# Performance Evaluation Report

## Health Plan of San Joaquin

July 1, 2012–June 30, 2013

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

April 2014

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# Performance Evaluation Report – Health Plan of San Joaquin

## July 1, 2012 – June 30, 2013



## Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs 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 provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and

[1] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Health Plan of San Joaquin ("HPSJ" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

## Managed Care Plan Overview

HPSJ is a full-scope MCP delivering services to its MCMC members as a "Local Initiative" (LI) MCP under the Two-Plan Model (TPM). In most TPM counties, there is an LI and a "commercial plan" (CP). DHCS contracts with both plans. The LI is designed—with the input of local government, community groups, and health care providers—to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. MCMC beneficiaries in San Joaquin and Stanislaus counties may enroll in HPSJ; the LI MCP; or in Health Net Community Solutions, Inc., the alternative CP.

HPSJ became operational in San Joaquin County to provide MCMC services effective February 1996 and in Stanislaus County in January 2013. As of June 30, 2013, HPSJ had 135,653 MCMC members in San Joaquin County and 42,072 in Stanislaus County—for a total of 177,725 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

## Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP'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 MCPs' 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, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

## Assessing the State's Compliance Review Activities

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

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP'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. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

### *Readiness Reviews*

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

### Medical Performance Audits and Member Rights Reviews

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

In HPSJ's 2011–12 MCP-specific evaluation report, HSAG reported on the February 2012 on-site routine medical survey conducted with the MCP by DMHC. At the time of the routine medical survey, DMHC also conducted an SPD Enrollment Survey; however, the results of the SPD survey were not available at the time the 2011–12 report was produced. The results of the SPD survey

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP 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 the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

were made available to HSAG as part of the process for producing the 2012–13 report and are therefore included below.

### Department of Managed Health Care Routine Medical Survey

In HPSJ's 2011–12 MCP-specific evaluation report, HSAG reported on deficiencies identified in the February 2012 Routine Medical Survey DMCH conducted with the MCP. At the time the 2011–12 MCP-specific evaluation report was being written, two deficiencies had not been fully resolved and were noted in the report. On October 3, 2013, DMHC issued a follow-up review report to HPSJ. Although the follow-up report was issued outside the July 1, 2012, through June 30, 2013, review period for this 2012–13 MCP-specific evaluation report, HSAG includes the results since they indicate resolution of the outstanding deficiencies. Specifically, DMHC indicated in the follow-up review report that:

- HPSJ provided all required documentation regarding the MCP's member grievance procedures and that the procedures are being consistently applied in practice by HPSJ.
- HPSJ submitted to DMHC the MCP's finalized policy regarding appointment availability and access standards, and the policy included the physician-to-member ratio, as required.

### Department of Managed Health Care SPD Enrollment Survey

DMHC conducted an SPD Enrollment Survey with HPSJ February 21, 2012, through February 23, 2012, covering the review period of November 1, 2010, through October 31, 2011. Although the survey occurred outside the review dates for this report, HSAG includes the findings since the follow-up letter was issued within the review dates of this report. The survey evaluated the following elements specifically related to the care of the SPD population:

- Utilization Management
- Continuity of Care
- Availability and Accessibility
- Member Rights
- Quality Management

DMHC identified four potential survey deficiencies related to the areas of Availability and Accessibility and Member Rights. In a follow-up letter from DHCS dated October 26, 2012, DHCS indicated that HPSJ submitted a corrective action plan (CAP) on October 1, 2012. DHCS noted that one of the deficiencies in the area of Member Rights had been corrected; however, three of the deficiencies were not fully corrected. The outstanding deficiencies and follow-up information are described below:

**Availability and Accessibility**

- DHCS found that HPSJ's online searchable provider directory does not incorporate the required level of access information or the accessibility indicators per provider site as required by MMCD Policy Letters 11-013 and 11-009. DHCS also recommended that the MCP consider making the online printable version of the provider directory available in the "Member Corner" section of the HPSJ Web site for easier access.
  - DHCS indicated that HPSJ submitted an updated version of the MCP's Medi-Cal Provider Directory (PDF Version September 2012) for review, but DHCS found no evidence that the level of access met per provider site was documented. DHCS also noted that as of August 8, 2012, the printable version of HPSJ's provider directory could be found in both the "Our Plans" and "Member Corner" sections of the HPSJ Web site.
- DHCS's review of HPSJ's Monitoring Provider to Member Ratios Policy revealed the absence of an established written standard for the ratio of enrollees to physicians within HPSJ's provider network.
  - DHCS indicated that HPSJ submitted a revised policy; however, the policy did not include the required information about the ratio for full-time physicians.

**Member Rights**

- While HPSJ's cultural and linguistic policy is consistent with regulations and requires that the notice be provided to SPD enrollees regarding the availability of language assistance, all Medi-Cal grievance case files reviewed lacked notice of available assistance for language services.
  - DHCS indicated that HPSJ submitted documentation showing that the language assistance information is included with all grievance resolution letters; however, the Mail Stop information for the Department of Social Services was incorrect, and DHCS indicated that the MCP is required to update this information.

## Strengths

HPSJ fully resolved all outstanding deficiencies from the February 2012 DMHC Routine Medical Survey. During the February 2012 SPD Enrollment Survey, DMHC found no potential deficiencies in the areas of Utilization Management, Continuity of Care, or Quality Management. Additionally, HPSJ fully corrected one of the potential deficiencies noted in the area of Member Rights through the CAP process.

## Opportunities for Improvement

HPSJ has the opportunity to make improvements in the areas of Availability and Accessibility and Member Rights, which impact the access and timeliness domains of care.

## Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal Managed Care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

## Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[5] The CMS EQR Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

## Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

To report HEDIS measure rates, MCPs must first have members meet continuous enrollment requirements for each measure being reported, which typically means members need to be enrolled in the MCP for 11 of 12 months during the measurement year. Since HPSJ began Medi-Cal operations in Stanislaus County in January 2013, HPSJ members in this county did not have continuous enrollment for HEDIS 2013, and data for Stanislaus County is not included in this report. Data for Stanislaus County will be included in HPSJ's 2013–14 MCP-specific evaluation report.

## Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for Health Plan of San Joaquin* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that HPSJ followed the appropriate specifications to produce valid rates. A review of the MCP's HEDIS audit report revealed the following observations:

- HPSJ did not have a claim backlog as had been experienced in the past, and had a quick turnaround time for processing claims.

[6] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[7] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

- As with the previous year's findings, HPSJ was proactive in engaging, incentivizing, and providing information to its providers and members. A comprehensive incentive program was in place for both providers and members designed to improve HEDIS scores, which typically leads to better health outcomes and performance.
- HPSJ staff members continued to be actively engaged in the HEDIS reporting process, setting goals for improved scores and outcomes.
- Although few processes were done manually, HPSJ continues to look for ways to further automate manual processes.
- HPSJ experienced challenges with the medical record software that impacted the MCP's ability to be as aggressive with medical record pursuit as it had been in prior years. The MCP worked with the vendor to resolve the issue; however, since abstractors had already begun to pursue medical records, they were not able to pursue multiple records for each member as had been done historically. HPSJ identified additional issues related to the *Comprehensive Diabetes Care* measures' records and made manual corrections. The auditor determined that the issues surrounding the medical record pursuit caused minimal impact on the findings.
- The auditor recommended that HPSJ include information about the MCP's new data warehouse in HPSJ's 2014 HEDIS Roadmap.

## Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

**Table 3.1—Name Key for Performance Measures in External Accountability Set**

| Performance Measure Abbreviation | Full Name of 2013 Reporting Year† Performance Measure |
|---|---|
| AAB | *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* |
| ACR | *All-Cause Readmissions* ‡ |
| AMB–ED | *Ambulatory Care—Emergency Department (ED) Visits* |
| AMB–OP | *Ambulatory Care—Outpatient 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)* |
| CBP | *Controlling High Blood Pressure* |
| 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)* |

**Table 3.1—Name Key for Performance Measures in External Accountability Set**

| Performance Measure Abbreviation | Full Name of 2013 Reporting Year† Performance Measure |
|---|---|
| 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* |
| MMA–50 | *Medication Management for People with Asthma—Medication Compliance 50% Total* |
| MMA–75 | *Medication Management for People with Asthma—Medication Compliance 75% Total* |
| 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* |

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.
‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Table 3.2 below presents a summary of HPSJ's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.2 shows the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

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 2012 and 2013 Performance Measure Results**
**HPSJ—San Joaquin County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| AAB | Q | 25.42% | 29.24% | ★★ | ↔ | 18.98% | 33.33% |
| ACR | Q, A | -- | 7.07% | -- | Not Comparable | -- | -- |
| AMB–ED | ‡ | 38.16 | 46.68 | ‡ | Not Comparable | ‡ | ‡ |
| AMB–OP | ‡ | 283.73 | 274.87 | ‡ | Not Comparable | ‡ | ‡ |
| CAP–1224 | A | 96.66% | 97.49% | ★★ | ↑ | 95.56% | 98.39% |
| CAP–256 | A | 86.82% | 87.59% | ★★ | ↑ | 86.62% | 92.63% |
| CAP–711 | A | 84.17% | 85.71% | ★ | ↑ | 87.56% | 94.51% |
| CAP–1219 | A | 83.53% | 84.94% | ★ | ↑ | 86.04% | 93.01% |
| CBP | Q | -- | 66.42% | -- | Not Comparable | -- | -- |
| CCS | Q,A | 68.61% | 64.23% | ★★ | ↔ | 61.81% | 78.51% |
| CDC–BP | Q | 77.62% | 78.28% | ★★★ | ↔ | 54.48% | 75.44% |
| CDC–E | Q,A | 53.28% | 45.62% | ★★ | ↓ | 45.03% | 69.72% |
| CDC–H8 (<8.0%) | Q | 55.96% | 52.37% | ★★ | ↔ | 42.09% | 59.37% |
| CDC–H9 (>9.0%) | Q | 36.74% | 39.60% | ★★ | ↔ | 50.31% | 28.95% |
| CDC–HT | Q,A | 81.51% | 80.66% | ★★ | ↔ | 78.54% | 91.13% |
| CDC–LC (<100) | Q | 39.17% | 35.22% | ★★ | ↔ | 28.47% | 46.44% |
| CDC–LS | Q,A | 78.59% | 75.55% | ★★ | ↔ | 70.34% | 83.45% |
| CDC–N | Q,A | 80.29% | 82.12% | ★★ | ↔ | 73.48% | 86.93% |
| CIS–3 | Q,A,T | 77.13% | 76.40% | ★★ | ↔ | 64.72% | 82.48% |
| IMA–1 | Q,A,T | 63.99% | 67.15% | ★★ | ↔ | 50.36% | 80.91% |
| LBP | Q | 80.67% | 81.80% | ★★ | ↔ | 72.04% | 82.04% |
| MMA–50 | Q | -- | 40.72% | -- | Not Comparable | -- | -- |
| MMA–75 | Q | -- | 21.82% | -- | Not Comparable | -- | -- |
| MPM–ACE | Q | 85.56% | 83.69% | ★ | ↔ | 83.72% | 91.33% |
| MPM–DIG | Q | NA | 92.11% | ★★ | Not Comparable | 87.93% | 95.56% |
| MPM–DIU | Q | 85.05% | 84.58% | ★★ | ↔ | 83.19% | 91.30% |
| PPC–Pre | Q,A,T | 88.08% | 85.64% | ★★ | ↔ | 80.54% | 93.33% |
| PPC–Pst | Q,A,T | 68.61% | 64.48% | ★★ | ↔ | 58.70% | 74.73% |
| W-34 | Q,A,T | 80.54% | 76.16% | ★★ | ↔ | 65.51% | 83.04% |

