

Performance Evaluation Report
Alameda Alliance for Health
July 1, 2008–June 30, 2009

Medi-Cal Managed Care Division
California Department of
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Performance Evaluation Report – Alameda Alliance for Health

July 1, 2008 – June 30, 2009

1. EXECUTIVE SUMMARY

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.4 million beneficiaries in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. *The Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Plan-specific reports are issued in tandem with the technical report. The plan-specific reports include findings for each plan regarding its organizational assessment and structure, performance measures, and QIPs as they relate to the quality, access, and timeliness domains. This report is specific to the MCMC Program's contracted plan, Alameda Alliance for Health ("AAH" or "the plan").

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

HSAG found that AAH demonstrated average performance for the quality domain of care. This was based on the plan's 2009 performance measure rates (which reflect 2008 measurement data), QIP outcomes, and compliance review standards related to measurement and improvement.

To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPL indicate low performance, rates at or above the HPL indicate high performance, and rates at the MPL or between the MPL and HPL demonstrate average performance.

Most of AAH's performance measure rates fell between the established MPLs and HPLs. Overall, AAH's performance measure rates demonstrated stable performance from the prior measurement period, with most rates showing no statistically significant increase or decrease.

During the review period, both of AAH's QIPs were in the baseline phase; therefore, HSAG could not assess for improvement of those health outcomes. HSAG noted that the plan has an opportunity to improve its documentation of both QIPs to meet compliance with federal requirements for conducting a QIP. Following the Centers for Medicare & Medicaid Services (CMS) protocol for conducting a QIP increases the likelihood of the plan achieving real and sustained improvement of health outcomes.

AAH's strengths in delivering quality care to members included its rate for childhood immunizations, which exceeded the national Medicaid 90th percentile, and its compliance review standards in the area of quality management.

Also, AAH demonstrated consistent improvement in its ability to report all DHCS-required performance measures for 2008 and 2009, an area previously identified by the EQRO as a significant opportunity for improvement.

AAH can improve the quality of care for its Medi-Cal managed care members by increasing its performance measure rates that fell below the established MPL related to diabetic retinal eye exams, poor control of diabetic HbA1c, and timeliness of prenatal care.

Joint audit findings showed that the plan has an opportunity to ensure that quality of care concerns and supporting documentation are contained within the providers' files and are considered as part of the recredentialing process.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members.

The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Many performance measures fall under more than one domain. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

AAH demonstrated average performance for the access domain of care based on its 2009 performance measure rates that relate to access, QIP outcomes that address access, and compliance review standards related to the availability of and access to care. AAH showed strengths as well as opportunities for improvement.

AAH's 2009 performance measures related to access fell primarily between the MPL and HPL. AAH was above the HPL for childhood immunizations while below the MPL for timeliness of prenatal care.

AAH conducted a member survey to better understand barriers related to its statewide collaborative QIP project aimed at reducing avoidable emergency room (ER) visits. Results showed that one reason members access the ER is lack of outpatient access.

Joint audit findings showed that AAH did not consistently monitor in-office appointment wait times and after-hours access. However, in AAH's 2008–2009 Quality Improvement and Utilization Management Program Evaluation, there was evidence that the plan had access indicators for monitoring network adequacy, appointment wait times, and member service call center standards, suggesting that AAH has adequately addressed some of the audit deficiencies in monitoring appointment wait times and after-hours access.

AAH implemented an additional initiative during the review period to increase the ability of health professionals to deliver linguistically appropriate services by participating in the Alameda County Coalition of Language Access in Healthcare, which enhances its provider network and increases access to culturally responsive care. AAH has an opportunity to ensure that its providers offer 24-hour oral translation services and discourage the use of family and/or friends as interpreters.

AAH's greatest opportunity for improvement is to provide prenatal care to women within their first trimester, an area that spans the quality, access, and timeliness domains.

Timeliness

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

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess a plan's 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 after a need is identified within a recommended period of time.

Based on 2009 performance measure rates for providing timely care and compliance review standards related to timeliness, AAH demonstrated average performance in the timeliness domain of care.

The plan performed within the MCMC-established thresholds for well-child visits and postpartum visits and above the HPL for childhood immunizations in the timeliness domain of care. The plan did not meet the MPL for timeliness of prenatal care.

