Performance Evaluation Report

San Francisco Health Plan

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, San Francisco Health Plan ("SFHP" or "the plan"), which delivers care in San Francisco 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

SFHP is a full-scope managed care plan in San Francisco County that 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 both counties may enroll in either the LI plan operated by SFHP or in the alternative commercial plan. SFHP became operational with the MCMC Program in January 1997, and as of June 30, 2011, SFHP had 43,361 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 SFHP'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 from March 23, 2009, through April 1, 2009, covering the review period of February 1, 2008, through January 31, 2009. HSAG reported findings from this audit in the 2009–2010 plan evaluation report.[3]

The review showed that SFHP 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 March 24, 2010 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 in the following areas: utilization management, access and availability, member rights, quality management, and administrative and organizational capacity. Based on these unresolved areas of deficiency, the plan needs to address the following recommendations:

- Utilization Management
  - Track prior authorization referrals to completion.
  - Ensure that the first-level appeals are adjudicated by a physician different from the one who was responsible for the initial denial decision.
- Access and Availability
  - Ensure that notice of action letters are sent to members in all cases of modification or denial of payment for emergency room claims and for family planning claims.
  - Implement policies and procedures for monitoring and oversight of after-hours pharmacy needs and member accessibility.
- Member Rights
  - Ensure that the plan's medical director reviews all grievances related to medical quality of care issues, and that the grievance files document such review.
  - Ensure adequate oversight of the grievance system including monitoring classification of clinical and nonclinical grievances, and ensure medical director participation in the clinical grievance process prior to the resolution letter.
  - Update the acknowledgment, resolution letter, member handbook, and grievance acknowledgment and resolution letters to include the DMHC statutory statement and contact information.
- Quality Management
  - Perform and document oversight of the pharmacy benefit management (PBM)'s credentialing process.

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

- Administrative and Organizational Capacity
  - Ensure that the medical director reviews all medical quality of care grievances, and that the grievance case files document such review.
  - Ensure new provider training is conducted within 10 days after the provider's active status date for all new providers.
  - Monitor delegated medical groups' compliance with new provider training requirements during the annual audit review.
  - Implement procedures to monitor and identify potential or suspected fraud and abuse committed by members and providers.
  - Reinstate Compliance Oversight Committee meetings as required in SFHP policies and procedures.

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.

MRPIU conducted an on-site review of SFHP in March 2010 covering the review period of January 1, 2009, through December 31, 2009. The plan was fully compliant with requirements related to marketing, program integrity, and detecting and reporting potential cases of fraud and abuse.

The MRPIU noted two findings related to cultural and linguistic services. MRPIU visited 10 provider offices and noted that the staff in two offices indicated that they did not discourage the use of family, friends, or minors as interpreters. Secondly, MRPIU noted that staff members in two of the 10 provider offices indicated that they did not document the request for, or refusal of, language interpreter services, another contract requirement.

Strengths

In the medical record audit, SFHP was able to correct several deficiencies with its corrective action plan. In the MRPIU monitoring review, the plan was fully compliant with requirements related to marketing, program integrity, and detecting and reporting potential cases of fraud and abuse.

Opportunities for Improvement

SFHP demonstrated multiple opportunities for improvement. The plan should ensure all open review issues are fully resolved. Even after submitting a corrective action plan (CAP) for the medical performance review; SFHP has open deficiencies in nearly every category of the medical record audit. This provides the plan an opportunity to improve policies, procedures, and processes in numerous areas.

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 SFHP'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 SFHP in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. While the audit team did not identify any concerns impacting the plan's ability to report valid rates, there were a few recommendations provided to the plan including:

- Require delegated groups to submit monthly internal monitoring reports for claims processing as a means for enhanced oversight.
- Consider a system upgrade to capture increased diagnosis code specificity for 4th and 5th digit coding.
- Implement a higher percentage of claims processing audits that are more comprehensive and include increased auditing of new delegated groups and a higher percentage of audits by claims processor.

[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 SFHP 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 Medicaid's 75th percentile and the HPL is based on the national Medicaid 10th percentile.

