Performance Evaluation Report

Alameda Alliance for Health

July 1, 2009–June 30, 2010

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

August 2011

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1. INTRODUCTION

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] 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 the 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. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] Medi-Cal Managed Care Enrollment Report, June 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Alameda Alliance for Health ("AAH" or "the plan"), which delivers care in Alameda County, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

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 has been Knox-Keene licensed since 1995. Knox-Keene licensure is granted by the Department of Managed Health Care (DMHC) to plans that meet minimum required standards according to the Knox-Keene Health Care Service Plan Act of 1975. The act includes a set of laws that regulate managed care organizations (MCOs).

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, 2010, AAH had 96,645 MCMC members.[2]

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.

[2] Medi-Cal Managed Care Enrollment Report, June 2010. 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 that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the 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 Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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 fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division often work in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits are conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

HSAG reviewed the most current medical performance review reports available as of June 30, 2010, to assess plans' compliance with State-specified standards. A&I and DMHC conducted a joint medical performance audit of AAH in October 2008. HSAG reported findings from this audit in the prior year's evaluation report.[3] The audit covered the areas of utilization management (UM), continuity of care, access and availability, member rights, quality management, and administrative and organizational capacity.[4] Most deficiencies from the October 2008 audit were due to lack of a process for tracking and/or monitoring information such as referrals, the forwarding of information to the primary care provider (PCP), appointment wait times, quality of care concerns within the recredentialing files, and new member health assessments.

In May 2010, the DHCS conducted a monitoring visit to follow up on AAH's progress with its corrective action plan to address the areas of noncompliance from the joint audit. A follow-up letter to the plan issued in August 2010 indicated that the plan adequately addressed all areas of noncompliance except for monitoring of wait times. While the plan made a policy change, the DHCS found no evidence that the plan developed a mechanism for monitoring wait times; therefore, this item remained an open issue.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's 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 member rights reviews are conducted 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 member rights 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, 2010. The most current MRPIU review for AAH was conducted in May 2010, covering the review period of July 1, 2008, through April 1, 2010.

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[3] *Performance Evaluation Report – Alameda Alliance for Health, July 1, 2008 – June 30, 2009.* California Department of Health Care Services. October 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

[4] *California Department of Health Services. Medical Review – Northern Section, Audits and Investigations. Alameda Alliance for Health*, April 8, 2009.

MRPIU's review showed that the plan was fully compliant in the areas of member grievances, marketing and enrollment programs, and program integrity, but not fully compliant in the areas of prior authorizations and cultural linguistics. MRPIU's review of prior-authorization notifications found that two of 50 files reviewed were not compliant. One file lacked the Notice of Action letter; the other lacked the original request for prior authorization. While MRPIU found that AAH's cultural and linguistic services policies and procedures were compliant, an interview with five of the plan's providers found that one provider did not have a grievance form and did not maintain a grievance log. Additionally, two providers were not aware of the 24-hour language line, and one provider did not discourage the use of a minor as an interpreter.

Strengths

AAH showed substantial progress with addressing and resolving nearly all medical performance audit deficiencies. MRPIU's review of 50 grievance files showed AAH to be in full compliance with State and federal policies. MRPIU commended the plan for excellent performance in the member grievance area.

Opportunities for Improvement

While the plan adequately addressed most of the medical performance audit deficiencies, the plan did not implement a mechanism to monitor appointment wait times; therefore, this continues to be an opportunity for improvement. Monitoring appointment wait times provides the plan with information related to members' ability to access available services.

Since MRPIU's review showed that not all of AAH's prior-authorization notification files were in compliance, the plan has an opportunity to monitor itself in this area. Finally, the plan has an opportunity to re-educate providers on cultural and linguistic services policies, including the grievance process and language interpreter services.