Joint audit review findings noted that AAH resolved all member grievances in a timely manner. In addition, the plan has shown improvement with tracking and trending grievance data and including that information in its annual evaluation. The plan has an opportunity to ensure that its

delegated entities log member grievances and submit them to the plan to be included in tracking and trending analysis. AAH can improve continuity and coordination of care for members specifically by referring information to PCPs on members receiving early intervention services and disability services.

AAH reported 99 percent compliance with standards for timeliness of medical necessity decisions in its program evaluation. AAH's prior-authorization denial rate and under- and overutilization rates were within plan-established benchmarks. These results support that AAH provided timely utilization decisions without disrupting care.

Conclusions and Recommendations

Overall, AAH demonstrated average performance in providing quality, accessible, and timely health care services to its MCMC members. AAH's performance measure rates were primarily between the established MPL and HPL. AAH exceeded the HPL for its *Childhood Immunization Status—Combination 3* measure. AAH had the worst performance of all MCMC plans for its *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure, which spans all domains of care.

AAH demonstrated compliance with many DHCS standards for structure and operations, quality measurement and improvement, and the grievance system; however, opportunities for improvement exist across all compliance standards.

Based on the overall assessment of AAH in the areas of quality and timeliness of and access to care, HSAG recommends the following:

- ◆ Continued and enhanced focus on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure. As plan resources allow, implement efforts on other low performance measure rates.
- ◆ Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance toward increasing compliance with the CMS protocol for conducting QIPs.
- ◆ Explore member access barriers cited as reasons for using the emergency room to determine if members are having difficulty accessing outpatient care. This may increase the likelihood of success on AAH's collaborative QIP.
- ◆ Implement a process to monitor audit deficiencies to ensure that they are fully resolved to reduce the number of repeat audit findings.
- ◆ Evaluate existing and/or implement new compliance monitoring processes to improve the tracking of information related to referrals, appointment wait times, and new member health assessment completion rates.

- ◆ Continue to monitor compliance with DHCS's standards for access to care, structure and operations, and quality measurement and improvement.

HSAG will evaluate AAH's progress with these recommendations along with continued successes in the next annual review.

Plan Overview

AAH is a full-scope Medi-Cal managed care plan created by the Alameda County Board of Supervisors as an independent, nonprofit, locally operated plan. AAH serves MCMC members in Alameda County as a local initiative (LI) under the Two-Plan model. AAH became operational with the MCMC Program in 1996. As of June 30, 2009, AAH had 89,090 MCMC members.¹

In a Two-Plan model county, the DHCS contracts with two managed care plans to provide medical services to members. Most Two-Plan model counties offer an LI plan and a nongovernmental commercial health plan. Members of the MCMC Program in Alameda County may enroll in either the LI plan operated by AAH or in the alternative commercial plan.

¹ Medi-Cal Managed Care Enrollment Report, June 2009. Available at:
<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

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

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about AAH's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards primarily fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care. *The Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, provides an overview of the objectives and methodology for conducting the EQRO review.

Joint Audit Review

The DHCS's Audits and Investigations (A&I) Division works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A joint audit is conducted for each MCMC plan approximately once every three years. In addition, the DHCS's A&I Division periodically conducts non-joint medical audits on five MCMC plans; however, AAH is not among those plans designated for a non-joint medical audit.

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. A joint audit of AAH was conducted in October 2008, covering the review period of October 1, 2007, through September 30, 2008. The scope of the audit covered the areas of utilization management, continuity of care, availability and accessibility,

member rights, quality management, and administrative and organizational capacity. Results from the audit showed strengths as well as opportunities for improvement.

In the utilization management (UM) area, the plan demonstrated the implementation and maintenance of a UM program, evidenced monitoring for under- and overutilization, and complied with prior-authorization review requirements and procedures. The audit noted one finding under UM: AAH did not have a mechanism in place to track prior-authorization referrals to determine whether members received authorized medical equipment and specialty services.

For continuity of care, AAH had policies and procedures in place, including guidelines for care coordination and for identifying and referring eligible children to California Children's Services. The audit noted that the plan had ongoing opportunities to improve coordination of care for the Early Start Program and for members with developmental disabilities. The plan lacked a mechanism to forward information on members receiving services to delegated groups and entities. The audit noted this as a repeat finding from the past three audits. Additionally, the audit showed that while the plan was able to track the rate of completed initial health assessments and individual health educational behavioral assessments, the plan did not have a process in place to address the low compliance rates. This finding was a repeat finding of the past two audits.

