

Performance Evaluation Report
Santa Clara Family Health Plan
July 1, 2009–June 30, 2010

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

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1.	INTRODUCTION.....	1
	Purpose of Report.....	1
	Plan Overview.....	2
2.	ORGANIZATIONAL ASSESSMENT AND STRUCTURE.....	3
	Conducting the Review.....	3
	Findings.....	3
	Medical Performance Review.....	3
	Medi-Cal Managed Care Member Rights and Program Integrity Review.....	4
	Strengths.....	5
	Opportunities for Improvement.....	5
3.	PERFORMANCE MEASURES.....	6
	Conducting the Review.....	6
	Findings.....	6
	Performance Measure Validation.....	6
	Performance Measure Results.....	7
	HEDIS Improvement Plans.....	9
	Strengths.....	9
	Opportunities for Improvement.....	9
4.	QUALITY IMPROVEMENT PROJECTS.....	10
	Conducting the Review.....	10
	Findings.....	10
	Quality Improvement Projects Conducted.....	10
	Quality Improvement Project Validation Findings.....	11
	Quality Improvement Project Outcomes.....	13
	Strengths.....	14
	Opportunities for Improvement.....	14
5.	MEMBER SATISFACTION SURVEY.....	15
	Conducting the Review.....	15
	Findings.....	15
	National Comparisons.....	16
	Strengths.....	17
	Opportunities for Improvement.....	17
6.	OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS.....	18
	Overall Findings Regarding Health Care Quality, Access, and Timeliness.....	18
	Quality.....	18
	Access.....	19
	Timeliness.....	20
	Follow-Up on Prior Year Recommendations.....	20
	Conclusions and Recommendations.....	21
<i>APPENDIX A.</i>	FOLLOW-UP ON THE PRIOR YEAR’S RECOMMENDATIONS GRID.....	A-1

Performance Evaluation Report – Santa Clara Family Health Plan

July 1, 2009 – June 30, 2010

1. INTRODUCTION

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)¹ in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law 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 plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to the domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- ◆ The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- ◆ Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

¹ *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at:
<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

This report is specific to the MCMC Program’s contracted plan, Santa Clara Family Health Plan (“SCFHP” or “the plan”), which delivers care in Santa Clara County, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

SCFHP is a full-scope managed care plan in Santa Clara County. SCFHP serves members as a local initiative (LI) under the Two-Plan Model. In a Two-Plan Model county, the DHCS contracts with two managed care plans in each county to provide medical services to members. Most counties offer an LI plan and a nongovernmental, commercial health plan.

SCFHP has been Knox-Keene licensed since December 1996. Knox-Keene licensure is granted by the Department of Managed Health Care (DMHC) to plans that meet minimum required standards according to the Knox-Keene Health Care Service Plan Act of 1975. The act includes a set of laws that regulate managed care organizations (MCOs).

Members of the MCMC Program may enroll in either the LI plan operated by SCFHP or in the alternative commercial plan. SCFHP became operational with the MCMC Program in February 1997, and as of June 30, 2010, SCFHP had 98,968 MCMC members.²

² *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at:
<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

2. ORGANIZATIONAL ASSESSMENT AND STRUCTURE

for Santa Clara Family Health Plan

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan'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.

The DHCS conducts this review activity through an extensive monitoring process that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the 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 Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division often work in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits are conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

For this report, HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plan's compliance with State-specified standards. The most recent medical performance review was conducted in May 2007, covering the review period of May 1, 2006, through April 30, 2007. HSAG reported findings from this audit in the 2008-2009 plan evaluation report.³

The review showed that SCFHP had audit findings in the areas of utilization management continuity of care, availability and accessibility, members' rights, quality management, and administrative and organizational capacity. The DHCS *Medical Audit Close-Out Report* letter dated March 27, 2008, noted that the plan had fully corrected several audit deficiencies; however, some issues remained unresolved at the time of the audit close-out report.

