Performance Evaluation Report

San Francisco Health Plan

July 1, 2012–June 30, 2013

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

April 2014

TABLE OF CONTENTS

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, San Francisco Health Plan ("SFHP" 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

SFHP 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 SFHP; the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative CP.

SFHP became operational in San Francisco County to provide MCMC services effective January 1997. As of June 30, 2013, SFHP had 67,824 MCMC members.[3]

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

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP's compliance with standards established by the state related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

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

Assessing the State's Compliance Review Activities

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

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.

SPD Enrollment Survey

DMHC conducted an on-site SPD Enrollment Survey with SFHP from March 20, 2012, through March 23, 2012. The survey evaluated the following elements specifically related to the care of the SPD population: Utilization Management, Continuity of Care, Availability and Accessibility,

[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).

Member Rights, and Quality Management. The survey covered the review period of March 20, 2012, through March 23, 2012. The survey report was issued on August 2, 2012. DMHC identified potential deficiencies in the areas of Utilization Management, Member Rights, and Quality Management. SFHP submitted a corrective action plan (CAP) to DHCS on September 14, 2012, in response to the potential deficiencies. In a letter from DHCS dated October 26, 2012, DHCS indicated it had reviewed SFHP's CAP and determined that the MCP resolved all potential deficiencies.

Routine Medical Survey

During the March 20, 2012, through March 23, 2012, on-site visit with SFHP, DMHC also conducted a Routine Medical Survey with the MCP. DMHC assessed the areas of Quality Management, Grievances and Appeals, Access and Availability of Services, Utilization Management, Continuity of Care, Access to Emergency Services and Payment, and Prescription (RX) Drug. DMHC issued the final survey report to the MCP on October 15, 2012. The report indicated that DMHC identified two deficiencies in the area of Utilization Management and one deficiency in the area of Grievances and Appeals. Additionally, the report indicated that the MCP had corrected all three deficiencies.

Member Rights/Program Integrity Unit Monitoring Review

In SFHP's 2011–12 MCP-Specific Evaluation Report, HSAG summarized the findings from the May 29, 2012, through May 31, 2012, DHCS Member Rights/Program Integrity Unit's (MR/PIU's) routine monitoring review of SFHP. On August 9, 2012, SFHP provided responses to MR/PIU regarding the findings; and in a letter dated May 21, 2013, MR/PIU indicated that the MCP had satisfactorily addressed all findings and areas of technical assistance.

Strengths

Although findings/deficiencies were identified through each of the surveys conducted with SFHP, all areas of concern were fully resolved by the MCP in the required time frames.

Opportunities for Improvement

Since SFHP resolved all areas of concern identified through the surveys, 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 San Francisco Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that SFHP 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:

- SFHP resolved the recommendation from the 2012 HEDIS audit regarding activation of specificity edits.
- As SFHP worked through the process of implementing a new transactional system, the MCP was able to activate and deactivate edits to suit its business needs. The MCP worked to resolve challenges related to the new system as they occurred, which caused a minor backlog to be present at the time of the audit; however, the backlog was quickly remedied.
- SFHP continued its robust member and provider incentive programs, and it was noted that in 2013 the MCP was given the DHCS Gold Award for HEDIS performance.

[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).

- SFHP's transition to a new enrollment processing system went smoothly and with few challenges, most likely due to the MCP's extensive planning, testing, and preparation.

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*

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

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
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 presents a summary of SFHP'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
SFHP—San Francisco 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	45.45%	53.75%	★★★	↔	18.98%	33.33%
ACR	Q, A	--	15.81%	--	Not Comparable	--	--
AMB–ED	‡	26.68	35.34	‡	Not Comparable	‡	‡
AMB–OP	‡	354.39	348.95	‡	Not Comparable	‡	‡
CAP–1224	A	92.98%	95.95%	★★	↑	95.56%	98.39%
CAP–256	A	87.90%	89.57%	★★	↑	86.62%	92.63%
CAP–711	A	90.08%	93.16%	★★	↑	87.56%	94.51%
CAP–1219	A	86.78%	91.13%	★★	↑	86.04%	93.01%
CBP	Q	--	66.46%	--	Not Comparable	--	--

