Performance Evaluation Report

Community Health Group Partnership Plan

July 1, 2013–June 30, 2014

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

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Performance Evaluation Report
Community Health Group Partnership Plan
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, Community Health Group Partnership Plan ("CHG" 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

CHG is a full-scope MCP delivering services to its MCMC members under a Geographic Managed Care (GMC) model. In the GMC model, DHCS allows MCMC beneficiaries to select from several commercial MCPs within a specified geographic area. The GMC model currently operates in San Diego and Sacramento counties.

CHG became operational in San Diego County to provide MCMC services in August 1998. As of June 30, 2014, CHG had 188,312 MCMC members.[3]

[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.

The most recent SPD medical survey for CHG was conducted June 24, 2013, through June 27, 2013, covering the review period of April 1, 2012, through March 31, 2013. DMHC evaluated the following elements specifically related to the MCP's delivery of care to the SPD population:

- Utilization Management
- Continuity of Care
- Availability and Accessibility
- Member Rights
- Quality Management

The initial report from DMHC dated November 26, 2013, indicated that DMHC identified three potential deficiencies:

- In the area of Utilization Management, DMHC found that the MCP allows nonclinical staff members to modify or deny utilization management decisions.

- In the area of Availability and Accessibility, DMHC found that the MCP's provider directory does not display the level of access results met per provider site as either limited or basic, nor does the site indicate medical equipment access.
- In the area of Member Rights, DMHC found that the MCP's member guide/evidence of coverage does not specify that translation services are available at no charge to members.

CHG was required to submit a CAP that described the actions the MCP took to correct the deficiencies and the results of the actions taken. In a follow-up letter dated April 8, 2014, DHCS indicated that, in December 2013, the MCP provided DHCS with a response to its CAP. The letter stated that the MCP addressed all potential deficiencies identified during the survey and that the survey is deemed closed.

Strengths

CHG resolved all potential deficiencies from the most recent SPD medical survey conducted by DMHC.

Opportunities for Improvement

Since CHG has no outstanding deficiencies from the most recent survey conducted by DMHC, HSAG has no recommendations related to compliance reviews.

Conducting the EQRO Review

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 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 performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[4] 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.

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

Performance Measure Validation

DHCS's 2014 External Accountability Set consisted of 14 HEDIS measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 32. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits 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. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for Community Health Group Partnership Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that CHG 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.

- The MCP implemented provider pay-for-performance programs for select measures.
- CHG exercised extreme diligence with regard to data quality and control and continued its efforts to increase measure rates by offering generous member incentives for select services.
- CHG successfully transitioned its Healthy Families Program population into MCMC with no impact on member operations (i.e., processes related to enrollment, customer service, member outreach, etc.).
- Due to the MCP's large volume of paper claims, the auditor suggested that CHG may want to consider implementing the use of optical character recognition technology to minimize manual data entry.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of CHG's performance measure results for 2011–14. Note that data may not be available for all four years.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 shows the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

DHCS based the MPLs and HPLs on the NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *CDC–H9 (>9.0 percent)* measure. For the *CDC–H9 (>9.0 percent)* measure, a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

The reader should note the following regarding Table 3.1:

- The *All-Cause Readmissions* measure is a non-HEDIS measure used for the ACR collaborative QIP; therefore, no MPL or HPL is established for this measure.
- For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- The *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures. No MPL or HPL is established for a utilization measure. Additionally, HSAG did not compare performance for these measures.
- Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for 2014:
  - All four *Children and Adolescents' Access to Primary Care* measures.
  - *Cervical Cancer Screening*. Note: MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008; however, due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014. Consequently, HSAG did not include or make comparisons to previous years' rates in this report.
  - *Comprehensive Diabetes Care—LDL-C Control.* (This measure is being eliminated for HEDIS 2015.)
  - *Comprehensive Diabetes Care—LDL-C Screening.* (This measure is being eliminated for HEDIS 2015.)

