Performance Evaluation Report

AHF Healthcare Centers

July 1, 2013–June 30, 2014

Managed Care Quality and Monitoring Division
California Department of Health Care Services

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TABLE OF CONTENTS

1. INTRODUCTION 1
Purpose of Report 1
Managed Care Health Plan Overview 2
2. MANAGED CARE HEALTH PLAN COMPLIANCE 3
Conducting the EQRO Review 3
Assessing the State's Compliance Review Activities 3
Readiness Reviews 3
Medical Audits and SPD Medical Surveys 3
Strengths 5
Opportunities for Improvement 5
3. PERFORMANCE MEASURES 6
Conducting the EQRO Review 6
Validating Performance Measures and Assessing Results 6
Performance Measure Validation 7
Performance Measure Validation Findings 7
Performance Measure Results 8
Performance Measure Result Findings 8
Improvement Plans 9
Assessment of MCP's Improvement Plans 9
Strengths 10
Opportunities for Improvement 10
4. QUALITY IMPROVEMENT PROJECTS 11
Conducting the EQRO Review 11
Validating Quality Improvement Projects and Assessing Results 11
Quality Improvement Project Objectives 12
Quality Improvement Project Validation Findings 13
Quality Improvement Project Outcomes and Interventions 15
Strengths 17
Opportunities for Improvement 18
5. ENCOUNTER DATA VALIDATION 19
Conducting the EQRO Review 19
6. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS 20
Overall Findings Regarding Health Care Quality, Access, and Timeliness 20
Quality 20

Access 21
Timeliness 22
Follow-Up on Prior Year Recommendations 22
Recommendations 23

APPENDIX A. MCP'S SELF-REPORTED FOLLOW-UP ON EXTERNAL QUALITY REVIEW RECOMMENDATIONS FROM THE JULY 1, 2012–JUNE 30, 2013 PERFORMANCE EVALUATION REPORT A-1

Performance Evaluation Report – AHF Healthcare Centers
July 1, 2013 – June 30, 2014

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)[1] in the State of California through a combination of contracted full-scope and specialty managed care health plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and

[1] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2013–June 30, 2014). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, AHF Healthcare Centers ("AHF" or "the MCP"), for the review period July 1, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Health Plan Overview

AHF is a Medi-Cal managed care specialty plan operating in Los Angeles County, providing services primarily to members living with HIV or AIDS. Some of the MCP's members are dual eligible (i.e., covered by both Medicare and Medi-Cal).

AHF became operational with the MCMC Program in April 1995. As of June 30, 2014, the MCP had 875 MCMC members.[3]

Due to the MCP's unique membership, some of AHF's contract requirements have been modified from MCMC's full-scope MCP contracts.

[3] *Medi-Cal Managed Care Enrollment Report —June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

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

This report section covers review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to evaluate key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

Medical Audits and SPD Medical Surveys

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were

conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

DHCS received authorization "1115 Waiver" from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-County Organized Health System (COHS) counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

Reviews Conducted for AHF

DHCS conducted no audits or reviews with AHF during the review period for this report. HSAG provided information regarding the June 2010 Member Rights & Program Integrity Unit review in AHF's 2011–12 and 2012–13 MCP-specific evaluation reports. As part of the process for producing the previous reports, AHF submitted documentation of actions the MCP had taken to resolve the findings from the June 2010 review. HSAG concluded that the MCP had resolved all outstanding findings from the review; however, HSAG indicated that AFH had the opportunity to ensure that 100 percent of grievance resolution letters are sent within the required time frame.

As part of the process for producing this report, AHF provided documentation of actions the MCP took to ensure that 100 percent of grievance resolution letters are sent within the required time frame (see Appendix A). The MCP reported that the timeliness rate improved from 97 percent to 100 percent, and the improvement was sustained during the review period.

Strengths

AHF appears to have implemented a successful monitoring process to ensure that 100 percent of grievance resolution letters are sent within the required time frame.

