Performance Evaluation Report

Health Plan of San Mateo

July 1, 2011–June 30, 2012

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

June 2013

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Performance Evaluation Report – Health Plan of San Mateo

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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.

[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 Mateo ("HPSM" or "the plan"), which delivers care in San Mateo 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

HPSM is a full-scope Medi-Cal managed care plan operating in San Mateo County. HPSM serves members in San Mateo County as a County Organized Health System (COHS). In a COHS model, DHCS contracts with a county-organized and county-operated plan to provide medical services to Medi-Cal beneficiaries with designated, mandatory aid codes. Under a COHS plan, Medi-Cal Managed Care beneficiaries can choose from a wide network of managed care providers.

HPSM became operational in San Mateo County to provide MCMC services in December 1987. As of June 30, 2012, HPSM had 64,193 enrolled Medi-Cal 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 HPSM's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. 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. 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.

The most recent medical performance review with HPSM was completed in January 2008, covering the review period of August 1, 2006, through July 31, 2007. HSAG initially reported the detailed findings from this audit in HPSM's 2008–2009 plan-specific evaluation report.[4] Although a review by the State Controller's Office was conducted in June 2011 covering the audit period of January 1, 2010, through December 31, 2010, the results from this audit were not approved by DHCS and are therefore not summarized in this report.

In the plan's previous plan-specific evaluation reports, HSAG noted deficiencies in the following areas from the January 2008 medical performance review:

- Utilization Management
- Coordination of Care: Within the Network
- Availability and Accessibility
- Member Rights
- Quality Management
- Administrative and Organizational Capacity

The DHCS *Medical Audit Close-Out Report* letter dated July 29, 2008, noted that HPSM had corrected several audit deficiencies; however, some issues remained unresolved at the time of the audit close-out report.

Since the medical performance audit was conducted more than three years prior to the review period for this report, HSAG includes a summary of the findings in this report for historical purposes of the most recent audit; however, HSAG does not include these outdated results when assessing overall plan performance during the review period. As part of the development of this report, HSAG reviewed documentation from the plan to determine what actions it has taken to resolve the outdated deficiencies and, when applicable, HSAG has included a description of those actions. Listed below are the unresolved deficiencies followed by actions the plan appears to have taken to resolve the deficiencies.

Utilization Management

Deficiency

- The plan did not submit its procedure, including delegated activities, for monitoring the plan's quality reporting process.

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

Plan Response:

- HPSM's self-report of actions taken to resolve this issue includes a process whereby the Quality Assurance and Improvement Program (QAIP) reports quarterly to senior managers in the Quality Management Oversight Committee (QMOC) regarding the status of quality initiatives. Additionally, the program requires the Physician Advisory Group (PAG) and the Quality Assessment Improvement Committee (QAIC) to provide insight and recommendations about HPSM's quality initiatives. The PAG meets bimonthly, and the QAIC meets quarterly. Minutes are recorded and retained for all QMOC, PAG, and QAIC meetings. Reports from all of these activities are provided at least quarterly to the San Mateo Health Commission (SMHC), HPSM's governing body. The QAIP is also required to create an annual work plan and conduct an annual evaluation of the work plan activities, which are reviewed by the QMOC and reported to the SMHC.

Deficiency

- A process for demonstrating HPSM's delegated entity for pharmacy benefits audits was not included in the plan's utilization management quality reporting process.

Plan Response:

- HPSM's self-report of actions taken to resolve this issue includes implementation of a process by the plan's delegated entity to audit pharmacy benefit set-up before program launch in a new benefit year. This process was started four years ago. Once the program is launched, utilization management reports are created to show utilization activities and patterns of pharmacy benefits. The pharmacy benefit manager (PBM) provides a reporting portal that allows the plan to access a variety of reports related to utilization management. Additionally, the PBM sends a weekly claims analysis dashboard report to the plan. HPSM delegates monitoring and reporting of pharmacy benefits through the plan's pharmacy consultant. The consultant provides the plan with utilization review reports from invoice screening and also specific clinical reports to demonstrate clinical quality of pharmacological treatments for HPSM members.

Coordination of Care: Within the Network

Deficiency

- The plan did not demonstrate a method to approve the use of alternative forms for initial health assessments (IHAs) and initial health education behavioral assessments (IHEBAs) when providers choose to use their own medical forms to gather information.

