Performance Evaluation Report

Health Plan of San Mateo

July 1, 2012–June 30, 2013

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

April 2014

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1. INTRODUCTION

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 Mateo ("HPSM" 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

HPSM is a full-scope MCP delivering services to its MCMC members as a County Organized Health System (COHS). A COHS is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of managed care providers. Each COHS MCP is sanctioned by the County Board of Supervisors and governed by an independent commission.

HPSM became operational to provide MCMC services in San Mateo County in December 1987. As of June 30, 2013, HPSM had 65,646 MCMC members in San Mateo County.[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 HPSM's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

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.

Member Rights/Program Integrity Unit Routine Monitoring Review

The most recent routine monitoring review for HPSM was conducted November 7, 2011, through November 9, 2011, covering the review period of July 1, 2010, through October 21, 2011. HSAG reported on the detailed findings from this review in HPSM's 2011–12 MCP-specific evaluation

[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).

report. The Member Rights/Program Integrity Unit (MR/PIU) identified findings in the areas of Member Grievances, Prior Authorization Notification, and Cultural and Linguistic Services. In a letter dated June 17, 2013, MR/PIU indicated that in September 2012, MR/PIU conducted a follow-up review of HPSM. As part of the follow-up review, MR/PIU evaluated HPSM's progress on conducting SPD sensitivity training and facility site review assessments.

The June 17, 2013, letter indicated that HPSM had taken appropriate action to correct all findings from the November 2011 review. Additionally, the letter indicated that MR/PIU found the MCP's progress on providing SPD sensitivity training and facility site review assessments to be satisfactory.

Strengths

HPSM resolved all outstanding findings from the most recent MR/PIU Routine Monitoring Review and was found to be making satisfactory progress on providing SPD sensitivity training and facility site review assessments.

Opportunities for Improvement

Since HPSM resolved all areas of concern identified through the most recent MR/PIU survey, HSAG does not have any recommendations for opportunities for improvement related to compliance reviews.

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.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for Health Plan of San Mateo* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that HPSM followed the appropriate specifications to produce valid rates. Although the auditor identified multiple areas of concern during the audit, the identified issues had minimal impact on the audit findings. A review of the MCP's HEDIS audit report revealed the following observations:

- As with the previous year, HPSM experienced a backlog of claims throughout the measurement year.
- The MCP had 10 claims that did not include the proper coding specificity. The auditor recommended that HPSM implement editing processes that require valid coding specificity.
- During the measurement year, HPSM did not receive pharmacy data for reversals/denials and there was a decrease in pharmacy per member per month (PMPM) rates. The auditor confirmed that the data being reported were reasonable; however, the auditor recommended that HPSM explore options to reconcile pharmacy reversals to ensure that the reported data are accurate.

[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).

- HPSM captured *Rendering Provider* as an optional field, which may result in underreporting or an increase in medical record review for some hybrid measures. To improve data capture, the auditor recommended that HPSM require billing providers to populate the *Rendering Provider* field rather than having it be optional.
- HPSM manually entered provider data into two systems—one for credentialing and one for claims processing. The auditor noted that the MCP does not reconcile the databases and recommended that HPSM reconcile the data at least annually.

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)*
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*