Opportunities for Improvement

Since AHF appears to have no outstanding findings from the June 2010 Member Rights & Program Integrity Unit review, HSAG has no recommendations for opportunities for improvement in the area of compliance reviews.

Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal Managed Care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

Due to the small size of specialty MCP populations, DHCS modified the performance measure requirements applied to these MCPs. Instead of requiring a specialty MCP to annually report the full list of performance measure rates as full-scope MCPs do, DHCS requires specialty MCPs to report only two performance measures. In collaboration with DHCS, a specialty MCP may select measures from the Healthcare Effectiveness Data and Information Set (HEDIS®)[4] or design a measure appropriate to the MCP's population. The measures put forth by the specialty MCPs are subject to approval by DHCS. Furthermore, specialty MCPs must report performance measure results specific to MCMC members.

HSAG conducts validation of the External Accountability Set performance measures as required by DHCS to evaluate the accuracy of the MCPs' reported results. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of

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

performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

For 2014, AHF was required to report two HEDIS measures: *Controlling High Blood Pressure* and *Colorectal Cancer Screening*.

HSAG performed NCQA HEDIS Compliance Audits™[6] of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased.

Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for AHF Healthcare Centers* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that AHF followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the findings and opportunities for improvement is included below.

- AHF exercised appropriate oversight of its vendor.
- AHF demonstrated excellent oversight of its pharmacy benefits manager.
- The MCP had no issues or delays with enrollment data.
- The auditor recommended that AHF:
  - Explore options for using an electronic application process.
  - Formally document findings from the MCP's reconciliation process and update the reconciliation procedures.
  - Review Roadmap responses prior to submission to ensure that the MCP's processes are accurately reflected.

[5] The CMS EQR Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.
[6] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of AHF's performance measure results for 2012–14.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS establishes a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. In addition to the performance measure results from 2012–14, Table 3.1 shows AHF's performance compared to the DHCS-established MPLs and HPLs for each year for the two required measures. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

Table 3.1—Performance Measure Results
AHF—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2012[3]	2013[4]	2014[5]	Performance Comparison[6]
*Controlling High Blood Pressure (CBP) 18–85 years**	Q,A	68.2%	62.20%	61.07%	↔
Colorectal Cancer Screening (COL) 50–75 years^	Q,A	64.2%	63.07%	**52.04%**	↓

[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 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011. Rates in 2012 were reported to one decimal place. To be consistent with how NCQA is reporting rates for 2013, two decimal places are used for the 2013 rates. Comparison between the 2012 and 2013 rates for the measure was calculated based on rates reported with two decimal places for both years.
[4] HEDIS 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] HEDIS 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[6] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
* The minimum performance level (MPL) and high performance level (HPL) for this measure are based on NCQA's national Medicaid 25th and 90th percentiles, respectively.
^ The MPL and HPL for this measure are based on NCQA's national commercial 25th and 90th percentiles, respectively, since no Medicaid benchmarks are available for this measure.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.

Performance Measure Result Findings

The rate for the *Controlling High Blood Pressure* measure showed no statistically significant change from 2013 to 2014 and remained above the MPL. The rate declined significantly from 2013 to 2014 for the *Colorectal Cancer Screening* measure, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act (PDSA) cycle. DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates (measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid cycle approach (including the PDSA cycle) to strengthen these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

Assessment of MCP's Improvement Plans

AHF was required to submit no IPs in 2013. Based on 2014 rates, the MCP will be required to submit a PDSA cycle focused on a major barrier identified by the MCP for the *Colorectal Cancer Screening* measure in 2014.

Strengths

HSAG auditors determined that AHF followed the appropriate specifications to produce valid performance measure rates. Additionally, the auditor noted that the MCP exercised appropriate oversight of its vendor, demonstrated excellent oversight of its pharmacy benefits manager, and had no issues or delays with enrollment data.

The rate was above the MPL for the *Controlling High Blood Pressure* measure.