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
SFHP—San Francisco 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]
CCS	Q,A	80.19%	76.76%	★★	↔	61.81%	78.51%
CDC–BP	Q	78.64%	74.77%	★★	↔	54.48%	75.44%
CDC–E	Q,A	69.72%	67.59%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	63.38%	62.27%	★★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	26.53%	26.39%	★★★	↔	50.31%	28.95%
CDC–HT	Q,A	91.08%	90.97%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	48.83%	47.69%	★★★	↔	28.47%	46.44%
CDC–LS	Q,A	83.33%	80.56%	★★	↔	70.34%	83.45%
CDC–N	Q,A	83.57%	87.73%	★★★	↔	73.48%	86.93%
CIS–3	Q,A,T	87.04%	85.81%	★★★	↔	64.72%	82.48%
IMA–1	Q,A,T	64.35%	81.02%	★★★	↑	50.36%	80.91%
LBP	Q	82.98%	86.53%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	42.82%	--	Not Comparable	--	--
MMA–75	Q	--	21.55%	--	Not Comparable	--	--
MPM–ACE	Q	73.20%	76.81%	★	↑	83.72%	91.33%
MPM–DIG	Q	NA	81.82%	★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	71.43%	78.74%	★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	93.44%	87.96%	★★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	75.64%	71.76%	★★	↔	58.70%	74.73%
W-34	Q,A,T	84.95%	84.26%	★★★	↔	65.51%	83.04%
WCC–BMI	Q	76.16%	85.19%	★★★	↑	29.20%	77.13%
WCC–N	Q	80.56%	85.19%	★★★	↔	42.82%	77.61%
WCC–PA	Q	72.69%	83.80%	★★★	↑	31.63%	64.87%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

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

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

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[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
SFHP—San Francisco County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.59%	18.08%	▼	15.81%
CAP–1224	95.91%	NA	Not Comparable	95.95%
CAP–256	89.65%	83.67%	↔	89.57%
CAP–711	93.25%	90.85%	↔	93.16%
CAP–1219	91.27%	87.06%	↔	91.13%
CDC–BP	76.39%	73.38%	↔	74.77%
CDC–E	69.68%	63.43%	↔	67.59%
CDC–H8 (<8.0%)	61.11%	65.97%	↔	62.27%
CDC–H9 (>9.0%)	27.78%	24.54%	↔	26.39%
CDC–HT	90.97%	90.51%	↔	90.97%
CDC–LC (<100)	48.61%	50.69%	↔	47.69%
CDC–LS	81.25%	81.48%	↔	80.56%
CDC–N	85.88%	87.27%	↔	87.73%
MPM–ACE	73.62%	77.85%	↑	76.81%
MPM–DIG	NA	80.56%	Not Comparable	81.82%
MPM–DIU	74.36%	79.97%	↑	78.74%

* 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
SFHP—San Francisco County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
300.16	24.57	527.95	74.89

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

Performance Measure Result Findings

Overall, SFHP demonstrated above-average performance on its measures in 2013, with 12 measures having rates above the HPLs. Although the MCP had three measures with rates below the MPLs, 2013 is the first year that SFHP has had any measures with rates below the MPLs. The measures with rates below the MPLs were:

- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The rates for the following 12 measures were above the HPLs in 2013:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*
- *Use of Imaging Studies for Low Back Pain*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: 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 Counseling: Total*

SFHP has performed above the HPLs for these measures for multiple years except for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* and *Immunizations for Adolescents—Combination 1* measures.

The rates for the following nine measures had statistically significant improvement from 2012 to 2013:

- *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)*
- *Immunizations for Adolescents—Combination 1*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*

The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure had a statistically significant decline in its rate from 2012 to 2013; however, the rate was still above the MPL.

Seniors and Persons with Disabilities Findings

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

- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

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

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

Improvement Plans

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

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

Since SFHP did not have any rates below the MPLs during 2012, no IPs were required. The MCP will be required to submit IPs for the following measures that had rates below the MPLs in 2013:

- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

Strengths

SFHP resolved the recommendation from the 2012 HEDIS audit regarding activation of specificity edits and successfully implemented new transactional and enrollment processing systems.

SFHP demonstrated statistically significant improvement on 9 measures and had 12 measures with rates above the HPLs. The MCP has shown consistent performance over the past five measurement years with only three measures falling below the MPLs in that time span. SFHP has a proven track record of being a high-performing MCP and in 2013 was given the DHCS Gold Award for its HEDIS performance.