Under access to medical care, the audit found that AAH had standards in place to monitor for access to routine, urgent, and specialty referral appointments; prenatal care; preventive assessments; and adult initial health assessments. The audit did not find effective mechanisms for tracking, monitoring, and addressing in-office wait times. Additionally, the plan did not monitor providers to ensure that members could reach a physician for after-hours calls. HSAG reviewed AAH's 2008–2009 Quality Improvement and Utilization Management Program Evaluation and found evidence that the plan has access indicators for monitoring network adequacy, appointment wait times, and member service call center standards.² This evidence suggests that AAH may have adequately addressed some of the audit deficiencies in monitoring appointment wait times and after-hours access.

For member grievances, the audit showed that AAH had a grievance process in place to resolve and track and trend data. All grievance files reviewed were resolved within the appropriate time frames. The audit noted one file that did not contain documentation of the medical director's review and final determination. Additional findings identified that the plan's online grievance form was not in compliance with the Health and Safety Code, which requires a secure server, and that AAH's policy and procedure lacked the appropriate notification time frames for reporting Health Insurance Portability and Accountability Act of 1996 (HIPAA) breaches to the DHCS.

² Alameda Alliance for Health. Quality Improvement and Utilization Management Program Evaluation. July 2008 – June 2009.

In the quality management area, the audit revealed one finding. The plan did include quality of care issues and supporting documentation for consideration with the providers' recertification files. In the administrative and organizational capacity area, the audit showed that new provider training was not conducted within 10 days from the date the provider was added to the network, and completion of training was not documented in the provider's file. AAH did not report a fraud and abuse case to the DHCS during the review period and noted that the plan's policies and procedures lacked steps for reporting fraud and abuse cases to the DHCS. Finally, the plan lacked appropriate review and approval of several policies and procedures.

Member Rights and Program Integrity Monitoring Review

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

As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2009.

MRPIU conducted an on-site review of AAH in January 2007 with follow-up visits in September 2007 and July 2008. The initial review in January 2007 noted five findings requiring follow-up in the area of member grievances and cultural and linguistic services. Based on subsequent review, the DHCS noted that AAH successfully addressed two of the three grievance concerns. MRPIU noted that the plan continued to have an opportunity to ensure that its provider offices track and log grievances and forward this information to AAH for tracking and trending.

For cultural and linguistic services, MRPIU noted continued opportunities for improvement. Not all provider offices had 24-hour access to oral interpreter services. Provider office answering machines did not provide an outgoing message in the required threshold languages. Additionally, the review showed a repeat finding for provider offices that did not discourage the use of family members and/or friends as interpreters.

Strengths

AAH demonstrated compliance with many requirements reviewed as part of the joint audit and MRPIU review. The plan demonstrated strong improvement in the area of member grievances. All grievance files reviewed were resolved within appropriate time frames. The plan showed tracking and trending of grievance data and initiatives to improve the capture of data in its quality improvement evaluation.

Opportunities for Improvement

The plan has an opportunity to resolve audit deficiencies. Many of the audit findings noted in both the joint audit and MRPIU review were repeat audit findings. Most deficiencies were due to lack of a process for monitoring or tracking information such as referrals, forwarding of information to the PCP, appointment wait times, quality of care concerns within the recertifying files, and new member health assessments. The plan has an opportunity to evaluate and modify its existing procedures to meet all plan requirements.

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about AAH's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness. *The Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, provides an overview of the objectives and methodology for conducting the EQRO review.

Performance Measure Validation

HSAG performed a HEDIS[®] Compliance Audit^{TM3} of AAH in 2009. HSAG found all measures to be reportable and that AAH's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

Recommendations from the audit involved tracking and trending encounter data from vendors and formalizing a process for updating submission threshold levels for comparative purposes. In addition, the plan may consider formalizing its follow-up process with vendors that do not meet the encounter data threshold, as the current process is on an ad hoc basis. These actions would strengthen AAH's process to ensure complete encounter data.

³ HEDIS[®] refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS Compliance AuditTM is a trademark of the NCQA.