Plan Response:

- HPSM submitted the plan's QAI-07 Initial Health Assessment and Initial Health Education Behavioral Assessment policy as evidence that the plan has a method to approve the use of

alternative forms for IHAs and IHEBAs. HSAG's review of the policy found that it includes a process for reviewing and approving alternative assessment tools.

Administrative and Organizational Capacity

Deficiency

- The plan did not provide evidence that new providers receive training within 10 working days of being placed on active status.

Plan Response:

- HPSM's self-report of actions taken to resolve this issue includes implementation of a policy and procedure addressing provider training.

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 HPSM in November 2011, covering the review period of July 1, 2010, through October 21, 2011. MR/PIU noted findings in the areas of Member Grievances, Prior Authorization Notification, and Cultural and Linguistic Services. HPSM was not

required to respond to the findings. MR/PIU will follow up with the plan on the findings. Listed below are the findings:

Findings

Member Grievances

- A review of HPSM's "Your Rights" pamphlet determined that the pamphlet was missing the required clear and concise explanation outlining the circumstances under which medical services shall be continued pending decision of the State Fair Hearing. MR/PIU noted that the plan was provided technical assistance on this issue and that follow-up would be conducted.

Prior Authorization Notification

- Three of 50 prior authorization files reviewed contained a notice of action (NOA) letter that was not sent within the required time frame.

Cultural and Linguistic Services

- The staff members in two of the five provider offices visited indicated that they do not discourage the use of family, friends, or minors as interpreters.

HSAG found the following information regarding actions the plan has taken to address the findings in the areas of Prior Authorization Notification and Cultural and Linguistic Services. HSAG did not identify any documentation related to actions the plan has taken to address the finding in the area of Member Grievances.

- In the area of Prior Authorization Notification, HPSM's self-report indicates that the plan's compliance auditors have begun to audit the prior authorization process to ensure that all communication is processed timely and that communications contain contractually required information. The plan indicates that auditing will continue in 2013 as part of HPSM's audit work plan.
- In the area of Cultural and Linguistic Services, HPSM's Quality Assessment and Improvement 2012 Work Plan indicates a third quarter activity of including an article in the provider newsletter about the use of family members/friends as interpreters. The work plan did not specify discouraging the use of minors as interpreters. Additionally, the work plan did not include a process to monitor compliance.

Strengths

Based on the review findings, HPSM demonstrated efforts to resolve many of the noted deficiencies and findings, indicating the plan's strong commitment to providing quality care to its members. Areas of note include:

- The majority of prior authorization files reviewed did not have deficiencies.
- The submitted 2011–2012 Quality Assessment and Improvement Program document describes a structure in place to support the provision of and continuous improvement in the quality of care and services provided to HPSM members.

Opportunities for Improvement

The plan has an opportunity to improve in the areas of Utilization Management, Coordination of Care, Administrative and Organizational Capacity, Member Grievances, Prior Authorization Notification, and Cultural and Linguistic Services. These areas can have an impact on quality, access, and timeliness of care provided to plan members. HPSM should document how the plan will address each of the deficiencies identified during the medical performance and MR/PIU reviews and how the plan will monitor the progress on resolving the deficiencies.

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®)[5] 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 HPSM in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

Performance Measure Validation Findings

HSAG found that HPSM submitted measures that were prepared according to the HEDIS technical specifications and were valid and reliable. The HSAG audit noted that the plan completed a multi-year conversion process to a new transactional system in April 2011. Due to the conversion, HPSM experienced a backlog of claims throughout the measurement year. Additionally, the plan was not able to capture all rendering provider data during the transition. HPSM was able to make the necessary corrections and adjustments, and HSAG found minimal impact to the 2012 measures.

