Performance Evaluation Report

San Francisco Health Plan

July 1, 2011–June 30, 2012

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

June 2013

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Purpose of Report

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

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

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

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

This report is specific to DHCS's contracted plan, San Francisco Health Plan ("SFHP" or "the plan"), which delivers care in San Francisco 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

SFHP is a full-scope managed care plan in San Francisco County. SFHP 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 to provide medical services to Medi-Cal beneficiaries. Most Two-Plan Model counties offer an LI plan and a nongovernmental, commercial health plan.

Medi-Cal Managed Care beneficiaries in San Francisco County may enroll in either SFHP, the LI plan, or in the alternative commercial plan. SFHP became operational to provide MCMC services in January 1997. As of June 30, 2012, SFHP had 56,396 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 SFHP's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. 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 (DMHC) to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

DMHC conducted an on-site audit of SFHP from March 20, 2012, through March 23, 2012. The review covered the following areas: Quality Management, Grievances and Appeals, Access and Availability of Services, Utilization Management, Continuity of Care, Access to Emergency Services and Payment, and Prescription Drugs. DMHC completed its investigatory phase and closed the survey on May 4, 2012; however, the report was not finalized and publicly released until October 25, 2012. Although the report was finalized outside of the review period for this plan-specific evaluation report, HSAG included the information from the report since the audit took place within the review period.

During the March 2012 audit, DMHC identified two deficiencies in the area of Utilization Management and one deficiency in the area of Grievances and Appeals. All three deficiencies were corrected by SFHP prior to the release of the October 25, 2012 report. DMHC also made a recommendation to SFHP in the area of Quality Management, and SFHP submitted information to DMHC in response to the recommendation. No further actions were required of the plan.

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.

The most recent MR/PIU review was conducted in May 2012 for the review period of January 1, 2010, through March 31, 2011. Please note that while the subsequent MR/PIU report dated August 3, 2012, was issued outside the July 1, 2011, through June 30, 2012, review period for this

plan-specific evaluation report, since the MR/PIU review was conducted within the review period, HSAG included the findings from the review.

The MR/PIU report dated August 3, 2012, indicated that the plan was fully compliant in the areas of Member Grievances, Cultural and Linguistic Services, Marketing, and Program Integrity. The report identified one finding in the area of Prior Authorization Notification. Additionally, MR/PIU provided technical assistance feedback in the areas of Prior Authorization Notification and Provider Visits. A summary of the finding identified in the area of Prior Authorization Notification follows.

Finding

MR/PIU reviewed 25 prior authorization notification case files from the plan's delegated entities. One of 25 prior authorization files reviewed contained a "Your Rights" attachment that was missing the required clear and concise explanation outlining the circumstances under which the medical service shall be continued pending a decision on the State Fair Hearing.

Based on the timing of the MR/PIU letter and the time frame for this report, the actions the plan has taken to address the finding were not available. HSAG will report on SFHP's actions to address the finding in SFHP's 2012–2013 plan-specific evaluation report.

Strengths

SFHP fully corrected all deficiencies identified during the most recent DMHC on-site audit and was fully compliant in the areas of Member Grievances, Cultural and Linguistic Services, Marketing, and Program Integrity from the most current MR/PIU review.

Opportunities for Improvement

In the area of Prior Authorization Notification, SFHP should ensure delegated entities provide clear and concise information to members.

Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). DHCS requires that plans collect and report EAS rates, which provide a standardized method for objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by DHCS for its EAS-specific performance measures when calculating rates.

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

Validating Performance Measures and Assessing Results

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

Performance Measure Validation

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

Performance Measure Validation Findings

HSAG auditors determined that SFHP submitted measures that were prepared according to the HEDIS Technical Specifications and were valid for reporting.