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

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
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 HPSM'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
HPSM—San Mateo 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	34.06%	34.46%	★★★	↔	18.98%	33.33%
ACR	Q, A	--	14.52%	--	Not Comparable	--	--
AMB–ED	‡	51.62	52.11	‡	Not Comparable	‡	‡
AMB–OP	‡	483.04	546.12	‡	Not Comparable	‡	‡
CAP–1224	A	95.89%	96.70%	★★	↔	95.56%	98.39%
CAP–256	A	88.34%	88.32%	★★	↔	86.62%	92.63%
CAP–711	A	87.75%	89.36%	★★	↑	87.56%	94.51%
CAP–1219	A	84.89%	85.61%	★	↔	86.04%	93.01%
CBP	Q	--	51.34%	--	Not Comparable	--	--
CCS	Q,A	61.99%	66.33%	★★	↔	61.81%	78.51%
CDC–BP	Q	66.18%	56.93%	★★	↓	54.48%	75.44%
CDC–E	Q,A	61.07%	57.42%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	55.72%	56.45%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	37.96%	35.28%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	79.81%	83.70%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	46.47%	46.96%	★★★	↔	28.47%	46.44%
CDC–LS	Q,A	82.00%	80.78%	★★	↔	70.34%	83.45%
CDC–N	Q,A	87.83%	82.97%	★★	↓	73.48%	86.93%
CIS–3	Q,A,T	80.29%	75.56%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	68.49%	70.28%	★★	↔	50.36%	80.91%
LBP	Q	81.51%	80.07%	★★	↔	72.04%	82.04%
MMA–50	Q	--	48.51%	--	Not Comparable	--	--
MMA–75	Q	--	26.38%	--	Not Comparable	--	--
MPM–ACE	Q	89.28%	89.51%	★★	↔	83.72%	91.33%
MPM–DIG	Q	92.71%	94.95%	★★	↔	87.93%	95.56%
MPM–DIU	Q	89.85%	90.57%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	81.89%	84.18%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	61.22%	59.18%	★★	↔	58.70%	74.73%
W-34	Q,A,T	73.80%	77.13%	★★	↔	65.51%	83.04%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
HPSM—San Mateo 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	66.67%	55.47%	★★	↓	29.20%	77.13%
WCC–N	Q	77.62%	70.05%	★★	↓	42.82%	77.61%
WCC–PA	Q	63.99%	53.91%	★★	↓	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 HPSM'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 HPSM—San Mateo County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	19.24%	13.28%	▲	14.52%
CAP–1224	96.98%	79.41%	↓	96.70%
CAP–256	88.77%	74.72%	↓	88.32%
CAP–711	90.72%	72.19%	↓	89.36%
CAP–1219	87.60%	65.03%	↓	85.61%
CDC–BP	13.38%	48.18%	↑	56.93%
CDC–E	32.36%	57.42%	↑	57.42%
CDC–H8 (<8.0%)	46.47%	55.72%	↑	56.45%
CDC–H9 (>9.0%)	35.52%	46.72%	▼	35.28%
CDC–HT	78.35%	83.94%	↑	83.70%
CDC–LC (<100)	30.90%	48.18%	↑	46.96%
CDC–LS	69.34%	83.21%	↑	80.78%
CDC–N	73.97%	85.16%	↑	82.97%
MPM–ACE	85.52%	89.95%	↑	89.51%
MPM–DIG	NA	94.79%	Not Comparable	94.95%
MPM–DIU	84.70%	91.23%	↑	90.57%

* 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 HPSM—San Mateo County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
405.92	49.86	924.90	58.21

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

Performance Measure Result Findings

Overall, HPSM performed average on its measures in 2013. The MCP had two measures with rates above the HPLs compared to five measures with rates above the HPLs in 2012. The rate for *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was above the HPL for the second year in a row. The MCP has consistently performed well on this measure, with the rate also being above the HPL in 2010. HPSM also has performed well on the *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure. The rate for this measure has been above the HPL since 2009.

The rate for the *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* measure improved significantly from 2012 to 2013. The rate for the *Cervical Cancer Screening* measure improved more than 4 percentage points from 2012 to 2013. Although the improvement on the *Cervical Cancer Screening* measure was not statistically significant, the rate for this measure moved from below the MPL in 2012 to above the MPL in 2013.

The rate for *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* measure was below the MPL in 2013, and the rates for the following measures declined significantly from 2012 to 2013:

- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assess: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity: Total*

The rates for the five measures that declined significantly from 2012 to 2013 were still above the MPLs in 2013; however, continued decline in the rates could result in the rates for these measures falling below the MPLs.

Seniors and Persons with Disabilities Findings

The SPD rates for the following measures were significantly better than the non-SPD rates:

- *All-Cause Readmissions*
- *Comprehensive Diabetes Care—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 Testing*
- *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 SPD rates for the following measures were significantly worse than the non-SPD rates:

- All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

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 *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.

HPSM had an IP in place for the *Cervical Cancer Screening* measure during the review period. Below is a summary of the IP and HSAG's assessment of the progress the MCP made toward improving the rate on the measure.