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*

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
W-34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of HPSM's HEDIS 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 Mateo—San Mateo 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	26.5%	34.1%	★★★	↔	18.8%	31.6%
AMB–ED	‡	--	51.6	--	Not Comparable	--	--
AMB–OP	‡	--	483.0	--	Not Comparable	--	--
AWC	Q,A,T	40.4%	53.3%	★★	↑	39.6%	64.1%
CAP–1224	A	--	95.9%	--	Not Comparable	--	--
CAP–256	A	--	88.3%	--	Not Comparable	--	--
CAP–711	A	--	87.7%	--	Not Comparable	--	--
CAP–1219	A	--	84.9%	--	Not Comparable	--	--
CCS	Q,A	61.2%	62.0%	★	↔	64.0%	78.7%
CDC–BP	Q	63.3%	66.2%	★★	↔	54.3%	76.0%
CDC–E	Q,A	59.9%	61.1%	★★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	57.4%	55.7%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	34.1%	38.0%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	86.6%	79.8%	★★	↓	77.6%	90.9%
CDC–LC (<100)	Q	47.0%	46.5%	★★★	↔	27.3%	45.9%
CDC–LS	Q,A	84.2%	82.0%	★★	↔	70.4%	84.2%
CDC–N	Q,A	86.6%	87.8%	★★★	↔	73.9%	86.9%
CIS–3	Q,A,T	83.7%	80.3%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	68.5%	--	Not Comparable	--	--
LBP	Q	84.6%	81.5%	★★	↔	72.3%	82.3%
MPM–ACE	Q	--	89.3%	--	Not Comparable	--	--
MPM–DIG	Q	--	92.7%	--	Not Comparable	--	--
MPM–DIU	Q	--	89.8%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	83.2%	81.9%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	61.8%	61.2%	★★	↔	59.6%	75.2%
W-34	Q,A,T	75.4%	73.8%	★★	↔	66.1%	82.9%
WCC–BMI	Q	47.9%	66.7%	★★	↑	19.7%	69.8%
WCC–N	Q	75.4%	77.6%	★★★	↔	39.0%	72.0%
WCC–PA	Q	59.1%	64.0%	★★★	↔	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

HPSM had above-average performance across the quality-related performance measures and average performance across the access- and timeliness-related measures.

Most of the plan's performance measure rates performed between the MPLs and HPLs. Five measures performed above the HPLs, and one measure performed below the MPL.

The *Adolescent Well-Care Visits* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* measures showed statistically significant improvement from their 2011 performance measure rates. The *Comprehensive Diabetes Care—HbA1c Testing* measure showed a statistically significant decline in performance from 2011 to 2012.

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.

HPSM did not have any measures fall below the MPLs in 2011; therefore, no IPs were required in 2012. HPSM will be required to submit an IP for the *Cervical Cancer Screening* measure in 2013 since this measure's rate fell below the MPL in 2012.

Strengths

Overall, HPSM demonstrated average performance in 2012, with most of the plan's measures performing between the MPLs and the HPLs.

Five performance measures performed above the HPLs in 2012:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)*
- *Comprehensive Diabetes Care—Medical Attention for Neuropathy*

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents —Nutrition Counseling: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents —Physical Activity Counseling: Total*

Statistically significant improvement on two performance measure rates demonstrates the plan's commitment to continuous improvement.

Opportunities for Improvement

The plan should focus on improving its performance on the *Cervical Cancer Screening* performance measure since the rate fell below the MPL in 2012.

The plan should also focus on the *Comprehensive Diabetes Care—HbA1c Testing* performance measure. This measure's rate showed a statistically significant decline from its 2011 performance measure rate.

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

Quality Improvement Project Objectives

HPSM 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 DHCS's current statewide collaborative QIP project. HPSM's second project, an internal QIP, aimed to increase the timeliness of prenatal care. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative, which focused on reducing readmissions for members aged 21 years and older. The three QIPs fell under the quality and access domains of care, and the prenatal care QIP also fell under the timeliness domain 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 in an office or clinic setting. At the initiation of the QIP, HPSM had identified 3,037 ER room visits that were avoidable, which was 15.0 percent of its ER visits. The plan's objective was to reduce this rate by 10 percent

with the use of 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 QIP 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.

For the prenatal QIP, HPSM's goal was twofold: to have women seen by a provider in their first trimester and then maintain a prenatal "home" throughout their pregnancy. At the initiation of the QIP, HPSM reported that 85.3 percent of eligible members received a prenatal visit within the appropriate time frame. The lack of timely prenatal care is associated with poorer pregnancy outcomes, including prematurity of the fetus.

