Performance Evaluation Report

Community Health Group Partnership Plan

July 1, 2012–June 30, 2013

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

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013.* This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and

[1] *Medi-Cal Managed Care Enrollment Report—June 2013.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Community Health Group Partnership Plan ("CHG" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

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.

CHG became operational in San Diego County to provide MCMC services in August 1998. As of June 30, 2013, CHG had 149,796 MCMC members.[3]

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

Conducting the EQRO Review

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

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

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

Assessing the State's Compliance Review Activities

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

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits and Member Rights Reviews

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

Audits and Investigations Division Medical Audit

The most recent A&I Medical Audit for CHG was conducted December 3, 2012, through December 14, 2012, covering the review period of May 1, 2011, through April 30, 2012. A&I evaluated CHG's compliance with contract requirements and regulations in the following areas:

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[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

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

The initial report from A&I issued April 22, 2013, indicated that A&I identified findings in all areas except Utilization Management and State Supported Services. Although the follow-up reports from A&I were issued outside the July 1, 2012, through June 30, 2013, review dates for this report, HSAG includes the information since the review took place during the review period and the latest correspondence from A&I indicates that all findings were fully corrected by CHG. A summary of the communication from A&I is below:

- In a letter from DHCS dated September 26, 2013, DHCS acknowledged receiving CHG's corrective action plan (CAP) on August 22, 2013, and provided DHCS's response to the CAP. Although several findings were corrected, the following findings remained open at the time of this letter:
  - In the area of Continuity of Care, the MCP submitted a revised policy and procedure regarding completion of initial health assessments; however, A&I indicated that the MCP did not provide policies and procedures demonstrating that a process is in place for wide implementation of the monitoring process or evidence that the revised policies and procedures are being implemented.
  - In the area of Availability and Accessibility, the MCP did not provide evidence of an updated policy indicating that CHG will ensure that 90 percent of all clean claims will be paid within 30 days of the date of receipt or that the policy is being implemented.
  - In the area of Member's Rights, CHG submitted documentation indicating that potential quality of care issues are addressed in the grievance process; however, the documentation did not indicate that when the resolution letter is sent to the member that the letter will address all issues/complaints initially identified by the member. Additionally, the policy submitted by CHG did not indicate that the MCP's appeals supervisor and medical officer meet regularly to view all expedited appeals and grievances.
  - In the area of Quality Management, the MCP did not provide documentation indicating that a broad approach is being implemented to ensure medical records are consistently maintained and that each facility secures and protects member personal health information in accordance with contract requirements.

- In the area of Quality Management, CHG did not provide all required documentation in the MCP's Sterilization and Hysterectomy Policy. Additionally, the MCP did not provide documentation demonstrating that providers are given additional education regarding the proper completion of the Informed Consent Form PM330 and the requirements to provide members with the sterilization booklet and discuss alternate birth control methods.

- In a letter from DHCS dated November 25, 2013, A&I acknowledged receiving CHG's CAP on October 31, 2013. DHCS indicated that after reviewing the CAP the medical audit is deemed closed.

Department of Managed Health Care Seniors and Persons with Disabilities Enrollment Survey

DMHC conducted an SPD Enrollment Survey for CHG June 24, 2013, through June 27, 2013, covering the review period of April 1, 2012, through March 31, 2013. The results of this survey will be included in CHG's 2013–14 MCP-specific evaluation report.

Member Rights/Program Integrity Unit Routine Monitoring Review

In CHG's 2011–12 MCP-specific evaluation report, HSAG included a summary of the January 2011 MR/PIU review conducted with the MCP. DHCS conducted a follow-up review with CHG on June 22, 2012. As part of the review, DHCS evaluated CHG's level of progress in performing cultural awareness and sensitivity training required to meet the needs of the SPD population and physical accessibility review surveys.

In a letter from MR/PIU dated June 3, 2013, MR/PIU indicated that CHG had taken appropriate action to correct the two findings from the January 2011 MR/PIU review in the area of Prior Authorization Notification. In the letter, MR/PIU indicated that it had reviewed and evaluated CHG's report on providing SPD sensitivity training and found the MCP's level of progress satisfactory. Additionally, MR/PIU noted that it had reviewed and evaluated CHG's submission regarding physical accessibility surveys and found the MCP's level of progress to be satisfactory. MR/PIU did not identify any findings from the June 2012 review.

Strengths

CHG had no deficiencies in the areas of Utilization Management and State Supported Services from the MCP's A&I December 2012 Medical Audit; and subsequent to the audit, the MCP fully corrected all deficiencies in the areas of Continuity of Care, Availability and Accessibility, Member's Rights, Quality Management, and Administrative and Organizational Capacity. Additionally, the MCP resolved all findings from the January 2011 MR/PIU review, and MR/PIU identified no findings over progress made related to providing cultural awareness and sensitivity training to meet the needs of the SPD population and conducting physical accessibility review surveys.

Opportunities for Improvement

Since CHG resolved all areas of concern identified through the previous reviews and HSAG does not yet have the results from the most recent SPD Enrollment Survey, HSAG does not have any recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

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

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

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

Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for 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 review of the MCP's HEDIS audit report revealed the following observations:

- CHG uses scanned paper claims for retention purposes and does did not use optical character recognition (OCR) software to lift the data and translate it to an electronic format. Due to the volume of paper claims received, the auditor suggested that CHG explore the use of OCR software to minimize manual entry.
- The auditor noted that CHG exercised extreme diligence with regard to data quality and control, and the MCP continued its efforts to increase measure rates by offering generous member incentives for receiving needed services.

