCFHP had 189,648 MCMC members in Santa Clara 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-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.

DHCS conducted no reviews for SCFHP during the review period for this report. HSAG summarized the findings from the 2007 medical performance and 2011 monitoring reviews in SCFHP's previous MCP-specific evaluation reports.

Strengths

It does not appear that SCFHP has any outstanding findings from previously-conducted reviews.

Opportunities for Improvement

Since DHCS has conducted no new reviews for SCFHP, 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 Santa Clara Family Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that SCFHP followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the findings is included below.

SCFHP:

- Had sufficient practices in place to process medical data.
- Successfully transitioned its Healthy Families Program population into MCMC with no impact on member operations (i.e., processes related to enrollment, customer service, member outreach, etc.).
- Conducted comprehensive oversight of its data integration prior to final verification.

[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 SCFHP'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
SCFHP—Santa Clara 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	—	—	13.77%	15.20%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	35.89	34.79	32.64	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	292.77	267.45	260.02	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	86.05%	87.60%	87.39%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	**87.18%**	88.10%	89.01%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	84.85%	88.08%	87.91%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	31.41%	25.81%	26.43%	29.40%	↔
Cervical Cancer Screening	Q,A	—	—	—	67.40%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	79.40%	80.05%	73.72%	75.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.22%	96.87%	97.15%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	88.63%	88.90%	88.94%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	89.69%	88.92%	90.46%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	86.78%	87.81%	87.46%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	62.70%	**45.01%**	**53.53%**	56.69%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	51.52%	47.69%	**41.85%**	46.72%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.38%	86.62%	86.62%	86.86%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	56.41%	51.09%	55.47%	54.01%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	51.28%	37.96%	42.82%	41.36%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	78.32%	81.02%	79.08%	81.02%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	76.22%	80.05%	79.81%	83.45%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	34.73%	40.88%	34.79%	33.82%	↔
Controlling High Blood Pressure	Q	—	—	52.80%	52.55%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	69.34%	75.67%	75.43%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	58.61%	61.13%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	35.95%	41.98%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	62.73%	**58.39%**	67.40%	59.61%	↓

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	83.56%	82.73%	82.97%	86.13%	↔
Use of Imaging Studies for Low Back Pain	Q	82.30%	80.37%	82.42%	86.37%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	60.88%	64.23%	66.91%	71.53%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	61.81%	63.99%	67.88%	67.40%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	40.05%	45.74%	41.85%	49.15%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.61%	75.67%	72.75%	69.59%	↔

[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 SCFHP'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 SCFHP—Santa Clara 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	8.29%	18.25%	▼	15.20%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.83%	89.10%	↑	87.39%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	88.61%	Not Comparable	89.01%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.68%	90.26%	↑	87.91%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.31%	80.95%	↓	97.15%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.94%	88.93%	↔	88.94%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.52%	88.55%	↔	90.46%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.49%	86.53%	↔	87.46%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58.64%	51.09%	↓	56.69%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.45%	44.53%	↔	46.72%
Comprehensive Diabetes Care—HbA1c Testing	80.29%	86.86%	↑	86.86%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.42%	56.45%	↑	54.01%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.74%	49.15%	↑	41.36%
Comprehensive Diabetes Care—LDL-C Screening	72.75%	80.29%	↑	81.02%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.86%	87.35%	↑	83.45%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	40.63%	34.06%	↔	33.82%

* 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
SCFHP—Santa Clara County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
240.37	30.95	411.17	45.66

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

Performance Measure Result Findings

No rates were below the MPLs in 2014, and the rates were above the HPLs for the *Medication Management for People with Asthma—Medication Compliance 75% Total* and *Use of Imaging Studies for Low Back Pain* measures. The rates improved significantly from 2013 to 2014 for the following measures:

- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Medication Management for People with Asthma—Medication Compliance 75% Total*
- *Use of Imaging Studies for Low Back Pain*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*

The rates improved for the following measures from 2013 to 2014. Although not statistically significant, the improvement resulted in the rates moving from below the MPLs to above the MPLs.

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

The rate declined significantly from 2013 to 2014 for the *Prenatal and Postpartum Care—Postpartum Care* measure.

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for seven 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 better 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—12 to 24 Months*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

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

SCFHP was required to submit on IP that included both the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measures. The MCP identified separate barriers and interventions for each measure. HSAG provides a summary of the barriers and interventions below.

Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)

The MCP identified the following barriers to the rate for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure being above the MPL:

- Members:
  - Had low health literacy.
  - Had language barriers.
  - Were not aware of plan benefits such as transportation services and durable medical equipment.
- Providers lacked education on the clinical guidelines.

To address the barriers, the MCP implemented several interventions, including:

- Promoting diabetes education programs to members and providers through outreach calls, newsletters, and the MCP's Web page.
- Promoting covered benefits of transportation services, health education classes, individualized diabetes teaching, and medical equipment and supplies.
- Monitoring diabetes program utilization monthly.
- Promoting the American Diabetes Association guidelines to all contracted providers through the MCP's website.

SCFHP's efforts resulted in the rate for this measure improving by more than 3 percentage points. Although not statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014. SCFHP will not be required to continue this IP in 2014.

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

The MCP identified the following barriers to the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure being above the MPL:

- The MCP's delegate's outreach program was not correctly identifying the targeted population; therefore, the targeted population did not receive notification letters. Reasons for the delegates failure to reach targeted members were:
  - The delegate was sending only two-year reminder letters for diabetic exams.
  - Members were not being identified as having a diagnosis of "having diabetic retinopathy" versus "diabetes no evidence of retinopathy"; therefore, no annual outreach was performed.
  - The delegate generated outreach letters that did not use mailing address fields to populate the mailings.
  - The delegate's outreach letter was not specific to the SCFHP population and was difficult to understand.
- The MCP had incomplete/invalid encounter data.
- Providers lacked education on the clinical guidelines.

To address the barriers, the MCP implemented several interventions, including:

- Rewriting the delegate's outreach letters.
- Promoting health education/diabetes education programs to members and providers through outreach calls, newsletters, and the MCP's Web page.
- Informing members of benefits, including transportation, health education, and medical supplies and equipment.
- Monitoring the delegate's outreach outcomes and volume and completeness of data monthly.
- Promoting the American Diabetes Association guidelines to all contracted providers through the MCP's website.

SCFHP's efforts resulted in the rate for this measure improving by more than 5 percentage points. Although not statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014. SCFHP will not be required to continue this IP in 2014.

IPs for 2014

Since SCFHP had no rates below the MPLs in 2014, the MCP will not be required to submit any IPs in 2014.

Strengths

During the 2014 HEDIS audit with SCFHP, HSAG auditors determined that the MCP followed the appropriate specifications to produce valid performance measure rates. Additionally, SCFHP successfully transitioned its Healthy Families Program population into MCMC with no impact on member operations. Finally, SCFHP conducted comprehensive oversight of the MCP's data integration prior to final verification.

SCFHP had two measures with rates above the HPLs, no measures with rates below the MPLs, and four rates that improved significantly from 2013 to 2014. Additionally, the MCP's IPs for two measures were successful in bringing the rates for the measures from below the MPLs in 2013 to above the MPLs in 2014.

Opportunities for Improvement

SCFHP has the opportunity to assess the factors leading to the rate declining significantly from 2013 to 2014 for the *Prenatal and Postpartum Care—Postpartum Care* measure and identify strategies to prevent the rate from declining to below the MPL. For the three measures with SPD rates significantly worse than the non-SPD rates, the MCP has the opportunity to assess the factors leading to the significantly worse SPD rates to ensure that the MCP is meeting the SPD population's health care needs. Note: SCFHP reported on actions the MCP has taken to reduce readmissions for the SPD population (see Appendix D); however, the SPD rate remained significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure.

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 SCFHP'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

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

Table 4.1 below lists SCFHP'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 SCFHP
July 1, 2013, through June 30, 2014

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Childhood Obesity Partnership and Education	Clinical	Q, A
Diabetic Retinopathy Improvement and Prevention by Screening	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.

SCFHP's *Childhood Obesity Partnership and Education* QIP attempted to improve the quality of care delivered to children by increasing the appropriate nutritional education for children with BMI percentiles greater than or equal to the 95th percentile for age and gender. SCFHP's goal was to increase the percentage of these children who attended a nutritional program by implementing member and provider improvement strategies. Childhood obesity is a condition seldom addressed that may be both an indicator of suboptimal preventive care or diminished overall health and a risk factor for many chronic conditions.

The *Diabetic Retinopathy Improvement and Prevention by Screening* QIP targeted the MCP's members with diabetes and focused on increasing retinal eye exams. Ongoing management of members with diabetes is critical both to preventing complications and to ensuring optimal health for those members.

