Performance Evaluation Report

Santa Clara Family Health Plan

July 1, 2012–June 30, 2013

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

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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, Santa Clara Family Health Plan ("SCFHP" 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

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

SCFHP became operational in Santa Clara County to provide MCMC services effective February 1997. As of June 30, 2013, SCFHP had 150,249 MCMC members in Santa Clara 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 SCFHP's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

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.

Status of Reviews and Follow-up from Outstanding Deficiencies and Findings Noted in 2011–12 MCP-Specific Evaluation Report

No reviews with SCFHP were conducted during the review period. In SCFHP's 2011–12 MCP-specific evaluation report, HSAG recommended that the MCP ensure all unresolved

[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).

deficiencies from the 2007 medical performance review and findings from the 2011 monitoring review were fully resolved. Although HSAG did not receive follow-up information from DHCS on the outstanding deficiencies and findings from these reviews, SCFHP's self-reported actions regarding the deficiencies and findings are included in Appendix B of this report. HSAG reviewed SCFHP's self-report of actions the MCP has taken to resolve the outstanding issues, and it appears the MCP has addressed them.

Strengths

SCFHP's self-report provides evidence that the MCP has addressed the outstanding deficiencies and findings from the 2007 medical performance review and the 2011 monitoring review.

Opportunities for Improvement

At this time, it does not appear that the MCP has any outstanding deficiencies or findings from DHCS reviews; therefore, HSAG has no recommendations for the MCP in the area of compliance.

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 Santa Clara Family Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that SCFHP followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A review of the MCP's HEDIS audit report revealed the following observations:

- SCFHP's transaction system had comprehensive controls, edits, and procedures that met or exceeded industry standards for processing both paper and electronic claims/encounters.
- SCFHP developed a stellar system for capturing and processing forms for the Child Health and Disability Prevention Program.
- SCFHP closely followed the NCQA guidelines for supplemental data use. The MCP has developed an ongoing comprehensive quality assurance protocol that is followed with each file received.

[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).

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*
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 SCFHP'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
SCFHP—Santa Clara County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	25.81%	26.43%	★★	↔	18.98%	33.33%
ACR	Q, A	--	13.77%	--	Not Comparable	--	--
AMB–ED	‡	35.89	34.79	‡	Not Comparable	‡	‡
AMB–OP	‡	292.77	267.45	‡	Not Comparable	‡	‡
CAP–1224	A	96.22%	96.87%	★★	↔	95.56%	98.39%
CAP–256	A	88.63%	88.90%	★★	↔	86.62%	92.63%
CAP–711	A	89.69%	88.92%	★★	↓	87.56%	94.51%
CAP–1219	A	86.78%	87.81%	★★	↑	86.04%	93.01%
CBP	Q	--	52.80%	--	Not Comparable	--	--
CCS	Q,A	71.29%	68.13%	★★	↔	61.81%	78.51%
CDC–BP	Q	45.01%	53.53%	★	↑	54.48%	75.44%
CDC–E	Q,A	47.69%	41.85%	★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	51.09%	55.47%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	40.88%	34.79%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	86.62%	86.62%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	37.96%	42.82%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	81.02%	79.08%	★★	↔	70.34%	83.45%
CDC–N	Q,A	80.05%	79.81%	★★	↔	73.48%	86.93%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
SCFHP—Santa Clara 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]
CIS–3	Q,A,T	80.05%	73.72%	★★	↓	64.72%	82.48%
IMA–1	Q,A,T	69.34%	75.67%	★★	↑	50.36%	80.91%
LBP	Q	80.37%	82.42%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	58.61%	--	Not Comparable	--	--
MMA–75	Q	--	35.95%	--	Not Comparable	--	--
MPM–ACE	Q	86.05%	87.60%	★★	↔	83.72%	91.33%
MPM–DIG	Q	87.18%	88.10%	★★	↔	87.93%	95.56%
MPM–DIU	Q	84.85%	88.08%	★★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	82.73%	82.97%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	58.39%	67.40%	★★	↑	58.70%	74.73%
W-34	Q,A,T	75.67%	72.75%	★★	↔	65.51%	83.04%
WCC–BMI	Q	64.23%	66.91%	★★	↔	29.20%	77.13%
WCC–N	Q	63.99%	67.88%	★★	↔	42.82%	77.61%
WCC–PA	Q	45.74%	41.85%	★★	↔	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 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 SCFHP'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)*

[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.