Table 3.1—Performance Measure Results
CHG—San Diego County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.37%	13.28%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	32.73	37.42	36.42	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	329	310.89	293.39	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	87.07%	84.99%	87.41%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	91.23%	95.71%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	85.01%	85.04%	88.16%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	**17.31%**	**14.08%**	32.02%	39.69%	↑
Cervical Cancer Screening	Q,A	—	—	—	65.21%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	78.10%	73.97%	73.97%	70.07%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.21%	97.32%	95.95%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	90.27%	89.85%	89.92%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	89.61%	89.90%	89.41%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	88.45%	88.64%	**85.47%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	65.69%	57.18%	64.72%	**45.99%**	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	61.07%	53.28%	55.47%	55.47%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	88.32%	87.35%	90.02%	86.13%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	52.31%	47.69%	56.45%	45.01%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	40.63%	35.04%	39.66%	39.66%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	84.67%	82.24%	83.70%	81.75%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	77.21%	79.08%	83.21%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	37.71%	43.80%	34.31%	40.88%	↔
Controlling High Blood Pressure	Q	—	—	52.07%	52.07%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	73.48%	79.32%	76.40%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**35.41%**	47.09%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**18.66%**	27.95%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**57.18%**	60.10%	**55.23%**	57.91%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**79.08%**	**77.86%**	82.24%	80.29%	↔
Use of Imaging Studies for Low Back Pain	Q	77.75%	75.03%	79.24%	77.32%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	63.26%	73.48%	78.10%	87.59%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	69.83%	71.53%	71.29%	75.43%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	40.39%	55.96%	63.99%	70.32%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	74.95%	77.13%	77.86%	78.10%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[5] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

[5] Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. Managed care health plan performance measures may include measures from HEDIS; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Table 3.2 and Table 3.3, which present a summary of CHG's 2014 SPD measure results. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[6] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[6] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.2.

Table 3.2—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for CHG—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	10.38%	14.88%	▼	13.28%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.18%	89.03%	↑	87.41%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	95.31%	Not Comparable	95.71%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.92%	90.33%	↑	88.16%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.94%	97.37%	↔	95.95%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.97%	88.30%	↔	89.92%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.39%	89.97%	↔	89.41%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	85.50%	84.81%	↔	85.47%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	47.93%	44.04%	↔	45.99%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	51.34%	57.18%	↔	55.47%
Comprehensive Diabetes Care—HbA1c Testing	82.73%	86.86%	↔	86.13%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	43.31%	46.47%	↔	45.01%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.85%	42.58%	↑	39.66%
Comprehensive Diabetes Care—LDL-C Screening	77.86%	82.97%	↔	81.75%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.72%	84.91%	↑	81.27%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	42.82%	39.66%	↔	40.88%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

▲▼ are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
CHG—San Diego County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
280.48	35.06	384.72	46.05

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

Performance Measure Result Findings

The rates for the following measures were above the HPLs:

- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* measures, with the rate for the *BMI Assessment: Total* indicator being above the HPL for the fourth consecutive year.

The rates for six measures improved significantly from 2013 to 2014:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- Both *Medication Management for People with Asthma* measures, resulting in the rates for both measures moving from below the MPLs to above the MPLs. Note that DHCS did not hold the MCPs accountable for meeting the MPLs for these measures in 2013 since 2013 was the first year the measures were reported.
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*

The rates for the following measures declined significantly from 2013 to 2014:

- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*, resulting in the rate for this measure moving from above the MPL in 2013 to below the MPL in 2014
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*, resulting in the rate for this measure moving from above the MPL in 2013 to below the MPL in 2014
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*

The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure improved from 2013 to 2014 and, although not statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014.

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for the following measures:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

The SPD rate for the *All-Cause Readmissions* measure was significantly worse than the non-SPD rate, meaning that significantly more members in the SPD population (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than members in the non-SPD population.

