Performance Evaluation Report

Health Plan of San Joaquin

July 1, 2010–June 30, 2011

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

June 2012

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1. INTRODUCTION

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 million beneficiaries (as of June 2011)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to the domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Health Plan of San Joaquin ("HPSJ" or "the plan"), which delivers care in San Joaquin County, for the review period July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

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

Members of the MCMC Program in San Joaquin County may enroll in either the LI plan operated by HPSJ or in the alternative commercial plan. HPSJ became operational with the MCMC Program in February 1996, and, as of June 30, 2011, HPSJ had 86,461 MCMC members.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about HPSJ's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

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

For this report, HSAG reviewed the most current audit reports available as of June 30, 2011, to assess plans' compliance with State-specified standards. The most recent medical performance review was completed in January 2009, covering the review period of January 1, 2008, through December 31, 2008. HSAG reported these findings in detail in the 2009–2010 plan evaluation report.[3]

The review showed that HPSJ had audit findings in the areas of utilization management, continuity of care, access and availability, member rights, quality management, and administrative and organizational capacity. The DHCS *Medical Audit Close-Out Report* letter dated December 29, 2009, noted that the plan had fully corrected several audit deficiencies; however, some issues remained unresolved at the time of the audit close-out report.

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

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These member rights reviews are conducted before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2011.

MRPIU conducted an on-site review of HPSJ in December 2010, covering the review period of November 1, 2008, through November 1, 2010. The scope of the review included grievances,

[3] California Department of Health Care Services. *Performance Evaluation Report, Health Plan of San Joaquin – July 1, 2009 through June 30, 2010*. October 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

prior authorization notifications, cultural and linguistic services, evidence of coverage, provider compliance with requirements over member rights, and the False Claims Act.

MRPIU noted several findings in the area of prior authorization. HPSJ's Notice of Action (NOA) letter and the plan's policies and procedures on NOA indicate that the plan does not include citations for denial reasons on the NOA. Next, MRPIU noted that one of 50 prior authorization files reviewed contained an NOA letter that exceeded the maximum 28-day requirement for such letters to be sent to the member. Finally, two of 50 prior authorization notification files reviewed contained an NOA letter that was missing the reason for the health plan's decision.

Strengths

In the MRPIU audit, the plan displayed satisfactory performance in the categories of grievances, cultural and linguistic services, evidence of coverage, and member rights, with no findings in these categories.

Opportunities for Improvement

In the medical audit review, HPSJ showed opportunities for improvement in every category. The MRPIU audit indicated that HPSJ has the opportunity to improve timeliness of NOAs and should be including citations for the denial reason in NOAs. The plan noted actions taken to address the deficient areas in Appendix A including a monthly audit; however, a review of the plan's internal quality work plan did not show the deficient areas were being tracked.

Conducting the Review

The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provide a standardized method for objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about HPSJ's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[4] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of HPSJ in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. The audit found HPSJ in compliance with all the information system standards to produce valid rates; however, during the demonstration of HPSJ's transactional systems, it was discovered that edits were not in place to prohibit invalid codes (lacking fourth and fifth digit specificity) from being entered into the system. HPSJ researched this issue, and it was determined that there would be no impact for the HEDIS measures under the scope of the audit; however, the auditors recommended building in front-end edits to further ensure complete and accurate data for future reporting purposes.

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

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Table 3.2.

Table 3.1—HEDIS® 2011 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2011 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of HPSJ's HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. The table shows the plan's HEDIS 2011 performance compared to the MCMC-established MPLs and HPLs.

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national Medicaid 25th percentile and 90th percentile, respectively. For the CDC–H9 (>9.0 percent) measure, a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the national Medicaid 10th percentile.

Table 3.2—2010–2011 Performance Measure Results for Health Plan of San Joaquin—San Joaquin County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	24.6%	27.1%	★★	↔	19.7%	35.9%
AWC	Q,A,T	51.1%	48.9%	★★	↔	38.8%	63.2%
BCS	Q,A	58.0%	53.2%	★★	↓	46.2%	63.8%
CCS	Q,A	65.5%	68.6%	★★	↔	61.0%	78.9%
CDC–BP	Q	66.2%	75.2%	★★★	↑	53.5%	73.4%
CDC–E	Q,A	52.1%	52.3%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	46.7%	51.8%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	44.5%	41.4%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	77.6%	80.5%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	30.2%	31.4%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	77.6%	75.9%	★★	↔	69.3%	84.0%
CDC–N	Q,A	74.9%	76.2%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	74.0%	74.5%	★★	↔	63.5%	82.0%
LBP	Q	74.5%	82.4%	★★	↑	72.0%	84.1%
PPC–Pre	Q,A,T	81.0%	87.8%	★★	↑	80.3%	92.7%
PPC–Pst	Q,A,T	62.8%	65.2%	★★	↔	58.7%	74.4%
URI	Q	85.5%	89.8%	★★	↑	82.1%	94.9%
W34	Q,A,T	82.2%	81.3%	★★	↔	65.9%	82.5%
WCC–BMI	Q	62.3%	67.2%	★★★	↔	13.0%	63.0%
WCC–N	Q	60.6%	69.6%	★★★	↑	34.3%	67.9%
WCC–PA	Q	41.8%	58.2%	★★★	↑	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).