Deficiencies needing continued attention were in the following areas:

- ◆ Tracking and follow-up of member referrals to specialists
- ◆ Ensuring that a consistent process is in place for resolving provider medical disputes
- ◆ Implementation of planned efforts to improve initial health education behavioral assessment rates
- ◆ Monitoring of provider waiting times including telephone access standards
- ◆ Implementation of a process to ensure appropriate claims processing for capitated subcontractors
- ◆ Establishing a mechanism to track payment of non-contract providers for family planning services
- ◆ Implementation of actions outlined to resolve member grievances
- ◆ Addressing specific time frames for reporting primary breaches of plan policies and procedures to DHCS

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These member rights reviews are conducted before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

³ *Performance Evaluation Report – Santa Clara Family Health Plan, July 1, 2008 – June 30, 2009*. California Department of Health Care Services. October 2010. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>.

As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2010.

MRPIU conducted an on-site review of SCFHP in December 2008, covering the review period of January 1, 2007, through June 30, 2008. The scope of the review included grievances, prior authorization notifications, cultural and linguistic services, and marketing. Details from this MRPIU were included in the plan's previous plan-specific evaluation report.

MRPIU noted review findings in member grievances and prior authorization notifications. For member grievances, the DHCS noted that SCFHP's policies did not contain language pertaining to continuation of services pending resolution of the grievance process. Under the prior authorization category, it was noted that in one of 32 prior authorization files, the notice of action letter did not contain a citation of the specific regulation or plan authorization procedures supporting the action. Also in 13 of 32 files, the "Your Rights" attachment was not included.

Strengths

The plan resolved several areas of deficiency identified under the 2007 joint audit review. MRPIU found the plan fully compliant with requirements for cultural and linguistic services and marketing as a result of the MRPIU review.

Opportunities for Improvement

While the plan adequately addressed some of the medical performance audit deficiencies, the plan did not fully address the following items from the Corrective Action Plan stemming from the May 2007 medical performance report: under- and overutilization, appeal procedures, provision of initial health assessment, monitoring of wait times, payment of emergency service providers, family planning, and member grievance system.

Conducting the Review

The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provide a standardized method for objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about SCFHP's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS[®]) measures; therefore, HSAG performed a HEDIS Compliance Audit[™] of SCFHP in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.⁴ Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

⁴ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

In addition to validating the plan’s HEDIS rates, HSAG also assessed the results. Table 3.1 displays a HEDIS performance measure name key.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
AWC	<i>Adolescent Well-Care Visits</i>
BCS	<i>Breast Cancer Screening</i>
CCS	<i>Cervical Cancer Screening</i>
CDC–BP	<i>Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)</i>
CDC–E	<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>
CDC–H8 (<8.0%)	<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)</i>
CDC–H9 (>9.0%)	<i>Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)</i>
CDC–HT	<i>Comprehensive Diabetes Care—HbA1c Testing</i>
CDC–LC (<100)	<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>
CDC–LS	<i>Comprehensive Diabetes Care—LDL-C Screening</i>
CDC–N	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>
CIS–3	<i>Childhood Immunization Status—Combination 3</i>
LBP	<i>Use of Imaging Studies for Low Back Pain</i>
PPC–Pre	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>
PPC–Pst	<i>Prenatal and Postpartum Care—Postpartum Care</i>
URI	<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>
W34	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
WCC–BMI	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>
WCC–N	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>
WCC–PA	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>

Table 3.2 presents a summary of SCFHP’s HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan’s HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance’s (NCQA’s) national Medicaid 25th percentile and 90th percentile, respectively. 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—2009–2010 Performance Measure Results for Santa Clara Family Health Plan—
Santa Clara County**

Performance Measure ¹	Domain of Care ²	2009 HEDIS Rates ³	2010 HEDIS Rates ⁴	Performance Level for 2010	Performance Comparison ⁵	MMCD's Minimum Performance Level ⁶	MMCD's High Performance Level (Goal) ⁷
AAB	Q	25.1%	30.4%	★★	↔	20.2%	33.4%
AWC	Q,A,T	42.2%	41.0%	★★	↔	37.9%	59.4%
BCS	Q,A	55.2%	52.2%	★★	↓	45.0%	63.0%
CCS	Q,A	74.4%	72.5%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	61.3%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	59.0%	54.5%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	52.0%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	38.7%	24.4%	★★★	↑	50.6%	29.2%
CDC–HT	Q,A	85.7%	86.4%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	42.1%	45.0%	★★★	↔	27.2%	44.7%
CDC–LS	Q,A	78.2%	79.0%	★★	↔	71.5%	82.5%
CDC–N	Q,A	77.7%	79.4%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	75.0%	75.8%	★★	↔	62.4%	80.6%
LBP	Q	‡	84.1%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	83.2%	84.8%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	66.4%	66.0%	★★	↔	57.9%	72.7%
URI	Q	92.6%	94.5%	★★	↑	81.1%	94.5%
W34	Q,A,T	73.1%	70.8%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	44.7%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	58.5%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	33.6%	Not Comparable	Not Comparable	NA	NA