[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.

- *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*

Table 3.3—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
SCFHP—Santa Clara County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	8.26%	16.54%	▼	13.77%
CAP–1224	96.87%	96.30%	↔	96.87%
CAP–256	88.91%	88.74%	↔	88.90%
CAP–711	88.91%	89.16%	↔	88.92%
CAP–1219	87.74%	89.55%	↔	87.81%
CDC–BP	55.72%	53.53%	↔	53.53%
CDC–E	38.20%	40.15%	↔	41.85%
CDC–H8 (<8.0%)	48.18%	61.07%	↑	55.47%
CDC–H9 (>9.0%)	41.61%	29.20%	▲	34.79%
CDC–HT	82.73%	89.05%	↑	86.62%
CDC–LC (<100)	35.77%	47.93%	↑	42.82%
CDC–LS	73.72%	84.67%	↑	79.08%
CDC–N	74.94%	87.83%	↑	79.81%
MPM–ACE	84.67%	88.79%	↑	87.60%
MPM–DIG	NA	89.33%	Not Comparable	88.10%
MPM–DIU	83.20%	90.07%	↑	88.08%

* 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
SCFHP—Santa Clara County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
244.89	33.44	403.89	42.92

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

Performance Measure Result Findings

As in previous years, SCFHP performed average on its measures in 2013. The rate for the *Use of Imaging Studies for Low Back Pain* measure was above the HPL in 2013, and the rates for the following measures improved significantly from 2012 to 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Immunizations for Adolescents—Combination 1*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Prenatal and Postpartum Care—Postpartum Care*

The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure was below the MPL in 2012, and the statistically significant improvement from 2012 to 2013 moved the rate to above the MPL in 2013.

Although the rate for the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* measure improved significantly, the rate continued to be below the MPL for the second consecutive year. Additionally, the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure was below the MPL in 2013.

The rates for the *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* and *Childhood Immunization Status—Combination 3* measures declined significantly from 2012 to 2013; however, the rates for both of these measures remained above the MPLs in 2013.

Seniors and Persons with Disabilities Findings

The SPD rates for eight of the 16 measures stratified for the SPD population were significantly better than the non-SPD rates. Six of the measures were *Comprehensive Diabetes Care* measures and two were *Annual Monitoring for Patients on Persistent Medications* measures. The better rates in the SPD

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

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

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however, rates should be interpreted with caution as high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures, and HSAG does not provide comparative analysis.

Improvement Plans

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

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

SCFHP had two IPs in place for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *Prenatal and Postpartum Care—Postpartum Care* measures during the review period. Below is a summary of the IPs and HSAG's assessment of the progress the MCP made toward improving the rate on the measure.

Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mmHg) and *Prenatal and Postpartum Care—Postpartum Care*

SCFHP identified the following barriers and challenges that prevented the rates for the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* and *Prenatal and Postpartum Care—Postpartum Care* measures from being above their respective MPLs in 2012:

- Several members who should have been excluded from the measures were included in the data sent to the vendor, resulting in a negative impact on the measures' rates.
- No "flag" was in place in the data sent to the vendor denoting the members who should have been excluded from each measure.

To address the identified barriers and improve the rates on these measures, SCFHP implemented the following interventions:

- Coordinated with the software vendor to ensure that all input files were complete and correctly formatted.
- Ensured that non-eligible members were "flagged" for the vendor so only eligible members would be included in each measure's rate.