Cervical Cancer Screening

HPSM described a variety of barriers that prevented the rate for the *Cervical Cancer Screening* measure from being above MPL in 2012, including:

- Lack of provider knowledge on how to appropriately bill for Pap tests.
- Lack of member knowledge about the importance of having an annual Pap test.
- Lack of member access to receiving an annual Pap test.

To address the identified barriers and improve the rate on this measure, HPSM implemented several interventions, including:

- Analyzed provider data to identify providers who are not billing appropriately and educated the providers on how to appropriately bill for Pap tests.
- Mailed cards to members aged 21 to 65 years reminding them to schedule an annual Pap test. The cards included a list of OB/GYNs.
- Conducted outreach calls through the MCP's Nurse Advice Line to members who had not received a Pap test in the previous three years.

HPSM's efforts resulted in the rate for this measure improving by more than 4 percentage points from 2012 to 2013, which led to the rate being above the MPL in 2013. HPSM will not be required to continue the IP for this measure.

Children and Adolescents' Access to Primary Care Practitioners

Although HPSM's rate for *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* measure was below the MPL in 2013, the MCP will not be required to submit an IP for this measure. 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

HSAG auditors determined that HPSM followed the appropriate specifications to produce valid performance measure rates. As a way to improve data capture, the MCP implemented a new scanning and batching process late in 2012.

HPSM had two measures with rates above the HPLs in 2013 and one measure with statistically significant improvement from 2012 to 2013. The MCP's IP for the *Cervical Cancer Screening* measure was successful at bringing the rate for this measure above the MPL in 2013.

Opportunities for Improvement

Although HSAG auditors determined that HPSM produced valid performance measure rates, the auditor recommended the following to the MCP:

- Implement editing processes that require valid coding specificity on claims.
- Explore options to reconcile pharmacy reversals to ensure that the reported data are accurate.
- To improve data capture, require billing providers to populate the *Rendering Provider* field rather than having it be optional.
- Reconcile the data in the MCP's credentialing and claims processing databases at least annually.

HPSM has an opportunity to improve its performance by focusing on the measures with rates that declined significantly from 2012 to 2013. By identifying the factors that have caused the rates on these measures to decline, the MCP can improve the rates on the measures and prevent them from moving from above the MPLs to below the MPLs. For measures with SPD rates that were significantly worse than the non-SPD rates, HPSM has the opportunity to assess the factors leading to the rates being significantly worse for the SPD population and identify strategies to ensure the MCP is meeting this population's needs.

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 HPSM'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

HPSM 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 HPSM's QIPs and indicates whether the QIP is clinical or nonclinical and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

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

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Increasing Timeliness of Prenatal Care	Clinical	Q, A, T

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, HPSM had a 30-day readmission rate of 12.24 percent among Medi-Cal beneficiaries. HPSM also found that the readmission rate for the SPD population was 12.54 percent, which was higher than the 9.02 percent rate for the non-SPD population.

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

Quality Improvement Project Validation Findings

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
HPSM—San Mateo 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	80%	100%	*Met*
Internal QIPs				
Increasing Timeliness of Prenatal Care	Annual Submission	91%	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 HPSM of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 80 percent of evaluation elements met. HPSM also received an overall validation status of *Met* for its *Increasing Timeliness of Prenatal Care* annual submission with 100 percent of critical elements and 91 percent of evaluation elements being met.

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

Table 4.3—Quality Improvement Project Average Rates*
HPSM—San Mateo 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	80%	10%	10%
Design Total**		**93%**	**4%**	**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	25%	0%	75%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**25%**	**0%**	**75%**

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

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

HSAG validated Activities I through VI for HPSM's *All-Cause Readmissions* QIP study design submission and Activities I through IX for the MCP's *Increasing Timeliness of Prenatal Care* QIP annual submission.

HPSM demonstrated a strong application of the Design stage, meeting 93 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP did not document consistent measurement dates or describe the data analysis plan for the *All-Cause Readmissions* QIP, resulting in a lower score for Activity VI. HPSM met 100 percent of the requirements for all applicable evaluation elements within the Design stage for the *Increasing Timeliness of Prenatal Care* QIP.