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

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

Table 3.2 presents a summary of SFHP'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 San Francisco Health Plan—San Francisco 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	44.5%	45.5%	★★★	↔	18.8%	31.6%
AMB–ED	‡	--	26.7	--	Not Comparable	--	--
AMB–OP	‡	--	354.4	--	Not Comparable	--	--
AWC	Q,A,T	64.4%	65.2%	★★★	↔	39.6%	64.1%
CAP–1224	A	--	93.0%	--	Not Comparable	--	--
CAP–256	A	--	87.9%	--	Not Comparable	--	--
CAP–711	A	--	90.1%	--	Not Comparable	--	--
CAP–1219	A	--	86.8%	--	Not Comparable	--	--
CCS	Q,A	79.4%	80.2%	★★★	↔	64.0%	78.7%
CDC–BP	Q	73.7%	78.6%	★★★	↔	54.3%	76.0%
CDC–E	Q,A	70.1%	69.7%	★★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	64.1%	63.4%	★★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	26.3%	26.5%	★★★	↔	52.1%	29.1%
CDC–HT	Q,A	90.4%	91.1%	★★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	47.9%	48.8%	★★★	↔	27.3%	45.9%
CDC–LS	Q,A	83.2%	83.3%	★★	↔	70.4%	84.2%
CDC–N	Q,A	85.1%	83.6%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	87.3%	87.0%	★★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	64.4%	--	Not Comparable	--	--
LBP	Q	82.2%	83.0%	★★★	↔	72.3%	82.3%
MPM–ACE	Q	--	73.2%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	71.4%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	90.3%	93.4%	★★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	63.6%	75.6%	★★★	↑	59.6%	75.2%
W-34	Q,A,T	85.2%	85.0%	★★★	↔	66.1%	82.9%
WCC–BMI	Q	60.6%	76.2%	★★★	↑	19.7%	69.8%
WCC–N	Q	78.5%	80.6%	★★★	↔	39.0%	72.0%
WCC–PA	Q	70.4%	72.7%	★★★	↔	28.5%	60.6%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, SFHP demonstrated above-average performance, with most performance measure rates above the HPLs. No measures fell below the MPLs in 2012.

The plan saw statistically significant improvements in performance on two measures, *Prenatal and Postpartum Care—Postpartum Care* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total.* No measures saw a statistically significant decline.

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.

SFHP was not required to submit any IPs based on the plan's 2011 performance and will not be required to submit any IPs based on the plan's 2012 performance.

Strengths

As in 2011, SFHP showed exceptional performance, with most measures performing above the HPLs and no rates falling below the MPLs. Additionally, no rates had statistically significant declines from 2011 to 2012. Two measures, *Prenatal and Postpartum Care—Postpartum Care* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*, had statistically significant improvement, demonstrating the plan's commitment to continued improvement in the area of performance measures.

Opportunities for Improvement

SFHP should continue to build on the plan's successful efforts to sustain and improve performance on the measures. HSAG has no formal recommendations for the plan in the area of performance measures.

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

Quality Improvement Project Objectives

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

The current statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. At the initiation of the QIP, SFHP had identified 1,477 ER visits that were avoidable, which was 17.4 percent of the plan's ER visits. SFHP's objective was to reduce this rate by

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

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

SFHP selected two global measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[5] Survey as a method to evaluate and improve the patient experience. The measures related to (1) rating of personal doctor, and (2) rating of all health care. By improving doctor-patient communication, the plan aimed to improve members' satisfaction with their personal doctor and overall health care. Improved doctor-patient communication is associated with improved adherence to physician recommendations and improved self-management skills.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for San Francisco Health Plan—San Francisco County July 1, 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	92%	100%	*Met*
*All-Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Pass*

[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.

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

For the review period of July 1, 2011, through June 30, 2012, SFHP was not required to submit its internal QIP, *Improving the Patient Experience*. The QIP's annual submission date was modified from May 2012 to August 2012 to align with the availability of the CAHPS® Survey results. Therefore, although the QIP is still active, validation results and additional outcome results fell outside the review period and were not included in this report.

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

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

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

Table 4.2—Quality Improvement Project Average Rates* for San Francisco Health Plan—San Francisco County (Number = 1 QIP Submission, 1 QIP Topic) 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	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation**	75%	13%	13%
	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**77%**	**8%**	**15%**

*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.

The *Reducing Avoidable ER Visits* QIP included Remeasurement 3 data and progressed through Activity X. SFHP demonstrated an accurate application of the design and implementation stages, scoring 100 percent on all applicable evaluation elements for all six applicable activities.

For the outcomes stage, SFHP was scored lower in Activity VIII for inaccurately reporting the resulting *p* values for the statistical testing between measurement periods. Additionally, the plan did not report whether there were factors that affected the ability to compare measurement periods. The *Reducing Avoidable Emergency Room Visits* QIP was also scored down in Activity X since the QIP outcome did 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 San Francisco Health Plan—San Francisco 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^	17.4%	17.4%	20.3%*	18.2%*	No

QIP #2—Improving the Patient Experience				
QIP Study Indicator**	**Baseline Period 7/1/09–12/31/09**	**Remeasurement 1 7/1/12–12/31/12**	**Remeasurement 2 7/1/14–12/31/14**	**Sustained Improvement¥**
Percentage of members responding "9" or "10" to the question "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?"	43.6%	‡	‡	‡
Percentage of members responding "9" or "10" to the question "Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?"	54.7%	‡	‡	‡

^ 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 study indicator descriptions and rates are different than what was reported in the plan's 2010-2011 plan-specific evaluation report. It was determined that the CAHPS survey administered by SFHP to members from five pilot clinics could not be continued; therefore, the State-approved CAHPS survey questions and results would be reported as the QIP outcomes.