Opportunities for Improvement

SFHP has an opportunity to improve its rates for the three *Annual Monitoring for Patients on Persistent Medications* measures. By identifying the factors that have caused the rates for these measures to fall below the MPLs, SFHP can identify strategies to improve the rates. Additionally, since readmissions have been associated with lack of proper discharge planning and poor care transition, SFHP has an opportunity to improve 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 SFHP'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

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

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Improving the Patient Experience	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, SFHP had a 30-day readmission rate of 9.21 percent among Medi-Cal beneficiaries. SFHP also found that the readmission rate for the SPD population was 9.06 percent, which was lower than the 9.42 percent rate for the non-SPD population.

SFHP selected two global measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] Survey as a method to evaluate and improve the patient experience. The measures chosen were (1) *Rating of Personal Doctor*, and (2) *Rating of All Health Care*. By improving doctor-patient communication, SFHP aimed to improve members' satisfaction with their personal doctor and overall health care. Improved doctor-patient communication is associated with improved adherence to physician recommendations and improved self-management skills.

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

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
SFHP—San Francisco County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Improving the Patient Experience	Annual Submission	87%	89%	*Partially Met*
	Annual Resubmission 1	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 SFHP's study design submission of its *All-Cause Readmissions* QIP received an overall validation status of *Met*, with 100 percent of critical elements and 90 percent of evaluation elements met. SFHP received a *Partially Met* validation status for its *Improving the Patient Experience* annual submission. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, SFHP resubmitted the QIP and upon subsequent validation, achieved 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 SFHP's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
SFHP—San Francisco County
(Number = 3 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	90%	0%	10%
Design Total		**98%**	**0%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	70%	20%	10%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**79%**	**14%**	**7%**
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 SFHP's *All-Cause Readmissions* study design submission and Activities I through VIII for the MCP's *Improving the Patient Experience* QIP annual submission.

SFHP met 98 percent of the requirements for the three QIP submissions for all applicable evaluation elements within the Design stage, demonstrating a strong application of this stage. SFHP did not describe its data analysis plan for the *All-Cause Readmissions* QIP, which resulted in a lower score for Activity VI.

SFHP struggled with the Implementation stage, meeting only 79 percent of the requirements for all applicable evaluation elements across the two *Improving the Patient Experience* QIP submissions. In the annual submission, the QIP received a lower score in Activity VII because the MCP did not include a comparison of the baseline rates to the goals, an interpretation of the baseline findings for either study indicator, and the numerators and denominators for the baseline measurement period. SFHP corrected these deficiencies in the resubmission and received an overall *Met* validation status.

Neither of SFHP's QIPs progressed to the Outcomes stage during the reporting period; therefore, the Outcomes stage was not 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 intervention or outcome information for this QIP is included in this report.

Table 4.4—Quality Improvement Project Outcomes
SFHP—San Francisco County
July 1, 2012, through June 30, 2013

QIP #1—Improving the Patient Experience			
Study Indicator 1: The percentage of eligible Medi-Cal patients (18+ for adults and 17 years or younger for children as of December 31) continuously enrolled for at least five of the last six months (July through December) who selected "9" or "10" on question "Rating of all health care" on the CAHPS Health Plan 4.0H Version (CAHPS Question #8)			
Baseline Period 7/1/09–12/31/09	**Remeasurement 1 7/1/12–12/31/12**	**Remeasurement 2 7/1/15–12/31/15**	**Sustained Improvement¥**
43.6%	‡	‡	‡
Study Indicator 2: The percentage of eligible Medi-Cal patients (18+ for adults and 17 years or younger for children as of December 31) continuously enrolled for at least five of the last six months (July through December) who selected "9" or "10" on measure "Rating of personal doctor" on the CAHPS Health Plan 4.0H Version (Adult CAHPS Question #15 and Child CAHPS Question #18)			
Baseline Period 7/1/09–12/31/09	**Remeasurement 1 7/1/12–12/31/12**	**Remeasurement 2 7/1/15–12/31/15**	**Sustained Improvement¥**
54.7%	‡	‡	‡

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

Improving the Patient Experience QIP

SFHP's goal for the *Improving the Patient Experience* QIP was to improve the CAHPS scores for the project outcomes by 25 percent. The MCP reported baseline data using the CAHPS Survey conducted in CY 2010. The CAHPS Survey is conducted every two years; however, DHCS decided not to administer the survey in CY 2012. Instead, the survey was delayed until CY 2013, which allowed integration of the SPD population into Medi-Cal Managed Care and ensured their representation in the 2013 CAHPS Survey. Consequently, SFHP's first remeasurement period was delayed, and the data will not be submitted until 2014.