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 HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.

⁴ HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

⁵ Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

⁶ The MMCD'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 The MMCD'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.

‡ The DHCS did not require plans to report this measure in 2009.

NA = The DHCS does not establish an MPL/HPL for first year measures.

★ = 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.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Not Comparable = Performance could not be compared due to either significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, SCFHP had average performance results across the spectrum of HEDIS measures. Two measures had statistically significant increases from 2009 to 2010; while only one measure had a statistically significant decrease. Two measures, scored above the HPL while no measures had rates below the MPL.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline steps to improve care.

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans. SCFHP did not have any 2009 performance measure rates that required an improvement plan.

Strengths

SCFHP's greatest strength is its consistent performance between years. Additionally, the plan did not have any measures fall below the MPL. The plan exceeded the national Medicaid 90th percentile in the *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)* and *LDL-C Control (<100 mg/dL)* measures.

Opportunities for Improvement

SCFHP should explore factors that may have contributed to the statistically significant decrease for the *Breast Cancer Screening* measure to ensure that its performance in 2011 does not continue to decrease.

Conducting the 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 Centers for Medicare & Medicaid Services' (CMS') validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Quality Improvement Projects Conducted

SCFHP had two clinical QIPs in progress during the review period of July 1, 2009, through June 30, 2010. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. SCFHP's second project, an internal QIP, aimed to increase the screening for obesity, thereby improving the health of members 12 to 18 years of age. Both QIPs fell under the quality and access domains of care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

Childhood obesity is often an indicator of reduced overall health and a risk factor for many chronic conditions. SCFHP's QIP, *Adolescent Health and Obesity Prevention*, attempted to improve the quality of care delivered to adolescents by increasing the obesity screening rate and appropriate counseling.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for both of SCFHP’s QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Santa Clara Family Health Plan—Santa Clara County July 1, 2009, through June 30, 2010

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				
<i>Reducing Avoidable Emergency Room Visits</i>	Annual Submission	89%	100%	<i>Met</i>
Internal QIPs				
<i>Adolescent Health and Obesity Prevention</i>	Annual Submission	86%	77%	<i>Partially Met</i>
	Resubmission	98%	100%	<i>Met</i>
¹ Type of Review —Designates the QIP review as a new proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG’s validation criteria to receive an overall <i>Met</i> validation status. ² Percentage Score of Evaluation Elements Met —The percentage score is calculated by dividing the total elements <i>Met</i> (critical and non-critical) by the sum of the total elements of all categories (<i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i>). ³ Percentage Score of Critical Elements Met —The percentage score of critical elements <i>Met</i> is calculated by dividing the total critical elements <i>Met</i> by the sum of the critical elements <i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i> . ⁴ Overall Validation Status —Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> .				

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met*, *Partially Met*, or *Not Met*. In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG’s application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that the annual submission by SCFHP of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. The annual submission for the *Adolescent Health and Obesity Prevention* QIP received a *Partially Met* validation status. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted their QIPs and upon subsequent validation, achieved an overall *Met* validation status.

Table 4.2 summarizes the validation results for both of SCFHP’s QIPs across the CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Santa Clara Family Health Plan—Santa Clara County (Number = 2 QIP Submissions, 2 QIP Topics) July 1, 2009, through June 30, 2010

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%
Design Total		100%	0%	0%
Implementation	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	83%	17%	0%
Implementation Total		96%	4%	0%
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved†	50%	13%	38%
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		84%	4%	12%
*The activity average rate represents the average percentage of applicable elements with a <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> finding across all the evaluation elements for a particular activity. †The sum of an activity or stage may not equal 100 percent due to rounding. ‡The QIP did not progress to this activity during the review period and could not be assessed.				