‡ 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, SFHP 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. While the plan did not meet its overall objective, it

reported one statistically significant increase in performance from the second to the third remeasurement period (2.1 percentage points). Conversely, there was a decline in performance from the first to the second remeasurement period; the rate of avoidable ER visits increased by a statistically significant amount. Ultimately, the plan did not demonstrate sustained improvement since the final remeasurement outcome was not improved over the baseline outcome. A critical analysis of the plan's improvement strategy resulted in the following observations:

- The plan documented implementing nine plan-specific interventions from July 2008 until April 2010; however, due to staffing changes and shortages, the plan reported the interventions were not applied consistently. The plan attributed the lack of improvement of the project outcome from baseline to the second remeasurement period to staffing issues.
- During this same time period, SFHP implemented the collaborative interventions. The collaborative interventions were initiated in early 2009; however, they were not associated with any improvement in the outcome. SFHP reported limited success with the collaborative data collection hospital intervention. In CY 2010, the plan received 75.8 percent of the ER visit data from the participating hospital within 5 days of the visit; however, the plan did not report the percentage of members contacted within 14 days of their ER visit. Additionally, for the participating hospital, the avoidable ER visit rate was significantly higher than for the non-participating hospitals (20.4 percent compared to 15.5 percent).
- Consistent implementation of the interventions began in October 2010 with newly dedicated staff members. The plan conducted detailed barrier analyses and developed targeted interventions which were implemented beginning in January 2011 and corresponded to a statistically significant decline in the avoidable ER visits. Interventions targeting one hospital included:
  - Providing case management of members with chronic diseases.
  - Triaging members at the ER and rerouting members from the hospital to a primary care clinic with same-day appointments.
  - Using a health navigator to contact members with an avoidable ER visit to the partner hospital; approximately 58 percent of the members were successfully contacted and provided educational materials.
  - Connecting frequent ER users and members with chronic diseases to case management, which educates the members about the Nurse Advise Line and facilitates follow-up appointments with their PCP.
  - Providing a list of members with multiple ER visits to the hospital's medical director to facilitate communication with the primary care clinics.
  - Providing a weekly list of members with ER visit data to the PCP.

- SFHP evaluated the effectiveness of the interventions and reported the continuation of successful interventions beyond the QIP's final remeasurement period.

Improving the Patient Experience QIP

For the *Improving the Patient Experience* QIP, the plan's goal was to improve the CAHPS® scores for the project outcomes by 25 percent. The plan reported baseline data using the CAHPS® Survey conducted in CY 2010. The CAHPS® Survey is conducted every two years; however, DHCS decided not to administer the survey in CY 2012. Instead, the survey was delayed until CY 2013, which allowed integration of the Seniors and Persons with Disabilities (SPD) population into Medi-Cal Managed Care and ensured their representation in the 2013 CAHPS® Survey. Consequently, the plan's first remeasurement period was also delayed and would not be available until the CY 2013 QIP submission.

Despite the delayed survey, the plan conducted thorough barrier analyses based on the baseline results. The plan identified the community clinics' lack of a quality improvement infrastructure to support training and measurement of outcomes. Therefore, SFHP chose to conduct a pilot project consisting of five community clinic sites. The five sites served approximately 14 percent of the plan's total Medi-Cal population. The plan implemented interventions and provided technical assistance to the clinics. Additionally, the plan documented a detailed evaluation plan to determine the effectiveness of the interventions. The plan's aim for the pilot project was threefold:

- Understand how to adapt the interventions to make improvements throughout the plan's providers' network.
- Learn about resources and infrastructure required to support clinics in making improvements.
- Learn about effective strategies for engaging clinics and their staff in making improvements.

SFHP's overall improvement strategy for the QIP was to spread the successful interventions from the pilot clinics to (1) additional community centers, then (2) medical groups, and finally (3) all SFHP contracted providers.

Strengths

SFHP demonstrated a strong application of the design and implementation stages and received *Met* scores for all applicable evaluation elements. The plan achieved these scores without the benefit of resubmission, indicating proficiency with the QIP validation process.

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

SFHP demonstrated a continued commitment to its *Improving the Patient Experience* QIP despite the modified submission date and delayed survey administration. The plan's strong improvement strategy and use of intervention evaluations should increase the likelihood of improving the members' ratings of their health care and personal doctor.

Opportunities for Improvement

The plan documented internal staffing issues as a contributory factor for the *Reducing Avoidable Emergency Room Visits* QIP's lack of success. The plan should consider involving additional staff in its improvement strategy process to minimize a lapse in a project's progress and success.