Performance Measure Results

The table below presents a summary of AAH's county-level HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measures results (based on calendar year 2007 data). In addition, the table shows the plan's HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the NCQA's national Medicaid 25th percentile and 90th percentile, respectively. For the CDC-H9 (>9.0 percent) measure, NCQA inverted the rate—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.

Appendix A includes a performance measure name key with abbreviations contained in the following table.

Table 4.1—2008–2009 Performance Measure Results for Alameda Alliance for Health—Alameda

Performance Measure ¹	Domain of Care ²	2008 HEDIS Rates ³	2009 HEDIS Rates ⁴	Performance Level for 2009	Performance Comparison ⁵	MMCD's Minimum Performance Level ⁶	MMCD's High Performance Level (Goal) ⁷
AAB	Q	25.9%	23.3%	★★	↔	20.6%	35.4%
ASM	Q	91.4%	87.6%	★★	↓	86.1%	91.9%
AWC	Q,A,T	45.3%	44.8%	★★	↔	35.9%	56.7%
BCS	Q,A	50.2%	45.2%	★★	↓	44.4%	61.2%
CCS	Q,A	72.5%	69.6%	★★	↔	56.5%	77.5%
CDC–E	Q,A	NR	31.4%	★	Not Comparable	39.7%	67.6%
CDC–H7 (<7.0%)	Q	30.4%	23.2%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	48.9%	54.4%	★	↔	52.5%	32.4%
CDC–HT	Q,A	73.5%	74.6%	★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	24.8%	35.4%	★★	↑	25.1%	42.6%
CDC–LS	Q,A	71.3%	76.1%	★★	↔	66.7%	81.8%
CDC–N	Q,A	74.2%	81.0%	★★	↑	67.9%	85.4%
CIS–3	Q,A,T	70.6%	79.0%	★★★	↑	59.9%	78.2%
PPC–Pre	Q,A,T	74.0%	69.2%	★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	57.7%	60.3%	★★	↔	54.0%	70.6%
URI	Q	94.9%	90.6%	★★	↓	79.6%	94.1%
W15	Q,A,T	53.5%	48.8%	★★	↔	44.5%	73.7%
W34	Q,A,T	73.5%	71.3%	★★	↔	59.8%	78.9%

¹ DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the full name of each HEDIS measure.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.

⁴ HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.

⁵ Performance comparisons are based on the z test of statistical significance with a p value of <0.05.

⁶ The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.

⁷ The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

†The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, AAH demonstrated average performance, falling between the 25th and 90th national Medicaid percentiles for most of its reported performance measures in 2009. The plan exceeded the MCMC goal, which reflects the national Medicaid 90th percentile for *Childhood Immunization Status—Combination 3*. The plan had below-average performance in three areas, two of which related to care for members with diabetes and the other related to providing timely prenatal care.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPL. Plans that have rates below this minimum level must submit an improvement plan to the DHCS for each area of deficiency, outlining the steps they will take to improve care.

In 2008, the DHCS required AAH to submit two improvement plans to the DHCS for *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* and *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing (CDC–HT)*. Although AAH did not have statistically significant improvement of its HbA1c testing rate, the plan's rate increased above the MPL for HEDIS 2009, and no improvement plan for this measure was required for its 2009 performance.

AAH's *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* rate fell below the MPL in 2008, and the rate decreased in 2009. The plan could not report its 2007 rate due to material bias. The plan submitted a HEDIS improvement plan to address its poor performance in 2008. The health plan indicated that identifying pregnant members early in their pregnancy was a challenge, making it difficult to provide successful outreach and link women with timely prenatal care. In addition, the health plan identified member barriers such as lack of transportation, lack of social support, lack of understanding of the importance of prenatal care, lack of literacy skills, and behavioral health issues—all factors that contributed to the low rates.

AAH outlined planned interventions to address its poor performance, including a redesign and reintroduction of its Baby Steps program and a new “Go Before You Show” informational campaign to raise awareness and educate members on the importance of prenatal care. To help identify women early in pregnancy, AAH planned to redesign payment for global billing.

AAH submitted its improvement plan with targeted interventions that began in November 2008; therefore, the plan's intervention activities were not in place long enough to impact its 2009 HEDIS rate (which is based on 2008 measurement data).