SCFHP submitted Remeasurement 1 data for both QIPs; therefore, HSAG validated Activities I through IX. The plan accurately applied the activities of the Design and Implementation stages, scoring 100 percent for six of the seven activities. For Activity VII of the Implementation stage, the plan did not explain how it was revising the intervention for the *Reducing Avoidable Emergency Room Visits* QIP based on the Remeasurement 1 study indicator results. For the Outcomes stage, the study indicator results improved for the *Adolescent Health and Obesity Prevention* QIP and did not improve for the *Reducing Avoidable Emergency Room Visits* QIP; therefore, Activity IX was scored 50 percent.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3—Quality Improvement Project Outcomes for Santa Clara Family Health Plan—Santa Clara County July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Remeasurement 2 1/1/09–12/31/09	Sustained Improvement
Percentage of ER visits that were avoidable	17.1%	18.5%*	‡	‡
QIP #2—Adolescent Obesity Prevention				
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Remeasurement 2 1/1/09–12/31/09	Sustained Improvement
1) Percentage of members 12-21 years of age with documentation in the medical record of at least one BMI with a primary care practitioner, obstetrician, or gynecologist during the measurement year	23.4%	33.2%*	‡	‡
2) Percentage of members 12 – 21 years of age with documentation in the medical record of counseling for nutrition, physical activity, healthy lifestyles, and/or weight management or referral for nutrition education, physical activity, healthy lifestyles, and/or weight management during the measurement year	33.6%	35.5%	‡	‡
^ The third study indicator was added to the QIP in July 2003; therefore, every measurement period is one year later than what is provided. *A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05) ‡The QIP did not progress to this phase during the review period and could not be assessed.				

SCFHP reported an increase in the percentage of avoidable ER visits, reflecting a statistically significant decline in performance. Conversely, both study indicators for the *Adolescent Health and Obesity Prevention* QIP improved; however, only the increase for Study Indicator 1 was statistically significant.

For the *Adolescent Health and Obesity Prevention* QIP, SCFHP conducted a barrier analysis of why there are more obese adolescents. Even if these barriers are addressed, the focus of the QIP is documentation of BMI and documentation of provider referrals for nutrition and physical activity counseling. The improvement noted for this study appears to be due to provider interventions that were implemented in 2007 and 2008.

SCFHP identified several plan-specific barriers related to reduction of avoidable ER visits; however, the plan relied on implementation of collaborative interventions. Since collaborative interventions were not initiated until 2009, HSAG cannot evaluate the effectiveness of those interventions.

Strengths

SCFHP successfully applied documentation requirements for the activities in both the Design and Implementation stages. The plan had partial success with its obesity QIP showing statistically significant improvement for one of two study indicators.

Opportunities for Improvement

For the ER statewide collaborative QIP, SCFHP identified several plan-specific barriers; however, SCFHP did not propose any interventions to address these barriers, and the plan may need to implement plan-specific interventions targeted to its population in order to achieve improvement for this QIP.

SCFHP acknowledged that it has been collecting information on providers' documentation of BMI and obesity referrals/counseling since 2004 and initiating ongoing provider interventions to improve in this area. The plan needs to conduct a new barrier analysis focusing on improvement of the two study indicators. Based on the results of this barrier analysis, the plan may need to initiate new, targeted interventions to improve its performance on the obesity QIP and to increase the likelihood of ongoing success.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) health plan surveys.⁵

The administration of the CAHPS surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS surveys be administered to both adult members and the parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

The Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about SCFHP's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures as follows:

CAHPS Global Rating Measures:

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

⁵ CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CAHPS Composite Measures:

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

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance (NCQA)'s HEDIS[®] benchmarks and thresholds or NCQA's national Medicaid data, when applicable. 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*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 5.1.