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 Mateo—San Mateo 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	84%	100%	*Met*
*All-Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIPs				
Increasing Timeliness of Prenatal Care	Annual Submission	88%	92%	*Partially Met*
	Resubmission	94%	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 initial submission of HPSM's *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. For its *Increasing Timeliness of Prenatal Care* QIP, the plan's annual submission received a *Partially Met* validation status. As of July 1, 2009, DHCS began requiring plans to resubmit their QIPs until they achieved an overall *Met* validation status. The plan incorporated the validation feedback and, upon resubmission, received a *Met* validation status. 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 HPSM's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Health Plan of San Mateo—San Mateo County (Number = 3 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	94%	0%	6%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	95%	5%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**96%**	**2%**	**2%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	92%	8%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**98%**	**2%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	92%	8%	0%
	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**69%**	**5%**	**26%**

*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.

For the *Increasing Timeliness of Prenatal Care* QIP, Remeasurement 1 data were submitted; therefore, Activities I through Activity IX were completed and validated. The *Reducing Avoidable ER Visits* QIP included Remeasurement 3 data and progressed through Activity X. HPSM demonstrated an accurate application of the design stage and received *Met* scores for 96 percent of all applicable evaluation elements. Similarly, for the implementation stage, the plan received *Met* scores for 98 percent of the applicable evaluation elements.

For the outcomes stage, HPSM was scored lower in Activity IX for both QIPs since the project outcomes did not demonstrate statistically significant improvement. For Activity X of the *Reducing Avoidable Emergency Room Visits* QIP, the plan never demonstrated improvement of its outcome; therefore, it could not achieve sustained improvement. 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 Mateo—San Mateo 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^	15.0%	16.2%*	17.2%*	17.5%	No
QIP #2—Increasing Timeliness of Prenatal Care					
QIP Study Indicator	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**		**Sustained Improvement¥**
Percentage of members that had a prenatal care visit in the first trimester or within 42 days of enrollment	85.3%	83.2%	‡		‡

^A lower percentage 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, HPSM set a goal to reduce the rate of avoidable ER visits by 10 percent over the life of the project. For this project outcome, a lower rate demonstrates improved performance. The plan did not meet its overall objective; furthermore, it never demonstrated statistically significant improvement of its outcome during the project. Instead, HPSM reported two separate statistically significant decreases in performance (1) from the baseline to the first remeasurement period (1.2 percentage points) and (2) from the first to the second remeasurement period (1.0 percentage points). Consequently, the plan's percentage of avoidable ER visits at the final remeasurement period demonstrated a statistically significant decline in performance when compared to the percentage of avoidable ER visits at baseline. Since the plan never reported improvement, it could not demonstrate sustained improvement. HSAG performed a critical analysis of the plan's improvement strategy that resulted in the following observations:

- The plan offered pay-for-performance incentives to providers that offered extended office hours beginning in January 2008; however, the plan did not include the evaluation results for this intervention.
- The plan implemented a nurse advice line in April 2008 to address the lack of after-hour office visits. The plan reported that the intervention was successful in reducing avoidable ER visits for members less than nine years of age. The plan did not address why other age groups did not demonstrate lower avoidable ER visits other than documenting that the numbers were small. This intervention was not evaluated in subsequent measurement periods.
- The plan distributed "fever kits" to members beginning in October 2009, targeting those members less than nine years of age. The kits included a digital thermometer and detailed instructions in English and Spanish on what parents should do when their child has a fever, how to take the child's temperature, and dosing charts for acetaminophen and ibuprofen for babies and children. The plan reported that an evaluation could not be performed due to the resources required for the collaborative interventions.
- Collaborative interventions were initiated in late 2008 and continued through 2010; however, they did not correspond to any improvement in performance. Specifically, the plan did not achieve success with the plan-hospital data collection collaboration. Evaluation of this intervention showed that the avoidable ER visit rates were significantly higher at the participating hospital compared to the non-participating hospitals (25.3 percent versus 16.5 percent).
- HPSM attributed the increase in avoidable ER visits during CY 2009 to the H1N1 epidemic and in CY 2010 to the pertussis outbreak.