Only the *Increasing Timeliness of Prenatal Care* QIP progressed to the Implementation and Outcomes stages during the reporting period. The MCP met 100 percent of the requirements for all applicable evaluation elements for the Implementation stage. Since the study indicator has not yet achieved statistically significant improvement over baseline, the QIP received a lower score in

Activity IX. Activity X was not scored for this QIP since sustained improvement could not be assessed.

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 implementation or outcome information for this QIP is included in Table 4.4 or the report.

Table 4.4—Quality Improvement Project Outcomes for HPSM—San Mateo County July 1, 2012, through June 30, 2013

QIP #1—Increasing Timeliness of Prenatal Care			
Study Indicator: Percentage of members that had a prenatal care visit in the first trimester or within 42 days of enrollment			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
85.3%	83.2%	81.9%	‡

¥ 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.

Increasing Timeliness of Prenatal Care QIP

The *Increasing Timeliness of Prenatal Care* QIP project goal was to increase the percentage of eligible members having a prenatal visit in the first trimester or within 42 days of enrollment in the MCP by 5 percent. Although not statistically significant, the rate for the study indicator declined from baseline to Remeasurement 1 and from Remeasurement 1 to Remeasurement 2. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- HPSM included interventions that were implemented in 1991. The baseline measurement period was CY 2009; therefore, the 1991 interventions should not be included in the QIP Summary Form. In addition, the MCP reported that it completed a member survey, and lack of knowledge was not identified as a barrier by the pregnant women that were surveyed; however, the member interventions addressed "lack of awareness." HPSM should re-evaluate if the MCP should address other barriers since the study indicator rate has declined since baseline.
- HPSM reported that the MCP continued to receive timely data from the Human Services Agency that included a monthly report of pregnant women who were approved for the Presumptive Eligibility for Pregnant Women Program and new HPSM members. The MCP

continued to document an increase in timely prenatal visits for women enrolled in HPSM after their pregnancy began.

- HPSM continued the social marketing campaign "Go Before You Show" targeting early prenatal care through Medi-Cal's Presumptive Eligibility for Pregnant Women Program. The campaign successfully increased enrollment in the program; however, prenatal visits received during the two months of eligibility in the program but prior to Medi-Cal enrollment in a specific MCP are not credited to the MCP. Consequently, these prenatal visits do not affect the MCP's project outcome. HPSM was able to identify through chart review that women had received timely prenatal care; however, since an additional prenatal visit did not occur within 42 days after the women were eligible for Medi-Cal and enrolled in HPSM, the marketing campaign was not successful in improving HPSM's prenatal visit rate. Despite these results, HPSM continued this intervention.
- HPSM added a "Secret Shopper" intervention to assess timeliness of access to OB/GYN providers for newly pregnant Medi-Cal members seeking prenatal care. Although HPSM indicated that, overall, the MCP did not identify any delays in members being able to schedule an appointment, the MCP learned that many OB/GYN providers are not willing to accept Medi-Cal members. The MCP indicated that it will continue to strategize about how to address this barrier.

Strengths

HPSM demonstrated an excellent application of the QIP design and implementation stages for both QIPs. The MCP achieved a *Met* validation status for both QIPs on the first submission.

Opportunities for Improvement

Since HPSM did not include all required documentation for the *All-Cause Readmissions* QIP, the MCP has the opportunity to improve the completeness of the documentation included in the MCP's QIP submissions.

For the *Increasing Timeliness of Prenatal Care* QIP, HPSM should continue to explore access-related barriers for beneficiaries seeking prenatal care. Specifically, the MCP should implement targeted interventions that may promote providers accepting new Medi-Cal beneficiaries. Additionally, HPSM should consider conducting a new barrier analysis and assessing if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers. While the MCP reports that some interventions are making a positive impact on the members' prenatal care, the improvements are not showing in the study indicator rate, which is declining rather than improving.

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.