Table 5.1—Star Ratings Crosswalk

Stars	Adult Percentiles	Child Percentiles
★★★★★	≥ 90th percentile	≥ 80th percentile
★★★★	75th percentile–89th percentile	60th percentile–79th percentile
★★★	50th percentile–74th percentile	40th percentile–59th percentile
★★	25th percentile–49th percentile	20th percentile–39th percentile
★	< 25th percentile	< 20th percentile

**Table 5.2—Santa Clara Family Health Plan—Santa Clara County
Medi-Cal Managed Care County-Level Global Ratings**

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★	★★★
Child	★★★	★	★★★	★★★★★ ⁺
<i>+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.</i>				

**Table 5.3—Santa Clara County Health Plan—Santa Clara County
Medi-Cal Managed Care County-Level Composite Ratings**

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Adult	★	★	★	★ ⁺	★
Child	★	★	★	★★	★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Strengths

At the global ratings level, SCFHP performed best in the child categories: *Rating of Specialist Seen Most Often* (five stars), *Rating of Personal Doctor* (three stars), and *Rating of Health Plan* (three stars). In the adult category, *Rating of Specialist Seen Most Often* scored above the 50th percentile.

Opportunities for Improvement

At the global ratings level, SCFHP's CAHPS results showed the opportunity for the most improvement in the *Rating of All Health Care* category as it received a single star in both the adult and child segments. At the composite rating level, the following four categories received single star scores in both the adult and child segments: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*.

HSAG conducted a key-drivers-of-satisfaction analysis that focused on the top three highest priorities based on the plan's CAHPS results. The purpose of the key-drivers-of-satisfaction analysis was to help decision makers identify specific aspects of care most likely to benefit from quality improvement (QI) activities. Based on the key-driver analysis, HSAG identified the following measures as SCFHP's highest priority: *Rating of All Health Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. The plan should review the detailed recommendations for improving member satisfaction in these areas, as outlined by HSAG in the *Medi-Cal Managed Care Program—2010 Santa Clara Family Health Plan*. Areas for improvement spanned the quality, access, and timeliness domains of care.

6. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

for Santa Clara Family Health Plan

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for Medi-Cal managed care members through the provision of health care services and the plan's structural and operational characteristics.

The DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to members by a plan 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, the DHCS monitors aspects of a plan'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.

The plan showed average performance in the quality domain. This assessment was based on SCFHP's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

The plan was able to report valid rates for all 2010 performance measures, and many rates remained constant between 2009 and 2010. Two quality measures, *HbA1c Poor Control (> 9.0 Percent)* and *LDL-C Control (<100 mg/dL)* performed above the HPL in 2010. SCFHP did not have any HEDIS improvement plans to complete in 2010 because 2009's results all exceed the MPLs.

QIP results showed that the plan did well at documenting the QIP study design and implementation phases; however, the plan had challenges with achieving improved outcomes for the *Reducing Avoidable Emergency Room Visits* QIP and has an opportunity to analyze factors that may be preventing the plan from achieving improved outcomes. Conversely, SCFHP did have statistically significant improvement in their *Adolescent Health and Obesity Prevention* QIP; however, the SCFHP did not document new interventions beyond activities that had already been initiated by the plan prior to project initiation to improve performance. With future projects, SCFHP

should work to address areas of low performance that are in need of barrier analysis and intervention implementation.

The Member Rights/Program Integrity Unit (MRPIU) review conducted in December 2008 and the medical performance review conducted in May 2007, revealed noncompliance with many areas covered under the scope of the review. However, there were several issues that were fully resolved at the closure of the medical performance review. The plan outlined many interventions and actions taken to address outstanding issues in Appendix A. Because of the age of the audit results, HSAG will look at more current reviews in subsequent evaluation reports to determine whether the plan sufficiently corrected all areas of noncompliance.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan'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 under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, and member satisfaction results are used 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 members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

The plan demonstrated average performance in the access domain. This assessment was based on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results.

Medical performance review results showed that, overall, SCHFP was compliant in the area of availability and accessibility of services and demonstrated progress towards monitoring wait time and tracking specialist referrals.

SCFHP's greatest opportunity for improvement regarding access to care is with its member satisfaction results, which showed poor performance for *Getting Needed Care* and *Getting Care Quickly*.

Timeliness

The timeliness domain of care relates to a plan'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.

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' 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.

