Performance Evaluation Report

Health Plan of San Joaquin

July 1, 2011–June 30, 2012

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

June 2013

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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services 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 designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more 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.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, 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.

This report is specific to DHCS's contracted plan, Health Plan of San Joaquin ("HPSJ" or "the plan"), which delivers care in San Joaquin County, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

Plan Overview

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

Medi-Cal Managed Care beneficiaries in San Joaquin County may enroll in HPSJ, the LI plan, or in the alternative commercial plan. HPSJ became operational in San Joaquin County to provide MCMC services in February 1996. As of June 30, 2012, HPSJ had 100,169 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period 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.

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 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing Structure and Operations

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

Medical Performance Review

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

DMHC conducted an on-site routine medical survey of HPSJ in February 2012. The survey assessed the plan's compliance with requirements in the areas of Quality Management, Grievances and Appeals, Access and Availability of Services, Utilization Management, Continuity of Care, Access to Emergency Services and Payment, and Prescription Drugs. Two deficiencies were identified in the area of Grievances and Appeals, and one deficiency was noted in the area of Access and Availability of Services. In response to the preliminary report, which was provided to the plan on June 19, 2012, HPSJ corrected one of the deficiencies in the area of Grievances and Appeals. The final report, issued September 26, 2012, indicated that two deficiencies remained unresolved.

Please note that while the DMHC final report was issued outside the July 1, 2011, through June 30, 2012, review period for this plan-specific evaluation report, since the DMHC routine medical survey was conducted within the review period, HSAG included the results. Listed below are the unresolved deficiencies, including information from the DMHC final report regarding the plan's initial efforts to resolve the deficiencies.

Deficiencies

- In the area of Grievances and Appeals, DMHC reviewed 52 Medi-Cal grievance files, and 23 files were found to be deficient. DMHC noted that HPSJ did not consistently send a written resolution letter to enrollees at an appropriate time within the 30-day grievance process. The DMHC final report indicated that while the plan implemented new procedures and revised its policy to address the deficiency, the revisions do not describe how the plan's Quality Improvement Department and Grievance Department will communicate regarding the status of grievances. Additionally, HPSJ's communication process does not include a clear process to ensure the Quality Improvement Department communicates to the Grievance Department when its investigation of a grievance is completed so the Grievance Department knows to send the resolution letter.
- In the area of Access and Availability of Services, DMHC noted that the plan had not established an enrollee to provider ratio as specified in the Knox Keene Act requirements. The DMHC final report indicated that HPSJ provided DMHC with a draft revised Appointment Availability and Access Standards policy; however, DMHC indicated that the final version of the policy needs to be submitted to DMHC so it can confirm the policy complies with the Knox Keene Act requirements.

Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current medical performance reviews and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

MR/PIU conducted an on-site review of HPSJ in December 2010, covering the review period of November 1, 2008, through November 1, 2010. The findings from this review were initially described in HPSJ's 2010–11 plan-specific evaluation report.

The plan was found to be fully compliant in the areas of Member Grievances, Marketing, Cultural and Linguistic Services, and Program Integrity. MR/PIU noted three findings in the area of Prior Authorization Notification. HPSJ was not required to respond to the findings. MR/PIU will follow up with the plan on the findings during its next review. Listed below are the findings.

Findings

All identified findings were related to the plan's NOA letters. Specifically:

- The plan's NOA letters and NOA policies and procedures did not include the required citations of the specific regulation or plan authorization procedures supporting the plan's decision.
- MR/PIU's review of 50 prior authorization files identified one file that contained an NOA letter that was not sent to the beneficiary within the 28-day requirement.

- MR/PIU's review of 50 prior authorization files identified two files with NOA letters that did not state the reason for the plan's decision.

Although not identified as a finding, MR/PIU noted that the plan's Member Services Guide did not include the required contact information for the person responsible for processing and resolving grievances and providing assistance with the completed request and that the plan should ensure this information is included on all member materials.