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, which provide a standardized method for objectively evaluating 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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed a HEDIS Compliance Audit™ of AAH in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[5] Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

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

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. Table 3.1 displays a HEDIS performance measure name key.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
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*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*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*

Table 3.2 below presents a summary of AAH's HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan's HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national Medicaid 25th percentile and 90th percentile, respectively. 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—2009–2010 Performance Measure Results for Alameda Alliance for Health—Alameda County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	23.3%	29.8%	★★	↔	20.2%	33.4%
AWC	Q,A,T	44.8%	38.7%	★★	↔	37.9%	59.4%
BCS	Q,A	45.2%	59.6%	★★	↑	45.0%	63.0%
CCS	Q,A	69.6%	62.1%	★★	↓	60.9%	79.5%
CDC–BP	Q	‡	57.1%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	31.4%	25.5%	★	↓	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	36.9%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	54.4%	54.3%	★	↔	50.6%	29.2%
CDC–HT	Q,A	74.6%	77.5%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	35.4%	29.5%	★★	↓	27.2%	44.7%
CDC–LS	Q,A	76.1%	70.3%	★	↓	71.5%	82.5%
CDC–N	Q,A	81.0%	72.2%	★	↓	73.4%	85.4%
CIS–3	Q,A,T	79.0%	71.3%	★★	↓	62.4%	80.6%
LBP	Q	‡	87.1%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	69.2%	60.5%	★	↓	78.5%	92.2%
PPC–Pst	Q,A,T	60.3%	50.9%	★	↓	57.9%	72.7%
URI	Q	90.6%	94.9%	★★★	↑	81.1%	94.5%
W34	Q,A,T	71.3%	69.9%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	37.0%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	83.8%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	60.4%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[5] Performance comparisons are based on the Chi-Square 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 DHCS did not require plans to report this measure in 2009.
NA= The DHCS does not establish an MPL/HPL for first year measures.
★ = 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 had average to below-average performance with substantial performance declines between 2009 and 2010. The plan had eight measures with statistically significant declines in 2010 and six measures that had 2010 rates below the national Medicaid 25th percentiles. Of the six measures with below-average performance, four were related to diabetes care and two were related to prenatal and postpartum care.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline the steps it will take to improve care.

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing towards the MPL. In addition, HSAG assessed the plan's need for continuing existing improvement plans and/or developing new improvement plans.

Based on AAH's 2009 performance measure rates, the DHCS required the plan to submit 2009 HEDIS improvement plans for three measures:

- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent).*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care.*

HSAG reviewed AAH's 2009 HEDIS improvement plans using HEDIS 2010 rates, and assessed whether the plan improved its performance in 2010. HSAG provides the following analysis of the plan's 2009 HEDIS improvement plans.

Prenatal Care

AAH has struggled to improve its performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* measure. AAH has been working on an improvement plan for this measure since 2008. In the initial 2008 improvement plan, AAH cited the following barriers:

- Identifying pregnant members early in their pregnancy, making it difficult to provide successful outreach and link women with timely prenatal care.
- Lack of transportation.
- Lack of social support.

- Lack of understanding of the importance of prenatal care.
- Lack of literacy skills.
- Behavioral health issues.

AAH implemented a "Go Before You Show" informational campaign to raise awareness and educate members on the importance of prenatal care. The plan did not have improvement with the 2008 intervention and identified new barriers in 2009 related primarily to data capture of prenatal care visits. AAH indicated that administrative data from one of its plan's delegated providers were not pulled appropriately; addresses for prenatal providers were inaccurate or unclear, making it difficult to locate the appropriate chart; and prenatal care transportation services were inappropriately coded as ambulance visits and deliveries. While these issues may have resulted in lower results from administrative data, the plan should have been able to mitigate most of these issues when collecting the medical record data. Additionally, the plan asserted that scoring was incorrect for members who were not with the plan during the first trimester and that some capitated provider groups' claims were not being captured as paid claims. To address these issues, the plan outlined actions to resolve each barrier. Most of the actions, however, were standard procedures for ensuring data integrity and accuracy. While these efforts are necessary, they will not improve the delivery of prenatal care services to the plan's members. The data issues should be resolved expeditiously so that stronger improvement efforts can be implemented that improve the rate of women receiving timely prenatal care.

Diabetes Care

AAH was required to develop HEDIS improvement plans to improve eye exam rates and decrease the percentage of members with poor HbA1c control. The plan's improvement plan outlined problems with the integrity and quality of claims and encounter data; therefore, AAH is using technical consultants to identify and resolve problems. Additionally, the plan focused on ensuring improvement of delegated medical groups' submission of complete data and that these data were appropriately mapped to the plan's data warehouse.

Between 2009 and 2010, the plan had a statistically significant decline in eye exam rates, although the plan indicated that it did not expect to see rates improve until HEDIS 2011 based on the plan's initiated interventions.