[6] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[7] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

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

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions* ‡
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
CBP	*Controlling High Blood Pressure*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MMA–75	*Medication Management for People with Asthma—Medication Compliance 75% Total*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.
‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Table 3.2 below presents a summary of CHG's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.2 shows the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

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

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
CHG—San Diego County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	14.08%	32.02%	★★	↑	18.98%	33.33%
ACR	Q, A	--	14.37%	--	Not Comparable	--	--
AMB–ED	‡	32.73	37.42	‡	Not Comparable	‡	‡
AMB–OP	‡	329.00	310.89	‡	Not Comparable	‡	‡
CAP–1224	A	96.21%	97.32%	★★	↑	95.56%	98.39%
CAP–256	A	90.27%	89.85%	★★	↔	86.62%	92.63%
CAP–711	A	89.61%	89.90%	★★	↔	87.56%	94.51%
CAP–1219	A	88.45%	88.64%	★★	↔	86.04%	93.01%
CBP	Q	--	52.07%	--	Not Comparable	--	--
CCS	Q,A	69.10%	69.59%	★★	↔	61.81%	78.51%
CDC–BP	Q	57.18%	64.72%	★★	↑	54.48%	75.44%
CDC–E	Q,A	53.28%	55.47%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	47.69%	56.45%	★★	↑	42.09%	59.37%
CDC–H9 (>9.0%)	Q	43.80%	34.31%	★★	▲	50.31%	28.95%
CDC–HT	Q,A	87.35%	90.02%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	35.04%	39.66%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	82.24%	83.70%	★★★	↔	70.34%	83.45%
CDC–N	Q,A	79.08%	83.21%	★★	↔	73.48%	86.93%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
CHG—San Diego County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
CIS–3	Q,A,T	73.97%	73.97%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	73.48%	79.32%	★★	↑	50.36%	80.91%
LBP	Q	75.03%	79.24%	★★	↑	72.04%	82.04%
MMA–50	Q	--	35.41%	--	Not Comparable	--	--
MMA–75	Q	--	18.66%	--	Not Comparable	--	--
MPM–ACE	Q	87.07%	84.99%	★★	↓	83.72%	91.33%
MPM–DIG	Q	NA	91.23%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	85.01%	85.04%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	77.86%	82.24%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	60.10%	55.23%	★	↔	58.70%	74.73%
W-34	Q,A,T	77.13%	77.86%	★★	↔	65.51%	83.04%
WCC–BMI	Q	73.48%	78.10%	★★★	↔	29.20%	77.13%
WCC–N	Q	71.53%	71.29%	★★	↔	42.82%	77.61%
WCC–PA	Q	55.96%	63.99%	★★	↑	31.63%	64.87%

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

Seniors and Persons with Disabilities Performance Measure Results

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

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

The final selected SPD measures are listed below. Following the list of measures are Tables 3.3 and 3.4, which present a summary of CHG's 2013 SPD measure results. Table 3.3 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.4 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*

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

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.3.

- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Table 3.3—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
CHG—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	10.79%	17.03%	▼	14.37%
CAP–1224	97.34%	NA	Not Comparable	97.32%
CAP–256	89.87%	88.46%	↔	89.85%
CAP–711	89.76%	94.09%	↑	89.90%
CAP–1219	88.70%	87.12%	↔	88.64%
CDC–BP	65.69%	62.53%	↔	64.72%
CDC–E	53.77%	60.58%	↑	55.47%
CDC–H8 (<8.0%)	56.69%	58.88%	↔	56.45%
CDC–H9 (>9.0%)	34.55%	30.66%	↔	34.31%
CDC–HT	86.86%	90.27%	↔	90.02%
CDC–LC (<100)	38.69%	46.47%	↑	39.66%
CDC–LS	82.24%	86.62%	↔	83.70%
CDC–N	80.05%	88.08%	↑	83.21%
MPM–ACE	84.91%	85.05%	↔	84.99%
MPM–DIG	NA	90.24%	Not Comparable	91.23%
MPM–DIU	84.06%	85.76%	↔	85.04%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

Not comparable = A rate comparison could not be made because data were not available for both populations.

Table 3.4—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
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
287.97	34.30	495.48	62.49

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

Performance Measure Result Findings

Overall, CHG performed average on its measures in 2013. Two measures had rates above the HPLs, and one measure had a rate below the MPL.

The rates for the *Comprehensive Diabetes Care—LDL-C Screening* measure and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* measures were above the HPLs. The rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* measure has been above the HPL since 2011, which was the first year the MCPs were held to performing above the MPL on this measure.

The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure was below the MPL in 2010 and 2011; however, the MCP was able to improve the rate to be above the MPL in 2012. Although not statistically significant, the rate for this measure declined in 2013, resulting in the rate again being below the MPL.

The rate for the *Annual Monitoring for Patients on Persistent Medications—ACE* measure declined significantly from 2012 to 2013. The following eight measures had rates with statistically significant improvement from 2012 to 2013:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Comprehensive Diabetes Care (CDC)–Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Immunizations for Adolescents—Combination 1*
- *Use of Imaging Studies for Low Back Pain*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*

The statistically significant improvement in the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure resulted in the rate on this measure being above the MPL for the first time in three years.

The rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure was below the MPL in 2012. Although the improvement on the rate for this measure from 2012 to 2013 was not statistically significant, the improvement resulted in the rate for this measure being above the MPL in 2013.

