



*Medi-Cal Managed Care Division*

# *state of california*



## Medi-Cal Managed Care External Quality Review Organization

### 2006 Annual Report of Performance for Health Plan of San Mateo

*Submitted by*  
Delmarva Foundation  
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## 2006 Annual Review: Health Plan of San Mateo

### Introduction

The California Department of Health Care Services (DHCS) is charged with the responsibility of evaluating the quality of care provided to Medi-Cal recipients enrolled in contracted Medi-Cal managed care plans. To ensure the care provided meets acceptable standards for quality, access, and timeliness, DHCS has contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO).

As set forth in 42 US Code, Section 1396U-2(c)(2), Delmarva has conducted an annual external independent review of managed care activities at Health Plan of San Mateo to include “the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract.”

For purposes of this annual review, Delmarva has adopted the following definitions:

- **Quality**, as it pertains to external quality review, is defined as “the degree to which a Managed Care Organization [MCO] or Prepaid Inpatient Health Plan [PIHP] increases the likelihood of desired health outcomes of its enrollees [as defined in 42 CFR 438.320(2)] through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge” (Centers for Medicare and Medicaid Services, *Final Rule: Medicaid Managed Care; 42 CFR Part 400, et.al. Subpart D- Quality Assessment and Performance Improvement*, (June 2002).
- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is “the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services” (*2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*).
- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether “the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care.” (*2006 Standards and Guidelines for the Accreditation of Managed Care*

*Organizations*). In addition, the Institute of Medicine National Health Care Quality Report refers to timeliness as “obtaining needed care and minimizing unnecessary delays in getting that care” (*Envisioning the National Health Care Quality Report, 2001*).

## Methodology and Data Sources

Delmarva’s task is to review how well the Health Plan of San Mateo (HPSM) performs in the areas of quality, access, and timeliness. To do this, Delmarva used four types of information to evaluate HPSM’s performance:

- The Health Plan Employer Data and Information Set (HEDIS®) is a nationally recognized set of performance measures developed by NCQA. These measures are used by health care purchasers to assess the quality and timeliness of care and service provided to members of managed care delivery systems. The results for the HEDIS measures used in this report were submitted by DHCS health plans in June 2006, and cover the 2005 measurement year (January 1, 2005, through December 31, 2005).
- Summaries of plan-conducted Quality Improvement Projects (QIPs).
- Audit and Investigation (A&I) Medical Audits conducted by the Audit and Investigation Division of DHCS to review compliance with contract requirements and State regulations.
- 2005 grievance and appeal data provided quarterly by health plans to DHCS.

Delmarva used this information to comprehensively review HPSM’s ability to provide timely, quality care and services that are accessible to its member population. To do this, the performance measures have been categorized into quality, access, and timeliness categories. However, it is important to note that these categories are interdependent; thus, a measure or attribute identified in one of the categories of quality, access, or timeliness may also be noted under either of the other two categories.

## Comparative Data

HEDIS data used in this report is obtained by Delmarva from the plan’s HEDIS data auditor as submitted in the NCQA HEDIS data submission tool. The state HEDIS average is calculated using a simple arithmetic mean methodology of the rates submitted by all health plans for a particular indicator. The weighted HEDIS average is calculated as the sum of the individual plans’ weighted averages. The weighted average is calculated by multiplying each plan’s rate for a measure by the “weighted ratio” for each measure. The performance targets are taken from the most recent version of NCQA’s *Quality Compass*.

The State mean used for performance comparison is determined by the California Medi-Cal Managed Care Division (MMCD). Where national commercial averages are used in data comparisons, NCQA uses the most current rates published on NCQA's website on the *HEDIS® 2005 Means, Percentiles & Ratios* page. Healthy People 2010 comparisons are found in the national publication of the U.S. Department of Health and Human Services' *Healthy People 2010: Understanding and Improving Health*. California Healthy People 2010 comparison goals are found on the DHCS website at:

<http://www.DHCS.ca.gov/hisp/chs/OHIR/hp2010/hc2010progressfiles/summary.pdf>.

## Background on HPSM

HPSM is a full-service health plan contracted in San Mateo County as a county organized health system (COHS). HPSM has been licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act since July 31, 1998. As of August 2006, HPSM's total Medi-Cal enrollment was 47, 816 members.

During the HEDIS reporting year (RY) of 2006, HPSM collected data on the following clinical performance measures to assess quality, timeliness, and access:

- Childhood Immunization Status - Combination 2
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Prenatal and Postpartum Care: Timeliness of Prenatal Care and Postpartum Check-Up Following Delivery
- Well-Child Visits in the First 15 Months of Life - 6 or More Visits
- Well-Child Visit in the 3rd, 4th, 5th, & 6th Years of Life
- Adolescent Well-Care Visits
- Use of Appropriate Medications for People with Asthma
- Inappropriate Treatment of Adults with Acute Bronchitis
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Comprehensive Diabetes Care - Retinal Eye Exams, Hemoglobin A1c (HbA1c) Testing, Serum Cholesterol Level (LDL-C) Screening, and Monitoring for Nephropathy (Kidney Disease)

To analyze member satisfaction with care and services offered by HPSM, Delmarva reviewed grievance and appeal data. As another assessment of enrollee satisfaction, Delmarva usually includes an analysis of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). However, DHCS did not have the CAHPS survey administered during the measurement year of 2005, so a CAHPS analysis is not included in this report.

