Performance Evaluation Report

Santa Clara Family Health Plan

July 1, 2011–June 30, 2012

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

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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS California Department of HealthCareServices

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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, Santa Clara Family Health Plan ("SCFHP" or "the plan"), which delivers care in Santa Clara 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

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

Medi-Cal Managed Care beneficiaries in Santa Clara County may enroll in SCFHP, the LI plan, or in the alternative commercial plan. SCFHP became operational in Santa Clara county to provide MCMC services in February 1997. As of June 30, 2012, SCFHP had 117,176 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 SCFHP'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 SCFHP was completed in May 2007, covering the review period of May 1, 2006, through April 30, 2007. HSAG initially reported findings from this review in SCFHP's 2008–2009 plan-specific evaluation report.[4] Although a review by the State Controller's Office was conducted in May 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.

As previously reported by HSAG, the DHCS *Medical Audit Close-Out Report* letter dated March 27, 2008, indicated that SCFHP had fully corrected several deficiencies identified during the May 2007 review; 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 has taken to resolve them.

Utilization Management

Deficiency

- The plan's utilization management policies and procedures only included referral monitoring and follow-up processes for one of seven specialist providers.

Plan Response:

- SCFHP's self-report of actions the plan has taken to address this deficiency indicate that the plan monitors referrals to specialists monthly. Additionally, the plan indicated that all delegated networks have the same requirement, which is reflected in Utilization Management Committee reports and the plan's policies and procedures.

Deficiency

- The plan did not submit documentation of an appeal process for provider medical disputes as evidence that the plan has an effective and consistent process for resolving these disputes.

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

Plan Response:

- SCFHP's self-report of actions the plan has taken to address this deficiency indicate that the plan's UM 44_04 Provider Medical Dispute Resolution Mechanism policy and procedure was attached to the *Follow-up on External Quality Review Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report* grid; however, HSAG was not able to locate this policy among the documentation submitted by SCFHP.

Additionally, the plan had unresolved deficiencies in the areas of Continuity of Care and Member's Rights; however, as reported by HSAG in SCFHP's 2010–2011 plan-specific evaluation report, SCFHP indicated that the plan had taken steps to rectify these deficiencies.

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 SCFHP in March 2011, covering the review period of January 1, 2009, through December 31, 2010. HSAG reported the findings from this review in SCFHP's 2010–2011 plan-specific evaluation report.

MR/PIU noted a finding in the area of Cultural and Linguistic Services, and a technical assistance observation was made in the area of Member Grievances. SCFHP was not required to respond to

the finding or technical assistance observation. MR/PIU will follow up with the plan on the finding during its next review.

In the area of Cultural and Linguistic Services, MR/PIU found that the staff members in two of five provider offices visited indicated that they do not discourage the use of family, friends, or minors as interpreters.

Information submitted by SCFHP to HSAG as part of the process for developing this report indicated that the plan has provided several trainings to providers and providers' office staff members on interpreter services. Information about interpreter services was discussed during quarterly provider visits and included in the provider manual, on the plan's Web site, and in member newsletters.

Strengths

Overall, the plan is operating in accordance with State requirements and appears to have resolved most of the deficiencies identified during the medical performance review. SCFHP also appears to have implemented actions to address the finding identified during the MR/PIU review.

Opportunities for Improvement

SCFHP has the opportunity to fully resolve the remaining deficiency in the area of Utilization Management by providing documentation of the appeal process for provider medical disputes. Additionally, although SCFHP reported implementation of provider and member training to address the finding in the area of Cultural and Linguistic Services, the plan has the opportunity to strengthen its efforts by monitoring providers' compliance with the requirement that they discourage the use of family, friends, and minors as interpreters.

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 SCFHP 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 auditors determined that SCFHP followed the appropriate specifications to produce valid performance measure rates. No issues were identified; however, to determine the completeness of encounter submissions by providers, HSAG recommended that SCFHP use fee-for-service volume as a gauge to monitor the volume of encounter data by capitated providers.