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
SCFHP—Santa Clara 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	88%	86%	*Partially Met*
	Annual Resubmission 1	100%	100%	*Met*
Internal QIPs				
Childhood Obesity Partnership and Education	Annual Submission	44%	43%	*Not Met*
	Annual Resubmission 1	30%	29%	*Not Met*
Diabetic Retinopathy Improvement and Prevention by Screening	Study Design Submission	83%	71%	*Not Met*
	Study Design Resubmission 1	100%	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 SCFHP'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, SCFHP resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score. The *Diabetic Retinopathy Improvement and Prevention by Screening* QIP study design submission received an overall validation status of *Not Met.* SCFHP resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score.

SCFHP's annual submission of the *Childhood Obesity Partnership and Education* QIP received an overall *Not Met* validation status. Through discussion with SCFHP, DHCS and HSAG determined that, due to the MCP making changes in the methodology between the baseline and Remeasurement 1 reporting periods, the QIP should be closed with no further validation. SCFHP

was not required to submit further documentation regarding this QIP.

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

Table 4.3—Quality Improvement Project Average Rates*
SCFHP—Santa Clara County
(Number = 6 QIP Submissions, 3 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)	83%	17%	0%
	III: Clearly Defined Study Indicator(s)**	71%	14%	14%
	IV: Correctly Identified Study Population	67%	0%	33%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection**	79%	4%	18%
Design Total		**83%**	**5%**	**12%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	63%	21%	17%
	VIII: Appropriate Improvement Strategies	25%	42%	33%
Implementation Total		**50%**	**28%**	**22%**
Outcomes	IX: Real Improvement Achieved	0%	0%	100%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**100%**

*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.

Please note that the aggregated percentages for Activities I through IX in Table 4.3 include the scores from SCFHP's *Childhood Obesity Partnership and Education* QIP. HSAG provides no details in this report regarding deficiencies noted during the validation process for this QIP, since the MCP was not required to resubmit the QIP to address the deficiencies and the QIP was closed.

HSAG validated Activities I through VIII for SCFHP's *All-Cause Readmissions* annual submission, Activities I through IX for the MCP's *Childhood Obesity Partnership and Education* annual submission, and Activities I through VI for the MCP's *Diabetic Retinopathy Improvement and Prevention by Screening* QIP study design submission.

SCFHP demonstrated an adequate application of the Design stage, meeting 83 percent of the requirements for all applicable evaluation elements within the study stage. The MCP met 100 percent of the requirements for all applicable evaluation elements within the Design stage for the

All-Cause Readmissions QIP. For the *Diabetic Retinopathy Improvement and Prevention by Screening* QIP, SCFHP did not provide an accurate study question; did not include staff qualifications, training, or experience for collecting manual data; and did not provide a copy of the manual data collection tool, resulting in a lower score for Activities II and VI. The MCP corrected the deficiencies in the resubmission, resulting in the QIP achieving an overall *Met* validation status. The remaining deficiencies attributed to this stage were found in the MCP's documentation in the *Childhood Obesity Partnership and Education* QIP. Since this QIP was closed prior to achieving a *Met* validation status, HSAG provides no details regarding deficiencies noted during the validation process.

Both the *All-Cause Readmissions* and the *Childhood Obesity Partnership and Education* QIPs progressed to the Implementation stage during the reporting period. SCFHP demonstrated poor application of the Implementation stage for these QIPs, meeting only 50 percent of the requirements for all applicable evaluation elements within the study stage. For the *All-Cause Readmissions* QIP, SCFHP did not indicate if any factors threatened the internal or external validity of the findings, did not provide the tool used to analyze the data, and did not prioritize the barriers, resulting in lower scores for Activities VII and VIII. The remaining deficiencies attributed to this stage were in the MCP's documentation in the *Childhood Obesity Partnership and Education* QIP. Since this QIP was closed prior to achieving a *Met* validation status, HSAG provides no details regarding deficiencies noted during the validation process.

Only the *Childhood Obesity Partnership and Education* QIP progressed to the Outcomes stage during the reporting period. Statistical significance could not be accurately assessed because the MCP changed the methodology and the baseline and Remeasurement 1 results were no longer comparable. Therefore, the score for Activity IX was lowered. This QIP was not assessed for sustained improvement (Activity X), since it had not yet progressed to that stage.