With respect to QIPs, HPSM submitted the following for review in 2005:

- Adolescent Health Collaborative
- Improve Chronic Care Management of Asthmatics by Plans and Providers
- Improving Use of Initial Health Assessment with New Members and Children with Special Needs
- Increasing Cervical Cancer Screening

The DHCS and Department of Managed Health Care (DMHC) last performed an audit of HPSM during September 13-16, 2004. The audit consisted of document review, verification studies, and interviews conducted at HPSM headquarters.

These activities assessed plan compliance in the following areas:

- Utilization Management
- Continuity of Care
- Availability and Accessibility
- Member's Rights
- Quality Management
- Administrative and Organizational Capacity

To demonstrate HPSM response to the issues of quality, timeliness, and access, Delmarva separated the HEDIS measures into single categories of quality, timeliness, or access. Many of these measures can be considered in relation to more than one of the categories. However, for purposes of this report Delmarva categorized the measures to best facilitate the reader's understanding of how HPSM comprehensively monitors the quality of care and services provided to its members.

## Quality at a Glance

### HEDIS®

A list of the HEDIS areas assessed for clinical quality is shown on page three of this report. Table 1 shows the aggregate quality measure results HPSM obtained.

**Table 1. HEDIS Quality Measure Results for HPSM**

HEDIS Measure	2005 HPSM Rate	Medi-Cal Managed Care Weighted Average	2005 National Medicaid HEDIS Average
Inappropriate Treatment of Adults with Acute Bronchitis*	26.9%	63.2%	N/A
Use of Appropriate Medications for People With Asthma	78.4%	84.5%	63.8%
Cervical Cancer Screening	49.6%	68.0%	64.5%
Comprehensive Diabetes Care - Retinal Eye Exams	66.3%	51.1%	44.1%
Comprehensive Diabetes Care - HbA1c Testing	68.9%	74.3%	75.0%
Comprehensive Diabetes Care - LDL-C Screening	72.6%	84.4%	78.6%
Comprehensive Diabetes Care - Monitoring for Nephropathy	47.3%	56.4%	45.8%
Chlamydia Screening in Women	54.5%	48.1%	46.4%
Appropriate Treatment for Children with Upper Respiratory Infection	91.3%	80.1%	80.0%

\* Lower rates are better for this measure; a negative difference signifies higher performance for this measure.

HPSM exceeded the Medi-Cal managed care average for three of the eight positive HEDIS measures and performed better (by scoring lower) on the only inverse HEDIS measure (Inappropriate Treatment of Adults with Acute Bronchitis). Thus, HPSM performed better than or met the Medi-Cal managed care average on four of the nine HEDIS measures, 44 percent of the measures. HPSM scored better than the National Medicaid HEDIS average on five of the eight measures. These results are an indication that HPSM effectively focuses its resources on quality processes in these areas.

The HEDIS quality measures in Table 1 assess quality processes as opposed to actual quality of care outcomes. Nevertheless, the assessment of the processes reflected by the HEDIS scores enables HPSM to then decide what kind of studies the plan should develop and conduct in order to measure actual quality of care outcomes. For HPSM, HEDIS scores indicate improvement is needed in Cervical Cancer Screening and two Comprehensive Diabetes Care measures: HbA1c Testing and LDL-C Screening.

## Quality Improvement Projects

For all plans, quality improvement is an ongoing process of fine-tuning selected interventions after each re-measurement in accordance with the degree of improvement achieved by the previously chosen interventions. As with all plans contracted with the DHCS, HPSM uses the quality improvement process of identifying a problem relevant to its population, setting a goal, obtaining a baseline measurement, and performing targeted interventions aimed at improving performance. Then, after each re-measurement, the plan uses qualitative analysis to identify new barriers to achieving its targeted goals and adjusts the targeted interventions as appropriate. The following section provides a synopsis of each QIP undertaken by HPSM.

### Adolescent Health Collaborative

➤ **Relevance:**

- HPSM recognized well-care visits were crucial to adolescent members and its HEDIS rates showed adolescents were underutilizing the plan's services.

➤ **Goals:**

- Increase the HEDIS rate of adolescent well-care visits by 10 percent per year.
- Improve adolescent well-care visit survey results by increasing the percentage of members who report they received a quality well-care visit by 10 percent per year.

➤ **Best Interventions:**

- Developed a brochure for newly enrolled adolescent members to educate them about covered benefits.
- Piloted an adolescent well-care visit incentive program in which adolescents received a movie ticket following completion of their annual visits.

➤ **Outcomes:**

- HEDIS Adolescent Well-Care Visits rate:
  - ◊ RY 2004: 30.1%
  - ◊ RY 2005: 32.2%
  - ◊ RY 2006: 32.2%
- Adolescent Report of Visit Survey rate:
  - ◊ April-June 2005: 63.0%

➤ **Attributes and Barriers to Outcomes:**

- Barrier: Providers lack knowledge about adolescent well-care visit components, coverage, and reimbursement.
- Barrier: Adolescents members and their parents were unclear on the benefits of well-care visits.