To address HbA1c control, the plan indicated similar issues related to data capture. This measure assesses the percentage of members with an HbA1c test that have a lab value of greater than 9 percent. Members without an HbA1c test lab value are considered to have poor control. It was difficult to determine from the documentation submitted by the plan whether analysis was done to distinguish between the percentage of members without a lab result and the percentage of members with a lab result of more than 9 percent. While actions related to capturing the lab values

seemed appropriately aligned, others were not consistent with identified barriers or were not consistent with the intent of the measure. Additionally, many actions listed in this improvement plan were related to improving diabetic eye exam rates. This suggests that the improvement plan may be an exercise in documentation compliance for the plan versus a thoughtful effort to improve the performance measure rate. The plan did not show an improvement in rates between 2009 and 2010.

Based on its 2010 performance measure rates, AAH will need to continue all three improvement plans from 2009. In addition, the plan will need to submit improvement plans to address the additional three measures that fell below the MPLs:

- *Comprehensive Diabetes Care—LDL-C Screening.*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy.*
- *Prenatal and Postpartum Care—Postpartum Care*.

Strengths

AAH had two measures with statistically significant increases between 2009 and 2010 for *Breast Cancer Screening* and *Appropriate Treatment for Children With Upper Respiratory Infection*. The plan exceeded the national Medicaid 90th percentile for the URI measure with a rate of 94.9 percent.

Opportunities for Improvement

AAH's opportunities for improvement in the area performance measures are great. The plan showed an alarming decline in performance between 2009 and 2010. Additionally, measures that were below the MPLs in 2009 all had further declines in 2010. The plan indicated that data capture issues contributed to the poor performance. If this is accurate, the plan should improve significantly its 2011 performance measure rates as the plan will have had adequate time to correct these deficiencies.

The plan has an opportunity to improve documentation in its HEDIS improvement plans to better support the identified barriers and ensure that interventions are aligned appropriately. As part of the 2010 improvement plans, AAH needs to include an update of all actions outlined in the 2009 improvement plans—specifically, the result and the analysis of the interventions.

If the plan does not significantly improve its 2011 *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* rate, the DHCS should consider taking additional, formal action to resolve the plan's ongoing low performance in this area.

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 clinical and nonclinical areas.

HSAG reviews each QIP using the Centers for Medicare & Medicaid Services' (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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Quality Improvement Projects Conducted

AAH had two clinical QIPs in progress during the review period of July 1, 2009, through June 30, 2010. 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 a 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 table below summarizes the validation results for both of AAH's QIPs across the CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Alameda Alliance for Health—Alameda County July 1, 2009, through June 30, 2010

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				
Reducing Avoidable Emergency Room Visits	Annual Submission	84%	100%	*Met*
Internal QIPs				
Decrease Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age	Annual Submission	89%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the plan 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*.

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met, Partially Met,* or *Not Met*. In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that the annual submission by AAH of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met* with 84 percent of all evaluation elements and 100 percent of critical elements receiving a *Met* score. Additionally, AAH received a *Met* validation status for its *Decreasing Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age* QIP submission. Eighty-nine percent of all elements and 100 percent of critical elements received a *Met* validation score. Neither QIP required a resubmission.

Table 4.2 summarizes the validation results for both of AAH's QIPs across the CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates*
for Alameda Alliance for Health—Alameda County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2009, through June 30, 2010

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%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	75%	19%	6%
	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		**58%**	**13%**	**29%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.
‡ The QIP did not progress to this activity during the review period and could not be assessed.

AAH submitted Remeasurement 1 data for both QIPs; therefore, HSAG validated Activity I through Activity IX. AAH demonstrated an excellent understanding of the design and implementation stages, scoring 100 percent on all evaluation elements. Conversely, for the outcomes stage, AAH was scored lower in Activity VIII for the plan's lack of statistical testing, incomplete interpretation of results, and inaccurate presentation results for its *Reducing Avoidable Emergency Room Visits* QIP. The *Decreasing Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age* QIP did not include documentation identifying if there were factors that affected the ability to compare results between measurement periods. Neither QIP demonstrated improvement; therefore, AAH received a score of 25 percent for Activity IX.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3—Quality Improvement Project Outcomes for Alameda Alliance for Health—Alameda County (Number = 2 QIP Submissions, 2 QIP Topics) July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits				
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)	Sustained Improvement
Percentage of avoidable ER visits	12.1%	15.0%*	‡	‡
QIP #2—Decrease Return ER Visits for Asthmatic Exacerbations in Children				
QIP Study Indicator	**Baseline Period (7/1/07–6/30/08)**	**Remeasurement 1 (7/1/08–6/30/09)**	**Remeasurement 2 (07/1/09–06/30/10)**	**Sustained Improvement**
Percentage of children 2 through 18 years of age who have more than two ER visits for asthma in one year	17.45%	20.67%	‡	‡

*A statistically significant difference between baseline and Remeasurement 1 (p value < 0.05)
‡The QIP did not progress to this phase during the review period and could not be assessed.