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

Table 5.3—Medi-Cal Managed Care County-Level Global Ratings
HPSM—San Mateo 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
HPSM—San Mateo 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

Overall, HPSM excelled at the adult and child global ratings measures, receiving a *Good* rating or better on all measures. The MCP received an *Excellent* rating on the *Rating of Specialist Seen Most Often* measure for both the adult and child populations and an *Excellent* rating on the child *Rating of Personal Doctor* measure. The MCP received a *Very Good* rating for the adult *Rating of All Health Care* and *Rating of Personal Doctor* measures.

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

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

Opportunities for Improvement

HPSM's CAHPS results showed below-average performance for the adult and child 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 HPSM's highest priorities: *Getting Care Quickly*, *Getting Needed Care,* and *How Well Doctors Communicate*. 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 HPSM CAHPS MCP-Specific Report*. Areas for improvement spanned the quality, access, 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.

HPSM'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

HPSM's processes for aggregating and submitting claims and encounter data files adhere to industry best practices. Pharmacy claims are processed by a delegated entity that is monitored annually. HPSM has developed its own encounter data extract program to prepare encounter files for submission to DHCS, and automated systems submit the encounter file. Some coding manipulations are used to ensure the encounter files are compliant with DHCS's requirements.

A payment system conversion, effective April 1, 2011, was not a smooth implementation for HPSM as numerous issues were identified after the system went live. HPSM does not take the necessary steps to ensure its capitated providers submit timely, accurate, and complete encounters. HPSM's policy and procedure for monitoring encounter data does not address processes for ensuring receipt of error reports.

Record Completeness

Overall, HPSM had very low record omission and record surplus rates, indicating relatively complete data when comparing DHCS's data and the encounter data extracted from HPSM's data system for this study. The record omission and record surplus rates were all at 5.0 percent or lower, with notable record omission and record surplus rates of 0.0 percent for the Pharmacy claim type. All of the record omission and record surplus rates were better than the statewide results. Notable performance included a record omission and record surplus rate for the

Hospital/Inpatient claim type that were better than the statewide rates by more than 5.0 percentage points. In addition, the Pharmacy record omission and record surplus rates and the Medical/Outpatient record surplus rate were better than the respective statewide rates by at least 10 percentage points.

Data Element Completeness

Overall, HPSM had fair data element completeness, although there were issues with a few data elements. All claim types had an element omission rate of 1.3 percent or less except for the *Referring/Prescribing/Admitting Provider Number* in the Medical/Outpatient claim type, and the *Primary Surgical Procedure Code* and *Secondary Surgical Procedure Code* in the Hospital/Inpatient claim type. All three element omission rates were worse than the statewide rates by more than 13 percentage points. Similarly, HPSM's performance for the element surplus rates varied considerably across the key data elements. The *Referring/Prescribing/Admitting Provider Number* had element surplus rates of 37.6 percent and 21.7 percent for the Hospital/Inpatient and Pharmacy claim types, respectively. The *Revenue Code* data element had the worst element surplus rate of 45.2 percent for the Hospital/Inpatient claim type mainly due to the value of "001" in DHCS's data. All three of these element surplus rates were worse than the statewide rates by more than 15 percentage points. HPSM converted to a new claims payment system on April 1, 2011. This system change might have contributed to the data element omission or data element surplus rates.

Data Element Accuracy

HPSM had fairly high data element accuracy rates, although a few data elements had much lower accuracy rates. The majority of the element accuracy rates were better than or similar to the statewide rates. However, a few elements had rates that fell below the respective statewide rates considerably. The *Referring/Prescribing/Admitting Provider Number* had element accuracy rates below the statewide rates by 90.1 percentage points and 70.8 percentage points for the Hospital/Inpatient claim type and Pharmacy claim type, respectively. The main reason for the inaccuracy was the truncation of the MCP values to 9 digits in DHCS's data. In the Medical/Outpatient claim type, the *CPT/HCPCS Codes* data element had an accuracy rate that was 15.0 percentage points below the statewide rate. This was mainly due to revenue codes populated in the DHCS records while *CPT/HCPCS Codes* were populated in the MCP records.

Due to issues with element omission and element surplus, as well as issues with element accuracy rates in a number of data elements, the all-element accuracy rates for the Medical/Outpatient, Hospital/Inpatient, and Pharmacy claim types were below the statewide rates by 23.4, 60.7, and 71.1 percentage points, respectively.