Opportunities for Improvement

The HSAG auditor recommended that AHF explore options for using an electronic application process, formally document findings from the MCP's reconciliation process, update the reconciliation procedures, and review Roadmap responses prior to submission to ensure that the MCP's processes are accurately reflected.

The MCP has the opportunity to assess the factors leading to the statistically significant decline in the rate for the *Colorectal Cancer Screening* measure and identify strategies to improve the rate.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[7] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Specialty MCPs must conduct a minimum of two QIPs; however, because specialty MCPs serve unique populations that are limited in size, DHCS does not require specialty MCPs to participate in the statewide collaborative QIP. Instead, specialty MCPs are required to design and maintain two internal QIPs with the goal to improve health care quality, access, and/or timeliness for the specialty MCP's MCMC members.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

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

[7] The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Quality Improvement Project Objectives

Specialty MCPs must be engaged in two QIPs at all times. However, because specialty MCPs serve unique populations that are limited in size, DHCS does not require them to participate in the statewide collaborative QIP. Instead, specialty MCPs are required to design and maintain two internal QIPs with the goal to improve health care quality, access, and/or timeliness for the specialty MCP's beneficiaries. AFH had four internal QIPs in progress during the review period of July 1, 2013, through June 30, 2014.

Table 4.1 lists AHF's QIPs and indicates whether the QIP is clinical or nonclinical and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

Table 4.1—Quality Improvement Projects for AHF—Los Angeles County
July 1, 2013, through June 30, 2014

QIP	Clinical/Nonclinical	Domains of Care
Advance Care Directives	Nonclinical	Q
CD4 and Viral Load Testing (Closed)	Clinical	Q, A
CD4 and Viral Load Testing (Open)	Clinical	Q, A
Reducing Avoidable Emergency Room Visits	Clinical	Q, A

AHF's *Advance Care Directives* QIP sought to increase the percentage of members with documentation of advance care planning. As defined by NCQA, advance care planning is a discussion about preferences for resuscitation, life-sustaining treatment, and end-of-life care. At the initiation of the QIP, 7.2 percent of eligible members had an advance care directive.

Both *CD4 and Viral Load Testing* QIPs focused on increasing CD4 and viral load testing for members with Human Immunodeficiency Virus (HIV). During the *CD4 and Viral Load Testing (Closed)* QIP, clinical practice guidelines changed to only require two tests per year for medically stable patients and three tests per year for medically unstable patients. Due to this change, the *CD4 and Viral Load Testing (Closed)* QIP study indicators were not consistent with the clinical guidelines, resulting in the QIP being closed. AHF implemented a new *CD4 and Viral Load Testing (Open)* QIP with indicators consistent with the new clinical practice guidelines.

AHF's *Reducing Avoidable Emergency Room Visits* QIP sought to decrease the percentage of avoidable emergency department visits for members. HIV positive patients have a significantly higher rate of emergency department visits and have a longer duration of stay compared to patients without HIV. AFH hopes to improve the continuity of care between members and their primary care providers (PCPs), improve access to PCPs, and encourage preventive care.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Validation Activity
AHF—Los Angeles County
July 1, 2013, through June 30, 2014

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]
Internal QIPs				
Advance Care Directives	Annual Submission	93%	100%	*Met*
CD4 and Viral Load Testing (Closed)	Annual Submission	81%	100%	*Met*
CD4 and Viral Load Testing (Open)	Study Design Submission	91%	100%	*Met*
Reducing Avoidable Emergency Room Visits	Study Design Submission	73%	40%	*Partially Met*
	Study Design Resubmission 1	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that AHF's annual submission of its *Advance Care Directives* QIP achieved an overall *Met* validation status, with 93 percent of the evaluation elements and 100 percent of the critical elements receiving a met score. The *CD4 and Viral Load Testing (Closed)* QIP annual submission achieved an overall *Met* validation status, with 81 percent of the evaluation elements and 100 percent of the critical elements receiving a met score. The *CD4 and Viral Load Testing (Open)* QIP study design submission achieved an overall *Met* validation status, with 91 percent of the evaluation elements and 100 percent of the critical elements receiving a met score. Finally, the *Reducing Avoidable Emergency Room Visits* QIP study design submission received an overall validation status of *Partially Met.* As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, AHF resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score.