**Table 3.2—Comparison of 2012 and 2013 Performance Measure Results**
**HPSJ—San Joaquin County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| WCC–BMI | Q | 73.48% | 69.10% | ★★ | ↔ | 29.20% | 77.13% |
| WCC–N | Q | 72.51% | 72.75% | ★★ | ↔ | 42.82% | 77.61% |
| WCC–PA | Q | 65.69% | 61.80% | ★★ | ↔ | 31.63% | 64.87% |

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

## Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[8] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in

[8] Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care plan and for the subset of enrollees who are seniors and persons with disabilities. Managed care plan performance measures may include measures from HEDIS; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Tables 3.3 and 3.4, which present a summary of HPSJ's 2013 SPD measure results. Table 3.3 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.4 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.3.

**Table 3.3—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**HPSJ—San Joaquin County**

| Performance Measure | Non-SPD Rate | SPD Rate | SPD Compared to Non-SPD* | Total Rate (Non-SPD and SPD) |
|---|---|---|---|---|
| ACR | 6.27% | 13.75% | ▼ | 7.07% |
| CAP–1224 | 97.51% | 96.30% | ↔ | 97.49% |
| CAP–256 | 87.52% | 89.90% | ↔ | 87.59% |
| CAP–711 | 85.55% | 88.53% | ↔ | 85.71% |
| CAP–1219 | 84.77% | 87.69% | ↑ | 84.94% |
| CDC–BP | 60.34% | 63.26% | ↔ | 78.28% |
| CDC–E | 42.58% | 45.01% | ↔ | 45.62% |
| CDC–H8 (<8.0%) | 45.99% | 51.09% | ↔ | 52.37% |
| CDC–H9 (>9.0%) | 47.20% | 43.55% | ↔ | 39.60% |
| CDC–HT | 77.62% | 82.00% | ↔ | 80.66% |
| CDC–LC (<100) | 27.74% | 34.79% | ↑ | 35.22% |
| CDC–LS | 71.29% | 77.86% | ↑ | 75.55% |
| CDC–N | 76.40% | 82.24% | ↑ | 82.12% |
| MPM–ACE | 80.70% | 85.44% | ↑ | 83.69% |
| MPM–DIG | NA | 90.91% | Not Comparable | 92.11% |
| MPM–DIU | 81.44% | 86.39% | ↑ | 84.58% |

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.4—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**HPSJ—San Joaquin County**

| Non-SPD Visits/1,000 Member Months* | | SPD Visits/1,000 Member Months* | |
|---|---|---|---|
| Outpatient Visits | Emergency Department Visits | Outpatient Visits | Emergency Department Visits |
| 246.24 | 43.01 | 474.21 | 72.22 |

*Member months are a member's "contribution" to the total yearly membership.

## Performance Measure Result Findings

Overall, HPSJ demonstrated average performance on its measures in 2013. The rate for the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* was above the HPL. The rate for this measure has been above the HPL since 2011, which was the first year the MCPs were held to performing above the MPL on this measure.

Although the rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures had statistically significant improvement from 2012 to 2013, the rates for the *7–11 Years* and *12–19 Years* measures were below the MPLs. Additionally, the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE* measure was below the MPL. Although the MCP had three measures with rates below the MPLs, 2013 is the first year that HPSJ has had any measures with rates below the MPLs.

The rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure declined significantly from 2012 and 2013; however, the rate remained above the MPL.

### Seniors and Persons with Disabilities Findings

The following SPD rates were significantly higher than the non-SPD rates:

- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to bettering monitoring of care.

The SPD rate for the *All-Cause Readmissions* measure was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however, rates should be interpreted with caution as high and low rates do not necessarily indicate better or worse performance. For this

reason, DHCS does not establish performance thresholds for these measures, and HSAG does not provide comparative analysis.

### Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

Since HPSJ did not have any measures with rates below the MPLs in 2012, no IPs were required. The MCP will be required to submit an IP for the *Annual Monitoring for Patients on Persistent Medications—ACE* measure since the measure for this rate was below the MPL in 2013. Although HPSJ's rate on the *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* and *(12–19 Years)* measures were below the MPLs in 2013, the MCP will not be required to submit IPs for these measures. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact.

## Strengths

The rate for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* was above the HPL for the third year in a row, and the MCP had four measures with rates that had statistically significant improvement from 2012 to 2013.

## Opportunities for Improvement

HPSJ has an opportunity to improve its rates by focusing on the two *Children and Adolescents' Access to Primary Care Practitioners* measures and the *Annual Monitoring for Patients on Persistent Medications—ACE* measure, which all had rates below the MPLs. By identifying the factors that have caused the rates for these measures to be below the MPLs, HPSJ can improve the MCP's performance on these measures. The MCP also has the opportunity to assess the factors that led to a statistically significant decline in the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure to prevent further decline on the rate. Finally, the MCP has the opportunity to assess the factors leading to a significantly higher rate of readmissions for the SPD population and identify interventions to be implemented that will result in a decrease in readmissions for this population.

## Conducting the EQRO 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 CMS validation protocol[10] to ensure that MCPs 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.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county.

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* 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 MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

HSAG organized, aggregated, and analyzed HPSJ's validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[10] The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

## Quality Improvement Project Objectives

HPSJ participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2012–June 30, 2013.

Table 4.1 below lists HPSJ's QIPs and indicates the county in which the QIP is being conducted, whether the QIP is clinical or nonclinical, and the domains of care (i.e., quality, access, timeliness) the QIP addresses. Although HPSJ delivered services in Stanislaus County during the review period, the MCP was not required to have QIPs in place for this county during the review period. The MCP will be required to initiate QIPs for Stanislaus County in 2014 and HSAG will report on these QIPs in the MCPs 2013–14 MCP-specific evaluation report.