Recommendations

Based on its review, HSAG recommends the following:

- HPSM should take the necessary steps to measure or ensure that its capitated providers submit timely, accurate, and complete encounters.
- HPSM should investigate the relatively high element omission rates for the *Referring/Prescribing/Admitting Provider Number* in the Medical/Outpatient claim type and the *Primary Surgical Procedure Code* and *Secondary Surgical Procedure Code* in the Hospital/Inpatient claim type, and take actions to address the issues.
- HPSM should investigate the relatively high element surplus rates for the *Referring/Prescribing/Admitting Provider Number* in the Hospital/Inpatient and Pharmacy claim types, and the *Primary Diagnosis Code* and *Revenue Code* in the Hospital/Inpatient claim type, and apply appropriate quality control procedures to prevent similar issues from occurring in the future.
- For the *Rendering Provider Number*, the percent of records without values in both data sources was high compared to the other MCPs in the study. HPSM should investigate whether more values for the data element *Rendering Provider Number* can be submitted to DHCS on future submissions.
- HPSM should work with DHCS to investigate why the *Referring/Prescribing/Admitting Provider Number* values from the MCP records were truncated to 9 digits in DHCS's Hospital/Inpatient and Pharmacy data.
- HPSM should review the element inaccuracies for the *Provider Type*, *Provider Specialty,* and *CPT/HCPCS Code* in the Medical/Outpatient claim type for future improvement on the accuracy rates for these data elements.
- HPSM should work with DHCS to investigate the reason(s) for the possible truncation or adjustment of the *Revenue Code* data element for the Hospital/Inpatient claim type in order to prevent similar issues in the future.

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 the quality documents HPSM submitted as part of the process for producing this MCP-specific evaluation report. HPSM appears to have a structure that supports the provision of quality care to the MCP's members. Additionally, the MCP's work plan includes objectives that directly impact the quality of care provided to members.

The two measures with rates above the HPLs in 2013 fall into the quality domain of care. No quality measures had rates below the MPLs in 2013. No quality measures had rates with statistically significant improvement from 2012 to 2013, and the following quality measures had rates that declined significantly from 2012 to 2013:

- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assess: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity: Total*

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and 10 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 *Comprehensive Diabetes Care—HbA1c Poor Control (<9.0 Percent)* measure, which falls into the quality domain of care, was significantly higher than the non-SPD rate, meaning that when compared to non-SPD members, significantly more SPD members had HbA1c levels that were not at the recommended level.

All CAHPS measures fall into the quality domain of care. The MCP received mixed results. Three measures received *Excellent* ratings, two measures received *Very Good* ratings, five measures received *Good* ratings, two measures received *Fair* ratings, and four measures received *Poor* ratings.

Both of HPSM's QIPs fall into the quality domain of care. The *All-Cause Readmissions* QIP did not progress to the Implementation or Outcomes stages, so HSAG was not able to assess the QIP's success at improving the quality of care delivered to the MCP's Medi-Cal members. The *Increasing*

Timeliness of Prenatal Care QIP reported Remeasurement 2 data. Although not statistically significant, the QIP has seen a decline in the number of women receiving prenatal care since the baseline measurement period. The QIP's interventions are not resulting in improved care for Medi-Cal members needing prenatal care.

Overall, HPSM 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.

The quality documents HPSM submitted as part of the process for producing this report included descriptions of processes and activities to ensure member access to needed services.

No measures falling into the access domain of care had rates above the HPLs, and one access measure, *Children and Adolescents' Access to Primary Car Practitioners (12–19 Years)*, had a rate below the MPL.

The rate for the *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* measure, which falls into the access domain of care, improved significantly from 2012 to 2013, and the rate for another access measure, *Comprehensive Diabetes Care—Medical Attention for Nephropathy,* declined significantly from 2012 to 2013.

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and five 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. All four *Children and Adolescents' Access to Primary Care Practitioners* measures had SPD rates that were significantly worse than the non-SPD rates.

One CAHPS measure, *Getting Needed Care*, falls into the access domain of care. HPSM received a *Fair* rating for the adult population and a *Poor* rating for the child population on this measure.