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

Table 4.3—Quality Improvement Project Average Rates*
AHF—Los Angeles County
(Number = 5 QIP Submissions, 3 QIP Topics)
July 1, 2013, through June 30, 2014

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	90%	10%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	87%	13%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	95%	5%	0%
Design Total		**93%**	**7%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	88%	6%	6%
	VIII: Appropriate Improvement Strategies	86%	14%	0%
Implementation Total		**87%**	**9%**	**4%**
Outcomes	IX: Real Improvement Achieved**	50%	13%	38%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total**		**56%**	**11%**	**33%**

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

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

HSAG validated Activities I through X for AHF's *Advance Care Directives* QIP annual submission, Activities I through IX for the *CD4 and Viral Load (Closed)* QIP annual submission, and Activities I through VI for the *CD4 and Viral Load (Open)* and *Reducing Avoidable Emergency Room Visits* QIPs' study design submissions.

AHF demonstrated a strong application of the Design stage, meeting 93 percent of the requirements for all applicable evaluation elements within the study stage for all QIPs. AHF met all requirements for all applicable evaluation elements within the Design stage for its *Advance Care Directives* and *CD4 and Viral Load (Closed)* QIPs. The MCP did not provide an accurate description of the eligible population for the *CD4 and Viral Load (Open)* QIP, resulting in a lower score for Activity VI. For the *Reducing Avoidable Emergency Room Visits* QIP, AHF did not provide an accurate rationale for the selection of the topic and did not provide well-defined study indicators, resulting in lower scores for Activities I and III. AHF corrected these deficiencies in the resubmission, resulting in the QIP achieving an overall *Met* validation status.

Both the *Advance Care Directives* and *CD4 and Viral Load (Closed)* QIPs progressed to the Implementation stage during the reporting period. AHF demonstrated an adequate application of the Implementation stage, meeting 87 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. For the *Advance Care Directives* QIP, AHF did not accurately document the statistical differences between the initial measurement period and the current measurement period, resulting in a lower score for Activity VII. The *CD4 and Viral Load (Closed)* QIP received lower scores for Activities VII and VIII because the MCP did not include an interpretation of the Remeasurement 3 results. Additionally, while the MCP documented interventions, they were not interventions likely to induce permanent change.

Both the *Advance Care Directives* and *CD4 and Viral Load (Closed)* QIPs progressed to the Outcomes stage during the reporting period. The indicator for the *Advance Care Directives* QIP achieved statistically significant improvement over baseline at Remeasurement 1 and sustained the improvement at Remeasurement 2, resulting in a *Met* score for Activity X. For the *CD4 and Viral Load (Closed)* QIP, the score for Activity IX was lowered because neither study indicator achieved statistically significant improvement over baseline. Activity X was not assessed for this QIP since sustained improvement cannot be assessed until the indicator has achieved statistically significant improvement over baseline.

Quality Improvement Project Outcomes and Interventions

The *CD4 and Viral Load (Open)* and *Reducing Avoidable Emergency Room Visits* QIPs did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information is included in this report.

Table 4.4 summarizes the *Advance Care Directives* and *CD4 and Viral Load (Closed)* QIPs study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period). Although the *CD4 and Viral Load (Closed)* QIP was closed, because the MCP reported outcomes for the QIP, they are included in this report.