Table 3.2—2010–2011 Performance Measure Results for San Francisco Health Plan—San Francisco 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	46.6%	44.5%	★★★	↔	19.7%	35.9%
AWC	Q,A,T	60.6%	64.4%	★★★	↔	38.8%	63.2%
BCS	Q,A	60.3%	62.0%	★★	↔	46.2%	63.8%
CCS	Q,A	79.7%	79.4%	★★★	↔	61.0%	78.9%
CDC–BP	Q	74.1%	73.7%	★★★	↔	53.5%	73.4%
CDC–E	Q,A	67.8%	70.1%	★★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	58.0%	64.1%	★★★	↑	38.7%	58.8%
CDC–H9 (>9.0%)	Q	21.8%	26.3%	★★★	↔	53.4%	27.7%
CDC–HT	Q,A	89.7%	90.4%	★★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	46.0%	47.9%	★★★	↔	27.2%	45.5%
CDC–LS	Q,A	82.8%	83.2%	★★	↔	69.3%	84.0%
CDC–N	Q,A	85.9%	85.1%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	87.0%	87.3%	★★★	↔	63.5%	82.0%
LBP	Q	85.1%	82.2%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	88.8%	90.3%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	66.4%	63.6%	★★	↔	58.7%	74.4%
URI	Q	97.2%	96.8%	★★★	↔	82.1%	94.9%
W34	Q,A,T	86.6%	85.2%	★★★	↔	65.9%	82.5%
WCC–BMI	Q	72.7%	60.6%	★★	↓	13.0%	63.0%
WCC–N	Q	74.5%	78.5%	★★★	↔	34.3%	67.9%
WCC–PA	Q	55.8%	70.4%	★★★	↑	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, SFHP demonstrated exceptional performance, achieving HPLs for 14 performance measures, which is up from 11 measures in 2010. Two measures had a statistically significant improvement, and no measures fell below MPLs. The plan had one measure (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total)* that experienced a statistically significant decline in 2011.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at, or above, established MPLs. The DHCS assesses each plan's rates against MPLs and requires plans with 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.

SFHP was not required to conduct any HEDIS improvement plans based on its 2010 performance.

Strengths

SFHP demonstrated strengths in all areas of 2011 HEDIS performance, particularly for comprehensive diabetes care measures. The plan achieved HPLs in 67 percent of HEDIS measures. In addition, despite high performance in 2010, the plan was able to achieve continued statistically significant improvement in two measures.

Opportunities for Improvement

SFHP should evaluate factors contributing to a statistically significant decline in performance for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*. The plan may also consider strategies to improve six measures with scores between MPL and HPL that had no statistically significant change during the past year.

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 SFHP's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Projects Conducted

SFHP 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. SFHP's second project, an internal QIP, aimed to improve the patient experience. Both 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.

SFHP selected two Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[5] measures as strategies to improve the patient experience. The measures related to (1) the communication between physician and patient, and (2) the patient's overall rating of care.

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

Improving doctor-patient communication is associated with improved adherence to physician recommendations and improved self-management skills.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for San Francisco Health Plan—San Francisco 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	76%	100%	*Partially Met*
Internal QIPs				
Improving the Patient Experience	Proposal Resubmission 1	73%	63%	*Partially Met*
	Proposal Resubmission 2	61%	54%	*Partially Met*
	Proposal Resubmission 3	84%	77%	*Partially Met*
	Annual Submission	89%	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 SFHP's annual submission of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Partially Met*. Since 100 percent of the critical elements were scored *Met,* the plan was not required to resubmit.

SFHP also received a *Partially Met* validation status for its QIP proposal, *Improving the Patient Experience* resubmission. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. The *Improving the Patient Experience* QIP proposal was resubmitted two more times, receiving an overall validation score of *Partially Met* each time. The QIP had one study indicator that was not completely defined; therefore, it did not appear to link to an overall rating item on the proposed member survey. Additionally, SFHP had some challenges with the survey data collection process, including: accounting for the possibility that

patients may see a provider at a clinic more than once during the measurement period; documenting what would be measured between measurement periods, given initial pilot sites with roll-out to additional sites in subsequent years of the QIP; and clarifying the measurement period spans for reporting rates. Some of these challenges resulted from the plan's participation in an innovative pilot project that did not easily fit into a format that would meet HSAG's QIP validation requirements without technical assistance. HSAG provided technical assistance, and the plan submitted the revised QIP as an annual submission. This final submission received a *Met* status.

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

Table 4.2––Quality Improvement Project Average Rates* for San Francisco Health Plan—San Francisco 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	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)	100%	0%	0%
	VI: Accurate/Complete Data Collection	91%	9%	0%
	VII: Appropriate Improvement Strategies	80%	20%	0%
Implementation Total		**91%**	**9%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation†	46%	38%	15%
	IX: Real Improvement Achieved†	25%	0%	75%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**39%**	**28%**	**33%**

*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.