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

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve 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 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 Plan-Do-Study-Act 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

Based on 2013 rates, CHG was required to submit an IP for the *Prenatal and Postpartum Care—Postpartum Care* measure. The MCP attempted to contact 188 members to determine the challenges affecting members being seen for postpartum care visits. The MCP was able to contact 36 members. The following barriers were identified:

- The telephone numbers in the State eligibility file are not always accurate, resulting in the MCP not being able to contact members.
- Members stated they were seen for a postpartum visit, but the MCP did not receive encounter data from the providers.
- Members were seen outside the required time frame for the postpartum care visit.
- Members were not aware of the importance of obtaining postpartum care.
- Members encountered difficulty with scheduling an appointment or had a negative experience with the provider's office staff.
- Members had healthy births previously and therefore did not feel the need to go to their postpartum care visit.

CHG implemented several interventions to address the barriers, including:

- When making calls to new mothers, reminded them to schedule their postpartum care visit.
- Offered a $25 gift card as an incentive to members who completed their postpartum visit during the required time frame.
- Contacted providers who bill for global delivery charges to obtain the specific date of the postpartum visit.
- Conducted outreach calls to members who delivered a baby and offered to assist them with scheduling their postpartum care visit and provided transportation assistance.
- Contracted with a home care vendor who provided nurse practitioners to conduct in-home postpartum visits to members who had not completed their visit.
- Educated practitioners regarding the HEDIS requirements.

CHG's efforts resulted in the rate for this measure improving from below the MPL in 2013 to above the MPL in 2014. The MCP will not be required to continue the IP for this measure in 2014.

Based on 2014 rates, CHG will be required to submit an IP for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure. Although the rate for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure was below the MPL, the MCP will not be required to submit an IP for this measure. DHCS elected not to require MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years to prioritize DHCS and MCP efforts in other areas of poor performance that have clear improvement paths and direct population health impact.

Strengths

CHG exercised extreme diligence with regard to data quality and control and continued its efforts to increase measure rates by offering generous member incentives for select services. Additionally, the MCP successfully transitioned its Healthy Families Program population into MCMC with no impact on member operations.

CHG had five measures with rates above the HPLs, and the rates for six measures improved significantly from 2013 to 2014. The improvement for two of the measures resulted in the rates moving from below the MPLs in 2013 to above the MPLs in 2014. The MCP's IP for the *Prenatal and Postpartum Care—Postpartum Care* measure was successful at moving the measure's rate from below the MPL in 2013 to above the MPL in 2014.

Opportunities for Improvement

Due to CHG's large volume of paper claims, the HSAG auditor suggested that the MCP may want to consider implementing the use of optical character recognition technology to minimize manual data entry.

CHG has the opportunity to assess the factors leading to the rate for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure declining significantly, resulting in the rate being below the MPL in 2014, and to identify strategies to improve the measure's rate. The MCP also has the opportunity to assess the factors leading to the rates for four measures declining significantly from 2013 to 2014 and identify strategies that will prevent further decline in the rates. Finally, CHG has the opportunity to assess the factors leading to the SPD rate for the *All-Cause Readmissions* measure being significantly worse than the non-SPD rate to ensure that the MCP is meeting the needs of the SPD population.

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.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county.

The *Medi-Cal Managed Care Technical Report, July 1, 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 CHG'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

CHG participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2013, through June 30, 2014.

Table 4.1 below lists CHG's QIPs and 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 CHG
July 1, 2013, through June 30, 2014

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Increasing Postpartum Care Visits within 6 Weeks of Delivery	Clinical	Q, A, T

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

The *Increasing Postpartum Care Visits within 6 Weeks of Delivery* QIP aimed to improve the rate of postpartum visits for women between 21 and 56 days after delivery because ensuring that a women is seen postpartum is important to the physical and mental health of the mother. The rate for *Prenatal and Postpartum Care—Postpartum Care* measure was below the DHCS-established MPL in 2010, 2011, and 2013. Using member, provider, and system interventions, the MCP's objective was to increase the outcome to at least the MPL for 2013.

