Performance Evaluation Report

Health Plan of San Mateo

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*, at http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Health Plan of San Mateo ("HPSM" or "the plan"), which delivers care in San Mateo County, for the review period 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

HPSM is a full-scope managed care plan in San Mateo County. HPSM serves members as a County Organized Health System (COHS) model type.

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

HPSM became operational with the MCMC Program in San Mateo County in December 1987. As of June 30, 2011, HPSM had 60,455 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 HPSM's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division 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.

HSAG reviewed the most current medical performance 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 2008, covering the review period of August 1, 2006, through July 31, 2007. HSAG reported findings from this audit in the 2008–2009 plan evaluation report.[3]

The review showed that HPSM had audit findings in the areas of utilization management, continuity of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity. The DHCS *Medical Audit Close-Out Report* letter dated July 29, 2008, noted that the plan had fully corrected several audit deficiencies; however, some issues remained unresolved at the time of the audit close-out report.

Deficiencies needing continued attention were:

- Including delegated utilization management activities in the plan's quality reporting process.
- Developing a process for approving the use of alternative forms for initial health assessments and initial health education behavioral assessments when providers choose to use their own medical forms to gather information.
- Implementing a process to ensure timely provider training (i.e., to provide evidence that new providers receive training within 10 working days of being placed on active status)

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, 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.

[3] *Performance Evaluation Report – Health Plan of San Mateo, July 1, 2008 – June 30, 2009*. California Department of Health Care Services. October 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

MRPIU conducted an on-site review of HPSM in November 2011, after the formal review period of this report. The results from this review will be included in the next annual evaluation report. Details from the November 2008 review were included in the prior plan evaluation report. The MRPIU noted deficiencies in the areas of grievance acknowledgement letters, prior authorization denial or modification notification letters, procedures for notification of suspected fraud and abuse, and cultural and linguistic requirements.

Strengths

Based on the review findings, HPSM was able to resolve most deficiencies prior to the close out of the most recent medical performance review, demonstrating the plan's strong commitment to providing quality care to its members.

Opportunities for Improvement

HPSM has additional opportunities for improvement related to unresolved deficiencies in its process for monitoring and implementing quality reporting processes; its process for evidencing that the delegated entity for conducting pharmacy benefit audits is included in HPSM's utilization management quality reporting process; implementation of a policy requiring prior approval by the DHCS of any assessment form differing from the DHCS-approved initial health education behavioral assessment form; and implementation of an administrative training policy evidencing that new providers receive training within 10 working days of being placed on active status with the plan.

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

Performance Measure Validation

The DHCS's 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[4] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of HPSM in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. While audit findings did not bias the reporting of a valid rate, the audit team noted two opportunities for improvement. First, HPSM contracted with Kaiser to provide primary care physician (PCP) and prenatal care services to a small number of plan members. Kaiser provided a monthly invoice for services rendered and was not required to submit standard encounter data. The auditors strongly recommended that the plan modify its contract with Kaiser to include standard encounter data. Secondly, for two multispecialty medical groups, claims were submitted using one national provider identifier (NPI) for the group; therefore, the plan was unable to identify the rendering provider. The audit team recommended that the plan take appropriate steps to capture the rendering provider.

