Performance Evaluation Report

AHF Healthcare Centers

July 1, 2009–June 30, 2010

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

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1. INTRODUCTION

Purpose of Report

The Department of Health Care Services (DHCS) administers 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, AHF Healthcare Centers ("AHF" or "the plan"), which delivers care in Los Angeles 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

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, 2010, the plan had 756 MCMC members.[2]

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.

[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 AHF'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

For most MCMC plans, 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. 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 medical performance review reports available as of June 30, 2010, to assess plans' compliance with State-specified standards. HSAG reported the April 2006 results in the prior year's plan evaluation report. The most recent medical performance review results were not available and will be reported in next year's plan evaluation report.

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.

MRPIU conducted a routine monitoring visit of AHF in June 2010 which covered the review period of January 1, 2008, through April 30, 2010.

The review found AHF to be fully compliant with prior authorization notification procedures; marketing; and fraud and abuse prevention, monitoring, and notification requirements. AHF was cited for the following deficiencies:

- A review of 50 grievance files found three cases in which the resolution letter was not sent within 30 days of receipt of the grievance. This was a repeat finding from the 2005 and 2008 reviews.
- In the area of cultural and linguistic services, there was a lack of awareness by some contracted providers of 24-hour access to interpreter services or procedures for referring members to community programs that offer cultural and linguistic services. Some providers did not adhere to requirements to document member requests for, or refusal of, language/interpreter services or discourage the use of family or friends as translators.
- Under member services, the plan's evidence of coverage document provided to members was missing various required information.

Strengths

AHF was fully compliant with several areas evaluated by the MRPIU, including prior authorization notification, marketing functions, and fraud and abuse. The plan resolved most of the grievance deficiencies that were identified during the prior MRPIU review conducted in May 2008.

Opportunities for Improvement

AHF has an opportunity to fully address and resolve the notification letter requirements for processing grievances.

In the area of cultural and linguistic services, it appears that many of AHF's contracted providers either do not understand or adhere to the requirements, or are not aware of services that are available for their patients. AHF should educate its providers regarding the cultural and linguistic requirements and services available, and implement a formal monitoring process to ensure the training was effective and providers are adhering to policies, procedures, and guidelines.

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.

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 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®)[3] or design a measure that is appropriate to the plan's population. Furthermore, 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.

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 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 AHF's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under two domains of care—quality and access.

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

Performance Measure Validation

AHF reported two HEDIS measures; therefore, HSAG performed an NCQA HEDIS Compliance Audit™ in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[4] Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern. The auditors recommended that AHF prepare flow diagrams covering key data processing functions, including claims/encounter data, enrollment data, and provider data as a means to further validate measure calculations.

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Table 3.2.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAP	*Adults' Access to Preventive/Ambulatory Health Service*
COL	*Colorectal Cancer Screening*

The table below presents a summary of AHF'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 the *Adults' Access to Preventive/Ambulatory Health Service (AAP)* 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 *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.

[4] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance.

Table 3.2—2009–20010 Performance Measure Results for AHF Healthcare Centers—Los Angeles 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]
Adults' Access to Preventive/Ambulatory Health Service (AAP)							
20–44 years	Q,A	98.5%	97.98%	★★★	↔	77.3%	88.4%
45–64 years		95.6%	100%	★★★	↑	83.9%	91.1%
65+ years		NA	NA	Not Comparable	Not Comparable	81.2%	93.7%
Colorectal Cancer Screening (COL)							
	Q,A	55.6%	64.19%	★★	↔	52.1%	69.6%

[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 COL measure, the MPL is based on the national Commercial 25th percentile since no Medicaid benchmark exists for this measure.
[7] 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 Commercial 90th percentile since no Medicaid benchmark exists for this measure.
★ = Below-average performance relative to the national Medicaid/Commercial 25th percentile.
★★ = Average performance relative to national Medicaid/Commercial percentiles (between the 25th and 90th percentiles).
★★★ = Above-average performance relative to the national Medicaid/Commercial 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.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, AHF demonstrated average to above average performance, achieving the HPL in both reported indicators for the *Adults' Access to Preventive/Ambulatory Health Service (AAP)* measure and a statistically significant improvement in the ages 45–64 years indicator. The rate for the *Colorectal Cancer Screening* measure fell between the MPL and HPL and showed a gain over the 2009 rate; however, the increase was not statistically significant.