Increasing Timeliness of Prenatal Care QIP

For the *Increasing Timeliness of Prenatal Care* QIP, the HPSM's project goal was to increase the percentage of eligible members having a prenatal visit in the first trimester or within 42 days of enrollment in a plan by 5 percent. The plan did not meet this goal. For the first remeasurement period, HPSM reported a decline in performance, although the decline was not statistically significant. HSAG performed a critical analysis of the plan's improvement strategy that led to the following observations:

- The plan conducted appropriate barrier analyses and implemented interventions that addressed the identified barriers. However, only two interventions targeting prenatal visits were implemented during the project time frame, while six other interventions implemented before the project were identified as ongoing interventions. The plan included evaluations of the effectiveness of each intervention, although the ongoing interventions were not evaluated each measurement period.
- HPSM implemented a system intervention to receive timely data from the Human Services Agency that included a monthly report of pregnant women who were approved for the Presumptive Eligibility for Pregnant Women Program and new HPSM members. The plan documented an increase in timely prenatal visits for women enrolled in HPSM after their pregnancy began.
- The plan identified that women continuously enrolled in Medi-Cal before their pregnancy were less likely to seek timely prenatal care than those women newly enrolled. In fact, the rate for timely prenatal care for these continuously enrolled women decreased by 5 percentage points from baseline to the first remeasurement period. The plan documented anecdotal barriers; however, the plan did not address these barriers.
- The social marketing campaign "Go Before You Show" targeted early prenatal care through Medi-Cal's Presumptive Eligibility for Pregnant Women Program. The campaign successfully increased enrollment in the program; however, prenatal visits received during the two months of eligibility in the program but prior to Medi-Cal enrollment in a specific plan are not credited to the plan. Consequently, these prenatal visits do not affect the plan's project outcome. HPSM was able to identify through chart review that women had received timely prenatal care; however, since an additional prenatal visit did not occur within 42 days after the women were eligible for Medi-Cal and enrolled in HPSM, the marketing campaign was not successful in improving HPSM's prenatal visit rate. Despite these results, the plan chose to continue this intervention.

Strengths

HPSM accurately documented the activities for the design and implementation stages.

Opportunities for Improvement

For its *Increasing Timeliness of Prenatal Care* QIP, the plan should continue to explore its access-related barriers for members seeking prenatal care. Specifically, the plan should implement targeted interventions that may promote the concept of a prenatal "home."

The plan should evaluate the efficacy of each intervention for each measurement period. Based on the evaluation results, the plan should modify or discontinue ongoing interventions or implement new interventions to address identified barriers and increase the likelihood of achieving project outcomes and improving performance.

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, HPSM showed above-average performance in the quality domain of care. HSAG's HEDIS auditor determined that the plan had valid rates for all 2012 performance measures, and overall performance on measures in the quality domain of care was above average. Five measures in the quality domain of care performed above the HPLs. One performance measure in the quality domain of care, *Cervical Cancer Screening*, performed below the MPL in 2012.

HPSM's three QIPs fell within the quality domain of care. The plan demonstrated an understanding of the activities for the QIP design and implementation stages.

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, HPSM showed average performance in the access domain of care. HSAG's HEDIS auditor determined that the plan had valid rates for all 2012 performance measures, and overall performance on measures in the access domain of care was average. One measure in the access domain of care, *Comprehensive Diabetes Care—Medical Attention for Nephropathy,* performed above the HPL. One performance measure in the access domain of care, *Cervical Cancer Screening*, performed below the MPL in 2012.

HPSM's three QIPs also fell within the access domain of care. Neither the *Reducing Avoidable ER Visits* QIP nor the *Increasing Timeliness of Prenatal Care* QIP demonstrated statistically significant or sustained improvement. Furthermore, the *Reducing Avoidable ER Visits* QIP showed an increase in the percentage of avoidable ER visits, which represented a decline in performance.

HPSM demonstrated efforts to resolve access-related deficiencies identified in the most recent medical performance and MR/PIU reviews.

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, HPSM showed average performance in the timeliness domain of care. Measures within the timeliness domain of care performed average, with no measures performing above the HPLs or below the MPLs.

HPSM had one QIP within the timeliness domain of care. Despite implementing several interventions to improve the outcome for its *Increasing Timeliness of Prenatal Care* QIP, the plan reported a decline in performance from baseline to its first remeasurement period.

HPSM made progress toward resolving the timeliness-related deficiencies identified during the plan's most recent medical performance and MR/PIU reviews.