[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.

[5] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.

[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.

[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, HPSJ had above-average performance results across the spectrum of HEDIS measures. Six measures had statistically significant increases from 2010 to 2011, while only one measure had a statistically significant decrease. Four measures scored above the national Medicaid 90th percentile, while the remaining measures fell between the 25th and 90th percentiles.

HEDIS Improvement Plans

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

For plan measure rates that required a 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with the plan's 2011 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans. In 2012, HPSJ will not need to develop improvement plans since all measures exceeded the MPLs.

Strengths

No measures fell below the MPL; and HPSJ scored above the HPL on four measures: *Blood Pressure Control (140/90 mm Hg)* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total, Nutrition Counseling: Total,* and *Physical Activity Counseling: Total* in 2011.

Opportunities for Improvement

HPSJ should focus on *Breast Cancer Screening,* as it was the only measure that had a statistically significant decrease from 2010 to 2011. Also, the plan should focus on improving any measures that are an attainable proximity to the HPLs. For example, all of the diabetes measures lacked statistically significant improvements this past year and did not reach the respective HPLs for each measure. The plan might consider how to boost performance in these measures so that they reach the HPLs.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas.

HSAG reviews each QIP using the Centers for Medicare & Medicaid Services' (CMS') validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Quality Improvement Projects Conducted

HPSJ had two clinical QIPs and one QIP proposal in progress during the review period of July 1, 2010–June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP project. HPSJ's second project, an internal QIP, aimed to increase Chlamydia screening. The third project, an internal QIP proposal, sought to increase HbA1c testing in members 18 to 75 years of age. All three QIPs fell under the quality and access domains of care.

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

For the *Chlamydia Screening* QIP, low screening rates may indicate suboptimal care or limited access to PCPs. HPSJ's project attempted to improve the quality of care delivered to women in this area.

Blood glucose monitoring assists in the development of appropriate treatment plans to decrease the risk of diabetes complications. Lack of appropriate testing in diabetics may indicate suboptimal care and case management. The plan's project attempted to increase HbA1c testing to minimize the development of diabetes complications.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for the three QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Health Plan of San Joaquin—San Joaquin County July 1, 2010, through June 30, 2011

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	90%	100%	*Met*
Internal QIPs				
Chlamydia Screening	Annual Submission	100%	100%	*Met*
HbA1c Testing	Proposal	86%	90%	*Partially Met*
	Resubmission	88%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that the annual submission by HPSJ of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met* with 90 percent of all evaluation elements and 100 percent of critical elements receiving a *Met* score. Additionally, HPSJ received a *Met* validation status for its *Chlamydia Screening* QIP submission. One hundred percent of all elements and 100 percent of critical elements received a *Met* validation score. Neither QIP required a resubmission. HPSJ received an overall validation status of *Partially Met* for its *HbA1c Testing* QIP. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted the *HbA1c Testing* QIP; and, after subsequent validation, HPSJ achieved an overall *Met* validation status.

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

Table 4.2—Quality Improvement Project Average Rates* for San Joaquin—San Joaquin County (Number = 3 QIP Submissions, 3 QIP Topics) July 1, 2010, through June 30, 2011

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	33%	0%	67%
	VI: Accurate/Complete Data Collection	95%	5%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total†		**86%**	**3%**	**11%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved†	63%	0%	38%
	X: Sustained Improvement Achieved	50%	0%	50%
Outcomes Total		**87%**	**0%**	**13%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.
† The sum may not equal 100 percent due to rounding.

HPSJ submitted baseline data for its *HbA1c Testing* QIP; therefore, the QIP was assessed for Activities I through VIII. The other two QIPs were assessed through Activity X.

