Performance Evaluation Report

AHF Healthcare Centers

July 1, 2008–June 30, 2009

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

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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. This report is unique to the MCMC Program's contracted plan, AHF Healthcare Centers ("AHF" or "the plan"), for the review period July 1, 2008, to June 30, 2009. 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 of care. Actions taken by the plan subsequent to June 30, 2009, regarding findings identified within this report will be included in the next annual plan-specific evaluation report.

AHF is a specialty plan that serves Medi-Cal managed care members living with HIV or AIDS, some of whom are dual eligible (covered by both Medicare and Medi-Cal). Due to the plan's unique membership, some of AHF's contract requirements have been modified from the MCMC Program's full-scope health plan contracts.

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 AHF demonstrated average to above-average performance for the quality domain of care. This assessment 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.

AHF had two quality-related performance measures, *Colorectal Cancer Screening (COL)* and *Adults' Access to Preventive/Ambulatory Health Services (AAP)*. AHF's performance on the *Colorectal Cancer Screening (COL)* measure fell between the MPL and the HPL. AHF's performance on the *Adults' Access to Preventive/Ambulatory Health Services (AAP)* measure exceeded the MCMC-established HPL for its two valid, reported rates. AHF has demonstrated consistently high and sustained performance on its *Adults' Access to Preventive/Ambulatory Health Services (AAP)* performance measure; therefore, the plan has an opportunity to consider an alternative performance measure that could address an area of low performance.

AHF's QIP, *Reducing Adverse Reactions to Coumadin for Patients With HIV/AIDS*, exhibited improvement for all three of its study indicators between the baseline and the first remeasurement period. The plan had a statistically significant increase in the number of patients with an international normalized ratio (INR) blood level within the desired range to prevent bleeding. AHF's second QIP, which focused on controlling blood pressure for members diagnosed with

hypertension, did not reach the point of remeasurement during the review period; therefore, HSAG could not assess for health outcomes.

Despite AHF's success with its first remeasurement period for its Coumadin QIP, AHF has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs.

AHF demonstrated a quality improvement structure that supported measuring, reporting, and analyzing data to improve care. The plan monitored many indicators tailored to the specific needs of its HIV/AIDS population.

Many findings from the Member Rights/Program Integrity Unit's (MRPIU's) review of AHF were repeat findings from a prior review period; therefore, the plan has an opportunity to incorporate areas of noncompliance into its quality improvement program and work plan to ensure that it takes appropriate action to address deficiencies and monitors for ongoing compliance.

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 plans' compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Performance measures can fall under more than one domain of care. For instance, a measure could fall under the domains of quality and access if members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

AHF 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.

Both of AHF's 2009 performance measures addressed access to care as well as quality of care. AHF's performance on these two measures was average to above average, falling between the MPL and HPL for one measure and above the HPL for the other.

AHF showed strength by ensuring that its adults had access to care for preventive services within the measurement year. The plan had an increase in its *Colorectal Cancer Screening (COL)* rate between

2008 and 2009, demonstrating that AHF provides members access to colorectal cancer screening and access to specialists and facilities that perform colonoscopies.

AHF's QIP, *Reducing Adverse Reactions to Coumadin for Patients With HIV/AIDS*, had one study indicator that was affected by access and availability of services. The plan is working to improve the percentage of members on continuous Coumadin (warfarin) who have seven or more INR test results within the measurement period. To achieve this improvement, patients must have access to providers and laboratory services. The plan improved its rate for that indicator between baseline and Remeasurement 1.

Based on audit review findings, the plan showed evidence of providing intensive case management services and coordination of care for members. AHF's internal annual evaluation showed that the plan administered an annual client satisfaction survey for its health care centers and pharmacy, and for the plan overall. Additionally, the evaluation showed that AHF uses utilization information and patterns to identify potential access issues. The plan noted an increase in its rate of behavioral health inpatient admissions in early 2008. As a result, in 2009 the plan initiated a recruitment strategy for psychiatric providers who have qualifications to address AHF's special population, particularly the complexity of chronic issues associated with HIV/AIDS and their effect on emotional and psychological health.