Seniors and Persons with Disabilities Findings

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

- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

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

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

Improvement Plans

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

improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

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

CHG had IPs in place for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Prenatal and Postpartum Care—Postpartum Care* measures. The rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was below the MPL in 2011 and 2012, and the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure had been below the MPL since 2009. Below is a summary of the IPs and HSAG's assessment of the progress the MCP made toward performing above the MPL on these measures.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Through review of medical records and responses from physicians to a letter from CHG regarding members who were inappropriately prescribed an antibiotic, CHG identified several barriers related to the MCP performing above the MPL on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure. These barriers included:

- Members insisting on receiving antibiotics because of their perception that antibiotics are needed for any respiratory condition.
- Providers inappropriately diagnosing members as having acute bronchitis when they may have another condition.
- Providers neglecting to include the diagnosis code for co-morbid conditions for which prescribing an antibiotic is appropriate.
- Mid-level staff or physician assistants inappropriately prescribing antibiotics.
- Emergency rooms or urgent care facilities prescribing antibiotics.

To address the barriers and improve the rate on this measure, CHG continued to focus on provider education that included mid-level practitioners as well as physicians. CHG indicated that while the interventions were having a positive impact throughout the year, the MCP noticed that the positive trend reversed during the cold and flu season. The MCP indicated that it will intensify its member education program prior to the cold and flu season by sending interactive voice response messaging and a news brief to members.

CHG's efforts resulted in the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure having statistically significant improvement from 2012 to 2013 and the rate being above the MPL. CHG will not be required to submit an IP for this measure in 2013.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

CHG indicated that the reason the rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure did not improve to above the MPL from 2011 to 2012 was because early identification of pregnant women continued to be a challenge. The MCP indicated that the use of pharmacy records to identify women of child-bearing age with new prescriptions for prenatal vitamins was not as successful as anticipated due to the MCP having incorrect telephone numbers and/or addresses for the members.

CHG did not implement any new interventions in 2012; however, CHG focused its efforts on the following:

- Greater emphasis was placed on the early identification of pregnant members. Member education focused on stressing the appropriate time frame for seeking prenatal care and the need for prenatal care despite previous experiences.
- When members' contact information was incorrect, CHG staff attempted to obtain a "good" telephone number by contacting the primary physician, pharmacies, and other providers on file based on paid claims.

CHG's efforts resulted in improvement on this measure's rate from 2012 to 2013. Although the improvement was not statistically significant, the improvement resulted in the rate for this measure being above the MPL. CHG will not be required to submit an IP for this measure in 2013.

2013 Improvement Plans

CHG will be required to submit an IP for the *Prenatal and Postpartum Care—Postpartum Care* measure because the rate for this measure was below the MPL in 2013.

Strengths

During the HEDIS audit process, the auditor noted that CHG exercised extreme diligence with regard to data quality and control, and the MCP continued its efforts to increase measure rates by offering generous member incentives for receiving needed services.

Two measures had rates above the HPL in 2013, one of which has been above the HPL since 2011. Eight measures had rates with statistically significant improvement from 2012 to 2013. Additionally, CHG's IPs for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and

Prenatal and Postpartum Care—Timeliness of Prenatal Care measures were successful at bringing the rates for these measures from below the MPLs in 2012 to above the MPLs in 2013.

Opportunities for Improvement

CHG has the opportunity to improve the efficiency of the MCP's claims retention process by considering the use of OCR software rather than using manual entry for the process.

CHG has the opportunity to focus efforts in identifying the factors leading to the rate on the *Prenatal and Postpartum Care—Postpartum Care* measure being below the MPL. Additionally, the MCP has the opportunity to 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. Finally, CHG has the opportunity to 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.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[10] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

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

Validating Quality Improvement Projects and Assessing Results

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

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

HSAG organized, aggregated, and analyzed 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.

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

Quality Improvement Project Objectives

CHG participated in the statewide collaborative QIP, a small-group collaborative QIP, and had one internal QIP in progress during the review period of July 1, 2012, through June 30, 2013.

Table 4.1 below lists CHG'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 CHG
July 1, 2012, through June 30, 2013

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD	Clinical	Q
Increasing Screens for Postpartum Depression	Clinical	Q, 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.

Prior to initiation of the statewide collaborative QIP, CHG had a 30-day readmission rate of 20.51 percent among Medi-Cal beneficiaries. CHG also found that the readmission rate for the SPD population was 15.25 percent, which was higher than the 10.12 percent rate for the non-SPD population.

CHG's *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* small-group collaborative QIP attempted to improve the quality of care delivered to members with chronic obstructive pulmonary disease (COPD) by evaluating aspects of care such as testing, treatment, and hospitalizations. At the initiation of the QIP, CHG identified that only 11.4 percent of eligible members had received the appropriate spirometry testing. Sixty-nine percent of members with COPD had an emergency room (ER) visit and 54.9 percent had an inpatient hospitalization. Of the members who had been to the ER or were hospitalized, 52.5 to 75.0 percent had been dispensed timely and appropriate medication.

The purpose of CHG's internal QIP, *Increasing Screens for Postpartum Depression*, was to increase the screening for postpartum depression, as well as the percentage of members with positive depression screens who received follow-up care since follow-up care is essential to ensure the mental health of the member. Initially, CHG identified that only 23.1 percent of the eligible members had been screened for depression. Of those, only 9.5 percent of the screenings had been

conducted with a screening tool. Of the members who were positive for postpartum depression, only 63.6 percent had documented follow-up 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
CHG—San Diego County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Small-Group Collaborative				
Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD	Annual Submission	78%	86%	*Partially Met*
	Annual Resubmission 1	85%	100%	*Met*
Internal QIPs				
Increasing Screens for Postpartum Depression	Annual Submission	95%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.
[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by CHG of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 90 percent of evaluation elements met. CHG received a *Partially Met* validation status for its *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* small-group collaborative QIP annual submission. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on the validation feedback, CHG resubmitted the QIP and, upon subsequent validation, achieved an overall *Met* validation status with 100 percent of critical elements and 85 percent of evaluation elements being met. Finally, CHG's internal QIP, *Increasing Screens for Postpartum Depression*, received an overall validation status of *Met* with 100 percent of critical elements and 95 percent of evaluation elements being met.