HPSJ accurately applied the QIP process for the design stage, scoring 100 percent for the four activities. For the implementation stage, the plan successfully documented the data collection process and its improvement strategies; however, for the *HbA1c Testing* QIP, the plan incorrectly documented that sampling was not used, when in fact, the plan followed the hybrid methodology and used a sample of 411. For the outcomes stage, the plan was scored down for not achieving statistically significant improvement for the *Reducing Avoidable Emergency Room Visits* QIP outcome. The plan was also scored down in Activity X for not achieving sustained improvement for the *Reducing Avoidable Emergency Room Visits* QIP outcome. Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

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

Table 4.3—Quality Improvement Project Outcomes for Health Plan of San Joaquin—San Joaquin County July 1, 2010, through June 30, 2011

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable	21.3%	16.7%*	21.5%*	No

QIP #2—Chlamydia Screening					
QIP Study Indicator	**Baseline Period 1/1/06–12/31/06**	**Remeasurement 1 1/1/07–12/31/07**	**Remeasurement 2 1/1/08–12/31/08**	**Remeasurement 3 1/1/09–12/31/09**	**Sustained Improvement¥**
Percentage of women 16–25 years of age who were identified as sexually active and who had at least one test for Chlamydia	39.2%	29.0%*	57.9%*	64.4%*	Yes

QIP #3—HbA1c Testing				
QIP Study Indicator	**Baseline Period 1/1/10–12/31/10**	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
Percentage of diabetic members with at least one HbA1c test	80.5%	‡	‡	‡

¥ Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05)

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

Although the collaborative interventions for the *Reducing Avoidable ER Visits* QIP were initiated in early 2009, they were not associated with a reduction in the avoidable ER visits. Instead, the plan reported a statistically significant increase in avoidable ER visits, which reflected a decline in performance from Remeasurement 1 to Remeasurement 2. The Remeasurement 2 rate was higher than the baseline rate, which indicated the plan's inability to sustain the improvement initially achieved from baseline to Remeasurement 1.

For the *Chlamydia Screening* QIP, the plan reported a statistically significant improvement in the percentage of women receiving a Chlamydia screening test from Remeasurement 2 to Remeasurement 3. Additionally, the Remeasurement 3 outcome demonstrated sustained improvement over baseline. The plan implemented several interventions including assisting with member outreach by provider offices and conducting on-site provider office visits. Additionally, the plan was able to access all lab data beginning with CY 2008, which was directly loaded into the HEDIS data warehouse. Based on the success of the QIP, the plan was able to close it out as a formal project to allow the plan to focus on other areas of low performance.

For the *HbA1c Testing* QIP, the plan had only progressed to the point of reporting baseline data; therefore, it was not assessed for real or sustained improvement. The plan implemented numerous member, provider, and system interventions, including provider incentives.

Strengths

HPSJ demonstrated a strong application of the QIP process for the design stage as well as the data collection and improvement strategies of the implementation stage. The plan documented statistically significant improvement for Chlamydia screening and achieved sustained improvement from baseline to the final remeasurement period. To increase Chlamydia screening, the plan implemented several interventions including a system intervention that may have a greater likelihood of achieving sustained improvement.

Opportunities for Improvement

The plan implemented the collaborative interventions in 2009 for the *Reducing Avoidable ER Visits* QIP; however, when multiple interventions are implemented, the plan should incorporate a method to evaluate the effectiveness of each intervention. The plan should also conduct subgroup analyses to determine why and for what groups the current interventions did not produce improvement in Remeasurement 2.

HPSJ should also include a plan to evaluate the efficacy of the interventions for its *HbA1c Testing* QIP, specifically, using subgroup analysis to determine if initiatives are affecting the entire study population in the same way. The plan should evaluate the outcomes by gender, age, provider, etc., to understand any disparities that may exist in the study population in relationship to the study outcomes. The plan should also ensure that the documented barriers the interventions are targeting are related specifically to HbA1c testing rather than to other diabetes measures.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for Medi-Cal managed care members through the provision of health care services and the plan's structural and operational characteristics.

The DHCS uses the results of performance measures and quality improvement project (QIP) to assess care delivered to members by a plan in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, the DHCS monitors aspects of a plan's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems.

The plan showed average performance in the quality domain. This assessment was based on HPSJ's 2011 performance measure rates (which reflect 2010 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

HPSJ was able to report valid rates for all 2011 performance measures, and no measures fell below the MPL. The plan had four measures above the HPL. The plan showed strong performance for each of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children* measures, with each one scoring above the HPL. One performance measure rate, *Breast Cancer Screenings,* had a statistically significant decline between 2010 and 2011, and six measures had a statistically significant increase in performance measure rates.