Both of HPSM's QIPs fall into the access domain of care. As indicated above, the *All-Cause Readmissions* QIP did not progress to the Implementation or Outcomes stages; therefore, HSAG was not able to assess the QIP's success at improving member access to needed services. Also as indicated above, the *Increasing Timeliness of Prenatal Care* QIP reported Remeasurement 2 data. Although not statistically significant, the QIP has seen a decline in the number of women receiving prenatal care since the baseline measurement period. The QIP's interventions are not resulting in improved access to prenatal care for Medi-Cal members.

Overall, HPSM showed 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.

HPSM's quality documents included some activities that support timeliness of care to the MCP's Medi-Cal members.

HPSM performed average on measures falling into the timeliness domain of care. The rates for all timeliness measures were above the MPLs, and no timeliness measures had rates with significant change from 2012 to 2013. The MCP's 2013 performance on timeliness measures is similar to previous years.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. This measure received a *Poor* rating for both the adult and child populations.

The *Increasing Timeliness of Prenatal Care* QIP falls into the timeliness domain of care. As indicated in the Quality and Access sections above, the QIP has seen a decline in the number of women

receiving prenatal care since the baseline measurement period, showing that the MCP's members in need of prenatal care are not receiving timely services.

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

Recommendations

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

- To ensure accurate and complete data reporting:
  - Implement editing processes that require valid coding specificity on claims.
  - Explore options to reconcile pharmacy reversals to ensure that the reported data are accurate.
  - Require billing providers to populate the *Rendering Provider* field rather than having it be optional.
  - Reconcile the data in the MCP's credentialing and claims processing databases at least annually.
- Assess the factors leading to the rate for the *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* measure being below the MPL in 2013 and identify improvement strategies that will result in an improvement on performance
- Assess the factors that caused the rates for the following measures to decline significantly from 2012 to 2013 and identify interventions to be implemented to prevent further decline on the rates:
  - *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
  - All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

- For the following measures with SPD rates that were significantly worse than the non-SPD rates, assess the factors leading to the rates being significantly worse for the SPD population and identify strategies to ensure the MCP is meeting this population's needs:
  - All four *Children and Adolescents' Access to Primary Care Practitioners* measures
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- Reference the QIP Completion Instructions to ensure that all required information is documented in the QIP Summary Form.
- For the *Increasing Timeliness of Prenatal Care* QIP:
  - Continue to explore access-related barriers for beneficiaries seeking prenatal care. Specifically, the MCP should implement targeted interventions that may promote providers accepting new Medi-Cal beneficiaries.
  - Consider conducting a new barrier analysis and assessing if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers. While the MCP reports that some interventions are making a positive impact on members' prenatal care, the improvements are not showing in the study indicator rate, which is declining rather than improving.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Getting Care Quickly, Getting Needed Care,* and *How Well Doctors Communicate* 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 HPSM'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 Mateo**

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with HPSM'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—HPSM'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	HPSM's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. Ensure that all outstanding deficiencies from the medical performance review are fully resolved.	Deficiencies resolved. Please see below for details.
2. Ensure that all findings from the MR/PIU review are fully resolved. Specifically:	
a. Provide evidence that all documentation related to member grievances includes clear and concise explanations outlining the circumstances under which the medical service shall be continued pending decision on the fair hearing.	Recommendation complete: HPSM's Member Rights pamphlet states, "While your case is being reviewed through a State Hearing process, HPSM will continue to pay for your medical care." This explanation can be found under the section "Option for MCE and Medi-Cal Members only" below the explanation of what a State Hearing is and how members can file. HPSM always continues to pay for a member's health care while a fair hearing decision is pending. Therefore, there is no need to outline specific circumstances. (pamphlet will be provided upon request)
b. Provide documentation that providers are informed that they should discourage the use of minors, as well as family and friends, as interpreters.	Recommendation implemented: Although the topic of interpreter services was covered in several provider newsletter articles, each one specifically stating that family members and friends should be discouraged to provide interpretation at medical appointments, this intervention has obviously not been as successful as we had hoped. As a result, the following new interventions have been implemented: Staff has distributed a cultural and linguistics provider toolkit to the network, which included a provider tip sheet, discouraging the use of family and friends as interpreters. Providers have also been informed that HPSM provides free interpretation services for limited English proficiency (LEP)