[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 HPSM'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 Mateo—San Mateo 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	33.5%	26.5%	★★	↔	19.7%	35.9%
AWC	Q,A,T	43.8%	40.4%	★★	↔	38.8%	63.2%
BCS	Q,A	57.0%	61.0%	★★	↑	46.2%	63.8%
CCS	Q,A	62.6%	61.2%	★★	↔	61.0%	78.9%
CDC–BP	Q	62.3%	63.3%	★★	↔	53.5%	73.4%
CDC–E	Q,A	60.3%	59.9%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	56.9%	57.4%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	35.8%	34.1%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	86.6%	86.6%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	45.0%	47.0%	★★★	↔	27.2%	45.5%
CDC–LS	Q,A	80.5%	84.2%	★★★	↔	69.3%	84.0%
CDC–N	Q,A	85.4%	86.6%	★★★	↔	72.5%	86.2%
CIS–3	Q,A,T	87.3%	83.7%	★★★	↔	63.5%	82.0%
LBP	Q	86.5%	84.6%	★★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	85.3%	83.2%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	63.5%	61.8%	★★	↔	58.7%	74.4%
URI	Q	89.7%	94.1%	★★	↑	82.1%	94.9%
W34	Q,A,T	70.7%	75.4%	★★	↔	65.9%	82.5%
WCC–BMI	Q	59.6%	47.9%	★★	↓	13.0%	63.0%
WCC–N	Q	67.9%	75.4%	★★★	↑	34.3%	67.9%
WCC–PA	Q	56.7%	59.1%	★★★	↔	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, HPSM had above-average performance with noted steady improvement over 2010's results. The plan achieved the HPLs for seven measures, had three measures with statistically significant improvement, and had only one measure with a statistically significant decline. For the second consecutive year, HPSM had zero measures fall below the MPLs.

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.

HPSM did not have any measures fall below the MPLs in 2010; therefore, no improvement plans were conducted during the measurement period.

Strengths

For 2011, HPSM achieved the HPL for seven measures with notable strengths demonstrated in the measures related to diabetes care and weight assessment and counseling.

Opportunities for Improvement

There are no glaring weaknesses in HPSM's HEDIS performance; however, the plan should focus on *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*, which was the only measure that had a statistically significant decrease in 2011. Among the eight diabetes measures, three measures exceeded the HPLs while five measures did not achieve the HPLs. HPSM may consider strategies to address lower scoring diabetes measures to identify possible inconsistencies in diabetes care. HPSM should continue efforts to improve measures that were not above 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 HPSM's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Projects Conducted

HPSM had two clinical QIPs 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. HPSM's second project, an internal QIP, aimed to increase the timeliness of prenatal care. The two QIPs fell under the quality and access domains of care, and the prenatal care QIP also fell under the timeliness domain of care.

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

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

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for Health Plan of San Mateo—San Mateo County July 1, 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	87%	100%	*Met*
Internal QIP				
Increasing Timeliness of Prenatal Care	Annual Submission	73%	92%	*Not Met*
	Resubmission	98%	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 HPSM of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met* with 87 percent of all applicable evaluation elements and 100 percent of critical elements receiving a *Met* score. HPSM received an overall validation status of *Not Met* for its *Increasing Timeliness of Prenatal Care* 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, HPSM included the final audit report and corrected the sampling methodology in the *Increasing Timeliness of Prenatal Care* QIP resubmission. After subsequent validation, HPSM achieved an overall *Met* validation status.

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

Table 4.2—Quality Improvement Project Average Rates*
for Health Plan of San Mateo—San Mateo County
(Number = 2 QIP Submissions, 2 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	92%	0%	8%
	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		**97%**	**0%**	**3%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	83%	17%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**96%**	**4%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**78%**	**0%**	**22%**

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

HPSM accurately documented the activities for the design and implementation stages, scoring 100 percent for five of the seven activities. The *Increasing Timeliness of Prenatal Care* QIP did not progress to the outcomes stage. The *Reducing Avoidable ER Visits* QIP did not demonstrate improvement; therefore, HPSM received a score of 25 percent for Activity IX. Additionally, the *Reducing Avoidable ER Visits* QIP progressed through Activity X and was assessed for, but did not achieve, sustained improvement. Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

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

Table 4.3—Quality Improvement Project Outcomes for Health Plan of San Mateo—San Mateo County (Number = 2 QIP Submissions, 2 QIP Topics) 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	15.0%	16.2%*	17.2%*	No
QIP #2—Increasing Timeliness of Prenatal Care				
QIP Study Indicator	**Baseline Period (11/6/08–11/5/09)**	**Remeasurement 1 11/6/09-11/5/10**	**Remeasurement 2 11/6/10-11/6/11**	**Sustained Improvement¥**
Percent of members that had a prenatal care visit in the first trimester or within 42 days of enrollment	85.3%	‡	‡	‡

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

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

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

For the *Reducing Avoidable ER Visits* QIP, the increase in the avoidable ER visits indicator rate was statistically significant and denoted a decline in performance. The *Increasing Timeliness of Prenatal Care* QIP had not progressed to the point of reporting a remeasurement period; therefore, improvement could not be assessed.