AAH reported a decline in performance for both QIP study indicators. The increase in the avoidable ER visits indicator rate was statistically significant while the increase in the multiple ER visits rate for the asthma measure was not statistically significant.

For the avoidable ER visits QIP, the plan implemented the statewide collaborative work group interventions following Remeasurement 1. AAH documented that an increase in H1N1 flu diagnoses during the remeasurement period may have contributed to the increase in asthmatics returning to the ER. In addition, AAH stated that an increase in membership during 2008 included more asthmatics that may have contributed to the increase in asthmatic ER visits. AAH continued its ATTACK Clinic at Children's Hospital in Oakland, which connected members to their medical home and provided families with tools/training to manage asthma at home.

Strengths

AAH demonstrated an excellent understanding of the design and implementation stages and received *Met* scores for all evaluation elements. The plan achieved these scores without the benefit of resubmission, indicating proficiency with the QIP validation process.

Opportunities for Improvement

AAH has an opportunity to improve its QIP documentation—specifically, its interpretation and accuracy of reported analysis as well as statistical testing—which is required in Activity VIII. In addition, to address the decline in performance for both QIPs, HSAG recommends that AAH conduct, at a minimum, annual causal-barrier and subgroup analyses to determine why and for what groups the current interventions did not produce improvement in Remeasurement 1.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan surveys.[6]

The administration of the CAHPS surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS surveys be administered to both adult members and the parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

The Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about AAH'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 as follows:

CAHPS Global Rating Measures:

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

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

CAHPS Composite Measures:

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

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance (NCQA)'s HEDIS® benchmarks and thresholds or NCQA's national Medicaid data, when applicable. 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*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 5.1.

Table 5.1—Star Ratings Crosswalk

Stars	Adult Percentiles	Child Percentiles
★★★★★	≥ 90th percentile	≥ 80th percentile
★★★★	75th percentile–89th percentile	60th percentile–79th percentile
★★★	50th percentile–74th percentile	40th percentile–59th percentile
★★	25th percentile–49th percentile	20th percentile–39th percentile
★	< 25th percentile	< 20th percentile

Table 5.2—Alameda Alliance for Health—Alameda County Medi-Cal Managed Care County-Level Global Ratings

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★	★
Child	★★	★	★★	★★+

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Table 5.3—Alameda Alliance for Health—Alameda County Medi-Cal Managed Care County-Level Composite Ratings

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Adult	★	★	★	★★+	★
Child	★	★	★	★+	★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Strengths

AAH performed best on the child global rating scores with all child global measure rates above the national Medicaid 20th percentiles except the *Rating of All Health Care* measure.

Opportunities for Improvement

AAH's CAHPS results showed primarily poor performance for all adult global rating categories and most composite measures for adult surveys. Child survey CAHPS results showed poor performance for all child composite ratings. While AAH showed a need for improvement in all areas of member satisfaction across both adult and child populations, HSAG conducted a key drivers of satisfaction analysis that focused on the top three highest priorities based on the plan's CAHPS results. The purpose of the key drivers of satisfaction analysis was to help decision makers identify specific aspects of care most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as AAH's highest priority: *Rating of All Health Care*, *Rating of Health Plan,* and *Getting Needed Care*. The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program – 2010 Alameda Alliance for Health CAHPS Plan-Specific Report.* Areas for improvement spanned the quality, access, and timeliness domains of care.

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 the results of performance measures and quality improvement projects (QIPs) 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.

The plan showed average to below-average performance in the quality domain. This assessment was based on AAH's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

While the plan was able to report valid rates for all 2010 performance measures, many rates decreased between 2009 and 2010, resulting in an increase in the number of measures below the MPL from three in 2009 to six in 2010. The plan had eight statistically significant declines in performance measure rates between 2009 and 2010 and two statistically significant increases in performance measure rates.