**Table 4.1—Quality Improvement Projects for HPSJ**
**July 1, 2012, through June 30, 2013**

| QIP | Counties | Clinical/Nonclinical | Domains of Care |
|---|---|---|---|
| *All-Cause Readmissions* | San Joaquin | Clinical | Q, A |
| *Improving the Percentage Rate of HbA1c Testing* | San Joaquin | Clinical | Q, A |

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. 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.

Prior to initiation of the statewide collaborative QIP, HPSJ had a 30-day readmission rate of 9 percent among Medi-Cal beneficiaries. HPSJ also found that the readmission rate for the SPD population was 12 percent, which was higher than the 6 percent rate for the non-SPD population.

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

## Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity**
**HPSJ—San Joaquin County**
**July 1, 2012, through June 30, 2013**

| 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** | | | | |
| *All-Cause Readmissions* | Study Design Submission | 90% | 100% | *Met* |
| **Internal QIPs** | | | | |
| *Improving the Percentage Rate of HbA1c Testing* | Annual Submission | 94% | 100% | *Met* |

[1] **Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP 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*.

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by HPSJ of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 90 percent of evaluation elements met. HPSJ also received an overall validation status of *Met* for its *Improving the Percentage Rate of HbA1c Testing* annual submission with 100 percent of critical elements and 94 percent of evaluation elements being met.

Table 4.3 summarizes the aggregated validation results for HPSJ's QIPs across CMS protocol activities during the review period.

**Table 4.3—Quality Improvement Project Average Rates***
**HPSJ—San Joaquin County**
**(Number = 2 QIP Submissions, 2 QIP Topics)**
**July 1, 2012, through June 30, 2013**

| 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% |
| | V: Valid Sampling Techniques (if sampling is used) | 100% | 0% | 0% |
| | VI: Accurate/Complete Data Collection | 90% | 0% | 10% |
| **Design Total** | | **96%** | **0%** | **4%** |
| Implementation | VII: Sufficient Data Analysis and Interpretation | 100% | 0% | 0% |
| | VIII: Appropriate Improvement Strategies | 100% | 0% | 0% |
| **Implementation Total** | | **100%** | **0%** | **0%** |
| Outcomes | IX: Real Improvement Achieved | 50% | 0% | 50% |
| | X: Sustained Improvement Achieved | Not Assessed | Not Assessed | Not Assessed |
| **Outcomes Total** | | **50%** | **0%** | **50%** |

*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.

HSAG validated Activities I through VI for HPSJ's *All-Cause Readmissions* study design submission and Activities I through IX for the MCP's *Improving the Percentage Rate of HbA1c Testing* QIP annual submission.

HPSJ demonstrated a strong application of the Design stage, meeting 96 percent of the requirements for all applicable evaluation elements within the stage across both QIPs. The MCP did not describe its data analysis plan for the *All-Cause Readmissions* QIP, which resulted in a lower score for Activity VI. HPSJ met all requirements for all applicable evaluation elements within the Design stage for its *Improving the Percentage Rate of HbA1c Testing* QIP.

Only the *Improving the Percentage Rate of HbA1c Testing* QIP progressed to the Implementation and Outcomes stages during the reporting period. The MCP demonstrated strong application of the Implementation stage, meeting 100 percent of the requirements for all applicable evaluation elements within the stage for the QIP. Although the study indicator for this QIP improved in Remeasurement 1, since the indicator did not achieve statistically significant improvement over

baseline, the score for Activity IX for this QIP was lowered. This QIP was not assessed for sustained improvement (Activity X) since it had not progressed to that stage yet.

## Quality Improvement Project Outcomes and Interventions

Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

The *All-Cause Readmissions* QIP did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information for this QIP is included in the table or report.

**Table 4.4—Quality Improvement Project Outcomes for HPSJ—San Joaquin County July 1, 2012, through June 30, 2013**

| QIP #1—*Improving the Percentage of HbA1c Testing* | | | |
|---|---|---|---|
| **Study Indicator:** Percentage of diabetic members with at least one HbA1c test | | | |
| **Baseline Period 1/1/10–12/31/10** | **Remeasurement 1 1/1/11–12/31/11** | **Remeasurement 2 1/1/12–12/31/12** | **Sustained Improvement¥** |
| 80.5% | 81.5% | ‡ | ‡ |

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.
‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

## *Improving the Percentage of HbA1c Testing* QIP

The *Improving the Percentage of HbA1c Testing* QIP project goal for Remeasurement 1 was a 5 percent increase from the baseline rate. HPSJ reported an improvement on the study indicator rate from baseline to Remeasurement 1; however, the improvement was not statistically significant. A review of the MCP's QIP Summary Form and Tool revealed the following observations:

- The MCP conducted data analysis according to the data analysis plan and included an interpretation of the findings for the study indicator.
- HPSJ completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process. Additionally, the documentation provided by the MCP included system interventions likely to have a long-term effect.
- HPSJ discussed an influx of new beneficiaries to the MCP during Remeasurement 1 and how the influx of beneficiaries may cause unique challenges; however, HPSJ did not provide any data on how the influx of the SPD population affected the rate on the *Comprehensive Diabetes Care*—

*HbA1c Testing* measure. In fact, HPSJ indicated a slight decrease in the eligible population for this measurement period.

- HPSJ did not select the type of administrative data used in the QIP. The MCP was provided feedback regarding this in the QIP's 2011–12 QIP Validation Tool, but the MCP did not include the information in its 2012 QIP submission.
- In the MCP's 2011–12 MCP-specific evaluation report, HSAG noted that one of the MCP's member incentive interventions for this QIP was related to diabetic members receiving eye exams, which was not related to the project outcome of increased HbA1c testing. In HPSJ's 2012 QIP submission, the MCP noted that it had assessed this incentive program and modified the incentive to support timely HbA1c testing for diabetic members.