To improve access to care, AHF needs to implement standards for access to care and procedures for monitoring wait time to obtain appointments, time to answer and return telephone calls, and waiting time in providers' offices. These results, along with an assessment of network adequacy, should be incorporated in the plan's internal annual evaluation.

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 plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management.

Based on a 2009 compliance review of standards related to timeliness, AHF demonstrated below-average performance in the timeliness domain of care.

The DHCS's MRPIU review findings noted several repeat findings related to AHF's grievance system. The plan was out of compliance with the requirement for resolving and sending a

resolution letter to members within 30 days. Of the 26 files reviewed, 11 were past the 30-day time frame and 4 missed the time frame for providing written acknowledgment within five calendar days of receipt of a grievance. MRPIU findings also showed that AHF's grievance policy and procedures lacked several required elements.

AHF has opportunities to improve compliance with grievance standards. This includes the modification of its policy and procedures to meet all State and federal requirements as well as resolving grievances within required time frames. Although the plan tracks and trends grievance and appeal data, it should consider categorizing the data to allow the plan to better understand areas of concern that warrant more focused action.

Conclusions and Recommendations

Overall, AHF demonstrated average to above-average performance in providing quality care, average performance in providing accessible care, and below-average performance with providing timely health care decisions to its Medi-Cal managed care members.

AHF's two reported rates for the *Adults' Access to Preventive/Ambulatory Health Services (AAP)* measure scored above the MPL. All of the study indicators improved for the plan's *Reducing Adverse Reactions to Coumadin for Patient With HIV/AIDS* QIP.

AHF demonstrated compliance with most standards of MRPIU and the DHCS's Audits and Investigations Division for cultural and linguistic services, quality management, administrative and organizational capacity, marketing and enrollment programs, and program integrity. The plan had opportunities to improve in the areas of availability and accessibility of services and the grievance system.

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

- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.
- Select a new performance measure to replace the *Adults' Access to Preventive/Ambulatory Health Services (AAP)* measure in order to address other areas of low performance.
- Implement standards for access to care and procedures to monitor the availability and accessibility of care.
- Review policies and procedures related to the grievance system to ensure that AHF's processes will meet all DHCS and federal requirements.

- Incorporate all areas of noncompliance, including repeat areas of noncompliance, into the quality improvement work plan to ensure they are resolved and monitored.
- Consider categorizing grievance and appeal data to track and trend patterns of concern for targeted action.

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

Plan Overview

AHF Healthcare Centers is a Medi-Cal managed care specialty plan operating in Los Angeles County and providing services primarily to members living with HIV or AIDS. Some of the plan's members are dual eligible (covered by both Medicare and Medi-Cal). The plan has been previously referred to as AIDS Healthcare Centers or Positive Healthcare.

AHF became operational with the MCMC Program in April 1995. As of June 30, 2009, the plan had 618 MCMC members.[1]

[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 AHF's performance in providing quality, accessible, and timely health care 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*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Joint Audit Review

For most MCMC plans, the DHCS's Audits and Investigations Division (A&I) works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. When a plan is not Knox-Keene licensed, as in the case of AHF, A&I will instead conduct a non-joint medical audit approximately once every three years. These A&I audits assess plans' compliance with contract requirements and State and federal regulations.