Quality Improvement Project Outcomes and Interventions

The *Diabetic Retinopathy Improvement and Prevention by Screening* QIP did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information is included in this report.

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:

- Added additional case management staff to increase the number of SPD members engaged in case management services.
- Implemented a post-discharge call policy and procedure.
- Implemented a discharge plan documentation pilot program with Stanford Hospital wherein, upon a member being discharged, the MCP's concurrent review team becomes responsible for

downloading the electronic discharge plans from Stanford's online system. The discharge plan information was used in the care planning and care coordination processes.

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

Although the *Childhood Obesity Partnership and Education* QIP was closed, since the MCP reported outcomes for the QIP, they are included in this report. Table 4.4 summarizes the *Childhood Obesity Partnership and Education* 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 SCFHP—Santa Clara County July 1, 2013, through June 30, 2014

QIP #1—Childhood Obesity Partnership and Education			
Study Indicator: The percentage of identified children aged 2 to 18 years with BMI ≥95th percentile for age and gender who attended at least one eligible program during the measurement year.			
Baseline Period 1/1/11–12/31/11	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**	**Sustained Improvement¥**
18.6%	2.9%*	‡	‡

¥ 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 baseline and Remeasurement 1 results could not be compared due to changes in the methodology.

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

Childhood Obesity Partnership and Education QIP

SCFHP's objective for the *Childhood Obesity Partnership and Education* QIP was to increase to 50 percent the number of eligible members attending at least one nutritional program. The MCP modified the methodology, so HSAG could not accurately assess if the QIP was successful at reaching this goal or if improvement was made from baseline to Remeasurement 1.

Strengths

SCFHP excelled at selecting an appropriate study topic and developing valid sampling techniques for the *All-Cause Readmissions, Childhood Obesity Partnership and Education,* and *Diabetic Retinopathy Improvement and Prevention by Screening* QIPs.

Opportunities for Improvement

SCFHP has the opportunity to ensure that all required documentation is included in the QIP Summary Form, since the MCP continued to have several instances of incomplete data. The MCP should reference the QIP Completion Instructions and the feedback in the QIP Validation Tool to ensure that all documentation requirements for each activity have been addressed prior to submission.

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.

SCFHP's quality improvement program description includes details of the MCP's organizational structure and processes, which support the provision of quality care to SCFHP's MCMC members.

Following is a summary of SCFHP's performance on measures falling into the quality domain of care:

- The rates moved from below the MPLs in 2013 to above the MPLs in 2014 for the following measures:
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- The rates improved significantly from 2013 to 2014 and were above the HPLs for the following measures:
  - *Medication Management for People with Asthma—Medication Compliance 75%*
  - *Use of Imaging Studies for Low Back Pain*
- The rate improved significantly from 2013 to 2014 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* measure.
- The rate declined significantly from 2013 to 2014 for the *Prenatal and Postpartum Care—Postpartum Care* measure.

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 seven of these 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 better monitoring of care. The SPD rates were significantly worse than the non-SPD rates for the following measures:

- *All-Cause Readmissions*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

All three of the MCP's QIPs fell into the quality domain of care. Only the *Childhood Obesity Partnership and Education* QIP progressed to the Outcomes stage. Because the MCP modified the methodology between the baseline and Remeasurement 1 reporting periods, HSAG could not accurately assess if the QIP was successful at improving the quality of care for MCMC members aged 2 to 18 years with a BMI ≥95th percentile for their ages and genders.

Overall, SCFHP 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.

SCFHP's quality improvement program description includes information about the MCP's commitment to ensuring access to care for its MCMC members. Additionally, the program description includes details of the MCP's processes to monitor access to care.

Following is a summary of SCFHP's performance on measures falling into the access domain of care:

- The rate improved significantly from 2013 to 2014 for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure.
- The rate moved from below the MPL in 2013 to above the MPL in 2014 for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure.
- The rate declined significantly from 2013 to 2014 for the *Prenatal and Postpartum Care—Postpartum Care* measure.

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and the SPD rates were significantly better than the non-SPD rates for three of these measures. As indicated above, 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 better 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—12 to 24 Months*

All three of the MCP's QIPs fell into the access domain of care. Only the *Childhood Obesity Partnership and Education* QIP progressed to the Outcomes stage. The MCP modified the methodology between the baseline and Remeasurement 1 reporting periods, so HSAG could not

accurately assess if the QIP was successful at improving access to care for MCMC members aged 2 to 18 years with a BMI ≥95th percentile for their ages and genders.