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 = 4 QIP Submissions, 3 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	94%	0%	6%
Design Total		**98%**	**0%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	88%	12%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**92%**	**8%**	**0%**
Outcomes	IX: Real Improvement Achieved	33%	67%	0%
	X: Sustained Improvement Achieved	67%	33%	0%
Outcomes Total		**40%**	**60%**	**0%**

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

HSAG validated Activities I through VI for CHG's *All-Cause Readmissions* study design submission and Activities I through X for the MCP's *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* and *Increasing Screens for Postpartum Depression* QIPs' annual submissions.

CHG demonstrated a strong application of the Design stage, meeting 98 percent of the requirements for all applicable evaluation elements within the study stage (Activities I through VI) for all four QIP submissions. CHG did not describe the MCP's data analysis plan for the *All-Cause Readmissions* QIP, which resulted in a lower score for Activity VI. The MCP met 100 percent of the requirements for all applicable evaluation elements within the Design stage for the *Increasing Screens for Postpartum Depression* QIP.

The *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* and the *Increasing Screens for Postpartum Depression* QIPs progressed to the Implementation and Outcomes stages during the reporting period. The MCP demonstrated a strong application of the Implementation stage, meeting 92 percent of the requirements for all applicable evaluation elements within the study stage for the three QIP submissions. For the *Increasing Assessment, Diagnosis, and Appropriate*

Treatment of COPD QIP, CHG received a lower score for Activity VII in the first submission because the MCP submitted incorrect data for Study Indicator 4b, which resulted in an inaccurate interpretation of findings. CHG corrected these deficiencies in the resubmission, and the QIP achieved an overall *Met* validation status. The MCP met 100 percent of the requirements for all applicable evaluation elements within the Implementation stage for the *Increasing Screens for Postpartum Depression* QIP.

Since the rate for Study Indicator 2 declined at Remeasurement 4 and study indicators 1 and 4 did not achieve statistically significant improvement above baseline, the *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* QIP received a lower score for Activity IX. This QIP also received a lower score for Activity X since not all study indicators achieved sustained improvement over baseline. For the *Increasing Screens for Postpartum Depression* QIP, study indicators 1 and 2 achieved statistically significant and sustained improvement over baseline; however, since Study Indicator 3 did not demonstrate statistically significant improvement over baseline, the QIP received a lower score for Activity IX.

Quality Improvement Project Outcomes and Interventions

Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

The *All-Cause Readmissions* QIP did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information is included in this report for this QIP.

Table 4.4—Quality Improvement Project Outcomes for CHG—San Diego County
July 1, 2012, through June 30, 2013

QIP #1—Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD					
Study Indicator 1: Percentage of members 40 years and older with a new diagnosis of newly active COPD who received appropriate spirometry testing to confirm the diagnosis					
Baseline Period 1/1/07–12/31/07	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Remeasurement 3 1/1/10–12/31/10**	**Remeasurement 4 1/1/11–12/31/11**	**Sustained Improvement¥**
11.4%	19.5%	11.1%	19.1%	20.7%	‡
Study Indicator 2: Percentage of acute inpatient hospitalization discharges of members with COPD^					
Baseline Period 1/1/07–12/31/07	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Remeasurement 3 1/1/10–12/31/10**	**Remeasurement 4 1/1/11–12/31/11**	**Sustained Improvement¥**
54.9%	68.8%*	23.5%*	8.3%*	14.2%*	Yes

QIP #1—Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD					
Study Indicator 3: Percentage of emergency department (ED) visits for members with COPD^					
Baseline Period 1/1/07–12/31/07	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Remeasurement 3 1/1/10–12/31/10**	**Remeasurement 4 1/1/11–12/31/11**	**Sustained Improvement¥**
69.0%	70.5%	30.3%*	20.0%*	19.3%	Yes
Study Indicator 4a: Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter who were dispensed Systemic cortico-steroid within 14 days of the event					
Baseline Period 1/1/07–12/31/07	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Remeasurement 3 1/1/10–12/31/10**	**Remeasurement 4 1/1/11–12/31/11**	**Sustained Improvement¥**
52.5%	41.1%	45.3%	55.6%	58.3%	‡
Study Indicator 4b: Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter who were dispensed Broncho-dilator within 30 days of the event					
Baseline Period 1/1/07–12/31/07	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Remeasurement 3 1/1/10–12/31/10**	**Remeasurement 4 1/1/11–12/31/11**	**Sustained Improvement¥**
75.0%	68.9%	60.0%	69.4%	85.0%	‡

QIP #2—Increasing Screening for Postpartum Depression					
Study Indicator 1: Percentage of members who had a live birth and were screened for depression at their postpartum visit					
Baseline Period 11/6/06–11/5/07	**Remeasurement 1 11/6/07–11/5/08**	**Remeasurement 2 11/6/08–11/5/09**	**Remeasurement 3 11/6/09–11/5/10**	**Remeasurement 4 11/6/10–11/5/11**	**Sustained Improvement¥**
23.1%	34.3%*	32.4%	43.3%*	48.2%	Yes
Study Indicator 2: Percentage of members who were screened for postpartum depression through the use of a screening tool					
Baseline Period 11/6/06–11/5/07	**Remeasurement 1 11/6/07–11/5/08**	**Remeasurement 2 11/6/08–11/5/09**	**Remeasurement 3 11/6/09–11/5/10**	**Remeasurement 4 11/6/10–11/5/11**	**Sustained Improvement¥**
9.5%	19.2%*	17.3%	21.9%	26.3%	Yes
Study Indicator 3: Percentage of members with a positive screen for postpartum depression and documentation of follow-up care					
Baseline Period 11/6/06–11/5/07	**Remeasurement 1 11/6/07–11/5/08**	**Remeasurement 2 11/6/08–11/5/09**	**Remeasurement 3 11/6/09–11/5/10**	**Remeasurement 4 11/6/10–11/5/11**	**Sustained Improvement¥**
63.6%	85.7%	81.3%	88.5%	90.6%	‡

^A lower percentage indicates better performance.