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess a plan's compliance with State-specified standards. A&I conducted an audit of AHF in April 2006, covering the review period of April 1, 2005, through March 31, 2006. The audit covered the areas of utilization management (UM), continuity of care, availability and accessibility, member rights,

quality management, and administrative and organizational capacity. Results from this audit identified strengths as well as opportunities for improvement:

- Under the UM category of review, it was noted that AHF's UM program used written criteria to determine medical necessity. The UM program measured for under- and overutilization of services. Findings in this area showed that the plan did not follow its policies and procedures for prior-authorization resolution and notification.
- For continuity of care, the plan assigns each member a registered nurse case manager who coordinates care with the member's primary care physician by using an electronic medical record. While the plan tracks its completion rates for initial health assessments and individual health education behavioral assessments, the plan did not evaluate the rates and consider strategies to ensure that all members receive the assessments with the required 120-day time frame.
- Under the availability and accessibility of services category, the audit found that the plan did not have appointment policies and procedures and standards in place for availability of routine, urgent, and emergent care. The plan lacked a process to monitor wait time to obtain appointments, time to answer and return telephone calls, and waiting time in providers' offices. These were repeat findings from the prior audit.
- For member rights, the audit noted that the plan was fully compliant with cultural and linguistic services requirements. Audit findings for this category showed that the plan was not monitoring grievance data for quality improvement. Additionally, the plan lacked a system to collect, analyze, and report grievance information.
- Under the quality management program, the plan demonstrated a quality improvement program that collected and analyzed data to improve care and services. The plan had a credentialing process to ensure that its providers met the criteria for HIV/AIDS specialists. The plan had one finding in this area related to lack of quality improvement and quality of care issues documentation in the Board of Directors meeting minutes.
- For the administrative and organizational capacity category, the audit showed that the plan was compliant with information systems and identifying, investigating, and reporting fraud and abuse. Audit findings included lack of a current job description for the chief medical officer, lack of a defined health education program and specialization of staff in health education, and lack of documentation of provider training and specific Medi-Cal managed care provider training.

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 a review of AHF in May 2008, covering the review period of January 1, 2006, through December 31, 2007. The review found that AHF was compliant with standards related to prior-authorization request notifications, marketing and enrollment programs, cultural and linguistic services, and program integrity. AHF was not compliant with all grievance requirements.

MRPIU noted eight findings under the grievance system. Five of the findings related to the plan's policy and procedures for grievances, which lacked the following information:

- A procedure for providing the member an oral notice of the resolution of an expedited review. This was a repeat finding from 2005.
- A procedure for systematic aggregation and analysis of grievance data for quality improvement. This was a repeat finding from 2005.
- Information about the continuation of medical services during the grievance process for State fair hearings.
- Information that members have the opportunity to present evidence, facts, and law in writing or in person before the individual(s) resolving the grievance.
- A system for addressing any cultural or linguistic requirements related to the processing of member grievances.

Additionally, the plan was out of compliance with the requirement for resolving and sending a resolution letter to the member within 30 days. Of the 26 files reviewed, 11 were past the 30-day time frame. Also, the resolution letters lacked written information about the member's right to request a fair hearing. Both were repeat findings from December 2005.

AHF was out of compliance with the requirement for providing written acknowledgment within five calendars days of receipt of a grievance. Of the 26 files reviewed, 4 missed the time frame, and one file did not have an acknowledgment letter. This was a repeat finding from December 2005.

Strengths

Based on the information available, AHF demonstrated compliance in the areas of marketing and enrollment programs, cultural and linguistic services, and program integrity.

HSAG's review of AHF's Quality Management Annual Evaluation for the period of January 1, 2008, through December 31, 2008, found that the plan had a structure that supported measuring, reporting, and analyzing data for quality improvement.[2] AHF monitored many indicators tailored to the specific needs of its HIV/AIDS population using HIVQUAL guidelines developed by the New York State Department of Health AIDS Institute. AHF produced a bimonthly report that assessed compliance by each provider in relation to selected core indicators. Indicator results that were out of compliance, as determined by a committee, were discussed at medical staff meetings.

Although findings from the 2006 A&I audit noted lack of tracking and trending of member grievances, HSAG found evidence that the plan included member grievance data within its 2008 annual evaluation report, which suggested that the plan may have adequately addressed this audit finding.