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
CHG—San Diego 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]
Statewide Collaborative QIP				
All-Cause Readmissions	Annual Submission	75%	71%	*Partially Met*
	Annual Resubmission 1	94%	86%	*Partially Met*
	Annual Resubmission 2	100%	100%	*Met*
Internal QIPs				
Increasing Postpartum Care Visits within 6 Weeks of Delivery	Study Design Submission	67%	71%	*Not Met*
	Study Design Resubmission 1	100%	100%	*Met*
	Annual Submission	76%	80%	*Partially Met*
	Annual Resubmission 1	96%	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 CHG's annual submission of its *All-Cause Readmissions* QIP 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, CHG resubmitted the QIP and, after the second resubmission, achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score.

During the review period, CHG submitted the study design for the *Increasing Postpartum Care Visits within 6 Weeks of Delivery* QIP and also submitted baseline results as part of the QIP annual submission process. The study design submission received an overall validation status of *Not Met*. CHG resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score. The annual submission for the

Increasing Postpartum Care Visits within 6 Weeks of Delivery QIP received an overall validation status of *Partially Met*. The MCP resubmitted the QIP and achieved an overall *Met* validation status, with 96 percent of the evaluation elements and 100 percent of the critical elements receiving a met score.

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

Table 4.3—Quality Improvement Project Average Rates*
CHG—San Diego County
(Number = 7 QIP Submissions, 2 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	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)**	88%	13%	0%
	VI: Accurate/Complete Data Collection**	92%	6%	3%
Design Total		**94%**	**5%**	**1%**
Implementation	VII: Sufficient Data Analysis and Interpretation	64%	27%	9%
	VIII: Appropriate Improvement Strategies	60%	40%	0%
Implementation Total		**63%**	**31%**	**6%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**

*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 VIII for CHG's *All-Cause Readmissions* QIP annual submission and Activities I through VI and I through VIII for the MCP's *Increasing Postpartum Care Visits within 6 Weeks of Delivery* QIP study design submission and annual submission, respectively.

CHG demonstrated a strong application of the Design stage, meeting 94 percent of the requirements for all applicable evaluation elements within the study stage. The MCP met 100 percent of the requirements for all applicable evaluation elements within the Design stage for the *All-Cause Readmissions* QIP. For the *Increasing Postpartum Care Visits within 6 Weeks of Delivery* QIP study design submission, CHG did not provide the correct HEDIS hybrid sampling methodology,

documented incorrect margin of error and sampling information, did not include a copy of the manual data collection tool, and did not describe its process for calculating data completeness or its hybrid data collection, resulting in a lower score for Activities V and VI. The MCP met 100 percent of the requirements for all applicable evaluation elements within the Design stage for the *Increasing Postpartum Care Visits within 6 Weeks of Delivery* QIP annual submission.

Both QIPs progressed to the Implementation stage during the reporting period. CHG struggled with its application of the Implementation stage for both QIPs, meeting 63 percent of the requirements for all applicable evaluation elements within the study stage. The *All-Cause Readmissions* and *Increasing Postpartum Care Visits within 6 Weeks of Delivery* QIPs had multiple implementation issues, resulting in lower scores for Activities VII and VIII. CHG corrected the deficiencies in the resubmissions, resulting in both QIPs achieving an overall *Met* validation status.

Quality Improvement Project Outcomes and Interventions

Neither of the MCP's QIPs progressed to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP's interventions for each QIP:

All-Cause Readmissions QIP

- A local pharmacy delivers the medications to the member immediately after discharge or while the member is still at the hospital.
- A home health nurse visits the member within one day of discharge to review post-discharge instructions/medications.
- A complex case management case manager contacts the member to facilitate follow-up with the member's PCP.
- The MCP provides non-covered services intended to have a positive impact on a member's condition or to prevent the worsening of an existing condition.
- Case managers conduct home visits to engage the member and complete a form to obtain basic information about the member and to assist in coordinating follow-up care post-discharge.