HSAG found the following information regarding actions HPSJ has taken that appear to address the findings:

- HPSJ's self-report indicated that the plan revised its NOA letters to include review criteria for utilization management determinations. Additionally, the plan indicated that medical criteria are cited for medical necessity determinations; and State and federal health care benefit coverage statues are cited for administrative determinations. Finally, the plan stated that NOA letters are audited by utilization management staff members monthly for timeliness and to determine compliance with the requirement that the NOA letters include the citation supporting the plan's decision.

Strengths

The December 2010 MR/PIU review found HPSJ to be fully compliant in the areas of Member Grievances, Marketing, Cultural and Linguistic Services, and Program Integrity. In response to HSAG's recommendations in the plan's 2010–2011 plan-specific evaluation report, HPSJ provided a description of actions the plan has taken to resolve the findings from the MR/PIU review.

Opportunities for Improvement

The plan should ensure that the two outstanding deficiencies from the medical performance review are fully resolved.

HPSJ also has an opportunity to make its Quality Improvement (QI) evaluation more robust to summarize the activities outlined in the work plan for the year. The QI evaluation currently does not appear to capture many of the activities that the plan may be implementing.

Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). 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 DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by DHCS for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the plan's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[4] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of HPSJ in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

Performance Measure Validation Findings

The HSAG audit team identified no concerns during HPSJ's HEDIS Compliance Audit, and all rates were valid. The auditors noted that HPSJ was proactive in engaging, incentivizing, and providing information to its providers and members. The plan has a comprehensive incentive program in place for providers and members designed to improve HEDIS scores, which typically lends itself to better health outcomes and performance. HPSJ staff members were actively engaged in the HEDIS reporting process, setting goals for improved scores and outcomes.

Performance Measure Results

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

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions (internally developed measure)*
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
AWC	*Adolescent Well-Care Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
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*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of HPSJ's HEDIS 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

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

Table 3.2—Comparison of 2011 and 2012 Performance Measure Results for Health Plan of San Joaquin—San Joaquin County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	27.1%	25.4%	★★	↔	18.8%	31.6%
AMB–ED	‡	--	38.2	--	Not Comparable	--	--
AMB–OP	‡	--	283.7	--	Not Comparable	--	--
AWC	Q,A,T	48.9%	55.5%	★★	↔	39.6%	64.1%
CAP–1224	A	--	96.7%	--	Not Comparable	--	--
CAP–256	A	--	86.8%	--	Not Comparable	--	--
CAP–711	A	--	84.2%	--	Not Comparable	--	--
CAP–1219	A	--	83.5%	--	Not Comparable	--	--
CCS	Q,A	68.6%	68.6%	★★	↔	64.0%	78.7%
CDC–BP	Q	75.2%	77.6%	★★★	↔	54.3%	76.0%
CDC–E	Q,A	52.3%	53.3%	★★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	51.8%	56.0%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	41.4%	36.7%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	80.5%	81.5%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	31.4%	39.2%	★★	↑	27.3%	45.9%
CDC–LS	Q,A	75.9%	78.6%	★★	↔	70.4%	84.2%
CDC–N	Q,A	76.2%	80.3%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	74.5%	77.1%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	64.0%	--	Not Comparable	--	--
LBP	Q	82.4%	80.7%	★★	↔	72.3%	82.3%
MPM–ACE	Q	--	85.6%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	85.1%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	87.8%	88.1%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	65.2%	68.6%	★★	↔	59.6%	75.2%
W-34	Q,A,T	81.3%	80.5%	★★	↔	66.1%	82.9%
WCC–BMI	Q	67.2%	73.5%	★★★	↑	19.7%	69.8%
WCC–N	Q	69.6%	72.5%	★★★	↔	39.0%	72.0%
WCC–PA	Q	58.2%	65.7%	★★★	↑	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS'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] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, HPSJ had average performance on the plan's HEDIS rates. No measures had a statistically significant decline in performance, and the following three measures had statistically significant improvement from 2011 to 2012:

- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dl)*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*

All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures performed above the HPLs, and the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)* measure also performed above the HPL. No measures performed below the MPLs.

HEDIS Improvement Plans

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

HSAG compared the plan's 2011 IP (if one was required) with the plan's 2012 HEDIS rate for that measure 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.

No performance measures fell below the MPLs in 2011; therefore, HPSJ was not required to conduct any IPs in 2012. Furthermore, no measures fell below the MPLs in 2012; therefore, HPSJ will not be required to conduct any IPs in 2013.