SCFHP's efforts resulted in the rate for the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* measure having statistically significant improvement from 2012 to 2013; however, the rate was still below the MPL in 2013. SCFHP will be required to continue the IP for this measure.

SCFHP's efforts resulted in the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure having statistically significant improvement from 2012 to 2013, which led to the rate being above the MPL in 2013. SCFHP will not be required to continue the IP for this measure in 2013.

Along with the IP for the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* measure, SCFHP will need to submit an IP for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure.

Strengths

HSAG auditors determined that SCFHP followed the appropriate specifications to produce valid performance measure rates and identified no issues of concern. The MCP had one measure with a rate above the HPL, and the rates for five measures improved significantly from 2012 to 2013. The MCP's IP for the *Prenatal and Postpartum Care—Postpartum Care* measure was successful in bringing the rate for this measure above the MPL in 2013.

Opportunities for Improvement

SCFHP has an opportunity to assess the factors leading to two measures having rates below the MPLs in 2013 and develop strategies to address the factors and improve the rates to above the MPLs. Additionally, the MCP has the opportunity to assess the factors leading to two measures having rates that declined significantly from 2012 to 2013 to ensure the rates for these measures remain above the MPLs. Finally, since readmissions have been associated with lack of proper discharge planning and poor care transition, SCFHP has an opportunity to improve the provision of these services to the SPD population to ensure fewer readmissions.

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 SCFHP'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

SCFHP 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 SCFHP'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 SCFHP
July 1, 2012, through June 30, 2013

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Childhood Obesity Partnership and Education	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members, leading to improved health outcomes.

Prior to initiation of the statewide collaborative QIP, SCFHP had a 30-day readmission rate of 10.16 percent among Medi-Cal beneficiaries. SCFHP also found that the readmission rate for the SPD population was 14.97 percent, which was higher than the 6.9 percent rate for the non-SPD population.

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

Quality Improvement Project Validation Findings

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
SCFHP—Santa Clara 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				
Childhood Obesity Partnership and Education	Annual Submission	37%	38%	*Not Met*
	Annual Resubmission 1	88%	86%	*Partially Met*
	Annual Resubmission 2	100%	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 SCFHP 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. SCFHP received a *Not Met* validation status for its *Childhood Obesity Partnership and Education* QIP annual submission. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. SCFHP resubmitted the QIP two times before achieving an overall *Met* validation status, with 100 percent of both the critical and evaluation elements being met.

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

Table 4.3—Quality Improvement Project Average Rates*
SCFHP—Santa Clara County
(Number = 4 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)	82%	18%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	61%	22%	17%
Design Total		**80%**	**13%**	**7%**
Implementation	VII: Sufficient Data Analysis and Interpretation	67%	25%	8%
	VIII: Appropriate Improvement Strategies	50%	50%	0%
Implementation Total		**61%**	**33%**	**6%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

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

HSAG validated Activities I through VI for SCFHP's *All-Cause Readmissions* study design submission and Activities I through VIII for the MCP's *Childhood Obesity Partnership and Education* QIP annual submission.

SCFHP demonstrated an adequate application of the Design stage, meeting 80 percent of the requirements for all applicable evaluation elements for this stage across both QIPs (four submissions). SCFHP only provided a partial description of the systematic method for collecting baseline and remeasurement data and did not describe the data analysis plan for the *All-Cause Readmissions* QIP, resulting in a lower score for Activity VI. SCFHP struggled with providing adequate documentation for the Design stage for the *Childhood Obesity Partnership and Education* QIP, resulting in multiple resubmissions before the QIP achieved a *Met* validation status.

SCFHP demonstrated a poor application of the Implementation stage, meeting 61 percent of the requirements for all applicable evaluation elements for this stage for the *Childhood Obesity*

Partnership and Education QIP across the three submissions. As with the Design stage, the MCP struggled with providing adequate documentation for the Implementation stage. The MCP was able to correct the issues by the second resubmission, resulting in a *Met* validation status for this QIP.