## Asthma Collaborative

### ➤ *Relevance:*

- In California, 11.9 percent of the population reported they have been diagnosed with asthma at one time. In addition, 2.9 million children and adults with asthma reported experiencing asthma symptoms at least once in the past 12 months, indicating an overall asthma symptom prevalence rate of 8.8 percent.

### ➤ *Goals:*

- Reduce asthma-related emergency department (ED) visits and inpatient hospital admissions by 50 percent.

### ➤ *Best Interventions:*

- Emphasized the education of the patient and family about their role in management of asthma.
- Conducted monthly identification of poorly controlled asthma patients via billing data (e.g.: hospitalizations, ED visits, and if available, medication use).
- Trained staff and provided tools to educate families about how to use spacers, inhalers, peak flow meters, and/or nebulizers during planned visits.
- Identified and used community resources such as smoking cessation programs and providers.

### ➤ *Outcomes:*

- Asthma-Related Hospital Admissions Per Thousand Members With Asthma per Year (PTMPY):
  - ◊ RY 2005: 3.0 admissions PTMPY
  - ◊ RY 2006: 3.0 admissions PTMPY
- Asthma-related ED Visits for Members with Asthma:
  - ◊ RY 2005: 32.0 visits PTMPY
  - ◊ RY 2006: 41.0 visits PTMPY
- Appropriate Use of Controller Medications By Members with Persistent Asthma:
  - ◊ RY 2005: 62.0%
  - ◊ RY 2006: 78.0%
- Appropriate Use Of Rescue Medications By Members With Persistent Asthma:
  - ◊ RY 2005: 16.0%
  - ◊ RY 2006: 24.0%

### ➤ *Attributes and Barriers to Outcomes:*

- Barrier: Provider office staff had limited involvement in asthma treatment activities.
- Barrier: Provider sites do not use the asthma registry.
- Barrier: There is a lack of information technology resources at provider sites.

## Initial Health Assessments

### ➤ *Relevance:*

- HPSM estimated between 2000 and 2003 that approximately 41 percent of new members received an Initial Health Assessment (IHA) by either a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) within 120 days of their enrollment.
- The most recent State audit report identified the plan as deficient in monitoring whether IHAs are provided to members.

### ➤ *Goals:*

- Achieve an improvement of 10 percent in the IHA rate for all new Medi-Cal members.
- Achieve an improvement of 10 percent in the IHA rate for children with special needs.

### ➤ *Best Interventions:*

- Increased the provider reimbursement rate for new patient IHAs from 60 to 90 dollars.
- Revised the new member welcome letters to simplify them and highlight the need to complete the Staying Healthy Assessment Form. This involved reformatting and lowering the reading level.
- HPSM leadership met with the San Mateo County Medical Group to discuss the effective use of case management lists (listing of their assigned members) and coordination with the county's system.
- HPSM met with the San Mateo Human Services Agency to obtain more accurate phone numbers and addresses for members.
- Sent postcards to newly enrolled members reminding them to obtain an IHA.

### ➤ *Outcomes:*

- IHA Rate for New Medi-Cal Members:
  - ◊ September 1, 2002 - August 31, 2003: 40.3%
  - ◊ September 1, 2003 - August 31, 2004: 44.6%
- IHA Rate for Children With Special Needs:
  - ◊ September 1, 2002 - August 31, 2003: 28.4%
  - ◊ September 1, 2003 - August 31, 2004: 31.3%

### ➤ *Attributes/Barriers to Outcomes:*

- Attribute: Financial incentives promoted to providers.
- Attribute: Increased outreach to members due to more accurate address information.
- Barrier: Children with special needs were not assigned a specific PCP responsible for tracking whether they received an IHA.

## Increasing Cervical Cancer Screening

### ➤ *Relevance:*

- HPSM members are considered a high-risk group for cervical cancer due to their low socioeconomic status and racial and ethnic backgrounds.

### ➤ *Goal:*

- Increase the HEDIS Cervical Cancer Screening rate to reach the 25<sup>th</sup> percentile of the National Medicaid average.

### ➤ *Best Interventions (Planned):*

- Identified 1200 women as being past due for a Pap test.
- A reminder protocol including an appointment confirmation letter and information about Bath and Body Works incentives, Pap tests, and provider lists, was to be implemented and carried out by the health promotion specialist with women who are due for a Pap test.
- Outreach and education to women regarding cervical cancer and Pap test to be provided by HPSM staff.

### ➤ *Outcomes:*

- N/A – this project is in a proposal phase.

### ➤ *Attributes and Barriers to Outcomes:*

- Barrier: Lack of awareness by members of the importance of a Pap test.
- Barrier: Lack of provider awareness of the challenges HPSM members encounter in navigating the healthcare system.