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

* 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.

Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD QIP

The *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* QIP reported varied performance across outcomes and measurement periods. Although the MCP saw improvement in all of the indicators' rates by Remeasurement 4, only indicators 2 and 3 demonstrated statistically significant and sustained improvement over baseline. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- In the first submission, CHG did not provide complete and/or accurate information in some parts of the QIP Summary Form. The MCP should reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to submission to avoid incomplete documentation of the various elements.
- CHG completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process. The documentation included system interventions that are likely to have a long-term effect.
- CHG included a narrative discussion about the success of quality improvement actions and how the interventions were standardized and monitored as a result of those actions; however, the MCP did not include documentation to support whether or not the ongoing interventions are standardized processes.

In March 2013, DHCS and HSAG reviewed the status of the MCP's QIPs and determined that the *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* QIP should be closed since it had experienced statistically significant and sustained improvement for some of the indicators.

Increasing Screens for Postpartum Depression QIP

Although all three study indicator rates for the *Increasing Screens for Postpartum Depression* QIP showed improvement at Remeasurement 4, only study indicators 1 and 2 demonstrated statistically significant and sustained improvement over baseline. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- CHG conducted the data analysis according to the data analysis plan, and documentation in the QIP Summary Form included an interpretation of the findings for each study indicator; however, the HSAG QIP reviewer noted three rounding errors.
- CHG completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process. The documentation included system interventions that are likely to have a long-term effect.
- CHG included a narrative discussion about the success of quality improvement actions and how the interventions were standardized and monitored as a result of those actions.

In March 2013, DHCS and HSAG reviewed the status of the MCP's QIPs and determined that the *Increasing Screens for Postpartum Depression* QIP should be closed since it had experienced statistically significant and sustained improvement for two of the three indicators.

Strengths

As in previous years, CHG demonstrated a strong understanding of the Design and Implementation stages. CHG experienced success at developing and implementing interventions that positively affected the outcomes for the *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* and *Increasing Screens for Postpartum Depression* QIPs.

Opportunities for Improvement

The MCP has the opportunity to improve the accuracy of its documentation on the QIP Summary Form.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

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

CHG's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about CHG's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

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

CAHPS Global Rating Measures:

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

CAHPS Composite Measures:

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

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

Table 5.1—CAHPS Measures Domains of Care

Measure	Domains of Care
Rating of Health Plan	Q
Rating of All Health Care	Q
Rating of Personal Doctor	Q
Rating of Specialist Seen Most Often	Q
Getting Needed Care	Q, A
Getting Care Quickly	Q, T
How Well Doctors Communicate	Q
Customer Service	Q
Shared Decision Making	Q

National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

Star Rating	Adult and Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or above the 75th and below the 90th percentiles
★★★ Good	At or above the 50th and below the 75th percentiles
★★ Fair	At or above the 25th and below the 50th percentiles
★ Poor	Below the 25th percentile

Table 5.3 through Table 5.4 present the star ratings for the global ratings and composite measures for CHG's adult and child Medicaid populations.[15]

Table 5.3—Medi-Cal Managed Care County-Level Global Ratings
CHG—San Diego County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★★★	★★
Child	★★★	★★	★★★★★	★★★★★
+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.				

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.
[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.
[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

Table 5.4—Medi-Cal Managed Care County-Level Composite Measures CHG—San Diego County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★	★★
Child	★	★	★	★★★★

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Strengths

The child global ratings measures received the highest ratings overall, with the *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often* measures receiving an *Excellent* rating, the *Customer Service* measure receiving a *Very Good* rating, and the *Rating of Health Plan* measure receiving a *Good* rating.

CHG improved its ratings on the following measures from 2010 to 2013:

- *Rating of Health Plan*—child population
- *Rating of Personal Doctor*—adult and child populations
- *Rating of Specialist Seen Most Often*—child population
- *Customer Service*—adult and child populations

Opportunities for Improvement

CHG's CAHPS results showed below-average performance for the majority of the child and adult global ratings and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as CHG's highest priorities: *Getting Needed Care, Getting Care Quickly,* and *How Well Doctors Communicate*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 CHG CAHPS MCP-Specific Report.* Areas for improvement spanned the quality, access, and timeliness domains of care.

Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[16] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[16] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

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

CHG's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

Encounter Data Validation Findings

Review of Encounter Systems and Processes

Overall, the information provided in CHG's Roadmap and Questionnaire consistently demonstrates that the MCP has sound operational policies and practices for the creation, validation, correction, and ongoing monitoring of encounter data submission. The MCP indicated that errors and rejections are reviewed and resubmitted for less than 1 percent of encounters. CHG is also developing policies and procedures to handle resubmissions that contain errors or are rejected.

Record Completeness

CHG had high record omission rates or high record surplus rates for each of the three claim types, indicating relatively incomplete data when comparing DHCS's data and the encounter data extracted from CHG's data system for this study. For example, the Pharmacy claim type had a poor record omission rate of 67.9 percent, and the Medical/Outpatient and Hospital/Inpatient claim types had poor record surplus rates of 76.1 percent and 96.5 percent, respectively. All three of these rates were worse than their respective statewide rates by more than 50 percentage points. For the Pharmacy claim type, approximately 53 percent of the records omitted from DHCS's data were due to the *CCNs* not being included in DHCS's data. The remaining 47 percent of the omitted Pharmacy records were due to the duplicated records (based on the *CCN* field) in the MCP's data. As for the high record surplus rates for the Medical/Outpatient and

Hospital/Inpatient claim types, these rates were likely due to CHG only extracting records with specific adjudication dates for this EDV study.