SCFHP demonstrated average performance in the timeliness domain of care. This assessment was based on 2010 performance measure rates for providing timely care, medical performance and member rights reviews related to timeliness, and member satisfaction results related to timeliness.

The plan was able to show timely resolution of prior authorization decisions and timely processing of grievances; however, the plan has a continued opportunity to monitor its notice of action letters to ensure they include the required components.

Performance measure rates related to timeliness showed that the plan performed above the MPL for well-child visits and childhood immunizations, suggesting that members are receiving care within the appropriate time frame after a need for preventive services is identified.

Member satisfaction results showed that the plan demonstrated poor performance in the *Getting Care Quickly* category for both adult and child populations. This suggests that members perceive that they do not always receive care in a timely manner.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. SCFHP's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, the plan had average performance in providing quality, accessible, and timely health care services to its MCMC members.

The plan showed steady performance in its HEDIS rates in 2010 compared with 2009 rates. The plan was generally compliant with documentation requirements across performance measures, QIPs, and State and federal requirements.

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

- ◆ Examine the statistically significant decrease on the *Breast Cancer Screening* measure.
- ◆ Propose interventions to address the barriers identified in the *Reducing Avoidable Emergency Room Visits* QIP.
- ◆ Conduct a new barrier analysis focusing on improvement of the two study indicators for the *Adolescent Health and Obesity Prevention* QIP.
- ◆ Review the 2010 plan-specific CAHPS results report and develop strategies to address all of the underperforming areas in the composite level rankings

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

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
<p>Explore factors that contributed to the decreased Breast Cancer Screening (BCS) rate to prevent further decline.</p>	<p>SCFHP's BCS HEDIS measure trends, along with other HEDIS measure trends, were presented to SCFHP's QI Committee (Oct. 2009) and other health plan committees. The committee members discussed barriers and improvement strategies. A number of factors were identified as contributing to the decrease in BCS rate: (1) In the past, BCS was a hybrid measure. In 2006, BCS measure specifications switched to administrative data collection; therefore, there was no additional pursuit of medical records and breast cancer screening reports as in the past. SCFHP has a delegated medical group model that is capitated for most preventive services such as breast cancer screening. The delegated groups send encounter data, but the data received is often incomplete; (2) Members who changed PCP, GYNs and/or changed health plans and may have had breast cancer screening, but the data was not sent to SCFHP; and (3) USPSTF had changed the age guidelines for when to start screening from 40 to 50 years of age. SCFHP's clinical practice guidelines for BCS were not changed by the QI Committee, but the public and our members hear on the news and television about this new recommendation and the possibility of confusion about the periodicity of breast cancer screening may exist.</p>
<p>Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance for increasing compliance with the CMS protocol for conducting QIPs.</p>	<p>On June 3, 2009, the QI staff attended the DHCS and HSAG teleconference on Technical Guidance for QIPs, validation process, and protocols and requirements set by CMS. DHCS and HSAG assisted SCFHP in ensuring that the QIPs met the documentation recommendations and assisted in providing guidance to increase compliance with the CMS protocol for conducting QIPs. The Decreasing Avoidable ER Visits QIP was re-submitted and met the required guidelines. The Adolescent Health and Obesity Prevention QIP re-submission met all recommended requirements.</p>
<p>Analyze obesity QIP interventions to determine whether additional targeted efforts are needed to achieve improvement.</p>	<p>Ongoing analysis of Adolescent Health and Obesity Prevention QIP data indicated that additional targeted efforts were needed to achieve BMI documentation improvement. Efforts included: (1) Sponsoring Childhood Feeding Collaborative CME Provider dinner trainings on Obesity Prevention During the Well Child Exam. (2) BMI wheels and graphs were distributed along with instruction and training to practitioners and their staff during Provider Services quarterly in-service visits and during the Facility Site and Medical Record reviews audits. (3.) IS and Medical Management Workgroup on converting CHDP PM160 paper-based forms to electronic forms for electronic submission of data, ICD-9-CM diagnosis codes, and more efficient billing.</p>