Strengths

No measures performed below the MPLs. From 2011 to 2012, the plan either sustained or significantly improved the performance for the four measures that performed above the HPLs.

Opportunities for Improvement

HSAG does not have specific recommendations for improvement since the plan performed above the MPLs for all measures, and no measure had a statistically significant decline in performance from 2011 to 2012. Instead, HSAG recommends that HPSJ continue to monitor its performance across all measures to ensure that its rates continue to exceed the MPLs.

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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about HPSJ's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Project Objectives

HPSJ had two clinical QIPs and one clinical QIP proposal in progress during the review period of July 1, 2011–June 30, 2012. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the current DHCS statewide collaborative QIP project. HPSJ's second project, an internal QIP, sought to increase HbA1c testing in members 18 to 75 years of age. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative which focused on reducing readmissions for members aged 21 years and older. All three QIPs fell under the quality and access domains of care.

The current 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. At the initiation of the QIP, HPSJ had identified 5,551 ER room visits that were avoidable, which was 21.3 percent of the plan's ER visits. HPSJ's objective was to reduce this rate

by using member, provider, and system improvement strategies. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

The new statewide collaborative proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members leading to improved health outcomes.

HPSJ's internal project attempted to increase HbA1c testing to minimize the development of diabetes complications. At the start of the QIP, 80.5 percent of the plan's diabetic members had received an HbA1c test within the measurement year. Blood glucose monitoring assists in the development of appropriate treatment plans to decrease the risk of diabetes complications. Lack of appropriate testing in diabetics may indicate suboptimal care and case management.

Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Health Plan of San Joaquin—San Joaquin County July 1, 2011, through June 30, 2012

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 ER Visits	Annual Submission	100%	100%	*Met*
*All-Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIPs				
Improving the Percentage of HbA1c Testing	Annual Submission	98%	100%	*Met*

[1] **Type of Review**—Designates the QIP review as a 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 noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

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

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

*During the review period, the *All-Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that the annual submission by HPSJ of its *Reducing Avoidable Emergency Room Visits* QIP and its *Improving the Percentage of HbA1c Testing* QIP both received an overall validation status of *Met*. For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

Due to unique, one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

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

Table 4.2—Quality Improvement Project Average Rates* for Health Plan of San Joaquin—San Joaquin County (Number = 2 QIP Submissions, 2 QIP Topics) July 1, 2011, through June 30, 2012

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	94%	6%	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	100%	0%	0%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**100%**	**0%**	**0%**

*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.

HPSJ submitted baseline data for its *Improving the Percentage of HbA1c Testing* QIP; therefore, the QIP was assessed for Activities I through VIII. The *Reducing Avoidable Emergency Room Visits* QIP included Remeasurement 3 data and was assessed through Activity X. One hundred percent of the applicable elements within the design stage were scored *Met*, and 96 percent of the applicable elements within the implementation stage were also scored *Met*.

For the outcomes stage of both QIPs, HPSJ scored 100 percent *Met* for the applicable elements. For the *Reducing Avoidable Emergency Room Visits* QIP, Activity IX was scored *Met* since the plan documented statistically significant improvement of the outcome. For the same QIP, Activity X was also scored *Met* since the plan achieved sustained improvement of the outcome. Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes and Interventions

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

Table 4.3—Quality Improvement Project Outcomes for Health Plan of San Joaquin—San Joaquin County July 1, 2011, through June 30, 2012

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**	**Remeasurement 3 1/1/10–12/31/10**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable^	21.3%	16.7%*	21.5%*	18.6%*	Yes
QIP #2—Improving the Percentage of HbA1c Testing					
QIP Study Indicator		**Baseline Period 1/1/10–12/31/10**	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
Percentage of diabetic members with at least one HbA1c test		80.5%	‡	‡	‡

^A lower rate indicates better performance.

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

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

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

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, HPSJ set a goal to reduce the avoidable ER visits by 10 percent. For this project outcome, a lower rate demonstrates improved performance. The plan met its overall objective; it was able to reduce the percentage of avoidable ER visits from baseline to Remeasurement 3 by 12.7 percent (2.7 percentage points). The plan reported two separate statistically significant increases in performance from baseline to the first remeasurement

period and from the second to the third remeasurement period. Since HPSJ reported multiple periods of improvement, resulting in overall improvement for the project, the plan achieved sustained improvement.