Data Element Completeness

CHG had excellent data completeness, with data element omission and element surplus rates of 0.0 percent for all key data elements. All of CHG's element omission and element surplus rates met or performed better than the statewide rates across all three claim types.

Data Element Accuracy

CHG had high data element accuracy with accuracy rates of 99.4 percent or higher for all key data elements except one element. The *Revenue Code* data element for the Hospital/Inpatient claim type had a low element accuracy rate of 25.1 percent because all records for the same *CCN* had the same revenue codes in the Hospital/Inpatient data CHG submitted to HSAG. Based on CHG's response to HSAG's preliminary file review document, the *Revenue Code* inaccuracies were not reflected in CHG's data system and were likely due to errors that occurred when CHG prepared the encounter data for this EDV study. The *Revenue Code* data element had an accuracy rate that fell below the statewide rate by 70 percentage points. Additionally, the *Drug/Medical Supply* data element had an accuracy rate that fell 0.5 percentage points below the statewide rate. Other than these two data elements, CHG had element accuracy rates that met or exceeded the respective statewide rates.

The all-element accuracy rates varied significantly among the three claim types. The Medical/Outpatient and Pharmacy claim types had all-element accuracy rates of more than 99 percent and exceeded the respective statewide rates by more than 20 percentage points. Due to the low element accuracy rate in the *Revenue Code* data element, the Hospital/Inpatient claim type had an all-element accuracy rate of 25.1 percent, which fell below the statewide rate by nearly 40 percentage points.

Recommendations

Based on its review, HSAG recommends the following:

- 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.
- 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.

- 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 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 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.
- 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.
- 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.
- 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.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[17]

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

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

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

HSAG reviewed CHG's 2012 Quality Improvement Program Summary, 2013 Quality Improvement Program Description, and 2013 Corporate Quality Improvement Work Plan. The documents include descriptions of quality improvement goals, objectives, and activities that support the delivery of quality care to CHG's Medi-Cal members. Additionally, the documents provide evidence that the MCP is monitoring the success of quality improvement efforts and engaging in continuous quality improvement efforts.

Two quality measures had rates above the HPLs:

- *Comprehensive Diabetes Care—LDL-C Screening*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*

Seven quality measures had rates with statistically significant improvement from 2012 to 2013, and the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE* measure, which falls into the quality domain of care, declined significantly from 2012 to 2013. Additionally, the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure was below the MPL in 2013.

Two quality measures—*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*—had rates below the MPLs in 2012, and the MCP engaged in successful efforts to improve the rates for these measures to above the MPLs in 2013.

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

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

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

All CAHPS measures fall into the quality domain of care. Most of the measures received a *Poor* rating; however, the *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often* measures received an *Excellent* rating for the child population and the *Customer Service* measure received a *Very Good* rating for the child population. Overall, the results of the CAHPS survey suggest that most members are not satisfied with the quality of care being provided.

All three of CHG's QIPs fall into the quality domain of care. The *All-Cause Readmissions* QIP did not progress to the Outcomes stage, so HSAG was not able to assess this QIP's success at improving the quality of care provided to the MCP's Medi-Cal members. The *Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD* and *Increasing Screens for Postpartum Depression* QIPs both had some success at meeting project objectives; as a result, both QIPs were closed during the reporting period.

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

Access

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

HSAG's review of CHG's 2012 Quality Improvement Program Summary, 2013 Quality Improvement Program Description, and 2013 Corporate Quality Improvement Work Plan found several activities designed to ensure member access to services. The 2012 Quality Improvement Program Summary summarizes the MCP's progress toward meeting access goals and shows that CHG met or exceeded many access goals.

The rate for the *Comprehensive Diabetes Care—LDL-C Screening* measure, which falls into the access domain of care, was above the HPL; and one access measure, *Prenatal and Postpartum Care—Postpartum Care,* had a rate that was below the MPL.

No access measures had rates that declined significantly from 2012 to 2013, and the following access measures' rates improved significantly from 2012 to 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Immunizations for Adolescents—Combination 1*

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and the SPD rates for the following access measures were significantly better than the non-SPD rates:

- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

As indicated above, the better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The SPD rate for the *All-Cause Readmissions* measure, which falls into the access domain of care, was significantly higher than the non-SPD rate. As indicated above, this means that the SPD population (aged 21 years and older) had significantly more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

CHG performed below average on the access-related CAHPS measure, *Getting Needed Care*, receiving a *Poor* rating on this measure for both the adult and child populations, suggesting that members are not satisfied with the level of access to needed services.

The MCP's *All-Cause Readmissions* QIP falls into the access domain of care. This QIP did not progress to the Outcomes stage, so HSAG was not able to assess the QIP's success at improving members' access to care.

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 2012 Quality Improvement Program Summary, 2013 Quality Improvement Program Description, and 2013 Corporate Quality Improvement Work Plan include activities related to the provision of timely care to members, including monitoring activities in the area of utilization management.

No measures in the timeliness domain of care had rates above the HPLs; and one timeliness measure, *Prenatal and Postpartum Care—Postpartum Care*, had a rate that was below the MPL. The rate for the *Immunizations for Adolescents—Combination 1* measure, which falls into the timeliness domain of care, had statistically significant improvement from 2012 to 2013, and no timeliness measures had significant decline in performance from 2012 to 2013.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. CHG received a *Poor* rating on this measure for both the adult and child populations, suggesting that members are not satisfied with the time it takes to receive health care services.