Compliance findings in the medical performance review indicate that the plan lacks a system to ensure accountability and monitoring of delegated quality improvement activities and that the plan should document how it performs oversight of delegated activities and issue corrective action plans with follow-up when required. There were also several recommendations in the area of grievances, including ensuring that the grievance file and database files contain complete documentation of the medical director's review and final determination, and verifying grievance resolution letters contain

adequate explanation and detail of grievance resolution. The plan's internal quality work plan did not provide sufficient documentation that these areas were being tracked as part of its quality program.

For the plan's *Reducing Avoidable ER Visits* QIP, HPSJ reported a statistically significant increase in avoidable ER visits, which reflected a decline in performance. However, the plan showed its ability to affect member quality of care through its *Chlamydia Screening* QIP. The plan reported a statistically significant improvement in the percentage of women receiving a Chlamydia screening test from Remeasurement 2 to Remeasurement 3. Additionally, the Remeasurement 3 outcome demonstrated sustained improvement over baseline. For the *HbA1c Testing* QIP, the plan had only progressed to the point of reporting baseline data.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

The plan demonstrated average performance in the access domain. This assessment was based on a review of 2011 performance measure rates that related to access, QIP outcomes, and results of the medical performance review.

In the HEDIS Performance Measures, all measures related to access scored at the MPL. *Prenatal and Postpartum Care—Timeliness of Prenatal Care* achieved a statistically significant improvement, while *Breast Cancer Screening* showed a statistically significant decrease.

The medical performance review had several recommendations based on unresolved deficiencies in the area of access. The recommendation included notifying members when a claim in deferred, denied, or adjusted, and reimbursing family planning claims without prior authorization; however, the plan has provided some feedback to these findings in Appendix A.

The plan's QIP performance related to member access to care was average. The *Reducing Avoidable ER Visits* QIP was unable to reduce the amount of unnecessary trips to the ER; however, the *Chlamydia Screening* QIP was able to significantly improve members' access to testing.

Timeliness

The timeliness domain of care relates to a plan's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

HPSJ demonstrated average performance in the timeliness domain of care. This assessment was based on 2011 performance measure rates for providing timely care and medical performance reviews.

HEDIS performance measure rates showed that the plan performed above the MPL for all timeliness-related measures. One measure, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, indicated a statistically significant increase. No measures showed a statistically significant decrease.

In the MRPIU review, one standard related to timeliness remained unresolved: several NOA letters exceeded the 28-day time frame. In the medical performance review, it was noted that the plan should amend policies to include reporting improper disclosures and notification of breach to the DHCS within 24 hours during a work week.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 plan-specific evaluation report. HPSJ's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, HPSJ had average performance in providing quality, accessible, and timely health care services to its MCMC members. HPSJ had steady improvement in its performance measures rates in 2011 compared with 2010 rates. The plan demonstrated a statistically significant decline in its avoidable ER visits rates but realized sustained improvement in its Chlamydia screening rates. The plan's greatest opportunity for improvement is related to improving compliance with State and federal requirements as part of the medical performance reviews. The plan must ensure that audit deficiencies are adequately addressed and monitored as part of the quality improvement program.

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

- Improve performance in every category of the medical audit review and show documented efforts to improve in the plan's quality work plan.
- Improve timeliness of NOAs and include citations for the denial reason in NOAs for the MRPIU audit.
- Explore factors that may have contributed to the statistically significant decline of the *Breast Cancer Screening* measure, as it was the only measure that had a statistically significant decrease from 2010 to 2011.
- Built in front-end claims edits for 4th and 5th digit specificity to further ensure complete and accurate data for future performance measure reporting.
- Incorporate a method to evaluate the effectiveness of each intervention for QIPs that have multiple interventions.
- Evaluate the efficacy of the interventions for its *HbA1c Testing* QIP, specifically, using subgroup analysis to determine if initiatives are affecting the entire study population in the same way.
- For HPSJ's *HbA1c Testing* QIP, ensure that the documented barriers the interventions are targeting are related specifically to HbA1c testing rather than other diabetes measures.

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

Appendix A. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

for Health Plan of San Joaquin

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with HPSJ's self-reported actions that address the recommendations. Neither Health Services Advisory Group, Inc. (the external quality review organization for Medi-Cal Managed Care) nor any State agency has confirmed implementation of the actions that the plan self-reported in the grid.