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*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
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 SCFHP'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 Santa Clara Family Health Plan—Santa Clara 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	31.4%	25.8%	★★	↔	18.8%	31.6%
AMB–ED	‡	--	35.9	--	Not Comparable	--	--
AMB–OP	‡	--	292.8	--	Not Comparable	--	--
AWC	Q,A,T	41.2%	53.3%	★★	↑	39.6%	64.1%
CAP–1224	A	--	96.2%	--	Not Comparable	--	--
CAP–256	A	--	88.6%	--	Not Comparable	--	--
CAP–711	A	--	89.7%	--	Not Comparable	--	--
CAP–1219	A	--	86.8%	--	Not Comparable	--	--
CCS	Q,A	74.4%	71.3%	★★	↔	64.0%	78.7%
CDC–BP	Q	62.7%	45.0%	★	↓	54.3%	76.0%
CDC–E	Q,A	51.5%	47.7%	★★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	56.4%	51.1%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	34.7%	40.9%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	84.4%	86.6%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	51.3%	38.0%	★★	↓	27.3%	45.9%
CDC–LS	Q,A	78.3%	81.0%	★★	↔	70.4%	84.2%
CDC–N	Q,A	76.2%	80.0%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	79.4%	80.0%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	69.3%	--	Not Comparable	--	--
LBP	Q	82.3%	80.4%	★★	↔	72.3%	82.3%
MPM–ACE	Q	--	86.1%	--	Not Comparable	--	--
MPM–DIG	Q	--	87.2%	--	Not Comparable	--	--
MPM–DIU	Q	--	84.9%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	83.6%	82.7%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	62.7%	58.4%	★	↔	59.6%	75.2%
W-34	Q,A,T	73.6%	75.7%	★★	↔	66.1%	82.9%
WCC–BMI	Q	60.9%	64.2%	★★	↔	19.7%	69.8%
WCC–N	Q	61.8%	64.0%	★★	↔	39.0%	72.0%
WCC–PA	Q	40.0%	45.7%	★★	↔	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

SCFHP's performance was average across all measures, with no measures performing above the HPLs. The *Prenatal and Postpartum Care—Postpartum Care* measure performed below the MPL in 2012. Two comprehensive diabetes control measures had statistically significant decline in performance from 2011 to 2012. The decline in the *Comprehensive Diabetes Control (CDC)—Blood Pressure Control (<140/90 mm Hg)* rate moved this measure from above the MPL in 2011 to below the MPL in 2012. The decline in the *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure resulted in performance on this measure moving from above the HPL in 2011 to average in 2012. The *Adolescent Well-Care Visits* measure had statistically significant improvement 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.

SCFHP did not have any measures perform below the MPLs in 2011; therefore, no IPs were required in 2012. The plan will be required to submit IPs in 2013 for the *Comprehensive Diabetes Control (CDC)—Blood Pressure Control (140/90 mm Hg)* and *Prenatal and Postpartum Care—Postpartum Care* measures since they performed below the MPLs in 2012.

Strengths

The *Adolescent Well-Care Visits* measure had statistically significant improvement in performance from 2011 to 2012. Rates on most measures remained stable from 2011 to 2012.

Opportunities for Improvement

SCFHP has the opportunity to assess factors leading to performance below the MPLs for the *Comprehensive Diabetes Control (CDC)—Blood Pressure Control (140/90 mm Hg)* and *Prenatal and Postpartum Care—Postpartum Care* measures and identify interventions to improve performance. The plan also has the opportunity to assess factors that led to a decline in performance on the *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure to prevent further decline on this measure's rate in 2013.

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

Quality Improvement Project Objectives

SCFHP had one clinical QIP and two clinical QIP proposals in progress during the review period of July 1, 2011, through 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. The plan's second project, an internal QIP, aimed to increase the participation in childhood obesity nutritional programs for members 2 to 18 years of age. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative QIP, 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 in an office or clinic setting. At the initiation of the QIP, SCFHP had identified 5,518 ER room visits that were avoidable,

which was 17.1 percent of the plan's ER visits. The plan'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 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.

SCFHP's QIP proposal, *Childhood Obesity Partnership and Education*, attempted to improve the quality of care delivered to children by increasing the appropriate nutritional education for children with BMI percentiles greater than or equal to the 95th percentile for age and gender. SCFHP's goal was to increase the percentage of these children who attended a nutritional program by implementing member and provider improvement strategies. Childhood obesity is a condition not often addressed that can be an indicator of suboptimal preventive care, reduced overall health, and a risk factor for many chronic conditions.