The plan administered an annual client satisfaction survey for its health care centers, pharmacy, and overall plan. Additionally, the plan monitored utilization measures related to hospital admissions, bed days, and average length of stay for acute, behavioral health, and skilled nursing facilities. The plan showed evidence of intensive case management services and coordination of care for members at risk for opportunistic infections.[3]

[2] AHF Healthcare Centers. *Quality Management Annual Evaluation Report. Fiscal Year 2008, January 1, 2008, through December 31, 2008*.
[3] Ibid.

Opportunities for Improvement

AHF needs to implement standards for access to care and procedures for monitoring wait time to obtain appointments, time to answer and return telephone calls, and waiting time in providers' offices. The plan needs to incorporate the monitoring results in the annual evaluation with analysis of results, identified opportunities for improvement, and strategies for improvement.

AHF has opportunities to improve compliance with grievances standards. These opportunities include modifying the plan's policy and procedures to meet all State and federal requirements, resolving grievances within required time frames, providing notification to members within required time frames, and including in member notifications the member's right to request a State fair hearing.

Because several of the A&I audit and MRPIU review findings were repeat findings from a prior review period, the plan needs to incorporate areas of deficiency in the plan's quality work plan and monitor improvement activities as part of the quality improvement program. The plan's goal should be to ensure that the deficiencies are resolved and monitored for ongoing compliance.

Although the plan tracks and trends grievance and appeal data, it should consider categorizing the data to allow the plan to better understand areas of concern that warrant more focused action.

Conducting the Review

For its full-scope contracted Medi-Cal managed care plans, 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. Under its original contract with the DHCS, AHF—as with other specialty plans—was not held to the same performance measure requirements as full-scope plans. In response to CMS' direction that the DHCS make specialty plans subject to the same external quality review requirements as other Medi-Cal managed care plans, AHF's contract was changed effective 2007 to include new performance measurement requirements.

Due to the small size of specialty plan populations, the DHCS modified the performance measure requirements applied to these plans. Instead of requiring a specialty plan to annually report the full list of performance measure rates to the external quality review organization as full-scope plans do, the DHCS required specialty plans to report only two performance measures. In collaboration with the DHCS, a specialty plan may select measures from the Healthcare Effectiveness Data and Information Set (HEDIS®)[4] or design a measure that is appropriate to the plan's population. Further, the specialty plan must report performance measure results specific to the plan's Medi-Cal managed care members, not for the plan's entire population.

As with all MCMC plans—full scope and specialty—HSAG validates these performance measures as required by the DHCS to evaluate the accuracy of the plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for performance measures when calculating rates.

[4] 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 Audit™ is a trademark of the NCQA.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about AHF's performance in providing quality, accessible, and timely care and services to its MCMC members. AHF's HEDIS measures fell under two of the three domains of care—quality and access. Neither of the measures related to the timeliness domain of care. 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.

Performance Measure Validation

HSAG performed a HEDIS® Compliance Audit™[5] of AHF in 2009, covering the measurement period of January 1, 2008, through December 31, 2008. HSAG found two of the three measures to be reportable. The *Adults' Access to Preventive/Ambulatory Health Services (AAP)* measure for its 65 years of age and older population was not reportable since the plan did not have enough members in this age category to report a valid rate. AHF'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 formalizing the validation process for encounter data transfer from electronic medical records to the plan's claims and encounters system, EZCAP. In addition, AHF should implement front-end edits for encounter data extraction, which would eliminate the need to wait for reject reports to identify errors. The plan should consider implementing a data warehouse and HEDIS repository as the plan continues to grow.

Performance Measure Results

The following table presents a summary of AHF's HEDIS 2009 performance measure results (based on calendar year 2008 data) compared with HEDIS 2008 performance measure 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. The MCMC Program based its MPLs and HPLs on National Committee for Quality Assurance (NCQA)'s national ***Medicaid*** 25th percentile and 90th percentile, respectively. For the *Colorectal Cancer Screening (COL)* measure, the MPL and HPL are based on NCQA's national ***Medicare*** 25th percentile and 90th percentile, respectively, since no Medicaid benchmark exists for this measure.