Overall, SCFHP 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.

SCFHP's quality improvement program description includes details of the MCP's organizational structure and processes related to oversight of grievances and utilization management, which affect the timeliness of care delivered to members.

The rates were above the MPLs for all performance measures falling into the timeliness domain of care. The rate declined significantly from 2013 to 2014 for the *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the timeliness domain of care.

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

Recommendations

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

- Assess the factors leading to the rate declining significantly from 2013 to 2014 for the *Prenatal and Postpartum Care—Postpartum Care* measure, and identify strategies to prevent the rate from declining to below the MPL.
- For the following measures with SPD rates significantly worse than the non-SPD rates, assess the factors leading to the significantly worse SPD rates to ensure that the MCP is meeting the SPD population's health care needs:
  - *All-Cause Readmissions*
  - *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- Reference the QIP Completion Instructions and the feedback in the QIP Validation Tool to ensure that all documentation requirements for each activity have been addressed prior to QIP submissions.

In the next annual review, HSAG will evaluate SCFHP'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
SCFHP—Santa Clara County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	16.54%	18.25%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	42.92	45.66	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	403.89	411.17	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.79%	89.10%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	89.33%	88.61%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.07%	90.26%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.30%	80.95%	↓
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.74%	88.93%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.16%	88.55%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	89.55%	86.53%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	53.53%	51.09%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	40.15%	44.53%	↔
Comprehensive Diabetes Care—HbA1c Testing	89.05%	86.86%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	61.07%	56.45%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	47.93%	49.15%	↔
Comprehensive Diabetes Care—LDL-C Screening	84.67%	80.29%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	87.83%	87.35%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	29.20%	34.06%	↔

*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
SCFHP—Santa Clara County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.26%	8.29%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	33.44	30.95	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	244.89	240.37	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.67%	82.83%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.20%	81.68%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.87%	97.31%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.91%	88.94%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.91%	90.52%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.74%	87.49%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	55.72%	58.64%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	38.20%	47.45%	↑
Comprehensive Diabetes Care—HbA1c Testing	82.73%	80.29%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.18%	48.42%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	35.77%	36.74%	↔
Comprehensive Diabetes Care—LDL-C Screening	73.72%	72.75%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.94%	77.86%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.61%	40.63%	↔

*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 Santa Clara Family Health Plan

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with SCFHP'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—SCFHP'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 SCFHP	Actions Taken by SCFHP During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Engage in the following efforts to improve performance related to required measures:	
a. Since the efforts to improve the rate for the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* measure resulted in the rate improving significantly from 2012 to 2013, continue to implement successful strategies and assess if modifications need to be made to strategies to ensure continued improvement on the rate.	Barrier analysis was completed and the 2012 HEDIS improvement plan (IP) document was submitted on December 9, 2013. DHCS approved the IP in January 2013 and closed it in July 2014. Interventions included: • Promote contracted diabetes educational programs to members and providers in outreach calls, newsletters, and Web page. • Promote covered benefits of transportation services, health education classes, and individualized teaching about diabetes (along with covered equipment and supplies) to members and providers. • Promote member incentive for completing diabetes education programs. • Targeted outreach by health plan for diabetic members with blood pressure medications. • Promote updated American Diabetes Association (ADA) clinical guidelines to all contracted providers through website, face-to-face education, facility site review (FSR) medical record reviews, and by providing/sponsoring continuing medical education (CME) opportunities. Additionally, a Plan-Do-Study-Act (PDSA) assessing the outcomes of these interventions was submitted and then approved and closed by DHCS in July 2014.
b. Assess the factors leading to the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal)* Performed measure being below the MPL and identify interventions that will improve the rate for this measure.	Barrier analysis was completed and the 2012 HEDIS IP document was submitted on December 9, 2013. DHCS approved the IP in January 2013 and closed it in July 2014. Interventions included: • Promote contracted diabetes educational programs to members and providers in outreach calls, newsletters, and