Activities IX and X were not assessed since neither QIP reached the Outcomes stage.

Quality Improvement Project Outcomes and Interventions

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

The *Childhood Obesity Partnership and Education* QIP progressed to the Implementation stage, and HSAG includes information about the QIP's improvement strategies and QIP documentation below.

Childhood Obesity Partnership and Education QIP

SCFHP's objective for the *Childhood Obesity Partnership and Education* QIP is to increase the number of eligible members attending at least one nutritional program. The baseline goal was 50 percent, and the QIP was not successful at reaching this goal. A critical analysis of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations related to improvement strategies:

- SCFHP initially did not document how the implemented interventions directly related to the identified causes/barriers. In the second resubmission, the MCP provided the required information and documented how the interventions were related to the causes/barriers.
- The MCP implemented several interventions, including:
  - Offered a free parenting class on healthy eating for parents of children 2 to 5 years of age and provided childcare while the parents were participating in the class.
  - Offered a family-based, group behavior and educational program for children 8 to 15 years of age that promotes lifelong healthy eating and exercise habits for overweight children, adolescents, and their families.
  - Conducted provider outreach site visits to educate providers regarding the importance of calculating and trending body mass index (BMI), informed providers of the educational programs available to members, and encouraged them to refer members to the programs.
  - Conducted member outreach telephone calls to inform them of the educational programs and encourage participation.

Strengths

SCFHP excelled at selecting an appropriate study topic, defining the study questions, and correctly identifying the study population for both the *All-Cause Readmissions* and *Childhood Obesity Partnership and Education* QIPs. The *All-Cause Readmissions* QIP achieved a fully *Met* validation status on the first submission.

Opportunities for Improvement

SCFHP has the opportunity to ensure all required documentation is included in the QIP Summary Form and to improve the MCP's response to validation feedback. Thorough documentation will prevent the MCP from having to submit QIPs multiple times before they achieve a *Met* validation status.

For the *Childhood Obesity Partnership and Education* QIP, SCFHP initially struggled with providing clearly defined study indicators and connecting the identified barriers to the interventions. Although the MCP eventually provided the required information and connected each intervention to an identified barrier, the MCP has the opportunity to ensure this detailed documentation is provided in the first QIP submission.

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.

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

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

CAHPS Global Rating Measures:

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

CAHPS Composite Measures:

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

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

Table 5.1—CAHPS Measures Domains of Care

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

National Comparisons

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

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

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

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

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

Table 5.3—Medi-Cal Managed Care County-Level Global Ratings
SCFHP—Santa Clara County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★★	★	★★	★★★
Child	★★★	★	★★★	★★★★

[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
SCFHP—Santa Clara County

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

Strengths

SCFHP received a *Very Good* rating on the child *Rating of Specialist Seen Most Often* measure and a *Good* rating on the following measures:

- *Rating of Health Plan*—child population
- *Rating of Personal Doctor*—child population
- *Rating of Specialist Seen Most Often*—adult population

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

- *Rating of Health Plan*—adult population
- *Rating of Personal Doctor*—adult population

Opportunities for Improvement

Overall, SCFHP CAHPS results showed below-average performance for both the adult and child populations. 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 SCFHP's highest priorities: *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 SCFHP 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.

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

Encounter Data Validation Findings

Review of Encounter Systems and Processes

The information provided in SCFHP's Roadmap and supplemental questionnaire demonstrates that SCFHP has sound procedures in place for the creation, validation, correction, and ongoing monitoring of encounter data. The MCP reported that less than 0.01 percent of its claims/encounters are rejected by DHCS, and it is able to remediate the rejected encounters with its trading partners.

Record Completeness

For SCFHP, long-term care (LTC) records were included under the Hospital/Inpatient claim type for the comparative analysis. Therefore, there are no LTC claim results for SCFHP.