Throughout the delay, SFHP continued to conduct thorough barrier analyses based on the baseline results. In Year 1 of the study, SFHP initiated a pilot program to improve the patient experience. Through this pilot program, SFHP learned that the clinics that were most successful in improving the patient experience were those with quality improvement experience and expertise. Due to the success of the pilot program, SFHP created the San Francisco Quality Culture Series (SFQCS) in 2011. During this series, 19 clinics participated in monthly day-long sessions for eight months to learn management and leadership skills in quality improvement. Each clinic was required to undertake a quality improvement project to improve timely access, achieve Meaningful Use of Electronic Health Records as a tool for quality and safety, or improve the patient experience.

In fall 2012, the MCP launched a new project, the Patient Experience Action Series. The focus of this series is to improve appointment access, provider-patient communications, and customer service.

Strengths

SFHP excelled at the Design stage for both the *All-Cause Readmissions* and *Improving the Patient Experience* QIPs.

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

Opportunities for Improvement

SFHP has the opportunity to improve documentation related to the MCP's data analysis and interpretation of the results. The MCP should refer to the QIP Completion Instructions prior to submitting QIPs to HSAG to ensure completeness of the data.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the CAHPS 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.

SFHP'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 SFHP'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).

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

Table 5.3—Medi-Cal Managed Care County-Level Global Ratings
SFHP—San Francisco 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
SFHP—San Francisco 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, SFHP received higher marks for the adult global ratings. The MCP received three stars for *Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often*. SFHP was able to improve upon its 2009–10 adult measures *Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often* and its child measure *Rating of Personal Doctor* marks by increasing its ratings from one star to three stars for these measures.

Opportunities for Improvement

SFHP's CAHPS results showed below-average performance for the majority of the child and adult global ratings and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as SFHP's highest priorities: *Getting Care Quickly*, *Getting Needed Care*, and *Rating of Health Plan*. 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 SFHP 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.

SFHP'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

Overall, the information provided in SFHP's Roadmap and supplemental questionnaire demonstrates sound operational policies and practices for the creation, validation, correction, and submission of encounter data. SFHP processes claims and encounter data to submit to DHCS monthly. The MCP uses an automated error-checking utility based on the DHCS encounter data submission rules and specifications. SFHP's Enterprise Data Warehouse maintains all claims and encounters in their final status. The majority of SFHP's providers are capitated and they account for the majority of the claims/encounters. The MCP monitors the encounter submission volumes and error rates for its providers. SFHP's provider relations staff works with the providers to encourage accurate encounter submissions and high data quality. SFHP does not fix the data on behalf of the providers. SFHP indicated it is less consistent with the resubmission of rejected encounters to DHCS within the requested time frames due to the difficulty in securing timely feedback and corrections from the submitting providers. This could have a minor impact on the consistency when comparing encounter records between SFHP's and DHCS's systems.

Record Completeness

Overall, SFHP had relatively high record omission and record surplus rates, indicating incomplete data when comparing DHCS's data and the encounter data extracted from SFHP's data system for this study. SFHP had record omission rates greater than 11 percent for all claim types except

Pharmacy data, and record surplus rates greater than 17 percent for all claim types. The LTC claim type had the highest record omission rate and record surplus rate, with 49.9 percent and 31.7 percent, respectively. The Pharmacy record omission rate was better than the statewide rate by 8.2 percentage points; however, all other record omission and record surplus rates were worse than the respective statewide rates. The record omissions for all claim types resulted mainly from the records in SFHP's data system that were not submitted to DHCS because they failed SFHP's internal audit rules for data quality. For all claim types except LTC, more than 70 percent of the surplus records in DHCS's data had beginning dates of service between July and December 2010. SFHP changed to a new data warehouse in February/March 2011. The data conversion to the new data warehouse may have been the main contributor to the relatively high record surplus rates.

Data Element Completeness

SFHP had fairly low element omission and element surplus rates, with rates lower than 1 percent for the majority of the key data elements. The element omission rates for the *Rendering Provider Number* and *Provider Specialty* data elements in the Medical/Outpatient claim type were worse than the statewide rates by 4.7 and 66.9 percentage points, respectively. The element surplus rates for the data element *Provider Type* were worse than the respective statewide rates for the Medical/Outpatient, Hospital/Inpatient, and LTC claim types by 5.0, 25.6, and 4.2 percentage points, respectively.