The MCP's *Increasing Screens for Postpartum Depression* QIP falls into the timeliness domain of care. As indicated above, this QIP had some success at meeting project objectives and as a result, was closed during the reporting period.

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

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-specific evaluation report. CHG's self-reported responses are included in Appendix B.

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:

- Consider using OCR software for the MCP's claims retention process rather than manual entry.
- 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.

- 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.
- 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.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Getting Needed Care, Getting Care Quickly,* and *How Well Doctors Communicate* priority areas.
- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

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

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

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

Access and Timeliness Domains

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

CAHPS Survey Measures

(Refer to Tables 5.3 through 5.4)

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

Quality Domain

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

Access Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

Timeliness Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Not all study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

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

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

Appendix B. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

for Community Health Group Partnership Plan

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with CHG's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table B.1—CHG's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	CHG's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
CHG should resolve all deficiencies identified during the June 2007 medical performance review. Specifically, the plan should:	
1. Provide evidence that requesting providers are notified of a decision to deny, defer, or modify a request for service within 24 hours of the decision and that members are notified within 28 days.	Community Health Group notifies providers of a decision to deny, defer, or modify a request for service within 24 hours of the decision and members within 28 days. Adherence to this standard is monitored through internal audits. Attached are the quarterly file reviews for pharmacy and medical files for the period July 1, 2012, to June 30, 2013, and sample letters: • 1.1 Quarterly Medical File Reviews 2012 (Excel) • 1.2 Quarterly Medical File Reviews 2013 (Excel) • 1.3 Quarterly Pharmacy File Reviews 2012 (Excel) • 1.4 Quarterly Pharmacy File Reviews 2013 (Excel) • 1.5 MD Notification Letter Sample • 1.6 Pharmacy NOA • 1.7 Medical NOA
2. Ensure that the plan's policies describe the mechanism for monitoring and ensuring that deferral letters for any required services are sent and in compliance with the contract and Health and Safety Code requirements.	Community Health Group's policies describe the mechanism for monitoring and ensuring that deferral letters for any required services are sent and in compliance with the contract and Health and Safety Code requirements. See attached policies and file review form: • 2.1 UM Policy 7251 Referrals and Prior Auth • 2.2 UM Policy 7251.7 Timeliness of UM Decisions • 2.3 UM Policy 7273.1 Review of Non-Cert Letters • 2.4 Non-certification Review Sheet

2011–12 External Quality Review Recommendation	CHG's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
3. Provide documented evidence of quarterly reviews of denied, modified, or deferred pharmacy and medical files.	Community Health Group reviews denied, modified, or deferred pharmacy and medical files on a quarterly basis based on the NCQA file review methodology. Eight files are randomly reviewed; if the standards are met in the first eight files, no further review is completed. Attached are the quarterly file reviews for pharmacy and medical files for the period July 1, 2012, to June 30, 2013, as well as a sample file review for pharmacy and medical. • 1.1 Quarterly Medical File Reviews 2012 (Excel) • 1.2 Quarterly Medical File Reviews 2013 (Excel) • 1.3 Quarterly Pharmacy File Reviews 2012 (Excel) • 1.4 Quarterly Pharmacy File Reviews 2013 (Excel) • 3.1 File Review Sample – Medical • 3.2 File Review Sample – Pharmacy
4. Provide a utilization management tool which clearly states that only a qualified physician may make decisions to deny requested authorizations for services.	One of the elements on the file review tool evaluates whether the denial decision was made by a qualified physician. Additionally, the annual delegation review tool assesses whether a qualified physician made the decision to deny a request for services. Attached are the file review and delegation review tools: • 2.4 Non-certification Review Sheet • 4.1 Delegate Annual Audit Tool 2013
5. Provide documented evidence of the implemented procedures for identifying plan members who are also receiving services through the Regional Center program.	Community Health Group receives a report from DHCS that identifies plan members who have an open case and are receiving services through the San Diego Regional Center (SDRC). See attached report: • 5.0 Regional Center Report, June, 2013.
6. Provide documented evidence that the plan coordinates all medical services with the Regional Center staff members to ensure that members who are identified as also receiving Regional Center services are provided necessary medical care, preventive care, and treatment through their PCP.	Community Health Group coordinates all medical services with Regional Center staff members to ensure that members who are identified as also receiving Regional Center services are also provided necessary medical care, preventive care, and treatment through their PCP. Members are identified as open to Regional Center with an identifier (SDRC) in their eligibility file. PCPs are notified when a member receives services through Regional Center to ensure necessary medical care, preventive care, and treatment is provided. Attached is an example of a case open to Regional Center and also receiving treatment as well as an example of the PCP letter. • 6.1 Sample, Case Coordination with Regional Center • 6.2 Sample PCP letter, Regional Center Coordination

2011–12 External Quality Review Recommendation	CHG's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
7. Provide evidence that the plan has implemented a process to monitor specialty access.	Community Health Group monitors members who have an open referral to specialty care and for whom a claim has not been received. Identified members and providers receive a follow-up letter reminding both parties of the open authorization in place. Refer to sample letters: • 7.0 Specialty Access Report • 7.1 Sample Specialty Access Member Letter • 7.2 Sample Specialty Access Physician Letter
8. Submit documentation regarding the development and implementation of a notice of action (NOA) letter that is compliant with State regulations to be sent to providers and patients to accompany denied, modified, or deferred claims.	Requested from Dr. Urbina, regulations citing the requirement to send this letter. On her e-mail dated 8/13/07, Dr. Urbina stated that the requirements under H and S Code 1367.01 and Sections 51041.1 and 53894 from Title 22 applied in the case of denied claims. **We have reviewed these documents and find no reference to the requirement to issue a letter when a claim is denied or deferred.** Dr. Urbina further stated that claim denial notices should be in accordance with Title 28, Section 1300.71.38 and H and S Code 1399.55. **This section relates to the provider dispute resolution process, not the claims process.** The plan asks for applicable citation to above CAP response previously submitted.
9. Provide evidence that it has amended the plan's ER policy to state that 99 percent of all clean ER claims shall be paid within 90 working days of submission.	• Please refer to Attachment 9.0. **NOTE:** HSAG reviewed the policy submitted by the MCP and it includes the required language regarding 99 percent of all clean ER claims being paid within 90 working days of submission.