While the plan did achieve overall improvement, there was a decline in performance from the first to the second remeasurement period; the rate of avoidable ER visits increased by a statistically significant amount. A critical analysis of the plan's improvement strategy resulted in the following observations:

- Collaborative interventions were initiated in early CY 2009, continued through CY 2010, and may have corresponded to the improvement in performance in CY 2010. Specifically, the plan reported success with the plan-hospital data collection collaboration. HPSJ reported that the participating hospital reported 75.3 percent of the data to the plan within five days. Similarly, HPSJ reported that it contacted between 97.9 percent and 98.5 percent of the members within 14 days of receiving notice of their first ER visit. Further evaluation of this intervention showed that the avoidable ER visit rates were lower at the participating hospital compared to the non-participating hospitals (16.7 percent versus 17.1 percent), although the rate may not be accurate. The plan continued the intervention by collaborating with three additional hospitals to obtain timely ER visit data.
- HPSJ provided a monthly list to providers that included their members' ER usage. Using feedback from the Physician Advisory Committee, the plan added the primary diagnosis to the ER visit data beginning in CY 2009 so that providers could identify avoidable ER visits. Additionally, the plan facilitated communication between the provider and the member regarding avoidable ER visits by supplying mailing labels to the providers that corresponded to the members on the monthly list. However, the plan did not provide any evaluation data to determine the intervention's effectiveness.
- The plan did not document the results of annual barrier analyses. Numerous plan-specific interventions were implemented throughout the project; however, the plan did not have an evaluation plan for each intervention. Consequently, the plan reported continuing interventions year after year, modifying some of the interventions, and adding additional interventions without any data to support its improvement strategy rationale. Without intervention evaluation results, the plan was unable to address the decline in performance from the first to the second remeasurement period.

The plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine whether to modify or discontinue existing interventions, or implement new ones, thereby reducing the likelihood of achieving project objectives and improving performance.

Improving the Percentage of HbA1c Testing QIP

For the *Improving the Percentage of HbA1c Testing* QIP, HPSJ had only progressed to the point of reporting baseline data; so HSAG could not assess for real or sustained improvement. The plan's project goal was to exceed the NCQA's national Medicaid 75th percentile. A critical analysis of the plan's improvement strategy led to the following observations:

- The plan documented the implementation of approximately 20 new member, provider, and system interventions beginning in August 2010 through August 2011. The plan did not document a method to evaluate the effectiveness of any of the interventions.
- The plan discussed several interventions including a member incentive to improve the percentage of diabetic members receiving eye exams; however, this is not related to the project outcome of increased HbA1c testing.
- The plan implemented a provider incentive program to improve comprehensive diabetes care. However, the plan did not provide any further details related to the requirements to receive the incentive beyond the statement that the provider must meet or exceed the MPL. Additionally, the plan did not document the amount of the incentive, which is often critical to the success of the intervention.

Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

Strengths

HPSJ demonstrated a strong application of the QIP process for the design and implementation stage. The plan documented statistically significant improvement for reducing avoidable ER visits and achieved sustained improvement from baseline to the final remeasurement period.

Opportunities for Improvement

HPSJ should conduct annual barrier analyses, providing results and data specific to the identified barriers. HPSJ should include a plan to evaluate the efficacy of the interventions for its *Improving the Percentage of HbA1c Testing* QIP, specifically, using subgroup analysis to determine if initiatives are uniformly affecting the entire eligible population. The plan could evaluate the outcomes by gender, age, provider, etc., to understand any disparities that may exist in the study population in relation to the study outcome. The plan should also ensure that the documented barriers and corresponding interventions are targeted specifically to HbA1c testing rather than to other diabetes measures.

Additionally, for the *Improving the Percentage of HbA1c Testing* QIP, HPSJ could potentially target interventions to high-volume providers with low performance. By targeting improvement efforts to fewer providers and providing more one-on–one education and support, the plan may increase the likelihood for success of the project.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care. A more detailed description of HSAG's scoring process is included in Appendix A.