Table 2: QIP Performance Results- HPSM

QIP Activity	Indicator	Baseline	Re-measurement		
			#1	#2	#3
Adolescent Health Collaborative	Adolescent Annual Well-Care Visits	<b>RY2004:</b> 30.1%	<b>RY2005:</b> 32.2%	<b>RY2006:</b> 32.2%	
	Adolescent Report of Visit Survey	<b>April-June 2005:</b> 63.0%			
Asthma Collaborative	Asthma-Related Hospital Admissions Per Thousand Members With Asthma per Year	<b>RY 2005:</b> 3.0	<b>RY 2006:</b> 3.0		
	Asthma-Related ED Visits Per Thousand Members With Asthma per Year	32.0	41.0		
	Appropriate Use of Controller Medications By Members with Persistent Asthma	62.0%	78.0%		
	Appropriate Use Of Rescue Medications By Members With Persistent Asthma	16.0%	24.0%		
Initial Health Assessments	IHA Rate for New Medi-Cal Members	<b>CY 2003:</b> 40.3%	<b>CY2004:</b> 44.6%		
	IHA Rate for Children With Special Needs	28.4%	31.3%		

## Audits Findings

Delmarva reviewed the results of the joint audit performed by DHCS and DMHC. The A&I component of the quality review, specifically assessed HPSM in the following areas:

- Continuity of Care
  - Coordination of Care: Within the Network
  - Coordination of Care: Outside the Network/Special Arrangements
  - Initial Health Assessment
  
- Member's Rights
  - Grievance System
  
- Quality Management
  - Qualified Providers
  - Program Description and Structure
  - Administrative Services
  - Delegation of QIP Activities

Auditors found that HPSM had opportunities for improvement within these audit categories.

- Within the Coordination of Care Within the Network component, protocols and procedures lacked clear and consistent identification of the PCP's role in case management.
- Within the Coordination of Care Outside-the-Network/Special Arrangements category, deficient policies and procedures were found related to identification of Early Start program participants (i.e. children in need of early intervention services) and members who are suspected and/or diagnosed with developmental disabilities (e.g. mental retardation, cerebral palsy, and autism).
- Recurring deficiencies were found related to IHAs and included poor compliance with newly enrolled members receiving an IHA and Individual Health Education Behavioral Assessment (IHEBA) within the required 120-day period; lack of HPSM's monitoring of the completion of IHAs and IHEBAs; and provision of timely feedback to providers.
- In the Grievance System Oversight category, the audit revealed improvements needed to the existing member grievance procedures to ensure all member grievances are resolved within thirty days.
- In the Quality Improvement Program category, auditors noted credentialing and recredentialing policies needed to be brought into conformance with standards.
- The Quality Improvement Program quality of care indicator performance goals were evaluated as substandard.

As the plan addressed these opportunities for improvement, DHCS and DMHC provided oversight of HPSM’s corrective action process. Within 45 calendar days from the date of the Exit Conference, HPSM was not able to resolve most of the identified deficiencies to the Department’s satisfaction and received additional time to correct the deficiencies

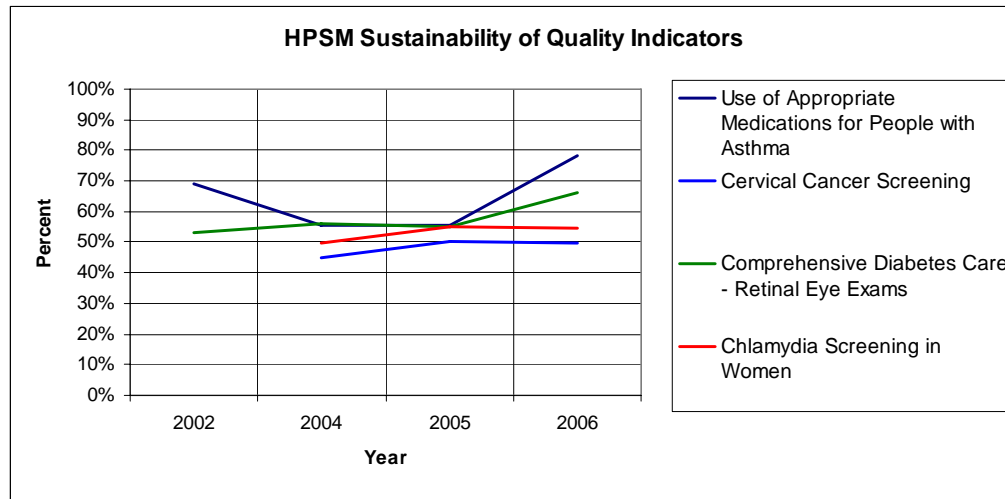
**Satisfaction with Quality of Care**

Member satisfaction is assessed using grievance and appeal data. Since Delmarva wasn’t provided with HPSM grievance and appeal data for 2005, this assessment could not be done for this report. The 2007 report will include a comprehensive assessment of member satisfaction with the quality of care and service based on an analysis of CAHPS results and 2006 grievance and appeal data.

**Sustainability of Quality Indicators**

HPSM demonstrates commitment to clinical quality in its sustained improvement of HEDIS scores. Figure 1 shows the improvement trend of HEDIS measures monitored since 2002. A trend of sustained improvement is evident for each of the four measures over the past three years. The Use of Appropriate Medications for People with Asthma measure results display the most significant increase over the three year period, especially from 2005 to 2006. Information regarding the statistical significance of the improvement attained, as it relates to the Medi-Cal mean, can be found in the *2005 Performance Measures for Medi-Cal Managed Care Members*, available on the DHCS website at [www.dhcs.ca.gov/mcs/mcmcd](http://www.dhcs.ca.gov/mcs/mcmcd).

**Figure 1: HPSM Sustainability of Quality Indicators**



## Summary of Quality

HPSM demonstrates some quality-focused approaches to administering care and services to its members. However, the health plan should focus on improvement in several areas of HEDIS relating to quality, including Cervical Cancer Screening and two Comprehensive Diabetes Care measures, HbA1c Testing and LDL-C Screening. Improvement is also needed in the deficient A&I categories relating to quality requirements. Through its QIP interventions, HPSM demonstrates an integrated approach to working with its members, practitioners, providers, community, and the internal health plan departments to improve overall healthcare quality processes and services.