## Strengths

HPSJ demonstrated an excellent application of the QIP Design and Implementation stages. The MCP achieved a *Met* validation status on its QIP submissions without needing to resubmit, indicating proficiency with the QIP validation process. For the *Improving the Percentage of HbA1c Testing* QIP, HPSJ modified one of the MCP's member incentive interventions to align with the project outcomes.

## Opportunities for Improvement

HPSJ has the opportunity to ensure that the MCP responds to all feedback provided in the QIP Validation Tool in subsequent QIP submissions.

## Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

HPSJ's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

## Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about HPSJ's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

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

CAHPS Global Rating Measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

CAHPS Composite Measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

**Table 5.1—CAHPS Measures Domains of Care**

| Measure | Domains of Care |
|---|---|
| *Rating of Health Plan* | Q |
| *Rating of All Health Care* | Q |
| *Rating of Personal Doctor* | Q |
| *Rating of Specialist Seen Most Often* | Q |
| *Getting Needed Care* | Q, A |
| *Getting Care Quickly* | Q, T |
| *How Well Doctors Communicate* | Q |
| *Customer Service* | Q |
| *Shared Decision Making* | Q |

## National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

**Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures**

| Star Rating | Adult and Child Percentiles |
|---|---|
| ★★★★★ Excellent | At or above the 90th percentile |
| ★★★★ Very Good | At or above the 75th and below the 90th percentiles |
| ★★★ Good | At or above the 50th and below the 75th percentiles |
| ★★ Fair | At or above the 25th and below the 50th percentiles |
| ★ Poor | Below the 25th percentile |

Table 5.3 and Table 5.4 present the star ratings for the global ratings and composite measures for HPSJ's adult and child Medicaid populations.[15]

**Table 5.3—Medi-Cal Managed Care County-Level Global Ratings**
**HPSJ—San Joaquin County**

| Population | Rating of Health Plan | Rating of All Health Care | Rating of Personal Doctor | Rating of Specialist Seen Most Often |
|---|---|---|---|---|
| **Adult** | ★★ | ★ | ★ | ★★★★ |
| **Child** | ★★★ | ★ | ★ | ★★★★+ |
| *+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.* | | | | |

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.
[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.
[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

**Table 5.4—Medi-Cal Managed Care County-Level Composite Measures**
**HPSJ—San Joaquin County**

| Population | Getting Needed Care | Getting Care Quickly | How Well Doctors Communicate | Customer Service |
|---|---|---|---|---|
| Adult | ★★ | ★ | ★ | ★★★★+ |
| Child | ★ | ★ | ★ | ★★★ |

*+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.*

## Strengths

HPSJ received a *Very Good* rating for the *Rating of Specialist Seen Most Often* for both the adult and child adult populations and a *Very Good* rating for the adult *Customer Service* measure. The MCP received a *Good* rating for the child *Rating of Health Plan* and *Customer Service* measures. Please note that since the MCP had fewer than 100 respondents for the child *Rating of Specialist Seen Most Often* and the adult *Customer Service* measures, caution should be exercised when evaluating these results.

HPSJ improved its ratings on the following measures from 2010 to 2013:

- *Rating of Health Plan*—adult and child populations
- *Rating of Specialist Seen Most Often*—adult and child populations
- *Getting Needed Care*—adult populations
- *Customer Service*—adult and child populations

## Opportunities for Improvement

HPSJ's CAHPS results showed below-average performance for the majority of the child and adult global ratings and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as HPSJ's highest priorities: *Rating of Personal Doctor, Rating of All Health Care,* and *Getting Care Quickly*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 HPSJ CAHPS MCP-Specific Report.* Areas for improvement spanned the quality and timeliness domains of care.

## Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

## Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[16] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[16] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

HPSJ's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

## Encounter Data Validation Findings

### *Review of Encounter Systems and Processes*

The information provided in HPSJ's Roadmap and the supplemental questionnaire demonstrate that the MCP has procedures in place for the creation, validation, correction, and ongoing monitoring of encounter data.

The MCP's process for submitting claims and encounters aligns with industry standards. HPSJ stated that it has implemented provider incentives to promote timely, complete, and accurate monthly encounter files from its contracted providers.

### *Record Completeness*

For both HPSJ and DHCS data sources, there were no long-term care (LTC) records. Overall, HPSJ had record omission rates greater than 20 percent across the Medical/Outpatient, Hospital/Inpatient, and Pharmacy claim types, indicating relatively incomplete data when comparing DHCS's data and the encounter data extracted from HPSJ's data system for this study. While all of the record omission rates were worse than the statewide rates by at least 6 percentage points, the record surplus rates were all relatively low (less than 7 percent) and performed better than their respective statewide rates by at least 4 percentage points. The record omissions for the Medical/Outpatient and Pharmacy claim types were mainly due to records without *CCNs* in the MCP's data. For the Hospital/Inpatient records omitted from the DHCS data, nearly 30 percent were without *CCNs,* and approximately 67 percent were records with *CCNs*.

## Data Element Completeness

HPSJ had high data element completeness results with element omission and element surplus rates of less than 2 percent for the key data elements, except the *Provider Specialty* and *Referring/Prescribing/Admitting Provider Number* in the Medical/Outpatient claim type. The element omission rate of 38.9 percent for the *Provider Specialty* was worse than the statewide rate of 3.7 percent. Nearly 56 percent of the records with *Provider Specialty* values omitted from the DHCS data had *Provider Specialty* "66" (Emergency Medicine), "08" (Family Practice), "40" (Pediatrics), or "16" (Obstetrics/Gynecology) in the MCP's data. The *Referring/Prescribing/Admitting Provider Number* in the Medical/Outpatient claim type had a very poor element surplus rate of 74.0 percent, which was worse than the statewide rate by more than 70 percentage points. For nearly all the records with *Referring/Prescribing/Admitting Provider Number* values in the DHCS data but not in the MCP's data, the values for the *Referring/Prescribing/Admitting Provider Number* were the same as those in the fields *Billing/Reporting Provider Number* and *Rendering Provider Number*. Additionally, the *Primary Surgical Procedure Code* and *Secondary Surgical Procedure Code* in the Hospital/Inpatient claim type had element surplus rates of 1.9 percent and 1.5 percent, respectively, which were slightly worse than the statewide rates of 0.0 percent.