Table 4.4—Quality Improvement Project Outcomes for AHF—Los Angeles County
July 1, 2013, through June 30, 2014

QIP #1—Advance Care Directives			
Study Indicator: Percentage of eligible members who have an advance directive or have had a discussion regarding advance directives with their provider.			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
7.2%	25.7%*	29.9%	Yes

QIP #2—CD4 and Viral Load Testing (Closed)				
Study Indicator 1: Percentage of eligible members receiving at least three CD4 lab tests.				
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
69.3%	69.7%	63.8%	64.9%	‡
Study Indicator 2: Percentage of eligible members receiving at least three viral load lab tests.				
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
68.9%	73.4%	65.7%**	62.9%	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement over baseline (p value < 0.05).

** A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Advance Care Directives QIP

The *Advance Care Directives* QIP met its goal for Remeasurement 1 with 25 percent of eligible members engaging in advance care planning or having had a discussion with their provider regarding advance care planning. Although AHF fell short of its Remeasurement 2 goal of 50 percent, the QIP indicator achieved statistically significant improvement over baseline at Remeasurement 1 and sustained that improvement at Remeasurement 2. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- AHF completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through the data analysis and a quality improvement process. The documentation included system interventions likely to have long-term effects and described problem-solving techniques using data analysis to identify possible causes and solutions.
- AHF indicated that several of its interventions were ongoing and described how the MCP monitored the interventions for efficacy in affecting the rate. The MCP also provided information about the success of the quality improvement actions and how the interventions were standardized and monitored.
- The following interventions were successful in improving the QIP outcomes:

- Provided a bi-monthly advance care directive member education class that explained what an advance care directive is, its importance, and how it works. The MCP also provided an opportunity for members to complete the Five Wishes advance directive during the class.
- Implemented the advance directive prompt which included electronic health record advance care directive encounter inclusion in internal protocol/audit system and medical visit flow sheets.
- Provided an annual member newsletter that discussed the importance of completing an advance directive and provided available resources to assist members in completing an advance directive.
- Produced an annual provider newsletter with information about the importance of completing an advance directive and listed the resources available to members.
- Provided a quarterly report card indicating the providers' rates for advance care directive completion and/or discussion of advance care directives.
- Nurse managers and referral coordinators detailed their roles in uploading electronic versions of advance directives into electronic medical records.
- Educated providers on the importance of all people living with HIV having a complete advance directive.

Due to the success of the QIP in increasing the number of members with documented advance care planning, HSAG recommended that AHF close the QIP and identify a new area in need of improvement.

CD4 and Viral Load Testing QIP

AHF's goal for the *CD4 and Viral Load Testing (Closed)* QIP was to achieve a 5 percent increase annually; however, due to changes in the clinical guidelines, AHF was not able to achieve its goal. After discussions with DHCS and HSAG, AHF closed the *CD4 and Viral Load Testing (Closed)* QIP and started a new *CD4 and Viral Load Testing (Open)* QIP, using the new clinical guidelines to develop the study indicators. As indicated above, the *CD4 and Viral Load (Open)* QIP did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information is included in this report.

Strengths

AHF demonstrated an excellent application of the QIP process for the Design stage for all QIPs. Additionally, the MCP achieved an overall *Met* validation status on the first submission for the *Advance Care Directives, CD4 and Viral Load (Closed),* and *CD4 and Viral Load (Open)* QIPs.

AHF excelled at developing and implementing interventions that positively affected the rates for the *Advance Care Directives* QIP. The MCP took advantage of the QIP process to increase the percentage of eligible members who have an advance directive or who have had a discussion regarding advance directives with their provider. The QIP achieved and sustained statistically significant improvement over baseline; therefore, this QIP was closed.