2012–13 External Quality Review Recommendation Directed to SCFHP	Actions Taken by SCFHP During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	Web page. • Promote covered benefits of transportation services, health education classes, and individualized teaching about diabetes (along with covered equipment and supplies) to members and providers. • Promote member incentive for completing diabetes education programs. • Targeted outreach by health plan for diabetic members without an eye exam in 2013. • Promote updated ADA clinical guidelines to all contracted providers through website, face-to-face education, FSR medical record reviews, and by providing/sponsoring CME opportunities. • Promote member incentive for completing diabetic eye screening. • Monthly monitoring of delegated provider's outreach outcomes and volume and completeness of encounter data. • Analyze encounter data for Current Procedural Terminology (CPT) II codes for volume and completeness. • Increase job order contraction (JOC) with delegate (VSP) to every other month. • Correct mailing address of Vision Service Plan (VSP) outreach letters. • Rewrite and co-brand delegates' (VSP) outreach letters. Additionally, a PDSA assessing the outcomes of these interventions was submitted and then approved and closed by DHCS in July 2014.
c. Assess the factors leading to the rate for the *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* measure declining significantly from 2012 to 2013 and implement strategies to address the factors to ensure the rate does not decline to below the MPL.	Measurement year 2012 was the first year that SCFHP's SPD members were included in the measures' rates. This increase in members caused a small decline in our *CAP* measure for 7-to-11-year-olds. SCFHP has increased provider education on timely access standards and preventive care needs for children during the measurement year 2013.
d. Assess the factors leading to the rate for the *Childhood Immunization Status—Combination 3* measure declining significantly from 2012 to 2013 and implement strategies to address the factors to ensure the rate does not decline to below the MPL.	A review of our medical records showed several factors leading to this decline in our *Childhood Immunization Status–Combination 3* rate: • Members received vaccines, but not in time for their second birthday. • Missed opportunities—Members visited primary care physicians (PCPs) for sick visits, but immunizations were not given. In an effort to increase this measure, SCFHP has continued to partner with Pfizer/TeleVox to send out reminder cards to members each month. SCFHP has also worked with its FSR nurse to provide our PCPs with the American Academy of Pediatrics guidelines for immunizations in children and adolescents. SCFHP has also worked with the California Immunization Registry to retrieve all of our

2012–13 External Quality Review Recommendation Directed to SCFHP	Actions Taken by SCFHP During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	member's registry records. SCFHP is collaborating with the Santa Clara County Public Health Department on provider and member/parent education of immunization schedules.
e. Assess the factors leading to the SPD rate for the *All-Cause Readmissions* measure being significantly higher than the non-SPD rate and identify strategies to ensure the MCP is meeting the SPD population's needs.	As a rule, SPD members are more vulnerable than non-SPD members. They are at a higher risk for hospital visits and readmissions due to their ages and disabilities. Following the QIP required by DHCS, SCFHP implemented the following interventions to try to lower the rate of readmissions for its members: • Increase case management services. • Increase post-discharge calls to members. • Increase the number of hospital discharge plans for members.
2. Engage in the following efforts to improve performance related to QIPs:	
a. Review the QIP Completion Instructions prior to submitting QIPs to ensure all required documentation is included in the QIP Summary Form.	Submitted 2013 annual submission for the *All-Cause Readmissions* collaboration QIP by due date.
b. Ensure that the MCP connects each intervention to an identified barrier when documenting interventions in the QIP Summary Form.	Submitted 2013 annual submission for the *All-Cause Readmissions* collaboration QIP by due date in September 2013 and achieved an overall status of "*Met*". In addition, SCFHP was asked to present our PDSA cycle method at the June 2014 Quarterly *ACR* statewide collaborative technical assistance call that outlined how to connect each intervention to an identified barrier when documenting interventions in the QIP Summary Form.
3. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the *Rating of All Health Care, Getting Needed Care*, and *Getting Care Quickly* priority areas.	SCFHP included this process in the 2014 Quality Improvement (QI) Work Plan that was approved by the Quality Improvement Committee June 2014. SCFHP is convening a CAHPS workgroup to develop and implement strategies to address the *Rating of All Health Care, Getting Needed Care*, and *Getting Care Quickly* as priorities. First workgroup meeting is scheduled in August 2014.
4. 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.	In 2013, SCFHP hired an additional financial analyst to develop strategies and implement quality improvement processes to ensure accurate and complete encounter data. All year, and into 2014, the SCFHP data warehouse has been updated; new reports are available to QI and Finance on the timeliness and completeness of encounter data. This information is now reported to our delegates and other training partners at quarterly Joint Operations Meetings or more frequently, as needed, for DHCS and/or HEDIS submissions.

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