2011–12 External Quality Review Recommendation	HPSM's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	members if bilingual staff members are not available to translate during a medical appointment. Finally, staff is reinforcing the above information during face-to-face visits while conducting facility site reviews, reminding providers that they should discourage the use of family, friends, and minors as interpreters. Compliance is monitored through the DHCS-mandated facility site review process, which only allows a family member or friend to be used as an interpreter if requested by the LEP individual *after* being informed of their right to use free interpreter services.
3. Explore the option of requiring the *Rendering Provider* for multi-specialty clinics to improve HEDIS reporting.	Recommendation complete: Beginning ~ June 2013, HPSM began requiring the rendering provider on claims.
4. Assess factors that led to poor performance on the *Cervical Cancer Screening* measure in 2012. Develop and implement strategies to improve performance above the MPL.	Recommendation complete: Contributing factors and improvement strategies for Cervical Cancer Screening were submitted via HEDIS Improvement Plan in March 2013. Measure results for HEDIS 2013 were above the MPL.
5. Assess factors that led to the *Comprehensive Diabetes Care—HbA1c Testing* performance measure rate's statistically significant decline from its 2011 performance measure rate. Develop and implement strategies to improve performance to prevent further decline.	Recommendation complete: The Quality Improvement team assessed factors leading to the decline in performance for CDC-A1c testing. As a result, several strategies have been implemented to improve performance: • Data capture: Successfully implemented data sharing agreements with the majority of labs in San Mateo County to send HPSM lab data, which includes tests performed and results. • Data capture: Beginning in June 2012, no longer contract with vendor to outsource HEDIS data collection. HPSM will now conduct HEDIS medical record review in-house. We believe that this will lead to an increase in hybrid rates moving forward. • Decision support tools for providers: Many contracted providers in HPSM's network still do not have access to electronic health records or other mechanisms for reminder/recall or to track when a member is due for A1c and other routine diabetic screenings. In May 2013, staff developed outreach reports for providers, called "Diabetic Super Reports." These reports contain lists of diabetic patients along with the date(s) of their most recent recommended screenings (A1c, LDL, eye, and nephropathy monitoring). Staff has sorted the reports so that patients who are missing or overdue for their A1c test are listed at the top of the report. Providers use the reports to outreach to their patients and remind them that they are due for these tests.

2011–12 External Quality Review Recommendation	HPSM's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	The Diabetic Super Reports are routinely updated and distributed to the PCPs, usually on a monthly basis, but at least quarterly. • Provider incentives: Although HPSM has included diabetic services in our primary care P4P program for several years, staff is now conducting more intensive outreach to PCPs with the intent of increasing provider engagement.
6. For its *Increasing Timeliness of Prenatal Care* QIP, continue to explore access-related barriers for members seeking prenatal care. Specifically, the plan should implement targeted interventions that may promote the concept of a prenatal "home."	Recommendation implemented: HPSM's Quality team now has a bilingual staff member dedicated to early identification of pregnant members and assisting them with getting into care, as necessary. Members are identified through a variety of sources (provider referrals, prenatal vitamin prescriptions, claims, and presumptive eligibility data). Outbound calls are made to all pregnant members. Members are asked whether they are already in care with an OB provider and encouraged to continue care consistently throughout their pregnancy. Members who have not yet sought care with an OB provider are given a list of participating providers near their home and encouraged to be seen within their first trimester. Assistance with scheduling a visit is offered to members, as necessary. Early identification and outreach to pregnant members allows for the creation of a medical home for the duration of the pregnancy.
7. Evaluate the efficacy of each QIP intervention for each measurement period. Based on the evaluation results, modify or discontinue ongoing interventions or implement new interventions to address identified barriers and increase the likelihood of achieving project outcomes and improving performance.	Recommendation implemented: Effectiveness of each intervention is evaluated after each measurement period for current and new QIPs. Changes (continue, modify, or delete) are made to interventions, based on the results of the evaluation. As new interventions are considered, staff now develops a plan for future evaluation. This is a new process and had not been done with past interventions.