Overall, SCFHP had low record omission and record surplus rates for the Medical/Outpatient claim type, indicating fairly complete Medical/Outpatient data when comparing DHCS's data and the encounter data extracted from SCFHP's system for this study. However, the Hospital/Inpatient and Pharmacy claim types had relatively incomplete data due to the fairly poor record omission rates of 12.2 percent and 31.2 percent, respectively. The record omission rate for the Pharmacy claim type was worse than the statewide rate by 17.9 percentage points. The Pharmacy records omitted from DHCS's data were mainly caused by the duplicated records (based on the Client Index Number [CIN], date of service, and payment) with one value in the

Referring/Prescribing/Admitting Provider field and the adjustment records in the MCP's data. None of SCFHP's record surplus rates exceeded 5.0 percent, and all were better than their respective statewide rates.

Data Element Completeness

SCFHP had fairly good data element completeness, with element omission surplus rates of 3.0 percent or less for all key data elements across the three claim types. SCFHP's element omission rates and surplus rates were generally similar to or better than the respective statewide rates. A few rates were worse than the statewide rates—but only by a few percentage points. The *Provider Specialty* element surplus rate was 2.7 percentage points worse than the statewide rate, and the remaining element omission or surplus rates were worse than their respective statewide rates by no more than 1.2 percentage points.

Data Element Accuracy

SCFHP had element accuracy rates that were greater than 90 percent for the majority of the key data elements across the three claim types. However, there were a number of data elements with relatively poor element accuracy rates. For the Pharmacy claim type, the *Billing/Reporting Provider Number* and the *Referring/Prescribing/Admitting Provider Number* data elements had element accuracy rates of 0.0 percent and 22.8 percent, respectively. The low accuracy rates were because the provider numbers in DHCS's data had field lengths less than 10 characters, and the values in the MCP's data were most likely the National Provider Identifiers (NPIs), with lengths of 10 characters. SCFHP stated that its PBM changed the data format in October 2011; this change likely caused the poor accuracy rates for these data elements. For the Hospital/Inpatient claim type, the *Provider Type* had an element accuracy rate of 56.6 percent. More than 97 percent of the records with mismatched provider types were due to the value of "17" (Certified Long Term Care Facility) in SCFHP's Hospital/Inpatient file and the value of "16" (Community Hospital Inpatient) in DHCS's records. For the Medical/Outpatient claim type, the *Provider Type* had an element accuracy rate of 78.8 percent mainly due to the value of "26" (Physicians) populated in the MCP's data and the value of "15" (Community Hospital Outpatient Departments) populated in DHCS's data. These four accuracy rates were worse than the respective statewide element accuracy rates by more than 15 percentage points. For the remaining data elements with accuracy rates below the statewide rates, the difference was no more than 3.1 percentage points.

For the all-element accuracy rates, the Medical/Outpatient claim type had a rate higher than the statewide rate by 8.1 percentage points. The remaining two claim types had all-element accuracy rates that fell below the respective statewide rates by more than 28 percentage points.

Recommendations

Based on its review, HSAG recommends the following:

- For DHCS's data and the data SCFHP submitted to HSAG, there were no LTC records based on the values in the data element *Claim Type*. However, in its response to HSAG's preliminary file review results, SCFHP indicated that its data system contains LTC records. In addition, the original submissions to DHCS may not have included the LTC records. However, SCFHP's current submission process to DHCS includes LTC records when the data are included in the 837 institutional format received from its trading partners. SCFHP should clarify with DHCS whether the LTC records should be submitted with the value of "L" for the data element *Format Code* so that DHCS can receive SCFHP's LTC records and separate them from the Hospital/Inpatient records.
- SCFHP should investigate the high record omission rates for the Pharmacy and Hospital/Inpatient claim types and create strategies for improvement.
- SCFHP should investigate the low element accuracy rates for the *Billing/Reporting Provider Number* and *Referring/Prescribing/Admitting Provider Number* in the Pharmacy claim type so that it can improve these rates in the future.
- SCFHP should investigate the low element accuracy for the *Provider Type* field in the Medical/Outpatient and Hospital/Inpatient claim types and modify its processes and procedures to improve this accuracy rate 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

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[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 SCFHP submitted as part of the process for developing this report and found that the MCP has a structure that supports the provision of quality care to the MCP's members.