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 Santa Clara Family Health Plan—Santa Clara 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	95%	100%	*Met*
*All-Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIPs				
Childhood Obesity Partnership and Education	Proposal	91%	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 SCFHP of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. The proposal submission for the *Childhood Obesity Partnership and Education* QIP also 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 SCFHP's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Santa Clara Family Health Plan—Santa Clara 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)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	80%	10%	10%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**86%**	**7%**	**7%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation**	88%	13%	0%
	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total**		**85%**	**8%**	**8%**

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

**The stage and/or activity totals may not equal 100 percent due to rounding.

SCFHP submitted Activities I through VI for its *Childhood Obesity Partnership and Education* QIP. For its *Reducing Avoidable Emergency Room Visits* QIP, the plan submitted a third remeasurement period and was assessed for Activities I through X.

The plan successfully applied the QIP process for the design and implementation stages, scoring 100 percent *Met* on all applicable evaluation elements for five of the six applicable activities. For the outcomes stage, the plan's *Reducing Avoidable Emergency Room Visits* QIP was scored down for not demonstrating sustained improvement in Activity X. 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 Santa Clara Family Health Plan—Santa Clara 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^	17.1%	20.8%*	24.8%*	23.8%*	No
QIP #2—Childhood Obesity Partnership and Education					
QIP Study Indicator	**Baseline Period 1/1/11–12/31/11**	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**		**Sustained Improvement¥**
The percentage of children aged 2 to 18 years with BMI ≥ 95th percentile for age and gender who attended at least one nutritional program during the measurement year	‡	‡	‡		‡

^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, SCFHP set a goal to reduce the rate of avoidable ER visits by 5 to 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; however, it demonstrated a statistically significant improvement of its outcome from the second to the third remeasurement period. SCFHP reported two separate statistically significant decreases in performance (1) from the baseline to the first remeasurement period (3.7 percentage points) and (2) from the first to the second remeasurement period (4.0 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. Without improvement in the percentage of avoidable ER visits from baseline to

the final remeasurement period, SCFHP could not demonstrate sustained improvement. A critical analysis of the plan's improvement strategy resulted in the following observations:

- Plan-specific interventions were limited in number and scope. SCFHP initiated a pilot project to notify physicians within one network of their members with three ER visits in one quarter. The plan was not clear in its documentation if the intervention was ever moved out of the pilot stage and implemented plan-wide. Additionally, the plan used member newsletters as a primary method to provide education related to avoidable ER visits. The plan did not evaluate the effectiveness of any of its plan-specific interventions.
- Most of the plan's improvement efforts were focused on the collaborative interventions. The collaborative interventions were initiated in late 2009; however, the interventions were not associated with any improvement in the outcome. SCFHP reported limited success with the collaborative hospital intervention. The plan only received 1.8 percent of the ER visit data from the participating hospital within 5 days. The plan contacted, at most, 11.1 percent of the members within 14 days of their ER visit at the participating hospital in CY 2010. For the participating hospital, the avoidable ER visit rate was 23.1 percent compared to the plan's overall rate of 23.8 percent.
- SCFHP reported undergoing internal restructuring during 2009, which negatively affected the plan's ability to continue interventions and/or implement new interventions.

Childhood Obesity Partnership and Education QIP

The *Childhood Obesity Partnership and Education* QIP had not progressed to the point of reporting results or implementing interventions.

Strengths

SCFHP successfully applied documentation requirements for the activities in both the design and implementation stages. Additionally, the plan received *Met* overall validation status scores without the benefit of resubmission, indicating proficiency with the QIP validation process.

For the current measurement period, SCFHP was able to achieve a statistically significant reduction in the percentage of avoidable ER visits.

Opportunities for Improvement

SCFHP has an opportunity to improve its intervention strategies in order to achieve and sustain improvement of its QIP outcomes. At a minimum, barrier analyses should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from annual analyses alone. Interventions that are

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

With the implementation of any intervention and especially for multiple interventions, 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 which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives 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, SCFHP performed average in the quality domain of care. HSAG's review of the plan's 2012 Quality Improvement Program Description found that the plan has a structure to support assessment of the quality of care provided to members and mechanisms to ensure needed improvements are made.

Measures falling into the quality domain of care performed average overall, with two quality measures performing below the MPLs: *Comprehensive Diabetes Control (CDC)—Blood Pressure Control (<140/90 mm Hg)* and *Prenatal and Postpartum Care—Postpartum Care.* No measures performed

above the HPLs in 2012. One quality measure had statistically significant improvement from 2011 to 2012, and two measures in the quality domain of care had a statistically significant decline in performance.