For the *Reducing Avoidable Emergency Room Visits* QIP, the plan implemented the statewide collaborative work group interventions following Remeasurement 1. Additionally, the plan offered pay-for-performance incentives to providers that offered extended office hours. These interventions were initiated in 2009; however, improvement was not achieved in calendar year 2009.

Strengths

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

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

Opportunities for Improvement

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

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.

HPSM showed average performance in the quality domain based on HPSM'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.

The plan attained the HPL on seven measures impacting quality, with three measures showing statistically significant improvement. While the plan showed a statistically significant decline in the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* measure, it should be noted that HPSM had zero measures fall below the MPL for the second consecutive year. The HEDIS audit found that the plan did not capture the rendering provider for multispecialty clinic providers. Additionally, one provider group only submitted an invoice for services instead of submitting actual encounter data. Both of these audit findings present opportunities for improvement.

Both of the plan's QIPs had an effect on the plan's overall quality domain score. The *Reducing Avoidable ER Visits* QIP received a *Met* validation status but had below-average performance for QIP outcomes. This QIP also did not achieve sustained improvement. The *Increasing Timeliness of Prenatal Care* QIP needed a resubmission in order to obtain a *Met* status.

Since there were no new results available from the medical performance review, HSAG did not use this activity as a part of the evaluation.

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.

HPSM 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 and member rights reviews related to the availability and accessibility of care.

HPSM attained the HPL in three performance measures addressing access to care. Additionally, the plan showed statistically significant improvement in the *Breast Cancer Screening* measure.

In the MRPIU review, staff in two of five provider offices visited did not discourage the use of family, friends, or minors as interpreters.

HPSM's QIP results showed accurate documentation of the QIP study design and implementation phases. HPSM followed last year's suggested opportunity for improving the *Reducing Avoidable Emergency Room Visits* QIP by conducting further analysis of factors that may be preventing improved outcome achievement. As a result, the plan implemented a nurse advice line, a number of member education initiatives, and a pay-for-performance initiative for providers offering extended hours.

Timeliness

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

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

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

Performance measure rates related to timeliness showed that the plan performed above the MPLs for all measures. Notably, HPSM attained the HPLs in the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Childhood Immunization Status—Combination 3* measures for providing timely care.

The MRPIU review showed HPSM had difficulties with timely notification, finding that three of 50 prior authorization files contained Notice of Action (NOA) letters exceeding the "three working days after the decision was made" requirement. Additionally, the review showed the "Your Rights" attachment was missing the required clear and concise explanation outlining the circumstances under which medical services will continue pending a fair hearing decision.

HPSM did not meet the overall validation status for the first measurement of its *Increasing Timeliness of Prenatal Care* QIP, which impacts timeliness. However, the plan reviewed validation feedback provided in the final audit report, corrected their sampling methodology, and attained an overall validation status of *Met* for its *Timeliness of Prenatal Care* QIP resubmission.

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

Conclusions and Recommendations

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

Overall, HPSM had average performance in providing quality, accessible, and timely health care services to its MCMC members.

HPSM has consistently demonstrated strong performance in performance measure results, with average to above-average rates and no rates below the MPL for the second consecutive year. The plan was compliant with documentation requirements across performance measures and QIPs; and, after correcting it sampling methodology, the plan demonstrated improvement for one of its QIPs.