For the *Improving the Patient Experience* QIP, the plan did not progress to a remeasurement period; therefore, the plan was assessed only through Activity VIII.

SFHP demonstrated an accurate application of the design stage, scoring 100 percent on all evaluation elements for all four of the activities. For the implementation stage, the plan was scored down in Activity VI for providing measurement periods that were inconsistent with the measurement periods provided in Activity III for the *Improving the Patient Experience* QIP. In

Activity VII of the *Reducing Avoidable ER Visits* QIP, the plan did not link the results of the barrier analysis to the selection of the interventions.

In the outcomes stage for both QIPs, the plan did not accurately or completely interpret the outcomes in Activity VIII. Additionally, in the *Improving the Patient Experience* QIP, the plan provided an incomplete data analysis plan and did not discuss whether there were factors that threatened the internal or external validity of the findings. For the *Improving the Patient Experience* QIP, the plan did not progress to a remeasurement period; therefore, the plan was assessed only through Activity VIII.

For the *Reducing Avoidable Emergency Room Visits* QIP, the plan was scored lower for not achieving statistically significant improvement in Activity IX and sustained improvement in Activity X. Sustained improvement was not achieved since none of the remeasurement results were improved over baseline. 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 San Francisco Health Plan—San Francisco Health Plan 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	17.4%	17.4%	20.3%*	No
QIP #2—Improving the Patient Experience				
QIP Study Indicator	**Baseline Period (4/5/10–4/23/10)**	**Remeasurement 1 (4/5/11–4/22/11)**	**Remeasurement 2 (4/8/12–4/22/12)**	**Sustained Improvement¥**
1) Percentage of patients surveyed within the measurement period in five (5) pilot clinics who selected the top response ("Yes, definitely") choice on the communication items that comprise the communication composite on the Clinician-Group CAHPS Visit Survey	93.6%	‡	‡	‡
2) Percentage of patients surveyed within the measurement period in five (5) pilot clinics who selected a "9" or "10" on the survey item, "Overall Ratings of Care" on the Clinician-Group CAHPS Visit Survey	89.7%	‡	‡	‡

*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.
¥ 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.

Although the collaborative interventions for the *Reducing Avoidable ER Visits* QIP were initiated in 2009, the plan reported a statistically significant increase in avoidable ER visits, which reflected a

decline in performance from Remeasurement 1 to Remeasurement 2. Additionally, the Remeasurement 2 rate was higher than the baseline rate. The plan did not achieve sustained improvement since it had not achieved any improvement over the baseline rate.

For the *Improving the Patient Experience* QIP, the plan had only progressed to the point of reporting baseline data; therefore, HSAG could not assess for real or sustained improvement.

Strengths

SFHP demonstrated an effective application of the QIP process for QIP topic selection, the development of study questions, and the definition of the study population. The plan is pursuing a QIP focused on improving member satisfaction, which is the plan's greatest area in need of improvement.

Opportunities for Improvement

SFHP has an opportunity to improve its QIP documentation to increase compliance with the validation requirements. HSAG recommends that the plan use HSAG's QIP Completion Instructions, which will help the plan document all required elements. SFHP should incorporate the recommendations provided in the QIP Validation Tool when it resubmits QIPs to avoid the need for a second resubmission. When encountering difficulties with the required documentation, the plan should request technical assistance before resubmitting its QIPs.

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 any of the remeasurement periods.

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.

Overall, the plan had average performance based on SFHP's 2011 HEDIS rates (which reflect 2010 measurement data), QIP outcomes, medical performance, and member rights reviews.

SFHP had above-average performance on its HEDIS 2011 measures. The plan achieved statistically significant improvement on two measures and met, or exceeded, HPL on 14 measures. The plan had one measure, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total,* with a statistically significant decline. SFHP was considered the top-performing MCMC plan, with respect to performance measures, at the time of this performance evaluation.

The plan had several remaining open deficiencies related to quality based on the DHCS' *Medical Audit Close-Out Report* letter of March 24, 2010. The deficiencies included, but were not limited to: tracking of prior authorization referrals, oversight of PBM's credentialing process, and procedures to monitor/identify potential, or suspected, fraud and abuse committed by members and providers.