## Data Element Accuracy

HPSJ had both high and low element accuracy rates across the three claim types. In the Medical/Outpatient claim type, five elements had accuracy rates above 99 percent, and six elements had rates below the respective statewide rates. The Medical/Outpatient claim type had element accuracy rates of approximately 50 percent for the *Billing/Reporting Provider Number, Rendering Provider Number,* and *Provider Type* data elements and a rate of 11.5 percent for the *Referring/Prescribing/Admitting Provider Number*. These low accuracy rates were caused by differing provider number lengths and differing values populated in the records from HPSJ and DHCS. In addition, the Medical/Outpatient claim type had a *CPT/HCPCS Codes* accuracy rate of 81.8 percent due to the additional letter populated in the MCP's data but not in the DHCS file (i.e., MCP file: "90471A"; DHCS file "90471"). The Hospital/Inpatient data elements generally had accuracy rates greater than 95 percent, except for the *Provider Type,* which had an accuracy rate of 0.0 percent. Nearly 80 percent of the disagreement was attributable to a value of "16" (Community Hospital Inpatient) in the DHCS file and values of "22" (Physicians Group), "26" (Physicians), or "99" (Dentists) in HPSJ's file. The Pharmacy data elements had accuracy rates of 100.0 percent, except for the *Billing/Reporting Provider Number*. This element had an element accuracy rate of 0.0 percent due to truncation of 12 digits in the MCP's data and 10 digits in the DHCS file.

Due to the poor element accuracy rates in numerous data elements, the all-element accuracy rates across all claim types were less than 3 percent. These rates fell below the respective statewide rates by at least 60 percentage points.

## Recommendations

Based on its review, HSAG recommends the following:

- For both HPSJ and DHCS data sources, there were no LTC records. However, in HPSJ's response to HSAG's preliminary file review, HPSJ indicated that it may have skilled nursing facility (SNF) records that are classified as interim claims while DHCS moves members to the FFS program. These records were included with the Hospital/Inpatient and Medical/Outpatient claim types. HPSJ should clarify with DHCS how these SNF records should be submitted to DHCS.
- HPSJ had a large number of record omissions for all three claim types. The record omissions for the Medical/Outpatient and Pharmacy claim types were mainly due to records without *CCNs* in the MCP's data. HPSJ did not create a *CCN* for these records because HPSJ did not plan to submit the records to DHCS. HPSJ should work with DHCS and evaluate whether the records without *CCNs* should be submitted to DHCS. As for the Hospital/Inpatient record omissions, nearly 30 percent were from the records without *CCNs*. HPSJ should investigate the high record omission rate for the Hospital/Inpatient claim type and create strategies for improvement.
- HPSJ had a poor element omission rate for the *Provider Specialty* for the Medical/Outpatient claim type. The MCP should investigate why the omitted *Provider Specialty* values were not populated in DHCS's data file.
- The *Referring/Prescribing/Admitting Provider Number* data element had a poor element surplus rate of 74.0 percent for the Medical/Outpatient claim type. This issue may be related to most of the Medical/Outpatient records in DHCS's data having the same values for the *Billing/Reporting Provider Number*, *Rendering Provider Number,* and *Referring/Prescribing/Admitting Provider Number,* but this did not occur for the MCP's Medical/Outpatient data. HPSJ should review its database to understand why DHCS had surplus values for this data element and establish protocols to prevent this issue from occurring in the future.
- The data element *Provider Type* did not match between the two data sources for all Hospital/Inpatient records. The MCP should review the differences and investigate the low *Provider Type* accuracy rates in the Hospital/Inpatient claim type.
- For the Pharmacy data, the *Billing/Reporting Provider Number* had an element accuracy rate of 0.0 percent due to truncation from values with 12 digits in length in the MCP's data to 10 digits in length in the DHCS data. For this data element, the field length is 12 characters based on the Encounter Data Element Dictionary. However, this data element was stored as a 10-character

field in the DHCS data warehouse. HPSJ should try to submit the providers' 10-digit National Provider Identifier (NPI) to DHCS whenever possible for this data element.

- For the Medical/Outpatient claim type, HPSJ should investigate the very low element accuracy rates (less than 55 percent) for the *Billing/Reporting Provider Number, Rendering/Operating Provider Number*, *Referring/Prescribing/Admitting Provider Number*, and *Provider Type* and apply appropriate quality control procedures to avoid similar issues occurring in future data submissions.
- The Medical/Outpatient claim type had a relatively low *CPT/HCPCS Codes* accuracy rate of 81.8 percent because the MCP submitted a procedure code with five alphanumeric values with an additional alpha character, and the DHCS data did not contain this additional character. HPSJ should take action to improve the accuracy rate for the *CPT/HCPCS Codes* in the Medical/Outpatient claim type.
- For the Hospital/Inpatient claim type, HPSJ used the values from the *Rendering Provider Number* in its data system to populate the *Referring/Prescribing/Admitting Provider Number* element. HPSJ should evaluate whether it is reasonable to continue this process.

## Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each MCP in the three domains of care—quality, access, and timeliness. A numerical score is calculated for each domain of care for performance measure rates, CAHPS survey measure ratings, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores, CAHPS survey measure ratings scores, and QIP performance scores, is then calculated for each domain of care and converted to a rating of above average, average, or below average. In addition to the performance score derived from performance measures, CAHPS survey measures, and QIPs, HSAG uses results from the MCPs' medical performance and Medi-Cal Managed Care Division reviews and assessment of the accuracy and completeness of encounter data to determine overall performance within each domain of care, as applicable. A more detailed description of HSAG's scoring process is included in Appendix A.