## Access at a Glance

Appropriate access to care is an essential aspect of a quality-driven system of healthcare. Access to care and services has historically been a challenge for Medicaid recipients enrolled in fee-for-service programs. One of MMCD's goals is to adequately protect enrollee access to care. The findings with regard to access for HPSM are discussed in the following sections.

### HEDIS®

From a HEDIS perspective, access and availability of care are addressed through two of the required HEDIS measures: Adolescent Well-Care Visits and Postpartum Check-up Following Delivery. The Postpartum Check-up Following Delivery measure could also be used as an indicator of timeliness, but is considered to be a better indicator of access. Table 3 shows HPSM's results for these access measures.

**Table 3: 2005 HEDIS Access Measure Results for HPSM**

HEDIS Measure	2005 HPSM Rate	Medi-Cal Managed Care Weighted Average	2005 National Medicaid HEDIS Average
Adolescent Well-Care Visits	32.2%	37.9%	40.3%
Postpartum Check-up Following Delivery	54.3%	57.3%	55.9%

HPSM scored below the Medi-Cal managed care weighted average and the national Medicaid average for both access measures, indicating a need for improvement in these areas. Plan staff directly involved in HPSM's Adolescent Collaborative QIP should continue to focus on increasing the rates for this measure to the same level or better than the comparison averages.

HPSM's Adolescent Collaborative QIP included collaboration with practitioners, community resources, and its member community, and the plan has implemented interventions aimed at improving adolescent well-care visits. However, the plan has also identified multiple barriers in adolescents' motivation to obtain care. HPSM should consider implementing additional strategies with demonstrated success in attracting adolescents, such as incentives to attend well-care visits. The national Medicaid average for Adolescent Well-Care Visits indicates this area is a challenge not only for HPSM, but also for all Medicaid health plans.

Because of HPSM's lower than average performance in the Postpartum Check-Up Following Delivery measure, HPSM is encouraged to consider focusing on this area in the future.

### Quality Improvement Projects

HPSM's QIPs focus on improvement of both clinical and non-clinical indicators. Within the barrier analyses for each project, the plan frequently identified access barriers. Identification of these access barriers should be followed by interventions targeted to improve access. For several of the QIP activities, such as Initial Health Assessments, HPSM has identified access as a barrier in the performance of the qualitative analysis of the project. HPSM should continue to take steps to mitigate or when possible, eliminate identified access barriers. For examples of access barriers identified, refer to the discussion of QIP activities under the headings "Attributes and Barriers to Outcomes."

### Audits Findings

Delmarva reviewed the results of the audit performed by DHCS and DMHC. This audit included compliance review of some requirements which represent proxy measures for access. The A&I component of the review specifically assessed HPSM in the following areas relating to access:

- Availability and Accessibility
  - Access to Medical Care
  - Access to Emergency Services
  - Access to Pharmaceutical Services
  - Access to Specific Services
  
- Member's Rights
  - Primary Care Physician
  - Cultural and Linguistic Services
  - Confidentiality Rights

Auditors found opportunities for improvement in the Availability and Accessibility category. A deficiency in the Access to Medical Care component related to HPSM's failure to provide tracking and trending of access

standards for waiting times in doctor’s offices, on the telephone, for scheduling an appointment, or for referrals to specialists. Within the Member’s Rights category in the Cultural and Linguistic Services component, auditors found HPSM deficient in the procedures for providing cultural and linguistic services to members. Additional deficiencies related to the primary care physician selection and assignment process.

To address these opportunities, DHCS and DMHC provided oversight for HPSM’s corrective action process. Within 45 calendar days from the date of the exit conference, HPSM was unable to address most of the deficient areas to the Department’s satisfaction and received additional time to correct the deficiencies.

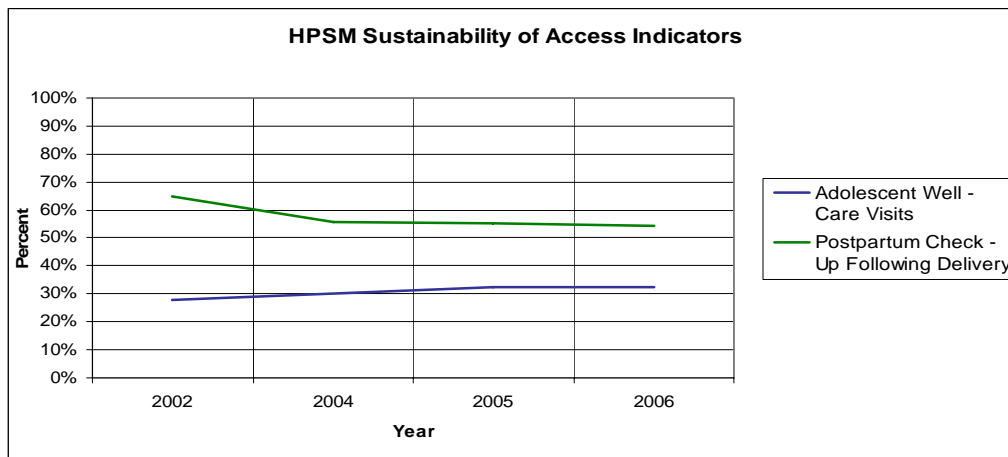
**Satisfaction with Access**

Delmarva was not provided with HPSM plan-specific grievance and appeal data for 2005 to form a basis of an assessment regarding member satisfaction. A comprehensive assessment of member satisfaction with the quality of care and service will be provided in the 2007 report, which may include an analysis of CAHPS results and of the 2006/2007 grievance and appeal data.