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
<p>Address access-related barriers to evening and weekend availability for members to increase the likelihood of decreasing avoidable ER visits.</p>	<p>The ER Hospital collaboration with Santa Clara Valley Medical Center (SCVMC) provided ER census data starting November 2009. SCFHP part-time QI nurses made educational and informational telephone outreach calls to members seen in the ER for “avoidable ER visits,” on appropriate ER use, follow-up with PCP, and education about urgent care centers closest to the member’s home for evening and weekend urgent care needs. From February to July 2010, 805 member calls were attempted and 371 (46.5%) of the members were contacted to discuss their experience, barriers to care, education on urgent care centers.</p>
<p>Implement a process to ensure delegated entity member grievances are included in the reporting of grievances within the quality improvement program.</p>	<p>Grievances are reported to the Quality Improvement Committee at its quarterly meeting. This includes delegated entity member grievances.</p>
<p>Develop a process to review all clinical grievances for potential quality of care issues.</p>	<p>Grievances concerning potential quality of care issues are referred to the Quality Improvement Department for review by the medical director. They are tracked and trended.</p>
<p>Implement internal monitoring to ensure that member rights information is included with notice of action letters to members.</p>	<p>Internal audits were conducted to ensure that the members’ rights information was included with notice of action letters to members. The audits revealed that the information is being provided to members.</p>
<p>Implement interventions to improve the rate of initial health education behavioral assessments (IHEBA) and monitor the effectiveness of the interventions.</p>	<p>According to the memo that was issued to the health plans by Dr. Michael Farber, Chief Medical Policy Section, on April 16, 2008, it indicates that Medi-Cal Managed Care Division (MMCD) began the process of updating the Individual Health Education Behavioral Assessment (IHEBA), the Staying Healthy Assessment (SHA) effective April 7, 2008.</p> <p>MMCD formed a workgroup made up of medical directors, medical providers, nurses and health educators. The goals were to (1) create a new user-friendly assessment format, and (2) address the needs and concerns of health plans and primary care providers responsible for implementing the SHA/IHEBA.</p> <p>MMCD acknowledges that health plan providers and subcontracted providers have a difficult time implementing the current Staying Healthy Assessment. Therefore, MMCD is temporarily suspending the negative scoring of the SHA/IHEBA on the Medical Record Review Survey during the facility site review process.</p>

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
	<p>From June 2008 to present, the health plan has been participating in the State-wide Pediatric and Adults Staying Health Assessment Collaborative Workgroups. The workgroups have completed the following activities:</p> <ol style="list-style-type: none"> 1. Developed provider survey questions and processes to assess providers' feedback on SHA/IHEBA 2. Implemented provider surveys through State developed, Web-based survey (Survey Monkey) and/or hard copy version 3. Developed member survey questions and processes to assess members' experiences in completing the SHA/IHEBA 4. Revised the Adult SHA/IHEBA questionnaires 5. Revised the Pediatric SHA/IHEBA questionnaires 6. Reviewed and analyzed the suggestions from both members and providers 7. Formatted the Adult SHA/IHEBA 8. Formatted the Pediatric SHA/IHEBA 9. Piloted test the Adult SHA/IHEBA and Pediatric SHA/IHEBA with providers and members 10. Currently, health plans are working on translation of SHA/IHEBA into Arabic, Armenian, Chinese, Farsi, Hmong, Khmer, Korean, Russian, Spanish, Tagalog, Vietnamese <p>Additionally, the health plan has implemented the following interventions:</p> <ol style="list-style-type: none"> 1. Continues the discussion of SHA/IHEBA discussion as applicable at the Quality Improvement Committee meeting 2. Posting the instructions on how to access the SHA/IHEBA form on the health plan's Web site 3. Monitoring SHA/IHEBA assessment by looking at claims codes 4. Continue to review medical records for evidence of SHA/IHEBA compliance during regular cyclic Facility Site Medical Record Reviews (FSR/MRR) 5. Continue to educate providers on the importance of SHA/IHEBA completion 6. Continue to educate members on the importance of completing the SHA/IHEBA
<p>Determine if successful strategies used to improve initial health assessment rates can be applied to increasing IHEBA rates.</p>	<p>The health plan hopes to distribute the SHA/IHEBA provider educational packets at facility site reviews and during provider quarterly visits when the State publishes the final SHA/IHEBA forms.</p>