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 toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans. AHF did not have any 2009 performance measure rates that required an improvement plan.

Strengths

AHF showed strong performance in its performance measures, particularly for the *Adults' Access to Preventive/Ambulatory Health Service (AAP)* measure. In fact, for the ages 45–64 year's indicator, AHF achieved a rate of 100 percent for this measure. The plan also demonstrated increases in two of the three reported rates, with one being statistically significant.

Opportunities for Improvement

Although AHF had an increase in the *Colorectal Cancer Screening* rate, the plan has an opportunity to improve performance on the measure. Given the consistently high performance for the *Adults' Access to Preventive/Ambulatory Health Service (AAP)* measure, HSAG recommends that AHF work with the DHCS to select an alternative measure for 2011 reporting. The selected measure should be actionable and meaningful to the AHF membership.

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 AHF's performance in providing quality, accessible, and timely care and services to its MCMC members.

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, 2009, through June 30, 2010. 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 table below summarizes the validation results for both of AHF's QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for AHF Healthcare Centers—Los Angeles 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				
Controlling High Blood Pressure	Annual Submission	47%	36%	*Not Met*
	Resubmission 1	70%	100%	*Partially Met*
Internal QIPs				
Coumadin Use in Patients Diagnosed With HIV/AIDS	Annual Submission	55%	45%	*Not Met*
	Resubmission 1	66%	91%	*Partially Met*
	Resubmission 2	77%	100%	*Partially 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, 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.

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that the initial submission by AHF of its *Controlling High Blood Pressure* QIP received an overall validation status of *Not Met.* As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted this QIP and upon subsequent validation, achieved an overall *Partially Met* validation status, with 70 percent of all evaluation elements and 100 percent of critical elements receiving a *Met* score.

Since 100 percent of critical elements were scored *Met,* the QIP was technically sound and AHF was not required to resubmit again.

Similarly, AHF received a *Not Met* validation status for its *Coumadin Use in Patients Diagnosed With HIV/AIDS* QIP. AHF resubmitted this QIP and received a *Partially Met* validation status. A second resubmission resulted in a *Partially Met* validation status with 77 percent of all elements and 100 percent of critical elements receiving a *Met* validation score. Since 100 percent of critical elements were scored *Met*, the QIP was technically sound and AHF was not required to resubmit again.

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

Table 4.2—Quality Improvement Project Average Rates*
for AHF Healthcare Centers—Los Angeles County (Number = 2 QIPs, 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	67%	8%	25%
	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		**88%**	**3%**	**9%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	25%	50%	25%
	VII: Appropriate Improvement Strategies	86%	14%	0%
Implementation Total†		**43%**	**39%**	**17%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved†	50%	38%	13%
	X: Sustained Improvement Achieved	50%	50%	0%
Outcomes Total		**81%**	**15%**	**4%**

*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 sum of an activity or stage may not equal 100 percent due to rounding.

AHF submitted Remeasurement 2 data for both QIPs; therefore, HSAG validated through Activity X. Of the three QIP Stages, AHF demonstrated an understanding of the design stage, scoring 100 percent on three of the four evaluation elements. Conversely, for the implementation stage, AHF was scored down in Activity VI and VII for data collection and improvement strategies. AHF did not properly document the elements associated with the use of manual data

collection and the plan failed to define how interventions were standardized. For the outcomes stage, the QIP demonstrated statistically significant improvement for one of the study indicators for the *Controlling High Blood Pressure* QIP, reflected by the 50 percent score for Activity IX. Similarly, the *Controlling High Blood Pressure* QIP demonstrated sustained improvement while the *Coumadin Use in Patients Diagnosed With HIV/AIDS* QIP did not achieve sustained improvement for all of its study indicators, reflected in the 50 percent score for Activity X.