**Sustainability of Access Measures**

Figure 2, shows HPSM’s consistent performance and sustainability since 2002 in the Adolescent Well-Care Visits measure and the Postpartum Check-up Following Delivery measure for access.

**Figure 2: HPSM Sustainability of Access Indicators**



**Summary of Access**

For HPSM, access is an area in which improvement have been made, but still requires a commitment to improvement. HPSM should focus on improving postpartum care by developing new strategies aimed at member outreach and incentives for receiving appropriate postpartum care. Delmarva recommends that

HPSM also focus on developing and implementing successful strategies and/or incentives to encourage adolescents to attend well-care visits. Additionally, HPSM must ensure its clinicians provide resources to the community or links to resources in order to provide the psychological and behavioral care needed by adolescents. HPSM’s audit results also confirmed a need for improvement in the area of access.

### Timeliness at a Glance

Access to necessary health care and related services alone is not enough to advance the health status of Medi-Cal managed care enrollees. Timely delivery of those services is equally important. The findings related to timeliness are discussed in the following sections.

#### HEDIS®

Timeliness of care is assessed using the results of the HEDIS measures for Breast Cancer Screening, Childhood Immunization Status-Combination 2, Timeliness of Prenatal Care, Well-Child Visits in the First 15 Months of Life - 6 or More Visits, and Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life. These measures were categorized in the timeliness domain because each is associated with the receipt of services within a certain timeframe. The results of the HEDIS timeliness measures are shown in Table 4.

Table 4: HEDIS Timeliness Measure Results for HPSM

HEDIS Measure	2005 HPSM Rate	Medi-Cal Managed Care Weighted Average	2005 National Medicaid HEDIS Average
Breast Cancer Screening	56.0%	55.0%	54.0%
Childhood Immunization Status - Combination 2	78.7%	76.6%	62.9%
Timeliness of Prenatal Care	74.7%	79.5%	78.3%
Well-Child Visits in the First 15 Months of Life - 6 or More Visits	59.2%	55.8%	46.8%
Well-Child Visit in the 3rd, 4th, 5th, & 6th Years of Life	66.7%	72.7%	61.9%

HPSM exceeded the Medi-Cal managed care average in HEDIS measures related to Breast Cancer Screening, Childhood Immunization Status-Combination 2, and Well-Child Visits in the First 15 Months of Life - 6 or More Visits and surpassed the national Medicaid HEDIS average in four out of the five measures. HPSM’s commitment to timeliness is confirmed by the plan’s competitive scores in the majority of timeliness-related

HEDIS measures. HPSM's achievements in the area of timeliness are to be commended, particularly for achieving meaningful improvement in measures not singled out for formal QIP activity.

### **Quality Improvement Projects**

Timeliness was a focus area in HPSM's QIPs. For example, one area of QIP intervention focused on ensuring members were reminded of preventive services prior to the age when the services are due. HPSM used a variety of approaches to address timeliness, such as sending reminders, distributing preventive health guidelines to members and clinicians, and providing evidence-based literature to the practitioner network. HPSM's QIPs noted that practitioner timeliness barriers center around missed opportunities to provide care or services.

### **Audits Findings**

Delmarva's review of DHCS and DMHC's audit findings focused on requirements that can be considered proxy measures for timeliness:

- Utilization Management
- Prior Authorization Review Requirements
- Prior Authorization Appeal Process
- Delegation of Utilization Management
- Pharmaceutical Services in Emergency Circumstances

Auditors found opportunities for HPSM to improve in the areas of prior authorization/concurrent review policies and procedures, appeal procedures, and delegated UM monitoring activities for HPSM's Pharmacy Benefit Manager (PBM). Auditors identified repeat deficiencies related to pharmaceutical services in emergencies, including the lack of a policy or monitoring procedure to ensure members seen in contracted hospital emergency rooms are provided an adequate supply of medication(s) to last them until they can reasonably expect to have a prescription filled.

As a follow-up to these finding, DHCS and DMHC provided oversight for HPSM's corrective action process. Within 45 calendar days from the date of the Exit Conference, HPSM was unable to address the identified deficiencies to the Department's satisfaction, but did address them when provided more time.