Based on its 2009 performance, the DHCS required AAH to submit improvement plans for its measures that fell below the MPL: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC–E)*, *Comprehensive Diabetes Care—HbA1c Poor Control (CDC–H9)*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)*.

Strengths

AAH performed above the MCMC Program goal and the national Medical 90th percentile on the *Childhood Immunization Status—Combination 3 (CIS–3)* measure and showed a statistically significant increase over the prior year. Childhood immunization spans the domains of quality, access, and timeliness. The plan noted collaboration with the Alameda County Public Health Department to increase provider utilization of an immunization registry by funding data entry for its network providers. This activity may have contributed to the increased rate.

In addition, two comprehensive diabetes measures showed statistically significant improvement in monitoring for nephropathy and low-density lipoprotein cholesterol (LDL-C) control, which demonstrated efforts to provide quality care.

For comparable measures, AAH outperformed the Two-Plan model commercial plan in Alameda County on 11 measures and performed below the commercial plan on 7 measures.⁴

Opportunities for Improvement

AAH had the lowest rate of all MCMC plans for its *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* measure, which continued to present a significant opportunity for improvement. AAH's performance in this area may point to issues with health care quality, access, and/or timeliness.⁵

Additional opportunities include increasing eye exam rates and achieving better control of glycated hemoglobin (HbA1c) levels among members with diabetes. The performance of these measures all fell below established MPLs.

AAH had three measures with a statistically significant decrease from the 2008 to 2009 HEDIS rate: *Use of Appropriate Medications for People With Asthma (ASM)*, *Breast Cancer Screening (BCS)*, and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*.

⁴ The California Department of Health Care Services. 2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program. June 2010.

⁵ Ibid.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas.

HSAG reviews each QIP using CMS' validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about AAH's performance in providing quality, accessible, and timely care and services to its MCMC members. *The Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, provides an overview of the objectives and methodology for conducting the EQRO review.

Quality Improvement Projects Conducted

AAH had two clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of DHCS's statewide collaborative QIP project. AAH's second project, an internal QIP, aimed to decrease return ER visits for asthmatic exacerbations in children 2–18 years of age.

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

Emergency room visits for asthmatic exacerbations in children are an indicator of poorly controlled asthma and suboptimal care. These visits may also indicate limited access to PCPs for asthma care. AAH's project attempted to improve the quality of care delivered to children with asthma.

Quality Improvement Project Validation Findings

The DHCS contracted with HSAG as its new EQRO in the second half of 2008. HSAG began validation for QIPs submitted by the plans after July 1, 2008.

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

Table 5.1—Quality Improvement Project Validation Results for Alameda Alliance for Health—Alameda (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	Partially Met	Not Met
I.	Appropriate Study Topic	84%	8%	8%
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	54%	31%	15%
IV.	Correctly Identified Study Population	0%	50%	50%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	59%	8%	33%
VII.	Appropriate Improvement Strategies	80%	0%	20%
VIII.	Sufficient Data Analysis and Interpretation	33%	17%	50%
IX.	Real Improvement Achieved	‡		
X.	Sustained Improvement Achieved	‡		
Percentage Score of Applicable Evaluation Elements Met		51%		
Validation Status		Not Applicable*		
‡ The QIP did not progress to this activity during the review period and could not be assessed. * QIPs were not given an overall validation status during the review period.				

AAH submitted baseline data for both projects during the review period; therefore, the QIPs have not progressed to the point of remeasurement and HSAG could not assess for real and sustained improvement.

During the period covered by this report, HSAG’s application of the CMS validation requirements was more rigorous than previously experienced by MCMC plans. As a result, many plans had difficulty complying fully with these requirements during the first cycle of QIP validations by HSAG. This was the case with AAH’s QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided AAH, as well as other plans, with an overall validation status of “Not Applicable” for both QIPs. This allowed time for plans to receive technical assistance and training with HSAG’s validation requirements without holding up the ongoing progress of QIPs that were already underway.

Quality Improvement Project Outcomes

Table 5.2 below displays AAH’s baseline data for its QIPs. AAH’s goal was a reduction of 10 percent in its avoidable ER visit rate and its ER visit rate for children with more than two ER visits within one year. The plan’s first remeasurement year data will be submitted in time to be included in the next performance evaluation report (July 1, 2009–June 30, 2010), at which time HSAG will assess for real improvement.