[5] 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 Audit™ is a trademark of the NCQA.

Table 4.1—2008–2009 Performance Measure Results for AHF Healthcare Centers Los Angeles County

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	MMCD's Minimum Performance Level[5]	MMCD's High Performance Level (Goal)[6]
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
20 – 44 years	Q,A	97.3%	98.5%	★★★	71.6%	87.6%
45 – 64 years		97.8%	95.6%	★★★	79.3%	90.2%
65+ years		95.5%	NA	Not Comparable	74.6%	93.5%
Colorectal Cancer Screening (COL)						
	Q,A	47.7%	55.6%	★★	49.9%	68.4%

[1] DHCS-selected HEDIS performance measures developed by NCQA.
[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] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the COL measure, the MPL is based on the national Medicare 25th percentile since no Medicaid benchmark exists for this measure.
[6] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the COL measure, the HPL is based on the national Medicare 90th percentile since no Medicaid benchmark exists for this measure.
★ = Below-average performance relative to the national Medicaid 25th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles).
★★★ = Above-average performance relative to the national Medicaid 90th percentile.
NA = Not applicable due to the plan's denominator being too small to report a valid rate (less than 30).
Not Comparable = Performance could not be compared due either to significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

AHF demonstrated average to above-average performance on the two measures reported in 2009. The plan's performance fell between the 25th and 90th national Medicaid percentiles for *Colorectal Cancer Screening (COL)*. For the other measure, *Adults' Access to Preventive/Ambulatory Health Services (AAP)*, the plan exceeded the MCMC-established HPL for two of the three age groups (20–44 years of age and 45–64 years of age). Both measures fell under quality and access domains of care.

HEDIS Improvement Plans

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

Based on its 2009 performance, AHF was not required to submit improvement plans for any of its measures.

Strengths

AHF demonstrated continued strong performance on the *Adults' Access to Preventive/Ambulatory Health Services (AAP)* measure. In addition, the plan improved its *Colorectal Cancer Screening (COL)* rate from 47.7 percent in 2008 to 55.6 percent in 2009.

Opportunities for Improvement

Because AHF has shown extremely high performance for adults' access to preventive and ambulatory care, the plan and the DHCS should consider an alternative performance measure that is meaningful to the plan and its specialty population and is actionable.

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 AHF'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*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Quality Improvement Projects Conducted

Specialty plans must be engaged in two QIPs at all times. However, because specialty plans serve unique populations that are limited in size, the DHCS does not require specialty plans to participate in the statewide collaborative QIP. Instead, specialty plans are required to design and maintain two internal QIPs with the goal to improve health care quality, access, and/or timeliness for the specialty plan's MCMC members.

AHF had two clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted control of high blood pressure in members diagnosed with hypertension. This QIP fell under the quality domain of care.

AHF's second project aimed to decrease adverse events for patients on continuous Coumadin. This QIP fell under both the quality and access domains of care.

Quality Improvement Project Validation Findings

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

Table 5.1 summarizes the validation results for both of AHF's QIPs across CMS protocol activities during the review period.

Table 5.1—Quality Improvement Project Validation Results for AHF Healthcare Centers—Los Angeles County (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	75%	17%	8%
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	58%	25%	17%
IV.	Correctly Identified Study Population	0%	100%	0%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	50%	33%	17%
VII.	Appropriate Improvement Strategies	80%	20%	0%
VIII.	Sufficient Data Analysis and Interpretation	42%┼	17%┼	42%┼
IX.	Real Improvement Achieved	75%	0%	25%
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.

┼ The sum may not equal 100 percent due to rounding.

AHF submitted baseline data for one project; therefore, the QIP had not progressed to remeasurement and HSAG could not assess for real or sustained improvement. The second QIP had not progressed to reporting a second remeasurement period, and HSAG could not assess for sustained improvement.