Data Element Accuracy

SFHP had relatively high data element accuracy with a rate greater than 95 percent for the majority of the key data elements except for certain notable data elements. For the Pharmacy claim type, the key data elements *Billing/Reporting Provider Number* and *Provider Type* had the lowest element accuracy rates of 8.6 percent and 68.7 percent, respectively. The low *Billing/Reporting Provider Number* element accuracy was due to the truncation of the provider number in DHCS's data. The lower *Provider Type* element accuracy was due to the value "24" (Pharmacies/Pharmacist) being populated in DHCS's data while the value "26" (Physicians) was populated in the data SFHP submitted to HSAG. Both of these data elements had element accuracy rates that fell substantially below the statewide rate, with the *Billing/Reporting Provider Number* accuracy rate falling 83.1 percentage points below the statewide rate. In addition, the Medical/Outpatient claim type had element accuracy rates below 95 percent for two key data elements. The *Provider Specialty* and *Rendering Provider Number* had accuracy rates of 83.4 percent and 94.0 percent, respectively. Nearly 90 percent of the records with differing provider specialties had a *Provider Specialty* of "99" (Unknown) in the MCP's data and other provider specialties in the DHCS data, such as "40" (Pediatrics) and "41" (Internal medicine). The inaccuracy for the data element *Rendering Provider Number* resulted mainly from the differing types of provider numbers that appeared in the two data sources.

For the all-accuracy rates, the Hospital/Inpatient and LTC claim types exceeded the respective statewide rates. However, the Medical/Outpatient and Pharmacy all-element accuracy rates fell below the statewide rates by 45.8 and 73.4 percentage points, respectively, due to the high element omission and/or poor element accuracy for certain data elements.

Recommendations

Based on its review, HSAG recommends the following:

- The relatively high record omission rates for all claim types resulted mainly from the records in SFHP's data system that failed SFHP's internal audit rules and were therefore not submitted to DHCS. SFHP should verify that its internal audit process aligns with the DHCS data submission requirements and correct the records that failed its internal audit process so that all records are submitted to DHCS.
- Although the high record surplus rates may be due to the data conversion to a new data warehouse, SFHP should investigate the reason(s) for the relatively high record surplus rates for all claim types and create strategies for future improvement.
- In the Medical/Outpatient data SFHP submitted to HSAG, more than 60 percent of the records had a *Provider Specialty* of "99" (Unknown), which caused the high element omission and inaccuracy for this data element. SFHP should investigate the issue in order to improve the completeness and accuracy for this data element.
- Similar to the data element *Provider Specialty*, there were element omissions and element inaccuracies for the data element *Rendering Provider Number*. SFHP should investigate the reason(s) in order to improve the completeness and accuracy for the *Rendering Provider Number*.
- The element surplus rate for the *Provider Type* was relatively high (27.9 percent) for the Hospital/Inpatient claim type. SFHP should investigate what caused this issue and apply appropriate quality control procedures to avoid similar issues occurring in future data submissions.
- For the data element *Billing/Reporting Provider Number* in the Pharmacy data, the field length is 12 characters based on the Encounter Data Element Dictionary. However, this data element was stored as a 10-character field in in the DHCS data warehouse. SFHP should try to submit the providers' 10-digit National Provider Identifier whenever possible for this data element.
- SFHP should investigate why the pharmacy data in the DHCS data warehouse contained the *Provider Type* "24" while SFHP's data system contained the *Provider Type* "26."
- All the Medical/Outpatient records were missing values for the data element *Referring/Prescribing/Admitting Provider Number*. More than 99 percent of the Hospital/Inpatient records were missing values for the *Primary Surgical Procedure Code* and the *Secondary Surgical Procedure Code*. SFHP should investigate whether more values for these three data elements can be submitted to DHCS.

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 SFHP's 2013 Quality Improvement Program Description, which includes detailed objectives and activities for ensuring quality health care is provided to the MCP's MCMC members.