Although the plan has complied with submitting 2009 HEDIS improvement plans for measures that fell below the minimum performance levels (MPLs), HSAG noted that at least one of the improvement plans, based on its low 2009 rates, did not appear to address the intent of the measure. Without modification, the improvement plan may have little to no impact on improving the rate in subsequent years. The plan performed best on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, which exceeded the national Medicaid 90th percentile. The

plan's greatest opportunities for performance measure improvement relate to diabetes care and prenatal and postpartum care.

QIP results showed that the plan did well with documenting the QIP study design and implementation phases; however, the plan had challenges with achieving improved outcomes. The plan has an opportunity to further analyze factors that may be preventing the plan from achieving improved outcomes.

Although AAH did not have improved performance based on the 2010 HEDIS and QIP study indicator rates, the plan did demonstrate substantial improvement in the area of compliance. The plan adequately addressed all but one area of concern identified as part of the October 2008 joint audit. Additionally, the Member Rights/Program Integrity Unit (MRPIU) review conducted in May 2010 revealed compliance with most areas covered under the scope of the review.

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 a plan'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 under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, and member satisfaction results are used 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 members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

The plan demonstrated average to below-average performance in the access domain. This assessment was based on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results. Overall, performance measure rates for which HSAG identified a need for focused improvement efforts—*Comprehensive Diabetes Care*, *Timeliness of Prenatal Care*, and *Postpartum Care*—fell under the access domain of care.

For access-related compliance standards, the plan had one outstanding medical performance audit issue related to monitoring wait times. The plan was not able to demonstrate a mechanism to track in-office wait times for members. The MRPIU review found that not all providers' offices interviewed were aware of the 24-hour language line, and not all providers discouraged the use of

a minor as an interpreter. Member satisfaction results for adults and children demonstrated poor performance for the *Getting Needed Care* composite. This composite assesses members' satisfaction with accessing care once a need is identified. This area was a significant opportunity for improvement. Despite the opportunities for continued improvement, the plan was fully compliant with the standards reviewed related to continuity and coordination of care for members and network adequacy.

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, to minimize any disruptions to care, and to 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. 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.

AAH demonstrated average performance in the timeliness domain of care. This assessment was based on 2010 performance measure rates for providing timely care, medical performance and member rights reviews related to timeliness, and member satisfaction results related to timeliness. AAH excelled in the area of member grievances. MRPIU commended the plan for its processes to resolve member grievances. AAH met all required time frames for handling member grievances.

Performance measure rates related to timeliness showed that the plan performed above the MPL for well-child visits and childhood immunizations, suggesting that members are receiving care within the appropriate time frame after a need is identified for preventive services. The plan has opportunities to improve its performance on both the prenatal and postpartum care measures.

Member satisfaction results showed that the plan demonstrated poor performance in the *Getting Care Quickly* category for both adult and child populations. This suggests that members perceive that they do not always receive care in a timely manner.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. AAH's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, AAH had below-average to average performance in providing quality and accessible health care services to its MCMC members. The plan had average performance in providing timely services.

AAH showed a decline in its performance measures rates in 2010 compared with 2009 rates. The plan was generally compliant with documentation requirements across performance measures, QIPs, and State and federal requirements; however, the plan experienced challenges with improving actual health outcomes for members.

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

- Implement a mechanism to monitor appointment wait times.
- Conduct periodic, internal, prior-authorization file audits to ensure compliance with the required documentation.
- Re-educate providers on the cultural and linguistic service requirements, including the grievance process and language interpreter services.
- Incorporate data capture issues into the quality improvement program's work plan as a mechanism to track and monitor progress.
- Submit 2010 HEDIS improvement plans that include an update on all actions outlined in the 2009 improvement plans, including the result and analysis of interventions.
- Review, rewrite, and resubmit the *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)* HEDIS improvement plan to better align barriers and interventions.
- Conduct annual causal-barrier and subgroup analyses to determine why and for what groups current QIP interventions did not produce improvement between measurement periods.
- Review the 2010 plan-specific CAHPS results report and develop strategies to address the following priority areas: *Getting Needed Care, Customer Service,* and *Rating of All Health.*