Opportunities for Improvement

In response to HSAG's recommendation in AHF's 2012–13 MCP-specific evaluation report, AHF implemented various processes to ensure that the QIP Summary Form was complete and accurate (see Appendix A). The MCP had to resubmit its *Reducing Avoidable Emergency Room Visits* QIP due to incomplete or inaccurate documentation; therefore, the MCP demonstrates continued opportunities for improving its QIP documentation. The MCP should continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

Conducting the EQRO Review

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Although HSAG uses a standardized scoring process to evaluate each full-scope Medi-Cal MCP's performance measure rates and QIP performance in the three domains of care—quality, access, and timeliness—HSAG does not use this scoring process for specialty MCPs, due to the small size of the specialty MCPs' populations. To determine the degree to which specialty MCPs provide quality, accessible, and timely care to beneficiaries, HSAG assesses each specialty MCP's performance related to medical audit/SPD medical survey reviews (as applicable), performance measure rates, QIP validation, QIP outcomes, member satisfaction surveys (as available), and accuracy and completeness of the MCP's encounter data (as applicable).

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[8]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, DHCS monitors aspects of an MCP's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems. DHCS also uses the results of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

As part of the process for producing this report, HSAG reviewed the quality documents AHF submitted. The MCP's quality and performance improvement program description includes details of the MCP's organizational structure, which supports the provision of quality care to the MCP's members.

[8] This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Both of the MCP's required performance measures fall into the quality domain of care. The rate for the *Controlling High Blood Pressure* measure showed no statistically significant change from 2013 to 2014 and remained above the MPL. The rate declined significantly from 2013 to 2014 for the *Colorectal Cancer Screening* measure, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014.

All four of the MCP's QIPs fell into the quality domain of care. Only the *Advance Care Directives* and *CD4 and Viral Load (Closed)* QIPs progressed to the Outcomes stage. The *Advance Care Directives* QIP was successful at significantly increasing the number of AHF Medi-Cal members with documented care directives from baseline to Remeasurement 1, and the improvement was sustained at Remeasurement 2, resulting in the QIP being successfully closed. The *CD4 and Viral Load (Closed)* QIP did not have positive results; however, this was due to changes in the clinical guidelines, resulting in the QIP study indicators no longer being consistent with the guidelines. As a result, the QIP was closed.

Overall, AHF showed average performance related to the quality domain of care, based on the performance measure and QIP results.

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care.

AHF's quality and performance improvement program evaluation shows that the MCP met or exceeded most access-related goals. Additionally, the evaluation document provides information about barriers to meeting quality improvement goals and recommendations for improvement. Finally, AHF included several access-related activities in the MCP's work plan.

Both of the MCP's required performance measures fall into the access domain of care. As indicated above, the rate for the *Controlling High Blood Pressure* measure showed no statistically significant change from 2013 to 2014 and remained above the MPL. Additionally, the rate declined significantly from 2013 to 2014 for the *Colorectal Cancer Screening* measure, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014.

Three of the MCP's QIPs fell into the quality domain of care. Only the *CD4 and Viral Load (Closed)* QIP progressed to the Outcomes stage. As indicated previously, the QIP did not have

positive results due to changes in the clinical guidelines and resulting in the QIP study indicators no longer being consistent with the guidelines. As a result, the QIP was closed.

Overall, AHF showed average performance related to the access domain of care based on performance measure results.

Timeliness

The timeliness domain of care relates to an MCP's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures that assess if a health care service is provided within a recommended period of time after a need is identified are used to assess if MCPs are ensuring timeliness of care. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

AHF's quality and performance improvement program description provides information about the MCP's activities and processes related to enrollee rights, grievances, continuity and coordination of care, and utilization management, which can all affect the timeliness of care delivered to members. Additionally, AHF included goals related to timely resolution of grievances in the MCP's work plan.

AHF appears to have implemented a successful monitoring process to ensure that 100 percent of grievance resolution letters are sent within the required time frame.

Since no performance measures or QIPs fall into the timeliness domain of care and no new compliance reviews were conducted with AHF, HSAG makes no assessment of the MCP's performance related to the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2012–13 MCP-specific evaluation report. AHF's self-reported responses are included in Appendix A.