Quality

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

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries 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, 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, HPSJ showed above-average performance in the quality domain of care. The plan's Quality Improvement/Utilization Management Plan Program Description includes components to support the delivery of quality care to Medi-Cal members. Additionally, HSAG's review of the HPSJ's quality documents revealed that the plan completes full-scope facility site reviews on all new PCPs and periodic reviews every three years of all PCP offices to ensure quality care is being provided to Medi-Cal members.

In 2012, four performance measures that fell into the quality domain of care performed above the HPLs; and three quality measures had statistically significant improvement from 2011 to 2012.

The plan's *Reducing Avoidable Emergency Room Visits* QIP, which falls into the quality domain of care, was successful in reducing the percentage of avoidable ER visits by 12.7 percent, which exceeded the plan's goal to reduce avoidable ER visits by 10 percent. Additionally, the plan reduced the percentage of avoidable ER visits from baseline to Remeasurement 3, demonstrating sustained improvement for the project.

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 MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and 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. Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Overall, HPSJ showed average performance in the access domain of care. Although the plan appears to have taken action to address access-related findings from the December 2010 MR/PIU review, one outstanding deficiency in the area of Access and Availability of Services remains from the plan's February 2012 DMHC on-site routine medical survey, which could affect members' access to care.

The plan performed average on all performance measures falling into the access domain of care, and no access measures showed statistically significant change from 2011 to 2012.

In addition to falling into the quality domain of care, the plan's *Reducing Avoidable Emergency Room Visits* QIP falls into the access domain of care. As described above, this QIP was successful in demonstrating sustained improvement, which suggests that Medi-Cal members are accessing their PCPs for care rather than using the ER for health care needs more appropriately managed by their PCP.

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.

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.

Overall, HPSJ performed average in the timeliness domain of care. HPSJ provided information to HSAG that demonstrates the plan has taken action to fully address the one timeliness-related finding identified during the MR/PIU review; however, the plan has one unresolved deficiency in the area of Grievances and Appeals from its February 2012 DMHC on-site routine medical survey. The plan performed average on all performance measures falling into the timeliness domain of care, and no timeliness measures showed statistically significant change from 2011 to 2012.

Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. HPSJ's self-reported responses are included in Appendix B.

Recommendations

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

- Ensure the two outstanding deficiencies from the DMHC on-site routine medical survey are fully resolved. Specifically:
  - Provide evidence that the plan's policies and procedures include how HPSJ's Quality Improvement and Grievance Departments will communicate regarding the status of grievances. Additionally, ensure the plan's policies include a process to ensure the Quality Improvement Department communicates to the Grievance Department when its investigation of a grievance is completed so the Grievance Department knows to send the resolution letter.

  - Provide DMHC with the final version of the plan's Appointment Availability and Access Standards policy.

- Consider making the QI evaluation more robust to summarize the activities outlined in the work plan for the year.
- Conduct annual QIP barrier analyses, providing results and data specific to the identified barriers. Additionally, incorporate a method to evaluate the effectiveness of each intervention.
- For its *Improving the Percentage of HbA1c Testing* QIP, include a plan to evaluate the efficacy of the interventions—specifically, using subgroup analysis to determine if initiatives are uniformly affecting the entire eligible population. The plan could evaluate the outcomes by gender, age, provider, etc., to understand any disparities that may exist in the study population in relation to the study outcome. The plan should also ensure that the documented barriers and corresponding interventions are targeted specifically to HbA1c testing rather than to other diabetes measures.
- For the *Improving the Percentage of HbA1c Testing* QIP, potentially target interventions to high-volume providers with low performance. By targeting improvement efforts to fewer providers and providing more one-on–one education and support, the plan may increase the likelihood for success of the project.

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

Quality, Access, and Timeliness

Scale
2.5–3.0 = Above Average
1.5–2.4 = Average
1.0–1.4 = Below Average

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) greater than negative three, if there are two or less measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than three.
3. To be considered ***Below Average***, a plan will have three or more measures below the MPLs than it has above the HPLs.