Increasing Postpartum Care Visits within 6 Weeks of Delivery

- Call new mothers to reminder them of postpartum visits.
- Send post-delivery congratulatory and educational letter for each live birth.
- Provide members with a $25 incentive gift card for completing the postpartum visit during the required time frame.

- Contact providers who bill for global delivery charges to obtain the specific dates of the postpartum visits.
- Assist members who have delivered with scheduling their postpartum visits 21 to 56 days after delivery, and provide taxi transportation to and from the visits.
- Contract with a home care vendor who can provide nurse practitioners to conduct postpartum visits, and offer an in-home postpartum visit to members who have not completed a visit.
- Obtain the member's hospital face sheet to compare the most current demographic data with data in the member profile, and update the information if necessary.

Outcome information for each QIP will be included in CHG's 2014–15 MCP-specific evaluation report.

Strengths

As in previous years, CHG continued to demonstrate an excellent application of the QIP Design stage for its QIPs. The MCP met all requirements for all applicable evaluation elements within the Design stage for its *All-Cause Readmissions* QIP.

Opportunities for Improvement

CHG has the opportunity to ensure that all required documentation is included in the QIP Summary Form since the MCP had several instances of incomplete data. The MCP should reference the QIP Completion Instructions and previous QIP validation tools to ensure that all documentation requirements for each activity have been addressed prior to submission.

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

HSAG developed a standardized scoring process to evaluate each MCP in the three domains of care—quality, access, and timeliness. A numerical score is calculated for each domain of care for performance measure rates, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care and converted to a rating of above average, average, or below average. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the MCPs' medical audit/SPD medical survey reviews and assessment of the accuracy and completeness of encounter data to determine overall performance within each domain of care, as applicable. A more detailed description of HSAG's scoring process is included in Appendix C.

Please note that when a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care.

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

[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.

of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

HSAG reviewed CHG's quality improvement program documents and found detailed descriptions of processes and goals that support the provision of quality care to members, including mechanisms for monitoring the quality of care provided. Additionally, the MCP's quality improvement program evaluation document provides a summary of CHG's accomplishments, which include indicators related to quality of care.

The rates for the following performance measures were above the HPL:

- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* measures, with the rate for the *BMI Assessment: Total* indicator being above the HPL for the fourth consecutive year.

The rates for six quality measures improved significantly from 2013 to 2014:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs.*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics.*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis.*
- Both *Medication Management for People with Asthma* measures, resulting in the rates for both measures moving from below the MPLs to above the MPLs. Note that DHCS did not hold the MCPs accountable for meeting the MPLs for these measures in 2013 since 2013 was the first year the measures were reported.
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total.*

The rates for the following quality measures declined significantly from 2013 to 2014:

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*, resulting in the rate for this measure moving from above the MPL in 2013 to below the MPL in 2014
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*

The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the quality domain of care, improved from 2013 to 2014 and, although not statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and the SPD rates for four of the measures were significantly better than the non-SPD

rates. The SPD rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care, was significantly worse than the non-SPD rate, meaning that significantly more members in the SPD population (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than members in the non-SPD population.

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

Overall, CHG showed above-average performance related to the quality domain of care.

Access

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

HSAG reviewed CHG's available quality improvement program information and found that the MCP included processes in its quality improvement program description designed to ensure members' access to needed health care services. Additionally, the MCP includes goals in its work plan related to monitoring member access and assessing member satisfaction with access and availability of services. CHG's quality improvement program evaluation document shows that the MCP met or exceeded most of its access-related goals in 2013.