Recommendations

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

- To improve the HEDIS audit process:
  - Explore options for using an electronic application process.
  - Formally document findings from the MCP's reconciliation process.
  - Update the MCP's reconciliation procedures.
  - Review Roadmap responses prior to submission to ensure that the MCP's processes are accurately reflected.
- Assess the factors leading to the statistically significant decline in the rate for the *Colorectal Cancer Screening* measure, and identify strategies to improve the rate to above the MPL.
- Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

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

Appendix A. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

for AHF Healthcare Centers

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with AHF's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table A.1—AHF's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

2012–13 External Quality Review Recommendation Directed to AHF	Actions Taken by AHF During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Ensure that 100 percent of grievance resolution letters are sent within the required time frame.	• Grievances are monitored weekly at the medical administration meeting attended by AHF MCP leadership. • Created supervisor of grievances position and hired supervisor (October 2014) to manage and provide oversight of complaints and grievances. • Timeliness rate increased from 97 percent to 100 percent and sustained during the Period; 100 percent (29 of 29) of grievance resolution letters were sent within the time frame requirements.
2. Since AHF has not yet reached its goal to attain NCQA's 90thpercentile for the *Controlling High Blood Pressure* and *Colorectal Cancer Screening* measures, consider conducting a causal/barrier analysis to identify the factors preventing the rates for these measures from improving. Once the barriers are identified, the MCP can identify improvement strategies to address the priority barriers.	• Provider report card under development with the MCP-contracted HEDIS reporting vendor (Innoapp). New reporting gives providers monthly updates on HEDIS compliance for particular panels. ▪ Same reporting system enables the MCP to see overall progress and identify providers in need of additional assistance. The chief of medicine and the MCP medical director review the overall results and the list of providers in need of additional help.
3. To improve performance related to QIPs:	
a. Refer to the QIP Completion Instructions prior to submitting QIPs to ensure that all required documentation is included in the QIP Summary Form.	• To improve performance related to QIPs, the QIP Completion Instructions will be reviewed and used as a checklist prior to submission of the QIP. • The proposed submission will be reviewed against the QIP Completion Instructions by at least one other individual, in order to address any noted or perceived deficiencies.

2012–13 External Quality Review Recommendation Directed to AHF	Actions Taken by AHF During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
b. For its *CD4 and Viral Load Testing* QIP:	
i. Assess if barriers need to be re-prioritized, existing interventions need to be revised, or new interventions need to be implemented.	• Inability to meet established goals initiated a reassessment of Clinical Practice Guidelines for testing frequency. New QIP reflecting revised guidelines differentiates between stable and unstable members. • Evaluation of barriers contributing to missed appointments uncovered potential discrepancies in the follow-up report provided to primary care provider. • Assessment of staffing roles and ratios will occur to determine more effective means to identify members with chronic missed appointments and to reengage them into care. Barriers identified and interventions implemented during the reporting period (see attachment). **NOTE:** HSAG reviewed the referenced document and confirmed that it contains AHF's identified barriers and implemented interventions.
ii. Implement organization-wide initiatives aimed at improving performance.	• Provider Performance: Chief of medicine and the MCP medical director educated the medical staff about increasing the frequency of clinical contact with members by scheduling follow-ups case by case. • Provider Education: MCP working with AHF Healthcare Center (HCC) leadership on retention efforts (e.g., linkage and coordination of care). Intensive follow-up calls and reminders to all providers and office administrators. Regional medical directors and chief of medicine intervene with nonresponsive providers (2014 year to date). • Outpatient Services: Geriatrics clinic opened at AHF HCCs during the review period to provide specialty consultation and assistance to MCP members who are aging and have comorbidities. • Staffing: Redesign of Utilization Management (UM)/Case Management (CM) Department to better address needs of high-risk members. UM/CM staff able to directly schedule provider office appointments via the MCP member's electronic health record. • Member Education: Revision of member health education materials to align with new Clinical Practice Guidelines differentiating between medically stable and unstable members. Inclusion of CD4 and VL testing in healthcare center media promotion campaign (October 2013.) • Information Systems: Established a systems intervention to remove inactive clients/members from the weekly missed appointment report to reduce burden on follow-up efforts.