Quality Improvement Project Outcomes

Table 4.3 summarizes 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 AHF Healthcare Centers—Los Angeles County (Number = 2 QIPs, 2 QIP Topics)
July 1, 2009, through June 30, 2010

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)**	**Sustained Improvement**
Percentage of patients with a systolic BP below 140 mmHg	66.5%	78.8%*	73.2%	Yes
Percentage of patients with a diastolic BP below 90 mmHg	74.5%	71.4%	79.8%*	Yes
QIP #2—Coumadin Use in Patients Diagnosed 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)**	**Sustained Improvement**
Percentage of AIDS/HIV members with 7 or more INR results on continuous Coumadin during the measurement year	40.0%	47.4%	37.5%	No
Percentage of AIDS/HIV members with INR values less than 4.0	86.4%	95.1%*	91.5%	Yes
Percentage of AIDS/HIV members admitted with anticoagulation as the primary diagnosis	8.6%	0%	0%	Yes
*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05).				

AHF reported statistically significant improvement for one of the *Controlling High Blood Pressure* QIP study indicators between the first and second remeasurement period; however, both study indicators achieved sustained improvement from baseline to Remeasurement 2. For the *Coumadin Use in Patients Diagnosed With HIV/AIDS* QIP, the plan showed mixed results. Two of the study

indicators had a decline in performance but the changes were not statistically significant. Overall, two of the three study indicators demonstrated sustained improvement from baseline to Remeasurement 2. Using member, provider, and system interventions, the plan was able to maintain improvements achieved during the QIP process. HSAG recommended that both QIPs be retired since two remeasurement periods had been completed and the QIPs achieved some success.

Strengths

AHF demonstrated an understanding of the design stage and received *Met* scores for three of the four activities. In addition, the plan received 100 percent *Met* scores for the evaluation elements in Activity VI related to statistical analysis. Between the two QIPs, AHF was able to achieve sustained improvement for four of the five study indicators demonstrating success in achieving desired outcomes and improved performance. AHF did not require resubmissions to achieve these scores, indicating proficiency with the QIP validation process.

Opportunities for Improvement

AHF has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs, specifically the manual data collection process required in Activity VI. Additionally, the plan should comply with the recommendations provided to eliminate the need for multiple submissions to achieve an overall *Met* validation score for its QIPs.

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. Specialty plans are required to administer an annual consumer satisfaction survey to their members to evaluate member satisfaction with care and services.

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

AHF reported the survey results within its internal quality evaluation for fiscal year 2009, covering the time period of January 1, 2009, through December 31, 2009.[5] HSAG reviewed the survey description, survey results, and AHF analysis. The survey results fell under the quality and timeliness domains.

AHF's client satisfaction survey involved collaboration between the plan, healthcare centers, and contracted pharmacies. The annual survey collected information regarding the general facility (cleanliness, feeling welcome, and overall satisfaction) front office staff performance (courteous, respectful, helpful), and the performance of the facilities staff and providers (courteous, respectful, attentive, understandable, responsive to concerns, and ability to explain medication purpose and dosage clearly). The survey results were based on a scale of one to six, with one representing very poor performance and six representing excellent performance. The overall rating of the healthcare centers was 5.5, and all areas measured showed results of 5.6 or greater. There were no areas of low performance, and the plan achieved improvement across all indicators over the past five years.

AHF's survey also evaluated the AHF pharmacy performance. Areas evaluated included an overall rating, courtesy/respect from staff and pharmacist, helpfulness, dispensing of medications in a timely manner, dispensing medications correctly and responses to concerns/complaints. In the 2009 survey, all indicators had results above 5.4 with no areas of low performance. Similar to the results for the healthcare centers, the plan achieved improvement across all indicators over the past five years.