Overall, the MCP performed average on quality measures. The rate for one quality measure, *Use of Imaging Studies for Low Back Pain,* was above the HPL, and the rates for the following quality measures were below the MPLs:

- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

The following quality measures had rates with statistically significant improvement from 2012 to 2013:

- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Immunizations for Adolescents—Combination 1*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Prenatal and Postpartum Care—Postpartum Care*

The improvement in the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure resulted in the rate for the measure moving from below the MPL in 2012 to above the MPL in 2013.

The rate for the *Childhood Immunization Status—Combination 3* measure, which falls into the quality domain of care, declined significantly from 2012 to 2013; however, the rate for the measure was above the MPL.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and eight of these measures had SPD rates that were significantly better than the non-SPD rates. Six of the measures were *Comprehensive Diabetes Care* measures and two were *Annual Monitoring for Patients on Persistent Medications* measures. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

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

All CAHPS measures fall into the quality domain of care. Overall, the MCP had below-average ratings for both the adult and child populations. The only measure with an above-average rating was the child *Rating of Specialist Seen Most Often* measure, which received a *Very Good* rating. The results of the survey suggest that members are dissatisfied with the quality of care being provided by the MCP.

Both of SCFHP's QIPs fall into the quality domain of care. Neither QIP progressed to the Outcomes stage; therefore, HSAG was not able to assess the QIPs' success at improving the quality of care delivered to the MCP's members.

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

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HSAG reviewed SCFHP's 2013 quality improvement program work plan and found that it includes access-related goals. Additionally, HSAG reviewed the MCP's quality improvement program description, and it appears the MCP's quality improvement program structure includes processes focused on ensuring members' access to needed services.

Overall, SCFHP had average performance on access measures, with no access measures having rates above the HPLs and one access measure, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, having a rate below the MPL. The rates for the following access measures improved significantly from 2012 to 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Postpartum Care*

As indicated above, the improvement in the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure resulted in the rate for the measure moving from below the MPL in 2012 to above the MPL in 2013.

The following access measures had rates that declined significantly from 2012 to 2013; however, the rates remained above the respective MPLs:

- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Childhood Immunization Status—Combination 3*

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and three of these measures had SPD rates that were significantly better than the non-SPD rates:

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

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

The *All-Cause Readmissions* measure falls into the access domain of care. As indicated above, the SPD rate for this measure was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had significantly more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population. This suggests that SPD members may not have adequate access to follow-up and care management services.

Overall, SCFHP performed below-average on the access-related CAHPS measure, *Getting Needed Care*, receiving a *Poor* rating for both the adult and child populations. These ratings suggest that members are not satisfied with the level of access to needed services.

Both of SCFHP's QIPs fall into the access domain of care. Neither QIP progressed to the Outcomes stage; therefore, HSAG was not able to assess the QIPs' success at improving members' access to needed services.

Overall, SCFHP 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.

SCFHP's quality improvement program description describes the MCP's structure for overseeing and assessing performance related to grievances and utilization management, which all impact the timeliness of care delivered to members.

All five measures falling into the timeliness domain of care had average rates. Two of the measures, *Immunizations for Adolescents—Combination 1* and *Prenatal and Postpartum Care—Postpartum Care*, had rates that improved significantly from 2012 to 2013. As indicated above, the improvement on the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure moved the rate from below the MPL in 2012 to above the MPL in 2013.

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, suggesting that members are not satisfied with the time it takes to receive needed health care services.

Overall, SCFHP showed average performance related to 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. SCFHP's self-reported responses are included in Appendix B.