SCFHP's *Reducing Avoidable Emergency Room Visits* QIP fell into the quality domain of care. The plan demonstrated a reduction in avoidable ER visits from the second to the third remeasurement period; however, SCFHP did not reach its goal of reducing the rate of avoidable ER visits by 5 to 10 percent over the life of the project. Additionally, the plan did not show sustained improvement over the life of the project and had statistically significant decline in performance between each measurement period and the prior measurement period.

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, SCFHP performed average in the access domain of care. The plan appears to have engaged in efforts to ensure member access to interpreter services in response to a finding identified during the MR/PIU review in the area of Cultural and Linguistic Services.

The *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the access domain of care, performed below the MPL in 2012, and no access measures performed above the HPLs. One access measure had statistically significant improvement in performance from 2011 to 2012, and all other measures in the access domain of care experienced no statistically significant change from 2011 to 2012.

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, SCFHP performed average in the timeliness domain of care. The *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the timeliness domain of care, performed below the MPL in 2012, and no measures performed above the HPLs. One timeliness measure had statistically significant improvement in performance from 2011 to 2012, and all other measures in the timeliness domain of care experienced no 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. SCFHP's self-reported responses are included in Appendix B.

Recommendations

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

- Ensure the remaining deficiency from the May 2007 medical performance review is fully resolved.
- Ensure that the plan is monitoring providers' compliance with the requirement that they discourage the use of family, friends, and minors as interpreters.
- Develop a process to use fee-for-service claims volume as a gauge to monitor the volume of encounter data submitted by capitated providers to ensure greater confidence in data completeness.
- Conduct barrier analysis to identify factors contributing to the poor performance on the *Comprehensive Diabetes Control (CDC)—Blood Pressure Control (140/90 mm Hg)* measure and implement interventions to improve performance.
- Conduct barrier analysis to identify factors contributing to the poor performance on the *Prenatal and Postpartum Care—Postpartum Care* measure and implement interventions to improve performance.

- Assess factors that led to a decline in performance on the *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure to prevent further decline on this measure's rate in 2013.
- Conduct QIP barrier analyses to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from annual analyses alone. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.
- Ensure that each QIP intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

In the next annual review, HSAG will evaluate SCFHP'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 Santa Clara Family Health Plan

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

2010–2011 EQR Recommendation	SCFHP's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Update the monitoring and follow-up of referrals to specialists for all network providers.	SCFHP monitors referrals to specialist on a monthly basis. All delegated networks have the same requirement, which is evidenced in UM Committee reports, and by standing policy and procedures.
Submit an appeal process for its provider medical disputes.	Attached policy and procedure: UM 44_04 Provider Medical Dispute Resolution Mechanism
Reeducate providers on the plan's cultural and linguistic services requirements.	SCFHP has provided several trainings on interpretation services to providers and provider offices' staff. Training methods include but are not limited to (1) quarterly provider visits, (2) provider manual, (3) website, and (4) member newsletters. Interpretation services education includes but is not limited to: 1. How to access interpreter services with contracted providers at no charge to members and providers. 2. How to document interpreter services. a. Refusal/offered b. Color code the member's charts c. Label the member's charts to identify the non-English languages. 3. How to discourage the use of family members, friends, or minors as interpreters. 4. How to communicate across language barriers. 5. Working with telephone interpreter, onsite interpreters, and American Sign Language interpreters
Ensure that all member grievances are resolved consistently and effectively.	Attached policy and procedure: GA001_09 Member Grievance and Appeals Process
Explore factors that may have contributed to the statistically significant decrease for the *HbA1c Poor Control (> 9.0 Percent)* measure to ensure that its performance in 2012 does not continue to decrease.	In 2011, SCFHP discovered that in previous years, Medicare members had been erroneously included in the calculation of this HEDIS measure. For 2011, this was corrected. Medicare members were removed from the calculation. HSAG auditors were informed and provided with documentation on this correction. Unfortunately, due to the late discovery, additional chart retrieval was not possible. This resulted in a statistical performance decrease for the measure. Again, this has been corrected; and SCFHP does not expect any statistical decreases for this measure going forward.
For the ER statewide collaborative QIP, the plan may need to implement plan-specific interventions targeted to its population in order to achieve improvement for this QIP.	The ER statewide collaborative QIP ended June 30, 2011. SCFHP received documentation from HSAG that our QIP was completed and we met all of the requirements. Attached completed document from HSAG.