SFHP QIP describes declining performance in *Reducing Avoidable Emergency Room Visits* QIP and did not achieve the goal of sustained improvement. The plan's *Improving the Patient Experience* QIP focused on quality indicators reflecting member experiences with communication and overall rating of care. The baseline measurements for both indicators provide evidence that members perceive a high-quality patient experience from the plan.

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 and 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, 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/postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access and availability of these services according to generally accepted clinical guidelines.

The plan demonstrated average performance based on review of 2011 performance measure rates related to access, QIP outcomes, medical performance, and member rights reviews.

SFHP's HEDIS performance was above-average: six of 11 performance measures, involving member access, achieved HPL.

For access-related compliance standards, the medical performance review noted that most access-related deficiencies were rectified with one exception. The plan needs to ensure notice of action letters are sent to members in all cases of modification, or denial, of payment for emergency room claims and family planning claims. The plan needs implementation of policies and procedures for monitoring and oversight of after-hours pharmacy needs and member accessibility.

Finally, the plan reported a decline in first remeasurement of *Reducing Avoidable Emergency Room Visits* QIP. The plan's *Improving the Patient Experience* QIP took four submissions to achieve a *Met* status on HSAG's QIP validation tool. The consequence of submiting QIP multiple times has lowered the plan's quality domain score from above average to average.

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/protections, grievance system, continuity/coordination of care, and utilization

management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal/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.

SFHP exhibited above average performance in the timeliness domain of care based on 2011 performance measure rates for providing timely care, medical performance, member rights reviews, and member satisfaction results.

Just as it did in 2010, the plan's performance measures indicate the plan met, or exceeded, the HPLs for three of five measures falling under the timeliness domain.

The plan did not have any remaining deficiencies related to timeliness in the medical performance review or MRPIU reports.

Neither of the plan's QIPs fell under the timeliness domain of care.

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

Conclusions and Recommendations

Overall, SFHP achieved average performance during this review period in the quality and access domains and above-average performance in the timeliness domain. Overall, the plan provided high-quality, accessible, timely health care services to MCMC members.

Just as in 2010, SFHP was a top-performing plan with respect to performance measures. However, SFHP's medical review describes numerous findings across all contract compliance areas, with several open deficiencies. As of June 30, 2011, there was no new evidence indicating the plan had corrected these open issues. The plan proposed a QIP targeting member satisfaction, demonstrating a concerted effort to improve performance in that area.

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

- Ensure all open medical performance review deficiencies are fully resolved and maintain clear evidence of corrective actions.
- Require delegated groups to submit monthly internal monitoring reports for claims processing as a means for enhanced oversight.

- Consider a system upgrade to capture increased diagnosis code specificity for 4th and 5th digit coding.
- Implement a higher percentage of claims processing audits that are more comprehensive and include increased auditing of new delegated groups and a higher percentage of audits by claims processor.
- Improve QIP documentation to increase compliance with validation requirements.
  - Use HSAG's QIP Completion Instructions, which will help the plan document all required elements.
  - Incorporate HSAG's recommendations provided in the QIP Validation Tool, when resubmitting QIPs, to avoid the need for a second resubmission.
  - Request technical assistance before resubmitting QIPs, when encountering difficulties with required documentation.
- Evaluate factors that led to a statistically significant decline in its performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* measure.

In the next annual review, HSAG will evaluate SFHP'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 San Francisco Health Plan

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

2009–2010 EQR Recommendation	SFHP's Self-Reported Actions That Address the EQR Recommendation
Ensure that all open medical performance review deficiencies are fully resolved and maintain clear evidence of the implementation of corrective actions.	Please see Attachment 1 – SFHP Response – Plan Actions Which Address EQRO Recommendation
Carefully monitor member grievances related to access issues and implement targeted actions to resolve any potential access to care issues.	Grievances related to access are no longer our #1 category. In 2010 our Quality Director and Quality Coordinator conducted a training regarding access at Castro-Mission, which had the most grievances during that time. In March 2010, SFHP launched a year-long collaborative aimed at improving access to care. The access collaborative, "Optimizing the Primary Care Experience (OPCE)," focuses on improving access to appointments and office efficiency during appointments. Four clinics are participating and the collaborative was led by expert Dr. Mark Murray. The goals of the OPCE project were to: 1) Reduce waiting times both for and at appointment services, and 2) Optimize health outcomes by improving clinical care delivery. In 2011, through the Strength in Numbers program, SFHP began paying incentives to providers in the community health network (our largest group) for improving their rates for Third Next Available Appointment (TNNA, and No-Show. As a result of these interventions grievances related to access decreased to 8% in 2010 from 23% in 2009.
Ensure that monitoring of after-hours access to prescription drug services is sufficient, and proactively address any potential access-related issues, given the reduction in after-hours pharmaceutical providers.	SFHP continued to review the "Access to After-Hours Pharmacy" report every six months in 2010 and 2011. The baseline report indicated that the percentage of member with prescriptions in 48 hours after ED visit for avoidable ED visits was 56% and for not avoidable ED visits was 41%. The bi-annual reports show a slight increase in percentage of patients with prescription in 48 hours after ED visits. SFHP will continue to monitor this item on a bi-annual basis.