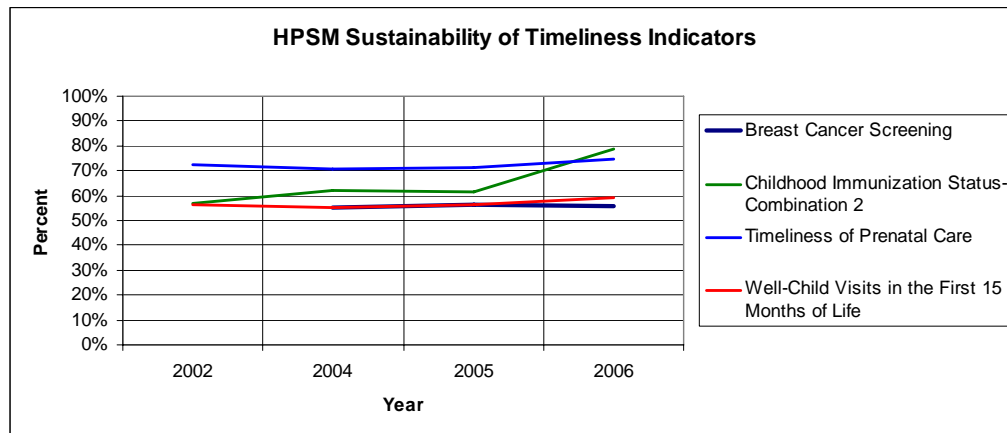
### **Satisfaction with Timeliness**

Delmarva was not provided with HPSM plan-specific grievance and appeal data for 2005, so cannot comment on this indicator of member satisfaction. In the next annual report, Delmarva will analyze 2007 CAHPS results and 2006 and 2007 grievance and appeal data to assess member satisfaction with the plan's quality of care and service.

### Sustainability of Timeliness Measures

Figure 3 below shows, HPSM’s overall sustained improvement in timeliness measures over a period of time. This sustained improvement is likely a result of the plan’s continued rising of the “quality bar” for these measures.

**Figure 3: HPSM Sustainability of Timeliness Indicators**



### Summary for Timeliness

Timeliness barriers are often identified as access issues. HPSM demonstrates strength in various aspects of timeliness as a component of quality care. It appears HPSM recognizes the importance of timeliness in the overall provision of care and services as indicated by their achievements in certain areas; however, the plan must improve in other areas to ensure future success. Additionally, HPSM must correct the timeliness deficiencies identified in audit findings.

### Comparison of Measures by Model Type

HPSM is a County Organized Health System (COHS) operating in San Mateo County. Whether the plan model type affects quality achievements versus opportunities for improvement cannot be absolutely determined. However, to begin to address this question, Delmarva prepared a table of the 2005 HEDIS performance measure outcomes by plan model type. Results are presented in Table 5 below.

Table 5: Comparison of 2005 HEDIS Measures by Plan Model Type

Comparison of 2005 HEDIS Measures by Plan Model Type											
Plan Model Type	Childhood Immunization Status Combo 2	Well-Child Visits in the First 15 Months of Life - 6 or More Visits	Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	Adolescent Well-Care Visits	Timeliness of Prenatal Care	Postpartum Check - Up Following Delivery	Chlamydia Screening in Women	Breast Cancer Screening	Cervical Cancer Screening	Appropriate Medications for People With Asthma	Appropriate Treatment for Children with URI
COHS	84.7%	63.0%	75.3%	47.4%	85.5%	67.4%	46.5%	59.6%	68.4%	87.0%	81.5%
CP	71.3%	44.9%	70.7%	32.7%	79.7%	56.1%	46.5%	49.6%	66.1%	82.8%	78.6%
GMC - North	71.4%	56.7%	68.9%	32.2%	78.5%	52.2%	52.8%	54.1%	66.0%	84.2%	90.0%
GMC - South	78.7%	34.6%	63.6%	25.0%	79.6%	47.9%	35.6%	59.7%	64.9%	81.7%	86.6%
LI	77.2%	54.6%	74.1%	40.5%	77.8%	56.2%	49.6%	53.5%	69.5%	84.7%	79.3%

Comprehensive Diabetes Care Measures				
Plan Model Type	Retinal Eye Exam	HbA1c Testing	LDL - C Screening	Nephropathy
COHS	71.1%	80.8%	86.5%	59.2%
CP	50.2%	73.9%	83.5%	62.3%
GMC - North	53.7%	72.4%	82.7%	67.3%
GMC - South	52.7%	69.7%	83.4%	51.8%
LI	40.7%	71.7%	84.1%	51.0%

**Plan Model Definitions:**

**COHS:** County Organized Health System - Mandatory enrollment of nearly all Medi-Cal eligible population into a managed care system developed by the county.

**CP & LI:** Two-Plan Model - Mandatory and voluntary enrollment of Temporary Assistance to Needy Families (TANF) and Seniors and Persons with Disabilities (SPD) populations into one of two managed care entities. Commercial Plan (CP) is a commercially operated managed care plan. The Local Initiative (LI) is a community-developed plan designed to meet the specific needs of the community served.

**GMC:** Geographic Managed Care - Mandatory and voluntary enrollment of the TANF and SPD populations into a commercially operated managed care plan, with enrollees choosing between multiple plans in the area.

Table 5 demonstrates that COHS model plans achieved the highest scores in 10 of 15 measures performed. In 66 percent of the measures, the COHS plans attained higher achievement than the other plan model types. As DHCS and contracted plans continue to track yearly HEDIS scores, trending of results by plan model type may help focus on practices used by the more successful model types that can be shared with other model plans.

### **Comparison to Healthy People 2010 and other National and California State Programs**

Because the HEDIS performance measures are basically concerned with the receipt of preventive services to reduce the need for secondary and tertiary care, Delmarva also compared performance measurement results and Healthy People 2010 objectives. Because the Healthy People 2010 objectives did not mirror the HEDIS performance measures, Delmarva began correlating the performance measure results with the projected impact the results would have on the Healthy People 2010 target objectives. Although many of the Healthy People 2010 objectives were not applicable to the 2005 performance measures reviewed, three were selected for this analysis.