Twelve quality performance measures had rates above the HPLs, and nine quality measures had rates that had statistically significant improvement from 2012 to 2013. The MCP had statistically significant decline in performance on one quality measure—*Prenatal and Postpartum Care—Timeliness of Prenatal Care,* and the following three quality measures had rates below the MPLs:

- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and two of these measures—*Annual Monitoring for Patients on Persistent Medications—ACE* and *Annual Monitoring for Patients on Persistent Medications—Diuretics* had SPD rates that were significantly better than the non-SPD rates. The SPD rate for the *All-Cause Readmissions* measure, which is in the quality domain of care, was significantly higher than the non-SPD rate, showing that more of the MCP's members in the SPD population (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than members in the non-SPD population.

All CAHPS measures fall into the quality domain of care. Most of the measures had a *Fair* or *Poor* rating for both the adult and child populations. The following measures had a *Good* rating:

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

Both of SFHP's QIPs fell into the quality domain of care. Neither QIP progressed to the Outcomes stage, so HSAG was not able to assess the QIPs' success at improving the quality of care delivered to the MCP's MCMC members.

Overall, SFHP 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.

SFHP's 2012 Quality Improvement & Utilization Management Program Evaluation and 2013 Quality Improvement Program Description include activities designed to improve access to care. SFHP also provides details on how it monitors success in providing access to needed services.

Four access-related performance measures had rates above the HPLs, and five access measures had rates with statistically significant improvement from 2012 to 2013. The MCP had statistically significant decline in performance on one access measure—*Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

Nine of the performance measures stratified for the SPD population fall into the access domain of care. The SPD rate for one of these measures—*All-Cause Readmissions*—was significantly higher than the non-SPD rate.

SFHP performed below average on the access-related CAHPS measure, *Getting Needed Care*, for both the adult and child populations.

Both of SFHP's QIPs fell into the quality domain of care. Neither QIP progressed to the Outcomes stage, so HSAG was not able to assess the QIPs' success at improving access to care for MCMC beneficiaries.

Overall, SFHP showed above-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.

SFHP's 2012 Quality Improvement & Utilization Management Program Evaluation and 2013 Quality Improvement Program Description include some activities related to assessing and monitoring timeliness of care being provided to members.

The following three measures falling into the timeliness domain of care had rates above the HPLs:

- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

One timeliness measure—*Immunizations for Adolescents—Combination 1*—had a rate with statistically significant improvement from 2012 to 2013. The MCP had statistically significant decline in performance on one timeliness measure—*Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

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.

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

Recommendations

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

- Assess the factors that are leading to the rates for the three *Annual Monitoring for Patients on Persistent Medications* measures falling below the MPLs and identify interventions to be implemented that will result in an improvement in performance.
- Assess the factors leading to the rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure declining significantly from 2012 to 2013 and identify improvement strategies to prevent further decline in the measure's rate.
- Assess the factors that are leading to a significantly higher rate of readmissions for the SPD population when compared to the non-SPD population and identify strategies to ensure the MCP is meeting the needs of the SPD population.
- Refer to the QIP Completion Instructions prior to submitting QIPs to HSAG to ensure all required documentation is included on the QIP Summary Form.
- Review the 2013 MCP-Specific CAHPS results report and develop strategies to address the *Getting Care Quickly*, *Getting Needed Care*, and *Rating of Health Plan* 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 SFHP'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 and 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 **San Francisco Health Plan**

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with SFHP'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—SFHP'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	SFHP's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. Ensure the plan's delegated entities include in the "Your Rights" attachment a required clear and concise explanation outlining the circumstances under which the medical service shall be continued pending a decision on the State fair hearing.	SFHP has confirmed that the delegated entities that have the responsibility for authorizations already include the "Your Rights" attachment with the concise statement about when and how authorized services may continue pending a decision on the State fair hearing.
2. Consider involving additional staff in its improvement strategy process for the Reducing Avoidable Emergency Room Visits QIP to minimize a lapse in a project's progress and success.	SFHP is broadening the group of staff members who contribute to its QIPs, which should minimize the transition period when staff members leave. For example, SFHP currently involves four core staff members to improve the patient experience (SFHP's plan-specific QIP).
3. Consistently document the data results of its QIP barrier analyses and intervention evaluations for each measurement period.	SFHP has incorporated barrier analyses into each of its QIPs. Additional analyses will be included in future QIPs.
4. Clearly document the date that a QIP intervention is implemented and indicate any lapses, restrictions, or modifications made to the intervention.	QIP interventions are currently documented in SFHP project plans. SFHP will incorporate these interventions in the QIP reports.