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

2009–2010 EQR Recommendation	SFHP's Self-Reported Actions That Address the EQR Recommendation
Address QIP data elements that did not achieve a *Met* status in the QIP validation results. Ensure future QIP submissions include all necessary documentation required for a valid QIP.	**Improving the Patient Experience QIP** – Activity III, regarding definition/description of the second study indicator was revised for the 2010-2011 submission. Items identified as *Partially Met* and *Not Met* were addressed during the 2010 -2011 submission, which received a passing score 82%. **Reducing Avoidable Emergency Room Visits QIP** – During the review period SFHP did not demonstrate a statistically significant improvement on its AER rates. This may have been due to the following two factors: 1) a significant increase in the number of participants in study population; and 2) SFHP was in the process of establishing a partnership to implement activities aimed at reducing AER rates with partner hospital and medical group. Items identified as *Partially Met* and *Not Met* were addressed during the 2009-2010 and 2010-2011 submissions, which received passing scores of 76% and 92% respectively.
Explore factors that led to a decline in performance on the *Comprehensive Diabetes Care—Eye Exams* measure and implement targeted improvement efforts.	The decrease in the *Comprehensive Diabetes Care—Eye Exams* rates in 2010 may have been due to changes in eye care benefit for the Medi-Cal population. We believed that members with diabetes may have been confused regarding whether or not eye exams were a covered benefit.
Review the 2010 plan-specific CAHPS results report and develop strategies to address the *Rating of All Health Care, Customer Service,* and *Getting Needed Care* priority areas.	San Francisco Health Plan has done multiple projects starting in 2010 to address appointment access, customer service, and other aspects of patient experience as measured by CAHPS. These interventions include provider-training programs to address areas where SFHP scored low on the 2010 CAHPS survey, and direct payments to providers for improvement in key aspects of patient experience. SFHP contracted with Mark Murray and Associates to pilot improvements in appointment access in four clinics from March 2010 to March 2011. All clinics saw their appointment delays (measured by Days to Third-next Available Appointment with a patient's own primary provider) cut by 50% or more. These improvements were sustained in these sites, and spread to five more primary care sites in SFHP's network through the year-long Quality Culture Series leadership development program for clinic management teams in 2011. TNAA and other access measures are now included in SFHP's Strength in Numbers incentive program for clinics, so clinics are reimbursed quarterly for improvement in these measures of access.

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

2009–2010 EQR Recommendation	SFHP's Self-Reported Actions That Address the EQR Recommendation
	SFHP also worked with the Institute for Healthcare Communication to pilot improvements in provider-patient communication and in staff-patient communication. This pilot with five clinics ran from March 2010 to March 2011. All clinics improved their CAHPS scores, based on in-clinic administration of the CAHPS survey three times during the pilot. Average improvement across all sites included improvement on 8 of 12 CAHPS composite measures (i.e., measures categories) and 3% improvement on the key composite measures of "Patient recommends practice" (3% improvement) and "overall rating of provider" (2.9%). Ratings of receptionists and clerks (as proxy for "customer service") also increased within this pilot. Communications and customer service was also a focus area in the Quality Culture Series program in calendar year 2012. Patient experience improvement is a measures domain in SFHP's pay-for-performance program called the Practice Improvement Program. We score clinics and medical groups on their trainings and improvement plans for patient experience, making improving CAHPS scores worth thousands of dollars to each clinic and medical group in our network. Finally, in 2012, SFHP has piloted a customer service training with national experts Sullivan-Luallin for one clinic site, and will spread this training to front-desk staff to five or more additional clinics in Spring 2012. More about SFHP's two 2010-2011 pilots to improve access and communications can be found at www.chcf.org and search "improving patient experience hands-on guide."