HPSM's rate of 78.4 percent in asthmatics receiving appropriate treatment has likely positively contributed to California's success in meeting the national Healthy People 2010 objective of fewer asthma hospitalizations for people less than 18 years old with asthma. In 2004, California met the national target of 17.3 hospitalizations per 10,000 people in the affected population with a rate in California of 13.8 hospitalizations per 10,000 people in the affected population.

HPSM also improved its rate in the HEDIS Comprehensive Diabetes Care performance measure, specifically HbA1c testing and retinal eye exams. Healthy People 2010's objectives for death rates and hospitalizations due to diabetes are 45 per 10,000 people in the affected population and 5.4 per 10,000 people in the affected population. Although California achieved the quantitative goal for hospitalizations in 2004, the state continued to strive to meet the target death rate. Delmarva believes HPSM's focus on improvement in the diabetes process measures positively impact the control of progression of the disease in the affected population and contribute to California's effort to meet the national targets for this illness.

Table 6: Comparison of HPSM Performance Measurement Results with Other National and California State Programs

Comparison of HPSM Performance Measurement Results with Other National and California State Programs					
Performance Measure	HPSM Rate	Medi-Cal Managed Care Weighted Average	HEDIS 2005 National Medicaid Average+	HEDIS 2005 National Commercial Average‡	Healthy Families++
Childhood Immunization Status - Combination 2	78.6%	76.6%	62.9%	72.5%	75.0%
Well-Child Visits in the First 15 Months of Life - 6 or More Visits	59.2%	55.8%	46.8%	68.7%	N/A
Well-Child Visit in the 3rd, 4th, 5th, & 6th Years of Life	66.7%	72.7%	61.9%	64.4%	68.0%
Adolescent Well-Care Visits	32.2%	37.9%	40.3%	38.3%	37.0%
Timeliness of Prenatal Care	74.7%	79.5%	78.3%	90.8%	N/A
Postpartum Check - Up Following Delivery	54.3%	57.3%	55.9%	80.6%	N/A
Chlamydia Screening in Women	54.5%	48.1%	46.4%	32.2%	N/A
Cervical Cancer Screening	49.6%	68.0%	64.5%	80.9%	N/A
Breast Cancer Screening	56.0%	55.0%	54.0%	73.4%	N/A
Comprehensive Diabetes Care - Retinal Eye Exam	66.3%	51.1%	44.1%	50.9%	N/A
Use of Appropriate Medications for People with Asthma	78.4%	84.5%	63.8%	72.8%	N/A

+Rate obtained from NCQA's *Quality Compass* (2005).

‡Rate obtained from NCQA's website: <http://www.ncqa.org/Programs/hedis/audit/2005MPR/Commercial.htm>

++Rate obtained from Healthy Families Website: [http://www.healthyfamilies.ca.gov/English/Quality/survey\\_quality.htm](http://www.healthyfamilies.ca.gov/English/Quality/survey_quality.htm)

How HPSM's rates compare with the Medi-Cal managed care average and national Medicaid averages was discussed earlier in the quality, access, and timeliness sections of this report. The HPSM Performance Measurement Comparison to National and California State Programs results (Table 6) offer a view of the various programs in relation to each other. HPSM's performance measurement achievements will now be compared to the 2005 HEDIS national commercial averages and Healthy Families averages.

HPSM exceeded one of the three Healthy Families measures and five of the 11 HEDIS national commercial measures. Continued improvements in its lower performing measures would allow HPSM to eventually compare more positively with other national averages and California's program performance rates.

## Overall Strengths

### Quality:

- HPSM's overall sustained improvement among quality measures indicate that the plan's management staff is committed to quality improvement.
- HPSM's QIPs precisely document the problem under study, the use of indicators, a tri-focused approach to interventions, and follow-up to reassess improvement.

### Access:

- HPSM demonstrated a commitment to improvement in the area of access through its implementation of QIP interventions.
- HPSM recognizes that access to care and services impacts the overall quality of care.

### Timeliness:

- HPSM recognizes the interdependence of access and timeliness of care and/or services for improvement.
- HPSM's QIPs focus on improved performance and sustainability of timeliness measures.

## Recommendations

- Perform one or more studies focused on clinical outcomes to determine whether quality in process performance actually leads to improved health outcomes.
- Ensure that repeat deficiencies from audit findings are successfully addressed and corrected.
- Continue work to improve the adolescent well-care visits rate.
- Assess the disparities in quality of care and/or services among different ethnic populations within the plan's Medi-Cal managed care membership. Understanding this will support more appropriate resource allocation.
- Perform root-cause analyses for project interventions that fail to improve performance. This will enable HPSM to better identify barriers to change and more effectively allocate resources to achieve systemic improvements.
- Perform further investigation of low performing HEDIS measures.
- Consider development of an ongoing QIP focused on postpartum care to address HPSM's lower than average performance.

Delmarva's assessment of HPSM performance, as summarized within this report, highlights both strengths and continued opportunities for improvement in the areas of quality, access, and timeliness. These opportunities for further improvement will be assessed again in the next annual report.

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