### *Quality*

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[17]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP 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 an MCP'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. DHCS also uses the results

[17] This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

HSAG reviewed HPSJ's quality improvement program description, work plan, and quality improvement activity results information, which include goals, objectives, and activities that support the provision of quality care to Medi-Cal beneficiaries, including monitoring processes that include continuous quality improvement.

DMHC did not identify any deficiencies in areas that are in the quality domain of care when conducting the February 2012 SPD Enrollment Survey.

The rate for one quality measure—*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*—was above the HPL for the third year in a row, and the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE* measure was below the MPL. No quality measures had rates with statistically significant improvement from 2012 to 2013, and the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure, which falls into the quality domain of care, had a significant decline in its rate from 2012 to 2013.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and five of these measures had SPD rates that were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The SPD rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care, was significantly higher than the non-SPD rate, meaning that significantly more members in the SPD population (aged 21 years and older) were readmitted due to all causes within 30 days of an inpatient discharge than members in the non-SPD population.

All CAHPS measures fall into the quality domain of care. Most of the measures had a *Poor* or *Fair* rating for both the adult and child populations, suggesting that most members are not fully satisfied with the quality of their care. The *Rating of Health Plan* and *Customer Service* measures received a *Good* rating for the child population and the following CAHPS measures received a *Very Good* rating:

- *Rating of Specialist Seen Most Often*—adult and child populations
- *Customer Service*—adult population

Both of HPSJ's QIPs fall into the quality domain of care. The *All-Cause Readmissions* QIP did not progress to the Outcomes stage, so HSAG was not able to assess this QIP's success at improving the quality of care delivered to the MCP's Medi-Cal members. The *Improving the Percentage of HbA1c*

*Testing* QIP progressed to Remeasurement 1 during the review period, and although the QIP achieved some improvement in its study indicator, the improvement was not statistically significant.

Overall, HPSJ showed average performance related to the quality domain of care.

### Access

The access domain of care relates to an MCP'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 MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP'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. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results 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.

HSAG reviewed HPSJ's quality improvement program description, work plan, and quality improvement activities results information. The MCP appears to have processes in place to ensure access to care for HPSJ's Medi-Cal members.

Two of the unresolved potential deficiencies from the February 2012 SPD Enrollment Survey fall into the access domain of care. These deficiencies are related to the MCP providing all required provider access information on the HPSJ Web site and the MCP's monitoring of provider-to-member ratios.

The four *Children and Adolescents' Access to Primary Care Practitioners* measures, which fall into the access domain of care, had rates with statistically significant improvement from 2012 to 2013. The *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure, which is also an access measure, had a significant decline in its rate from 2012 to 2013.

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and three of these measures had SPD rates that were significantly better than the non-SPD rates. As indicated above, the better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. The SPD rate for the *All-Cause Readmissions* measure, which falls into the access domain of care, was significantly higher than the non-SPD

rate. As indicated above, this means that significantly more members in the SPD population (aged 21 years and older) were readmitted due to all causes within 30 days of an inpatient discharge than members in the non-SPD population.

The *Getting Needed Care* CAHPS measure falls into the access domain of care. HPSJ received a *Fair* rating on this measure for the adult population and a *Poor* rating for the child population, suggesting that members are not satisfied with the level of access to needed services.

Both of HPSJ's QIPs fall into the access domain of care. As indicated above, the *All-Cause Readmissions* QIP did not progress to the Outcomes stage; therefore, HSAG was not able to assess this QIP's success at improving access to care for the MCP's Medi-Cal members. Also as indicated above, the *Improving the Percentage of HbA1c Testing* QIP progressed to Remeasurement 1 during the review period, and although the QIP achieved some improvement in its study indicator, the improvement was not statistically significant.

Overall, HPSJ showed below-average performance related to the access domain of care.

### Timeliness

The timeliness domain of care relates to an MCP'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 MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' 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. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

One of the unresolved potential deficiencies from the February 2012 SPD Enrollment Survey falls into the timeliness domain of care. The deficiency is in the area of Member Rights and is related to HPSJ providing accurate information in the MCP's grievance resolution letters.

HPSJ performed average on all timeliness performance measures included in DHCS's External Accountability Set. One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care, and HPSJ received a *Poor* rating on this measure for both the adult and child populations, suggesting that members are not satisfied with the time it takes to receive health care services.

Overall, HPSJ showed average performance in the timeliness domain of care.

## Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-specific evaluation report. HPSJ's self-reported responses are included in Appendix B.

## Recommendations

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

- Ensure all potential deficiencies from the February 21, 2012, through February 23, 2012, SPD Enrollment Survey are resolved. Specifically:
  - Ensure that the level of access met per provider site is documented in the MCP's Medi-Cal Provider Directory.
  - Ensure that HPSJ's Monitoring Provider to Member Ratios Policy includes the required information about the ratio for full-time physicians.
  - Ensure that the Mail Stop information for the Department of Social Services is corrected on the MCP's grievance resolution letters.
- Assess the factors that have led to the rates on the *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*, *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*, and *Annual Monitoring for Patients on Persistent Medications—ACE* measures falling below the MPLs and identify interventions to be implemented that will result in an improvement on performance.
- Assess the factors that led to a statistically significant decline in the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure from 2012 to 2013 to prevent further decline on the rate.
- Assess the factors leading to a significantly higher rate of readmissions for the SPD population and identify strategies to ensure the MCP is meeting the needs of the SPD population.
- Ensure that all comments from the QIP Validation Tool are responded to when completing the QIP Summary Form for all QIPs.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Rating of Personal Doctor, Rating of All Health Care,* and *Getting Care Quickly* priority areas.
- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

## Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the 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**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.
   - If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.