Table 5.2—Quality Improvement Project Outcomes for Alameda Alliance for Health

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	Baseline Period (1/1/07–12/21/07)	Remeasurement 1	Remeasurement 2	Sustained Improvement
Percentage of avoidable ER visits	12.1%	‡	‡	‡
QIP #2—Decrease Return Emergency Room Visits for Asthmatic Exacerbations in Children				
QIP Study Indicator	Baseline Period (7/1/07–6/30/08)	Remeasurement 1	Remeasurement 2	Sustained Improvement
Percentage of children 2 through 18 years of age who have more than two ER visits for asthma within one year	17.45%	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

Strengths

AAH demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data. In addition, AAH’s interventions to address identified causes/barriers and system interventions are likely to induce permanent change.

AAH’s internal QIP on asthma has the potential to impact the plan’s declining performance measure rate for the *Use of Appropriate Medications for People With Asthma (ASM)*, which showed a statistically significant decrease between 2008 and 2009. Interventions selected by AAH to decrease asthmatic exacerbations—specifically asthma education, physician follow-up visits, and case management—were among interventions given a moderate evidence rating on the Agency for Healthcare Research and Quality’s (AHRQ’s) Health Care Innovations Exchange.⁶ The evidence rating showed that the interventions resulted in less severe disease, enhanced quality of life,

⁶ AHRQ Health Care Innovations Exchange. Pediatric home visits, specialist visits, and follow-up enhance access and improve outcomes for low-income children with asthma. Available at: <http://www.innovations.ahrq.gov/content.aspx?id=1740>. Accessed September 22, 2009.

reduced ER visits and hospitalizations, and cost savings. AAH's use of the demonstrated interventions suggested that the plan may be more successful with achieving real and sustained improvement.

AAH implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits. AAH identified early in 2008 that its data systems provided limited access to useful data. The plan focused on an expanded analysis of data to help identify utilization patterns and characteristics of its MCMC members who use the ER and completed the analysis in 2009. In addition, the plan has partnered with two of its delegated provider groups to try to reduce ER visits by alerting the delegated group of members who have used the ER multiple times. Providers for these members would then counsel them on appropriate use of the ER and/or identify possible case management issues.

Opportunities for Improvement

AAH has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with DHCS's requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

As part of AAH's group needs assessment and telephonic survey on ER use for the ER collaborative QIP, the plan identified that approximately half of members who accessed the ER contacted their PCP first. Approximately 80 percent of these members were told to go to the ER by their provider. The statewide collaborative member health education campaign attempts to educate members on contacting their provider before going to the ER for many common, nonurgent conditions. AAH will need to gain provider support and participation to meet the collaborative campaign goal of treating patients in an outpatient setting rather than referring them to the ER.

AAH identified several access-related barriers cited by members as reasons for using the ER, such as a lack of same-day or after-hours alternatives to the ER. Due to staffing and budget constraints, AAH postponed many of the planned interventions to address access. AAH may need to further explore if members have difficulty accessing care.

The table below provides abbreviations of HEDIS performance measures used throughout this report.

Table A.1—HEDIS® Performance Measures Name Key

Abbreviation	Full Name of HEDIS® Performance Measure
AAB	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
ASM	<i>Use of Appropriate Medications for People With Asthma</i>
AWC	<i>Adolescent Well-Care Visits</i>
BCS	<i>Breast Cancer Screening</i>
CCS	<i>Cervical Cancer Screening</i>
CDC-E	<i>Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed</i>
CDC-H7	<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)</i>
CDC-H9	<i>Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)</i>
CDC-HT	<i>Comprehensive Diabetes Care—HbA1c Testing</i>
CDC-LC	<i>Comprehensive Diabetes Care—LDL-C Control</i>
CDC-LS	<i>Comprehensive Diabetes Care—LDL-C Screening</i>
CDC-N	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>
CIS-3	<i>Childhood Immunization Status—Combination 3</i>
PPC-Pre	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>
PPC-Pst	<i>Prenatal and Postpartum Care—Postpartum Care</i>
URI	<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>
W15	<i>Well-Child Visits in the First 15 Months of Life (Six or More Visits)</i>
W34	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>