The rates for the following access performance measures declined significantly from 2013 to 2014:

- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*, resulting in the rate for this measure moving from above the MPL in 2013 to below the MPL in 2014

The *Prenatal and Postpartum Care—Postpartum Care* measure falls into the access domain of care. As indicated above, the rate for this measure improved from 2013 to 2014 and, although not

statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014.

Nine of the performance measures stratified for the SPD population fall into the access domain of care. The SPD rate for one of the measures, *Comprehensive Diabetes Care—Medical Attention for Nephropathy*, was significantly better than the non-SPD rate. The *All-Cause Readmissions* measure falls into the access domain of care. As indicated previously, the SPD rate for this measure was significantly worse than the non-SPD rate, meaning that significantly more members in the SPD population (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than members in the non-SPD population.

Both of CHG's QIPs fell into the access domain of care. Since neither QIP progressed to the Outcomes stage, HSAG was not able to assess the QIPs' success at improving access to care for the MCP's MCMC members.

Overall, CHG showed average performance related to the access domain of care.

Timeliness

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

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

CHG's quality improvement program description includes descriptions of processes related to enrollee rights; grievances; continuity and coordination of care; and utilization management, which all affect the timeliness of care delivered to members.

Five of the required performance measures fall into the timeliness domain of care, and the rates for all measures were between the MPLs and HPLs.

The *Prenatal and Postpartum Care—Postpartum Care* measure falls into the timeliness domain of care. As indicated above, the rate for this measure improved from 2013 to 2014 and, although not statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014.

The *Increasing Postpartum Care Visits within 6 Weeks of Delivery* QIP fell into the timeliness domain of care. Since the QIP did not progress to the Outcomes stage, HSAG was not able to assess the QIP's success at improving the timeliness of care provided for the MCP's MCMC members.

Overall, CHG showed average performance related to the timeliness domain of care.

Follow-Up on Prior Year Recommendations

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

Recommendations

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

- Due to CHG's large volume of paper claims, the MCP may want to consider implementing the use of optical character recognition technology to minimize manual data entry.
- Assess the factors leading to the rate for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure declining significantly, resulting in the rate being below the MPL in 2014; and identify strategies to improve the measure's rate.
- Assess the factors leading to the rates for the following four measures declining significantly from 2013 to 2014, and identify strategies that will prevent further decline in the rates:
  - *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
  - *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- Assess the factors leading to the SPD rate for the *All-Cause Readmissions* measure being significantly worse than the non-SPD rate to ensure that the MCP is meeting the needs of the SPD population.
- Ensure that all required documentation is included in the QIP Summary Form. The MCP should reference the QIP Completion Instructions and previous QIP validation tools to ensure that all documentation requirements for each activity have been addressed prior to submission.

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

Table A.1 provides two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table A.1—HEDIS 2014 SPD Trend Table
CHG—San Diego County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	17.03%	14.88%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	62.49	46.05	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	495.48	384.72	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.05%	89.03%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	90.24%	95.31%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.76%	90.33%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	97.37%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.46%	88.30%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	94.09%	89.97%	↓
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.12%	84.81%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.53%	44.04%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	60.58%	57.18%	↔
Comprehensive Diabetes Care—HbA1c Testing	90.27%	86.86%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	58.88%	46.47%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.47%	42.58%	↔
Comprehensive Diabetes Care—LDL-C Screening	86.62%	82.97%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	88.08%	84.91%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	30.66%	39.66%	▼

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

Table B.1 provides two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table B.1—HEDIS 2014 Non-SPD Trend Table
CHG—San Diego County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	10.79%	10.38%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	34.30	35.06	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	287.97	280.48	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.91%	83.18%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.06%	81.92%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.34%	95.94%	↓
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.87%	89.97%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.76%	89.39%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.70%	85.50%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	65.69%	47.93%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.77%	51.34%	↔
Comprehensive Diabetes Care—HbA1c Testing	86.86%	82.73%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.69%	43.31%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.69%	32.85%	↔
Comprehensive Diabetes Care—LDL-C Screening	82.24%	77.86%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.05%	73.72%	↓
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	34.55%	42.82%	▼