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

- Implement a process for monitoring of quality reporting processes.
- Develop a process for demonstrating HPSM's delegated entity for pharmacy benefit audits is included in the plan's utilization management quality reporting process.
- Implement a policy requiring prior DHCS approval of any assessment form differing from the DHCS-approved initial health education behavioral assessment form.
- Develop an administrative training policy evidencing that new providers receive training within 10 working days of being placed on active status with the plan.
- Implement a mechanism to ensure ongoing provider education in the area of cultural and linguistic services and member grievance.
- Ensure prior authorization communications contain contractually required information.
- Modify the provider contract with Kaiser to include a requirement for the provider to submit standard encounter data.
- Implement a process to capture the rendering provider for multi-clinic specialty providers currently listed under one NPI to improve data for HEDIS reporting.
- Continue to monitor performance measure results and targets for future improvement efforts, focusing on *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total.*
- Review the *Increasing Timeliness of Prenatal Care* QIP, to identify and explore access-related barriers for members seeking prenatal care and implement targeted interventions that may increase the concept of a prenatal "home."

- Continue to conduct subgroup analysis for the *Reducing Avoidable Emergency Room Visits* QIP, evaluating the efficacy of the interventions that have been implemented and developing new interventions to address any barriers identified with the lack of improvement in performance.

In the next annual review, HSAG will evaluate HPSM'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 Mateo

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with HPSM'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 HPSM's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	HPSM's Self-Reported Actions That Address the EQR Recommendation
Ensure all review deficiencies are fully resolved.	Deficiencies noted in Medical Audit, including those related to Utilization Management (delegated services), Coordination of Care (IHA/IHEBA), and Provider Training were addressed and corrected. The issues addressed by MR/PIU were also addressed by HPSM in 2009.
Monitor performance measure results and prioritize what measures will be targeted for future improvement efforts.	Several performance measures were targeted for improvement during the measurement period. 1) Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS) To further the modest gains made in the rates of BCS and CCS, during 2010, HPSM engaged our Nurse Advice Line (NAL) vendor to contact eligible women who were overdue for PAP test or mammogram. NAL callers encourage members to schedule screening, assist them with making appointments, and send them information about mammograms and PAP tests. 2) Well Child Visits. HPSM experienced a small decline in the rate of well child visits for 3–6 year olds. In 2010, we implemented a member incentive of $15 Target gift card. Member parents/guardians were mailed a birthday card with information on how to receive the incentive once a well-child visit had been completed. 3) Access to Prenatal Care-PPC pre. HPSM collaborated with the San Mateo County Health Department to promote "Go Before You Show" efforts: a 1-800 number is available to all women who think they might be pregnant. Outreach included bus ads, flyers, and brochures.
Conduct annual causal-barrier and subgroup analyses to determine why and for what groups current QIP interventions did not produce improvement between measurement periods for the *Reducing Avoidable Emergency Room Visits* QIP.	During the measurement period, HPSM identified that Pediatric members continued to have the highest rates of avoidable ED visits: reasons for this were felt to be several-fold. During 2008, 2009, the number of Medi-Cal eligible participants increased, yet the provider network that serves Medi-Cal recipients did not increase concomitantly. Through our Nurse Advice Line, we also became aware that members often sought Emergency Room care for fever, yet often did not have a thermometer at home. HPSM mailed "Fever Kits" to all pediatric member households – these kits contained a thermometer with instructions, the brochure "Not Sure It's an Emergency," and a contact number for the Nurse Advice Line for questions.

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

2009–2010 EQR Recommendation	HPSM's Self-Reported Actions That Address the EQR Recommendation
Review the 2010 plan-specific CAHPS results report and develop strategies to address the following priority areas: *Customer Service, Getting Care Quickly,* and *Getting Needed Care.*	Strategies to improving Customer Service, Getting Care Quickly, and Getting Needed Care included enhancing Nurse Advice Line services. Specifically, HPSM facilitated the linkage of Nurse Advice Line, directly with county clinics to make appointments and ensured triage reports were directed to appropriate clinic staff for follow up. HPSM also appreciated that CAHPS responses may also reflect service from a variety of different providers: pharmacy, DME, transportation and will continue to address those areas as well. The grievance and appeals committee meets biweekly to address concerns of staff/member relations, delay in accessing care, and difficulties in accessing care.