Table A.1—Grid of HPSJ's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	HPSJ's Self-Reported Actions That Address the EQR Recommendation
Review the DHCS close-out reports for the Medical Performance Report and MRPIU to identify all open CAP items and incorporate a mechanism to include the implementation and monitoring of these areas within the quality improvement program to ensure that deficiencies are fully resolved.	In review of CAP findings remaining on the EQRO report the following is reconfirmation of improvement processes implemented that remain in effect. The plan reviewed the grievance process and revised policies and procedures as necessary to ensure written notification to members for grievances not resolved within 30 days. These data are closely monitored by the Grievance Committee. Please note this was not a finding in the December 2010 MRPIU on-site review. The plan has revised policies and procedures to ensure Notice of Action letters contain all required information, consistent with contract requirements. NOAs are monitored for accurate information and turnaround-time. Notification to members of denied, adjusted, or deferred claims for emergency and family planning services was noted as a CAP item; however, this is non-applicable as HPSJ does not deny claims for these services.
Conduct periodic, internal, prior-authorization file audits to ensure compliance with required documentation.	On a monthly basis, the UM Supervisor randomly selects five Notice of Action letters completed by each UM Intake staff person. These letters are audited for accuracy and compliance with Turn Around Times (TAT). The following list of objectives are audited for compliance: 1. The decision to deny was made by the medical director. 2. The decision to deny, defer, or modify was made within the specific TAT for the type. 3. The appropriate reason for the decision is stated. 4. Reference to the benefit provision, guideline, protocol, or other criterion on which the decision is based is stated. 5. The letter was processed within the required two working days following the decision to deny, defer, or modify. 6. The signature, contact information, and availability of the physician reviewer to speak with the requesting physician is stated on the letter. 7. Language needs were identified and appropriate letter utilized. 8. The phone number for the physician to appeal is stamped on the physician letter.
Explore factors that may have contributed to the decline in the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure.	During HEDIS reporting and follow-up review for 2010 rates, the Quality Improvement Team discussed the factors that may have contributed to the reduction of Health Plan of San Joaquin diabetic eye exam rates. It was noted that during this time period, FFS Medi-Cal no longer provided this as a benefit, and there may have been both provider and member confusion as to the benefit between FFS Medi-Cal and MCMC.

Table A.1—Grid of HPSJ's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	HPSJ's Self-Reported Actions That Address the EQR Recommendation
Re-educate providers on the cultural and linguistic service requirements, including the grievance process and language interpreter services.	HPSJ hosted provider training relating to cultural disparities and sensitivity issues. Providers are educated about access to interpreter services for members during provider in-service trainings. HPSJ also produces a provider newsletter specific to cultural & linguistic issues. Marketing policies have been updated.
Review the detailed recommendations for improving member satisfaction, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 Health Plan of San Joaquin*.	Health Plan of San Joaquin demonstrated average performance in the access domain based upon 2010 performance measures that relate to access, QIP outcomes, results of medical performance, and member rights reviews relayed to availability and accessibility of care. HEDIS 2011 performance measures for access/availability to care and effectiveness of care showed improvement and six measure with statically improvement scores. HPSJ continues to complete an annual access survey for timeliness to care and reports out to the QI/UM committee and to providers as well for results of the survey as they compare to their peers. HPSJ QI department per follow-up with member outreach for member dissatisfaction demonstrated an increase in resolutions with an increase in member contact either directly or via letter outreach. The Grievance Committee also meets monthly to review grievance data which are also reported to QI/UM for recommendations and action as needed. The 2010 HPSJ CAHPS survey was presented to the QI/UM Committee on 3/10/11. Provider directory includes expanded physician information that includes language spoken and beginnings of disabilities access designation. To address "How Well Doctors Communicate." part of the QI Department's FSR is to ensure educational materials are present/available to improve members' understanding of their condition. Providers are educated about the health plan's health educator as a resource for educational materials, and HPSJ hosted provider trainings related to cultural and sensitivity issues. HPSJ's Provider Services Department monitors physician/patient ratios by verifying on an ongoing basis PCPs' extenders (NPs and PAs) and updates the PCPs' capacity as needed.
Include subgroup analyses in the plan's QIP evaluation plan to determine the effects of the intervention across the population.	During the 2010 QIP process, additional analysis was used to address the data and the intervention benefits. Data were reviewed via age and locations and days of the week for issues. As HPSJ developed new QIPs and completed the next year's data, all data were reviewed for additional benefit and impact. QIP process and focus has been updated to reflect the subgroup analysis and to assess interventions and action in the populations addressed. This focus has become a part of all QIP processes going forward.