2012–13 External Quality Review Recommendation Directed to AHF	Actions Taken by AHF During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
iii. Ensure that the MCP has processes in place to monitor interventions and determine why implemented interventions are not having a positive impact on the outcomes and that it documents these processes in the QIP Summary Form.	• Implemented mechanism to track responsiveness to 104-day reports monthly as one component of the quarterly performance-based bonuses for the providers. • Monthly tracking reports are trended to identify patterns of nonresponsiveness and address them with providers. • Educational interventions are monitored through the Quality and Performance Work Plan and reported to the MCP's Quality Management Committee quarterly.
4. Review the detailed CAHPS®[9] results report from Department of Social Services, and develop strategies to address the priority areas of:	
a. PHCP nurse (satisfied with help from nurse, satisfied with treatment plan)	• Care manager contact information provided as part of the complaint/grievance resolution letter. Example: *If you need assistance with your care plan, please contact your nurse care manager, Dean Mares, at (323) 243-6941.* • MCP clinical quality specialist and supervisor of grievances attend the MCP's weekly Interdisciplinary Care Team (ICT) meeting and present MCP members who have issues that require care manager or social worker follow-up. • Transition of Care and catastrophic nurse care managers added to the ICT to proactively and assertively work with very complex MCP members. Transition of Care (TOC) registered nurse (RN) follows MCP member through all care setting admissions and for 30 days following each admission. Hired March 2014. The TOC RN collaborates with providers/ facilities to coordinate and promote understanding of treatment plan. Catastrophic Care RN care managers to follow the highest complexity of MCP members, providing one resource for coordination of all care of these highly vulnerable patients. Hired April 2014.
b. How well doctors communicate (shows respect)	• Chief of medicine and MCP medical director actively working with AHF primary care providers to improve service at point of care. • In addition to CAHPS results, the AHF HCC Client Satisfaction Survey results are available at the individual provider level and reviewed with the primary care provider by the chief of medicine. • Overall CAHPS results are shared with providers annually at medical staff meetings.

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

2012–13 External Quality Review Recommendation Directed to AHF	Actions Taken by AHF During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
c. Customer service (gave information needed, treated with courtesy/ respect)	• The MCP Member Services Department increased staff to improve call answer timeliness and support non-English speaking members and held routine staff meetings to address call center issues and customer service. • The manager of Member Services provided a comprehensive review of individual agents' call statistics, evaluations to improve agent performance and training of proper call handling, and how to deal with difficult members. Member Services representatives refers to the Member Services Guide to provide information to MCP members. • The manager of Member Services monitors call center performance daily and, during staff meetings, discusses tactics and/or methods of how to improve customer service. • During the review period there were zero complaints received about MCP customer service; 3,302 English calls and 160 Spanish calls were received during this time.
d. Getting care quickly (urgent care, got care within 24 hours)	• Urgent Care Centers (UCC) identified and targeted recruitment; two additional UCCs contracted. • Routine joint operating meetings with Molina (nurse after-hours advice line) via teleconference. MCP staff met on-site with Molina to review assessment and referral processes for MCP members (April 16, 2014). • Implementation of scheduling access for AHF team staff members (nurse care managers, care partners and care coordinators) to directly schedule MCP members in AHF electronic health record (May 2014).
5. Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.	• Weekly interdepartmental meetings held with IT, Provider Relations, Compliance, Member Services, Claims, Risk Adjustment, and MCP leadership to address data issues. Areas of focus for process improvement during the weekly meetings to ensure accurate and complete encounter data include: ▪ Encounter data validation and any other key IT issues and updates. ▪ Coordination of internal process improvement activities in the organization. ▪ Upgrade and transition to system changes (e.g., 5010 encounter data). ▪ Link between provider information in the system so encounters are consistent with State system.