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

Recommendations

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

- Ensure that all outstanding deficiencies from the medical performance review are fully resolved.
- Ensure that all findings from the MR/PIU review are fully resolved. Specifically:
  - Provide evidence that all documentation related to member grievances includes clear and concise explanations outlining the circumstances under which the medical service shall be continued pending decision on the fair hearing.
  - Provide documentation that providers are informed that they should discourage the use of minors, as well as family and friends, as interpreters.
- Explore the option of requiring the rendering provider for multi-specialty clinics to improve HEDIS reporting.
- Assess factors that led to poor performance on the *Cervical Cancer Screening* measure in 2012. Develop and implement strategies to improve performance above the MPL.

- Assess factors that led to the *Comprehensive Diabetes Care—HbA1c Testing* performance measure rate's statistically significant decline from its 2011 performance measure rate. Develop and implement strategies to improve performance to prevent further decline.
- For its *Increasing Timeliness of Prenatal Care* QIP, continue to explore access-related barriers for members seeking prenatal care. Specifically, the plan should implement targeted interventions that may promote the concept of a prenatal "home."
- Evaluate the efficacy of each QIP intervention for each measurement period. Based on the evaluation results, modify or discontinue ongoing interventions or implement new interventions to address identified barriers and increase the likelihood of achieving project outcomes and improving performance.

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

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with HPSM'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 HPSM's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	HPSM's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Implement a process for monitoring quality reporting processes.	The Quality Assurance and Improvement Program (QAIP) reports quarterly to senior managers in the Quality Management Oversight Committee (QMOC) regarding the status of quality initiatives. In addition, the Physician Advisory Group (PAG) and the Quality Assessment Improvement Committee (QAIC) provide insight and recommendations about HPSM quality initiatives. The PAG meets bimonthly and the QAIC meets quarterly. Minutes are recorded and retained for all QMOC, PAG, and QAIC meetings. Reports from all of these activities are provided at least quarterly to the San Mateo Health Commission (SMHC), HPSM's governing body. The QAIP also creates an annual work plan as well as conducts an annual evaluation of its activities that are both reviewed by the QMOC and reported to the SMHC.
Develop a process for demonstrating HPSM's delegated entity for pharmacy benefit audits is included in the plan's utilization management quality reporting process.	HPSM's delegated entity has a process in place to audit pharmacy benefit setup before program launch in a new benefit year. The current PBM goes through internal testing of over 300 scenarios of the pharmacy benefit (ex. 2013 Part D). A report of the testing will be provided to the plan. Once program is launched, UM reports can be retrieved to show utilization activities and patterns of pharmacy benefits. The PBM provides a reporting portal for the plan to access a variety of UM-related reports. The PBM also sends a weekly claims analysis dashboard report to the plan. HPSM also delegates monitoring and reporting of pharmacy benefits through the plan's pharmacy consultant. The consultant provides the plan UR type reports from invoice screening and also specific clinical reports to demonstrate clinical quality of pharmacological treatments for HPSM members. These reporting activities have been ongoing for the last 4 years.
Implement a policy requiring prior DHCS approval of any assessment form differing from the DHCS-approved initial health education behavioral assessment form.	HPSM has a policy (QAI-07 Initial Health Assessment and Initial Health Education Behavioral Assessment) explaining the process for providers who utilize a non-DHCS initial health education behavioral assessment form. The policy is submitted along with this grid.
Develop an administrative training policy evidencing that new providers receive training within 10 working days of being placed on active status with the plan.	Attached with this grid is a policy and procedure that HPSM staff developed regarding provider training.
Implement a mechanism to ensure ongoing provider education in the area of cultural and linguistic services and member grievance.	Health Education and Provider Services provide ongoing provider education through one-on-one office visits, monthly provider trainings and through the provider newsletter and Web site.
Ensure prior authorization communications contain contractually required information.	HPSM Compliance Auditors have begun to audit the prior authorization process to ensure that all communication is processed timely and that communications contain contractually required information. Auditing will continue in 2013 as part of HPSM's audit workplan.

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

2010–2011 EQR Recommendation	HPSM's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Modify the provider contract with Kaiser to include a requirement for the provider to submit standard encounter data.	The contract with Kaiser was modified to include a requirement for Kaiser to submit standard encounter data.
Implement a process to capture the rendering provider for multi-clinic specialty providers currently listed under one National Provider Identifier (NPI) to improve data for HEDIS reporting.	A process has been implemented for HPSM to capture the rendering provider for multi-clinic specialty providers currently listed under one NPI to improve data for HEDIS reporting if it is provided on the electronic claim.