During the period covered by this report, HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the 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 AHF's QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided AHF, 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 AHF's data for its QIPs. For the *Controlling High Blood Pressure* QIP, the plan's goal was for 90 percent of members diagnosed with hypertension to have a systolic blood pressure of less than 140 mmHg and a diastolic blood pressure of less than 90 mmHg.

For the *Reducing Adverse Reactions to Coumadin for Patients With HIV/AIDS* QIP, the plan's goal was to increase the proportion of patients on continuous Coumadin who had seven or more INR results in a given measurement year. In addition, the plan set a goal to increase the proportion of patients with INR values of less than 4.0 to 95 percent and to decrease the anticoagulation-related hospital admission rate for patients on Coumadin to two hospitalizations or fewer.

Table 5.2—Quality Improvement Project Outcomes for AHF Healthcare Centers

QIP #1—*Controlling High Blood Pressure*			
QIP Study Indicator	**Baseline Period (1/1/07–12/31/07)**	**Remeasurement 1 (1/1/08–12/31/08)**	**Remeasurement 2 (1/1/09–12/31/09)**
Percentage of patients whose last systolic blood pressure was less than 140 mmHg	70.6%	‡	‡
Percentage of patients whose last diastolic blood pressure was less than 90 mmHg	73.5%	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.			

QIP #2—*Reducing Adverse Reactions to Coumadin for Patients With HIV/AIDS*			
QIP Study Indicator	**Baseline Period (3/1/06–2/28/07)**	**Remeasurement 1 (3/1/07–2/28/08)**	**Remeasurement 2 (3/1/08–2/28/09)**
Percentage of patients on Coumadin with seven or more INR results in a given measurement year	40.0%	47.4%	‡
Percentage of INR values of less than 4.0	86.4%	95.1%*	‡
Rate of anticoagulation-related hospital admissions per 1,000 patients on Coumadin	85.7	0¥	‡
‡The QIP did not progress to this phase during the review period and could not be assessed. * Designates statistically significant improvement over the prior measurement period. ¥ The denominator was less than 40.			

Strengths

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

AHF's QIP to reduce adverse reactions in members on continuous Coumadin showed improvement for all three of its indicators during the first remeasurement period. The plan had a statistically significant increase in the number of members with INR levels of less than 4.0 between baseline and Remeasurement 1. Although AHF did not have a statistically significant decrease in the rate of anticoagulation-related hospital admissions, the plan had meaningful improvement. In 2008, three members were hospitalized. In 2009, none of the plan's members was hospitalized due to an adverse reaction to Coumadin.

With its Coumadin QIP, the plan demonstrated good quality of care and access to care for the targeted members. The plan increased the percentage of patients with seven or more INR results during the measurement year, showing that patients have access to providers and laboratory services to have their blood drawn for the test. More frequent monitoring of these levels allows the provider to make adjustments as needed, which may prevent a patient from having an adverse reaction. The plan also demonstrated better INR levels for members, which may be the result of the more frequent monitoring. INR levels that exceed 4.0 indicate an increased risk of bleeding, with no therapeutic benefit.[6]

The plan initiated several interventions, including the development of a medical policy and procedure addressing Coumadin that it distributed to case managers and medical staff. AHF also developed an electronic reporting tool for Coumadin, which medical staff reviewed monthly. AHF identified patients whose INR values were out of compliance and used case managers to track and follow patients. In addition, the plan provided closer tracking of INR values for patients requiring more frequent INR measurement.

Opportunities for Improvement

Despite AHF's success with its first remeasurement period for its Coumadin QIP, AHF has the opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs.

HSAG recommends that the plan comply with the 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.

[6] AHF Healthcare Centers. 2008-2009 QIP Summary Form. Reducing Adverse Reactions to Coumadin for Patients with HIV/AIDS.