Access Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus and the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Timeliness Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

Validation *(Table 4.1)*: For each QIP submission and subsequent resubmission(s), if applicable.

- **Above Average** is not applicable.
- **Average** = *Met* validation status.
- **Below Average** = *Partially Met* or *Not Met* validation status.

Outcomes *(Table 4.3)*: Activity IX, Element 4—**Real Improvement**

- **Above Average** = All study indicators demonstrated statistically significant improvement.
- **Average** = Not all study indicators demonstrated statistically significant improvement.
- **Below Average** = No study indicators demonstrated statistically significant improvement.

Sustained Improvement *(Table 4.3)*: Activity X—**Achieved Sustained Improvement**

- **Above Average =** All study indicators achieved sustained improvement.
- **Average =** Not all study indicators achieved sustained improvement.
- **Below Average =** No study indicators achieved sustained improvement**.**

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain.

Appendix B. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

for Health Plan of San Joaquin

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with HPSJ's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table B.1—Grid of HPSJ's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	HPSJ's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Improve performance in every category of the medical audit review and show documented efforts to improve in the plan's quality work plan.	See attachment. (HSAG comment: HSAG reviewed the attachment submitted with the plan's self-reported actions and found the attachment was related to HEDIS performance measures and not related to medical audit review recommendations; therefore, HSAG did not include or summarize the information provided in the attachment.)
Improve timeliness of NOAs and include citations for the denial reason in NOAs for the MR/PIU audit.	NOA's letters have been revised to include review criteria for UM determinations. Medical criteria are cited for medical necessity determinations and State and federal health care benefit coverage statues are cited for administrative determinations. NOAs are audited by UM management monthly for timeliness and determination criteria citation compliance.
Explore factors that may have contributed to the statistically significant decline of the *Breast Cancer Screening* measure, as it was the only measure that had a statistically significant decrease from 2010 to 2011.	Health Plan of San Joaquin stakeholders met to review decline of the BCS measure for our 2011 HEDIS year. Upon review it was deduced that the decline in part was due to the change of member incentive for this measurement year from BCS to CCS. Strategically surmised that if the provider was completing a CCS he/she would refer pt for BCS as well. Stakeholders also contributed the decline to provider confusion in USPTF BCS's recommendation to change annual BCS from age 40 to age 50. Health Plan of San Joaquin continues to recommend BCS annually beginning at age 40. HPSJ sends to providers preventive health guidelines citing these recommendations, on an annual basis at the beginning of each calendar year. Our recent HEDIS summer run shows an improvement in administrative BCS rates at 42.42 % vs. last year's summer run at 40.06 %.
Built in front-end claims edits for 4th and 5th digit specificity to further ensure complete and accurate data for future performance measure reporting.	Our former core claims system did not alert or require the necessity to enter 4th and 5th digit specificity for ICD-code selection. HPSJ has implemented a new core claims system, QNXT, which requires data entry of code specificity to the 4th and 5th digit. Code specificity enhancement was confirmed during our last on-site HEDIS audit in February 2012.
Incorporate a method to evaluate the effectiveness of each intervention for QIPs that have multiple interventions.	Interventions are targeted to specific populations and groups with means to evaluate the impact. Have targeted specific populations members assigned to specific providers for interventions. Interventions are being developed based on the barrier analysis and data review. Interventions are developed to address needs as well as outcomes. And analysis of projected interventions will continue in the QIP projects going forward.

Table B.1—Grid of HPSJ's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	HPSJ's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Evaluate the efficacy of the interventions for its *HbA1c Testing* QIP, specifically, using subgroup analysis to determine if initiatives are affecting the entire study population in the same way.	Assessment of data and groups by age and gender was added to the process for the 2012 submission. QIP data were specific to gender, age, and practitioners analysis. HPSJ was able to note the age bracket with the lowest testing—18–38 year olds, as well as rank the testing, noting that 60+ year olds had the best testing rate. Compliance between male and female membership with diabetes was reviewed. Practitioner data were assessed, and it was noted that more than 50% of HPSJ's diabetic members are assigned to 10 key providers; and they do a good job getting the lab work done. Outreach was identified for the low-ranking providers. Also noted was that 73 PCPs have just one diabetic member assigned; this may be a target in the future.