Recommendations

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

- Engage in the following efforts to improve performance related to required measures:
  - Since the efforts to improve the rate for the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* measure resulted in the rate improving significantly from 2012 to 2013, continue to implement successful strategies and assess if modifications need to be made to strategies to ensure continued improvement on the rate.
  - Assess the factors leading to the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure being below the MPL and identify interventions that will improve the rate for this measure.
  - Assess the factors leading to the rate for the *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* measure declining significantly from 2012 to 2013 and implement strategies to address the factors to ensure the rate does not decline to below the MPL.
  - Assess the factors leading to the rate for the *Childhood Immunization Status—Combination 3* measure declining significantly from 2012 to 2013 and implement strategies to address the factors to ensure the rate does not decline to below the MPL.
  - Assess the factors leading to the SPD rate for the *All-Cause Readmissions* measure being significantly higher than the non-SPD rate and identify strategies to ensure the MCP is meeting the SPD population's needs.
- Engage in the following efforts to improve performance related to QIPs:
  - Review the QIP Completion Instructions prior to submitting QIPs to ensure all required documentation is included in the QIP Summary Form.
  - Ensure that the MCP connects each intervention to an identified barrier when documenting interventions in the QIP Summary Form.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly* priority areas.
- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with SCFHP'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—SCFHP'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	SCFHP's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. Ensure the remaining deficiency from the May 2007 medical performance review is fully resolved.	In 2007, the medical performance review recommendations included auditing our delegates and independent providers on the Access and Availability Standards. SCFHP has implemented this and continues to audit. The other recommendations were related to Adolescent Well Child (AWC) measure improvements. In 2007, SCFHP's AWC rate was 35 percent. In 2012, SCFHP's AWC rate was 46 percent. In 2013, the AWC measure was retired.
2. Ensure that the plan is monitoring providers' compliance with the requirement that they discourage the use of family, friends, and minors as interpreters.	In January 2012, SCFHP implemented a Cultural Linguistics Audit tool which includes monitoring the provider offices on appropriate interpreter services. SCFHP delegates are audited annually. If this requirement is not met, SCFHP will issue a CAP. All providers are also monitored through the facility site review/medical record review process. Specifically, the medical records are reviewed for compliance in securing an appropriate interpreter. In addition, all independent providers and delegates were educated on the requirement in the 3rd and 4th quarter of FY 2013.
3. Develop a process to use fee-for-service claims volume as a gauge to monitor the volume of encounter data submitted by capitated providers to ensure greater confidence in data completeness.	No actions were taken on this recommendation prior to June 30, 2013, due to limited IT resources. The project is expected to begin January 2, 2014.
4. Conduct barrier analysis to identify factors contributing to the poor performance on the *Comprehensive Diabetes Control (CDC)—Blood Pressure Control (140/90 mm Hg)* measure and implement interventions to improve performance.	Barrier analysis was completed, and the 2012 HEDIS IP document was submitted on 3/15/2013. DHCS approved the IP in June 2013.

2011–12 External Quality Review Recommendation	SCFHP's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
5. Conduct a barrier analysis to identify factors contributing to the poor performance on the *Prenatal and Postpartum Care—Postpartum Care* measure and implement interventions to improve performance.	Barrier analysis was completed, and the 2012 HEDIS IP document was submitted on 3/18/2013. DHCS approved the IP on 8/6/13.
6. Assess factors that led to a decline in performance on the *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure to prevent further decline on this measure's rate in 2013.	During the barrier analysis for the *Comprehensive Diabetes Control (CDC)—Blood Pressure Control (140/90 mm Hg)* measure, the LDL-C Control (<100 mg/dL) measure was also assessed. Similar to the issues with BP control, this measure was identified as a data issue and was corrected to ensure an increase for this measure in 2013.
7. Conduct QIP barrier analyses to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from annual analyses alone. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.	Conducted *All Cause Readmissions (ACR)* QIP barrier analysis in January 2013. Submitted ACR QIP for review on September 30, 2013.
8. Ensure that each QIP intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.	Submitted an evaluation plan for each QIP intervention for the ACR QIP on September 30, 2013.