SFHP should consistently document the data results of its barrier analyses and intervention evaluations for each measurement period in all of its QIPs.

The plan should clearly document the date that an intervention is implemented and indicate any lapses, restrictions, or modifications made to the intervention.

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.

SFHP showed above-average performance, with most performance measures in the quality domain of care performing above the HPLs and the remainder performing above the MPLs. The plan had statistically significant improvement on two performance measures in the quality domain of care, *Prenatal and Postpartum Care—Postpartum Care* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total,* demonstrating a commitment to continued improvement in the quality domain of care.

SFHP's two QIPs fell into the quality domain of care. The plan demonstrated a strong application of the design and implementation stages and received *Met* scores for all applicable evaluation elements. The plan achieved these scores without the benefit of resubmission, indicating proficiency with the QIP validation process. While it did not achieve sustained improvement, the plan's *Reducing Avoidable Emergency Room Visits* QIP did show a statistically significant reduction in the percentage of avoidable ER visits for the current 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.

SFHP demonstrated above-average performance on performance measures in the access domain of care, with seven access measures performing above the HPLs. One of the two performance measures that showed statistically significant improvement, *Prenatal and Postpartum Care—Postpartum Care,* was in the access domain of care.

In addition to falling into the quality domain of care, SFHP's two QIPs fell into the access domain of care. As indicated above, the *Reducing Avoidable Emergency Room Visits* QIP did not achieve sustained improvement; however, the project had statistically significant improvement for the current measurement period, suggesting that more members are accessing their PCP for conditions more appropriately managed by a PCP, rather than using the ER.

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.

SFHP demonstrated above-average performance on performance measures in the timeliness domain of care, with five timeliness measures performing above the HPLs. One of the two performance measures that showed statistically significant improvement, *Prenatal and Postpartum Care—Postpartum Care,* was in the timeliness domain of care.

The most recent MR/PIU review found only one timeliness-related finding in the area of Prior Authorization Notification. SFHP's response to this finding will be reported in the plan's 2012–2013 plan-specific evaluation report.

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

Recommendations

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

- Ensure the plan's delegated entities include in the "Your Rights" attachment a required clear and concise explanation outlining the circumstances under which the medical service shall be continued pending a decision on the State Fair Hearing.
- Consider involving additional staff in its improvement strategy process for the *Reducing Avoidable Emergency Room Visits* QIP to minimize a lapse in a project's progress and success.
- Consistently document the data results of its QIP barrier analyses and intervention evaluations for each measurement period.
- Clearly document the date that a QIP intervention is implemented and indicate any lapses, restrictions, or modifications made to the intervention.

In the next annual review, HSAG will evaluate SFHP'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 San Francisco 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 SFHP'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 SFHP's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	SFHP's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Ensure all open medical performance review deficiencies are fully resolved and maintain clear evidence of corrective actions.	SFHP currently has no open medical performance review deficiencies at this time.
Require delegated groups to submit monthly internal monitoring reports for claims processing as a means for enhanced oversight.	SFHP is in the process of hiring a quality analyst that will be partly responsible for monitoring monthly claims received from delegated groups as well as claims processed by the plan.
Consider a system upgrade to capture increased diagnosis code specificity for 4th and 5th digit coding.	SFHP's current system, QNXT, currently accommodates diagnosis codes to the fourth and fifth digit. If the data submitted include digits beyond the primary three digits, SFHP's current system accepts the data and includes them. With the advent of electronic medical records, SFHP expects more specific diagnosis codes in the future.
Implement a higher percentage of claims processing audits that are more comprehensive and include increased auditing of new delegated groups and a higher percentage of audits by claims processors.	SFHP is revamping its delegation oversight processes to ensure a higher level of monitoring to its delegates. In 2012, SFHP began using the Industry Collaboration Effort (ICE) tool for the claims file review. In 2013, SFHP plans to revise auditing tools and methodologies, as well as our delegation agreement and report deliverables tracking and validation.
Improve QIP documentation to increase compliance with validation requirements. ◆ Use HSAG's QIP Completion Instructions, which will help the plan document all required elements. ◆ Incorporate HSAG's recommendations provided in the QIP Validation Tool when resubmitting QIPs, to avoid the need for a second resubmission. ◆ Request technical assistance before resubmitting QIPs, when encountering difficulties with required documentation.	For future QIP submissions, SFHP will consult with HSAG to clarify questions regarding required documentation.
Evaluate factors that led to a statistically significant decline in the plan's performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* measure.	In 2010, this measure was new; and the BMI value was recorded, as opposed to the BMI percentile. The 2011 performance decrease is a reflection of a modified recording methodology.