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

APPENDIX A. FOLLOW-UP ON THE PRIOR YEAR'S RECOMMENDATIONS GRID

for Alameda Alliance for Health

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address Recommendation	Comments
1. 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	A HEDIS Quality Improvement Plan was submitted in February 2010 to improve performance on the PPC-Pre Measure below MPL score received in HEDIS 2009 reporting. Interventions for improved encounter and provider demographic data and a new supplementary data source were implemented. Encounter and provider demographic data quality continue to be a challenge. However, county birth data was successfully obtained and used as supplemental data for the measure.	The 2010 HEDIS score for this measure was again below the MPL. Completeness of encounter data for the Prenatal and Postpartum Care—Timeliness of Prenatal Care measure has been a challenge for two major reasons: (1) AAH historically paid obstetricians using a global reimbursement rate and did not receive claims until after the delivery, and (2) Kaiser Health Plan (KHP) encounter data may not accurately represent services because of KHP's unique coding practices. Solutions for these issues have been implemented. First, reimbursement rates for obstetricians are being renegotiated in 2011.The lack of data related to the global payment will be corrected in future HEDIS reporting years. Second, an incentive amendment was added to the plan's contract with KHP requiring the timely and accurate submission of HEDIS measure data. This performance guarantee is expected to produce more complete HEDIS data.
2. Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance toward increasing compliance with the CMS protocol for conducting QIPs.	Effective July 1, 2009, in accordance with MMCD APL 09-008, Alliance staff began to use the HSAG QIP Summary Form for submission of QIP documents to MMCD-DHCS. The annual ER Collaborative reports were submitted in 2009 and 2010 using the required QIP Summary Form.	AAH submitted the plan's annual ER Collaborative reports for 2009 and 2010 using the QIP Summary Form. HSAG feedback on the plan's performance and progress in the collaborative was provided in the HSAG QIP Validation Tool. This feedback was incorporated/ implemented and *Points of Clarification*, *Partially Met* and *Not Met* evaluation elements were addressed as appropriate.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address Recommendation	Comments
3. 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.	Members calling with access complaints are offered assistance with making an appointment or given the option to change their PCP. Grievances and appeals about access are regularly monitored for patterns and trends and reported quarterly to the plan's Health Care Quality Committee and to the DHCS and DMHC. Multiple access complaints about a provider or increased PCP change requests for a specific provider are forwarded to the chief medical officer (CMO) and the director of provider services for review and action. Access complaints that involve care quality are investigated as potential quality of care (PQI) issues by staff and the CMO. Appropriate actions for this type of PQI may include Credential Committee review. The Provider Services Department is actively involved with provider access issues and visits offices/clinics to assess and assist with access problem resolution. A quarterly report to directly contracted PCPs containing ER utilization data for their assigned members was initiated in January 2010. In March 2010, this report was expanded to include a list of members without a PCP visit in the last 12 months. The CMO began regular meetings with high-volume panel directly contracted PCPs to highlight the importance of reducing avoidable ER visits among their patients. The CMO reviews the PCP's member utilization report and discusses the benefits of reducing ER usage with the provider. AAH is waiting for results from member and provider timely access surveys conducted in Spring 2011. These surveys will be conducted annually.	A June 2010 interim report on the statewide ER collaborative included the statement that the "collaborative expresses concern that its efforts to reduce avoidable visits may not be enough to impact this multifaceted problem." This statement underscores the difficulty changing member utilization patterns. The Alliance Medi-Cal HEDIS 2010 use of service rate for ER visits/1000 member months is 3 percentage points lower than the rate for HEDIS 2008. This is significant because the Medi-Cal population increased 18 percent between 2008 and 2010.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address Recommendation	Comments
	The plan conducts an annual analysis of network adequacy for PCP and high-volume specialist access and uses the findings to inform provider contracting decisions. The 2011 analysis indicated the following about current network providers: (1) cultural competency was within acceptable ranges, (2) there is a sufficient number of PCPs at the 1:2000 ratio, (3) the 1:10,000 ratio of specialists to members is exceeded in all categories, and (4) there is a sufficient number of high-volume specialists within a 30-mile radius of each member's residence. Contracted delegated medical groups focus on improving member access to their provider networks. Children's First Medical Group (CFMG) initiated a quarterly report to its providers in January 2010 that identifies members with three or more ER visits within the prior quarter. CFMG also conducts an annual ER utilization study. Community Health Center Network (CHCN) provides quarterly ER utilization reports to clinics for members with five or more ER visits in the prior quarter. One CHCN clinic has a pilot project to reduce ER visits at one local hospital by contacting the member after an avoidable ER visit. Project results are not yet available. AAH's network includes the federally qualified health care clinics, the Alameda County Medical Center clinics, and Kaiser Health Plan. These providers offer increased access through extended and after-hour schedules for a significant portion of the Alliance Medi-Cal population.	