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

Quality, Access, and Timeliness Scoring Process

Scale
2.5–3.0 = Above Average
1.5–2.4 = Average
1.0–1.4 = Below Average

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[9] This process allows HSAG to evaluate each MCP's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.1)

Quality Domain

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.
   - If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.
3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

[9] The CMS protocols specify that the EQRO must include an assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Access and Timeliness Domains

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.
   - If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

Validation *(Table 4.2)*: For each QIP submission and subsequent resubmission(s), if applicable.

1. **Above Average** is not applicable.
2. **Average** = *Met* validation status.
3. **Below Average** = *Partially Met* or *Not Met* validation status.

Outcomes *(Table 4.4)*: Activity IX, Element 4—Real Improvement

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

Sustained Improvement *(Table 4.4)*: Activity X—Achieved Sustained Improvement

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Some, but not all, study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

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

for Community Health Group Partnership Plan

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with CHG'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 D.1—CHG'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 CHG	Actions Taken by CHG During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Consider using OCR software for the MCP's claims retention process rather than manual entry.	In June 2014, the Executive team of Community Health Group agreed to pursue an agreement with Emdeon. The purpose of this contract is to require that all providers (or the vast majority of them) submit their claims electronically, thus avoiding manual entry of claims.
2. Assess the factors leading to the rate on the *Prenatal and Postpartum Care—Postpartum Care* measure being below the MPL and identify interventions to be implemented that will result in an improvement on performance.	HSAG completed validation of our Postpartum QIP study design submission August 28, 2013. The QIP received an overall Met validation status. The 2014 MPL was met at 57.91 percent.
3. Assess the factors leading to the significant decline in the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE* measure and identify strategies for preventing further decline.	Action plan was developed by the Total Quality Integration Team. • Identify members receiving targeted medications and who do not have a monitoring event encounter. • Contact primary care physician (PCP) site to determine if a monitoring test was performed; if not, assist in scheduling the member for testing.
4. Assess the factors leading to the SPD population having a significantly higher rate of readmissions when compared to the non-SPD population and identify strategies for reducing the number of readmissions for this population.	Evaluation showed that the SPD population has a significantly higher rate of members with multiple chronic conditions and were not scheduling follow-up appointments. SPD members are identified monthly using the following criteria: • Chronic diseases—diabetes, congestive heart failure, chronic obstructive pulmonary disease, asthma, cellulitis, lymphedema, heart disease, hypertension • Utilization pattern—Three or more hospital admissions within 12 month period The following interventions are implemented: • Members are assigned to patient care coordinators (PCCs). PCC staff conducts home visit within five days of case assignment.

2012–13 External Quality Review Recommendation Directed to CHG	Actions Taken by CHG During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	• PCC staff discusses completed assessments with assigned high risk case manager (HRCM) for internal review and follow up. • Care plans—PCC and HRCM develop a member-specific care plan once member is reached. • Phone call to the hospital—For patients who are readmitted, registered nurse (RN) calls the patient while in the hospital to assess reason for readmission. RN works with concurrent review and hospital staff to secure an order from the admitting physician for a home health referral as part of discharge plan. • Home health visit post-discharge—Contracted agencies conduct a home visit within 24 hours of discharge (agency contracts have a built-in incentive to ensure access to RNs for same day and weekend referrals–pay 25 percent more for these visits). • Home visits by health educator—On a case-by-case basis, for members with the four targeted disease management conditions, home visits are done by MedEd staff to provide extended health education. • Medication and dressing supply delivery—Through a special arrangement with Medical Center Pharmacy, medications and dressing change supplies are delivered to either the hospital or home, on case by case. Injectables (i.e., Lovenox) may be delivered to the hospital prior to discharge or are delivered to patients' homes on the day of discharge. • Outpatient physician follow up—PCC helps schedule members for PCP and/or specialty follow-up appointments within five days of discharge (Three days is goal). • Extensive member education—RN works with members, PCPs, health educators, and other community resources to help members comply with treatment plans. • Other resources—Based on member needs, to ensure compliance with outpatient follow up and to prevent further complications, additional benefits are accessed (i.e., extra pressure stockings for members with lymphedema and cellulitis and short term transportation via cab).
5. Review the 2013 MCP-specific CAHPS®[10] results report and develop strategies to address the *Getting Needed Care, Getting Care Quickly,* and *How Well Doctors Communicate* priority areas.	The Member/Provider Satisfaction work group developed/implemented the following to improve the identified areas: 1. Added more specific questions to the Provider Utilization Management Satisfaction Survey regarding availability of specialty appointments.