2011–12 External Quality Review Recommendation	CHG's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
10. Provide documentation to show that the plan is monitoring and analyzing the prescription activity of members with an ER encounter by hospital and addressing identified issues with hospitals, as appropriate.	Community Health Group monitors and analyzes the prescription activity of members with an ER encounter by hospital prescription activity through member complaints activity. During the period July 1, 2012, to June 30, 2013, there were no complaints or calls relating to access to prescriptions upon ER discharge. Community Health Group ensures access to at least a 72-hour supply of a covered outpatient drug in an emergency situation by doing the following: 1) CHG's hospital contract template states that "the Compensation Rate is inclusive of all services, medical supplies or medications used or provided during the Plan Member's hospital stay. Such services, medical supplies or medications shall include, but are not limited to, bandages, splints, syringes, tubing, equipment and discharge medications." 2) CHG provides member access to at least a 72-hour supply of drugs to members through our extensive pharmacy network which includes all 24-hour pharmacies in San Diego County and many pharmacies with delivery service. Additionally, members have access to CHG's Member Services Department, CHG's on-call pharmacist, and MedImpact's Customer Service Call Center 24 hours a day, 7 days a week, to assist with transportation or issues that may occur at the point-of-sale, if necessary. Refer to the screen print of the call tracking screen which is used by Member Services to document any complaints or access issues. • 10.1 Call Tracking Screen

<table>
<tr><th>2011–12 External Quality Review Recommendation</th><th>CHG's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation</th></tr>
<tr><td colspan="2">CHG also should ensure the findings from the January 2011 MR/PIU review are addressed. Specifically, the plan should:</td></tr>
<tr><td>1. Ensure that all NOA letters sent by delegated medical groups contain the reason or citation supporting the action taken.</td><td>Community Health Group monitors denial, modification, and pend letters sent by a delegated entity to plan members. Delegates are required to send Community Health Group a copy of the letter at the time that it is sent to the member. The letters are randomly reviewed on a monthly basis to determine whether required the reason or citation supporting the action has been taken. Community Health Group provides feedback to the Independent Practice Association (IPA) on any letters that do not contain the required elements. The letter review is incorporated into the annual delegation review report. Any adverse findings require the delegate to submit a corrective action plan. See attached sample of feedback notice, sample of denial letter sent by delegate, and sample annual delegation review report.

Refer to a sample of a NOA sent by a delegated entity:
• 11.1 Delegate Sample NOA
• 11.2 Delegate Medical Group File Audit Sheet 2012
• 4.1 Delegate Annual Audit 2013
• 11.3 Delegate File Review Feedback Letter</td></tr>
<tr><td>2. Ensure that all delegated medical groups include the "Your Rights" attachment when sending NOA letters to members.</td><td>Community Health Group monitors denial, modification, and pend letters sent by a delegated entity to plan members. Delegates are required to send Community Health Group a copy of the letter at the time that it is sent to the member. The letters are randomly reviewed on a monthly basis to determine whether required attachments are included with the NOA. Community Health Group provides feedback to the IPA on any letters that do not contain the required elements. The letter review is incorporated into the annual delegation review report. Any adverse findings require the delegate to submit a corrective action plan. See attached sample of feedback notice, sample of denial letter sent by delegate, and sample annual delegation review report.

Refer to a sample of a NOA sent by a delegated entity:
• 11.1 Delegate Sample NOA
• 11.2 Delegate Medical Group File Audit Sheet 2012
• 4.1 Delegate Annual Audit 2013
• 11.3 Delegate File Review Feedback Letter</td></tr>
</table>

2011–12 External Quality Review Recommendation	CHG's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
HSAG recommends the following to the plan related to performance measures:	
1. Assess the factors that are leading to a continued decline in performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure and identify interventions to be implemented that will result in an improvement on performance.	Corrective Action Plan approved by DHCS July 29, 2013.
2. Assess the factors that are leading to a continued decline in performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and identify interventions to be implemented that will result in an improvement on performance.	Corrective Action Plan resubmitted to DHCS August 13, 2013; awaiting response.
3. Assess the factors that led to a statistically significant decline in performance on the *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measures to prevent further decline in performance.	Both measures are under review by our internal Total Quality Integration Committee. • We are conducting medical record review to identify barriers for blood pressure control. • We are working with vision providers to contact and schedule members for retinal exams.
HSAG recommends the following to the plan related to QIPs:	
1. Conduct an annual QIP barrier analysis, at minimum. The plan should improve the documentation of the barrier analysis, providing the data, the identified barriers, and the rationale for how the barriers are prioritized. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone.	We have implemented recommendations and will include improved documentation in future QIP submissions.
2. Ensure that the QIP interventions implemented address the high-priority barriers. A method to evaluate the effectiveness of each intervention should be documented, as well as the results of the intervention's evaluation for each measurement period.	We have implemented recommendations and will include improved documentation in future QIP submissions.