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address Recommendation	Comments
4. Implement a process to monitor audit deficiencies to ensure that they are fully resolved to reduce the number of repeat audit findings.	The Alliance Compliance and Government Relations Departments coordinate, monitor and provide direction for operational departments to correct deficiencies identified on external audits. Audits/reviews conducted after the 2008–2009 DHCS plan evaluation report include: (1) a November 2010 DHCS Follow-up Report on Corrective Action Plan (CAP) Items [from the Medical Audit Close-Out Report of October 6, 2009] indicated that CAPs for 11 of 12 deficiencies were accepted and considered closed. The open CAP for monitoring wait times has been addressed by the annual member and provider timely access surveys initiated in Spring 2011; and (2) DHCS's May 2010 MRPIU monitoring visit had no corrective action plan but deficiencies noted in findings were corrected (e.g., a prior authorization file checklist was implemented to ensure inclusion of all NOA letters; and provider orientation/education materials about cultural and linguistic service requirements and the availability of oral translation services were developed and deployed to current and new network providers). Past audit findings on monitoring network adequacy, appointment wait times, and member service call standards have been corrected. Plan actions that address network adequacy and appointment wait times are discussed earlier in this document and in the response to Recommendation #3. Plan performance to meet member service call standards was improved with the September 2010 installation of *inContact* call center services and ACD software. Member service call center staff performance is continuously monitored and benchmarked against contract and industry call center standards. A repeat audit finding identified the plan's low compliance rate for PCP completion of members' initial health assessments (IHAs). 2010 plan actions to improve these completion rates	In June 2011, AAH implemented a new system for compliance and audit management. Compliance 360 (C360) is a Web-based service that houses, tracks and manages audits, policies and procedures, regulatory submissions and contracts. This new system will allow AAH to more effectively follow up on audit findings and enhance future monitoring activities.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address Recommendation	Comments
	are briefly described in the Plan Actions for Recommendation #5 below. A finding about the failure to include quality of care issues and supporting documentation for consideration with a provider's recredentialing files was corrected. All recredential records include updated documentation of quality of care issues that involve the provider under review. A finding that provider offices need to track and log grievances and forward this information to the plan has been corrected by two plan actions. The DHCS Facility Site Review tool includes two questions that measure providers' knowledge of and compliance with the plan's member grievance and appeal process. A second action that addresses this finding is the discussion of member grievance and appeal process requirements during provider orientation and re-orientation visits by Provider Services Department representatives.	
5. 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.	AAH is waiting for results from member and provider timely access surveys conducted in Spring 2011. These surveys will be conducted annually to assess whether appointment times meet acceptable standards The results will be used to design improvement programs. Starting in March 2010, AAH began sending each directly contracted PCP a list of assigned members for whom it had not received a claim in the previous 12 months. This report is provided every quarter and is meant to alert every PCP to members who require an annual or initial health assessment (IHA). In 2010, AAH implemented a quarterly report of authorizations and claims for non-network specialty referrals in response to a DHCS corrective action plan from a 2008 joint DHCS-DMHC audit finding. The plan continues to provide standing referrals to specialists in accordance with Health and Safety Code, CCR, Section 1374.16.	AAH's current referral process is designed to maximize member access to specialist visits. No plan prior authorization is required for PCP referrals to in-network specialists. AAH's data systems have historically limited the plan's ability to share member information between contracted providers for the purpose of improving continuity and coordination of care. Contract negotiations are in process to implement secure provider and member Web portals before the end of 2011. This new capability will support provider access to their members' information and allow the plan to send meaningful use data about members to their PCPs. For example, the plan will now be able to notify providers about members who receive developmental services from the Regional Center of the East Bay (RCEB) and services from other disability or county health care organizations.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address Recommendation	Comments
6. Continue to monitor compliance with DHCS's standards for access to care, structure and operations, and quality measurement and improvement.	AAH is compliant with DHCS's contract requirements in Exhibit A, Attachment 4 for the quality improvement system. The Quality improvement plan description, work plan, and each year's QI evaluation have been prepared, updated and submitted annually to the Health Care Quality Committee, the Alliance Board of Governors, and the DHCS.	The QI plan description and work plan address the standards for access to care, structure and operations, and quality measurement and improvement.