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

2012–13 External Quality Review Recommendation Directed to CHG	Actions Taken by CHG During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	2. When deficiencies are noted on the Office Management Survey, staff assess for detailed information regarding specialty type and locations during facility site reviews. 3. Developed materials for case management meeting dedicated to member satisfaction results and issue resolution. 4. Developed a "Doctor's Visit Checklist" for members to use during their appointments. To start distribution with disease management mailings to members. 5. Developed article for provider newsletter with results of member satisfaction survey.
6. 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.	CHG provides a response to each recommendation below: • For both data sources, there were no long-term care (LTC) records. However, in CHG's response to HSAG's preliminary file review document, CHG indicated that its data system contained LTC records. CHG should submit the LTC records to DHCS in the future. CHG response: In development. • The Medical/Outpatient encounters in the DHCS data warehouse did not contain Outpatient records as identified by the data element *Claim Type* with a value of "1" (Outpatient). CHG should evaluate whether its data system contains any Outpatient records to be included in data submissions to DHCS. CHG response: In development. • For the Medical/Outpatient data from both data sources, the *Provider Type* field contained only two values: "20" (Optometrists) and "26" (Physicians). It is unusual that no records with provider types such as "09" (Clinical Laboratories), "22" (Physicians Group), "15" (Community Hospital Outpatient Departments), or "30" (Ground Medical Transportation) were present. CHG should review its data system and evaluate whether it submits encounters from all provider types for enrolled Medi-Cal beneficiaries. CHG response: This has already been implemented in production process. • CHG should investigate the reason(s) for the high record omission rates for the Medical/Outpatient and Pharmacy claim types and create strategies for future improvement. CHG response: In development.

2012–13 External Quality Review Recommendation Directed to CHG	Actions Taken by CHG During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	• CHG should investigate the reason(s) for the high record surplus rates for the Medical/Outpatient and Hospital/Inpatient claim types and create strategies for future improvement. CHG response: In development. • All Medical/Outpatient records in both data sources were missing values for the *Referring/Prescribing/Admitting Provider Number* data element. However, in CHG's response to HSAG's preliminary file review document, CHG stated that its data system contained values for this data element. CHG should modify its processes/procedures so that the values for the data element *Referring/Prescribing/Admitting Provider Number* can be submitted to DHCS. CHG response: This has already been implemented in production process. • All Hospital/Inpatient records in both data sources were missing values for the *Primary Surgical Procedure Code* and *Secondary Surgical Procedure Code* data elements. However, in CHG's response to HSAG's preliminary file review document, CHG stated that its data system contained values for these data elements. CHG should modify its processes/procedures so that the values for these data elements can be submitted to DHCS. CHG response: This has already been implemented in production process. • Regarding the low *Revenue Code* accuracy rate for Hospital/Inpatient encounters, CHG should investigate what caused the errors during data preparation for this EDV study and create policies and procedures to prevent this type of error from occurring in the future. CHG response: This has already been implemented in production process.