[18] The CMS protocols specify that the EQRO must include an assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

### Access and Timeliness Domains

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.
   - If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

## CAHPS Survey Measures

*(Refer to Tables 5.3 through 5.4)*

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

### Quality Domain

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

### Access Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

### Timeliness Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

## Quality Improvement Projects (QIPs)

***Validation*** *(Table 4.2)*: For each QIP submission and subsequent resubmission(s), if applicable.

1. **Above Average** is not applicable.
2. **Average** = *Met* validation status.
3. **Below Average** = *Partially Met* or *Not Met* validation status.

***Outcomes*** *(Table 4.4)*: Activity IX, Element 4—Real Improvement

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

***Sustained Improvement*** *(Table 4.4)*: Activity X—Achieved Sustained Improvement

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **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.

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

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 and Medi-Cal Managed Care Division reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures, CAHPS measures, and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the encounter data validation (EDV) study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

# *Appendix B.* MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

*for* Health Plan of San Joaquin

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with HPSJ's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

**Table B.1—HPSJ's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report**

| 2011–12 External Quality Review Recommendation | HPSJ's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation |
|---|---|
| 1. Ensure the two outstanding deficiencies from the DMHC on-site routine medical survey are fully resolved. Specifically: | |
| a. Provide evidence that the plan's policies and procedures include how HPSJ's Quality Improvement and Grievance Departments will communicate regarding the status of grievances. Additionally, ensure the plan's policies include a process to ensure the Quality Improvement Department communicates to the Grievance Department when its investigation of a grievance is completed so the Grievance Department knows to send the resolution letter. | HPSJ's Grievance policy and procedure, GRV02 and Quality Management call log workflow processes have been updated to reflect communication flow between the Grievance Department and Quality Management.<br>(attached for your review)<br><br>**NOTE:** HSAG reviewed the policy, which appears to include all required information. |
| b. Provide DMHC with the final version of the plan's Appointment Availability and Access Standards policy. | HPSJ's Appointment Availability and Access Standard policy and procedure, QA04, has been updated and attached for your review.<br>**NOTE:** HSAG reviewed the policy; however, the MCP did not indicate if the policy had been submitted to DMHC. |
| 2. Consider making the QI evaluation more robust to summarize the activities outlined in the work plan for the year. | HPSJ is working toward NCQA accreditation and as such has expanded the Quality Management and Utilization Work Plan as well as the QM/UM work plan evaluation. The QM/UM work plan attached highlights the 2012–2013 accomplishments. The QM/UM Work Plan program revisions are based on clinical outcomes, effectiveness of interventions, contractual agreements, and NCQA accreditation standards.<br><br>**NOTE:** HSAG reviewed the work plan, which shows more robust evaluation efforts. |

| 2011–12 External Quality Review Recommendation | HPSJ's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation |
|---|---|
| 3. Conduct annual QIP barrier analyses, providing results and data specific to the identified barriers. Additionally, incorporate a method to evaluate the effectiveness of each intervention. | HPSJ currently has three QIPs that include ACR, improving percent of HbA1c testing, and improving the HEDIS measure MPM-ACE. Each QIP will have a minimum of biannual data review, barrier analysis, and evaluation of effectiveness of its interventions. HPSJ stakeholders are invited to review each QIP for qualitative and quantitative analysis to promote discussion for further development to ensure QIP improvement goals can be reached and sustained.<br>HPSJ currently uses the Plan-Do-Study-Act (PDSA) process to assess interventions and programs in place for quality improvement projects. |
| 4. For its *Improving the Percentage of HbA1c Testing* QIP, include a plan to evaluate the efficacy of the interventions—specifically, using subgroup analysis to determine if initiatives are uniformly affecting the entire eligible population. The plan could evaluate the outcomes by gender, age, provider, etc., to understand any disparities that may exist in the study population in relation to the study outcome. The plan should also ensure that the documented barriers and corresponding interventions are targeted specifically to HbA1c testing rather than to other diabetes measures. | HPSJ stakeholders completed analysis for HEDIS data measure A1C testing for age and provider information. This analysis identified that younger members age band 18–38 were not getting their HbA1c testing completed as compared to other age bands. It was identified that the 18-to-21-age members within this age band may have received care for their diabetes within the CCS system, and HPSJ would not have record or access to these lab values. Data analysis via stakeholders' meeting also identified that providers with low-volume membership could be unaware of best practice/clinical guidelines for diabetic care.<br>HPSJ noted that specific focus on HbA1c testing will need to be a required focus going forward for this QIP. The data reviewed indicated previous interventions were not effective and HPSJ is revising the program to be more specific to HbA1c testing. Outreach to identify providers and members is being developed with a focus on the HbA1c testing. Case Management along with Disease Management programs were redesigned with a focus on diabetes.<br>HPSJ's QIP to improve A1C testing was revised, resubmitted to DHCS, and submission was approved. |
| 5. For the *Improving the Percentage of HbA1c Testing* QIP, potentially target interventions to high-volume providers with low performance. By targeting improvement efforts to fewer providers and providing more one-on-one education and support, the plan may increase the likelihood for success of the project. | Targeted provider outreach was completed to address HbA1c testing to achieve desired lab completion for both low-volume, poor performing providers as well as high-volume, low-performing providers. During the 2012–2013 fiscal years, HPSJ also partnered with our safety net providers who have a large diabetic population to develop Patient Centered Medical Home Programs within their clinics. Diabetes was the targeted disease management intervention that included evaluation of coexisting depression. Access to care, patient care coordination, and diabetic guidelines that included HbA1C testing were among some of the PCMH goals.<br>Part of HPSJ's corporate metric is to improve HbA1C testing and control. HEDIS scores for 2014 will be assessed to evaluate effectiveness of HPSJ's targeted outreach. |