[5] AHF Healthcare Foundation. *Quality Management Annual Evaluation – Fiscal Year 2009, January 1, 2009 through December 31, 2009.*

AHF also evaluated the overall plan rating. AHF achieved a rating of 5.5 in 2009, representing very good performance.

Strengths

AHF exhibited strong performance in the consumer satisfaction survey results earned by its healthcare centers and pharmacy, which demonstrated a progressive increase in ratings year over year.

Opportunities for Improvement

AHF should continue to monitor survey results and trends to proactively address any areas of concern as they are identified.

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 project (QIP) 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. Finally, some member satisfaction measures relate to quality of care.

The plan showed above-average performance based on AHF's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, member satisfaction survey results, and the results of the medical performance and member rights reviews as they related to measurement and improvement. The plan attained the HPL on both reported indicators for the *Adults' Access to Preventive/Ambulatory Health Service* measure as well as statistically significant improvement in one indicator. The plan also improved its rate for the *Colorectal Cancer Screening* measure, with performance well above the MPL.

AHF reported very high member satisfaction in the performance of its healthcare centers and pharmacies and demonstrated an annual upward trend over the past five years.

QIP results showed that the plan did well with documenting the QIP study design and implementation phase and produced positive QIP outcomes. The plan established sustained improvement for both *Controlling High Blood Pressure* QIP indicators and in two of the three indicators for the *Coumadin Use in Patients Diagnosed With HIV/AIDS* QIP. Both QIPs progressed through Remeasurement 2 and obtained a *Met* validation status.

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, cultural and linguistic services, and coverage of services.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as *Adults' Access to Preventive/Ambulatory Health Service* fall under the domains of quality and access because members rely on access to services and their availability to receive care according to generally accepted clinical guidelines.

The plan demonstrated average to below-average performance based on a review of 2010 performance measure rates that related to access, results of the medical performance and member rights reviews regarding availability and accessibility of care, and member satisfaction results. The *Adults' Access to Preventive/Ambulatory Health Service* measure showed very high performance results.

For access-related compliance standards, several audit findings were noted in the area of cultural and linguistic services. If these services were not offered to members, or members did not have access to them then plan performance would have been impacted in the area of access to care.

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.

AHF exhibited average to below-average performance in the timeliness domain of care 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.

Member satisfaction results showed that the plan pharmacies performed very well in providing medications in a timely manner.

AHF was fully compliant with prior authorization procedures when evaluated by the MRPIU review; however, the plan experienced challenges with sending out grievance notification letters.

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. AHF's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, AHF achieved above-average performance in providing quality healthcare services to its MCMC members. The plan demonstrated average to below-average performance, however, in providing accessible and timely services.

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

- Conduct periodic, internal grievance file audits to ensure compliance with the DHCS standards.
- Focus efforts on educating providers on cultural and linguistic services and conduct routine monitoring to ensure compliance with policies and procedures.
- Identify an alternative performance measure that assesses quality, access, and/or timeliness of care provided to AHF members.
- Develop and implement two new QIPs targeting areas that need performance improvement.

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

Appendix A. Follow-Up on the Prior Year's Recommendations Grid

for AHF Healthcare Centers

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 the Recommendation
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.	The plan has already adopted use of the HSAG QIP Summary Form. All QIPs submitted in 2010 and 2011 have been submitted using this form and have been approved by HSAG and the DHCS.
Select a new performance measure to replace the *Adults' Access to Preventive/Ambulatory Health Service (AAP)* measure in order to address other areas of low performance.	The Plan has selected *Controlling High Blood Pressure* as the second measure. Selection of this measure was approved by the State.
Implement standards for access to care and procedures to monitor the availability and accessibility of care.	The plan monitors access to care annually and availability of practitioners semiannually. The Access to Care survey is part of the Provider Satisfaction survey. The plan generates GeoAccess reports to monitor availability.
Review policies and procedures related to the grievance system to ensure that AHF's processes will meet all DHCS and federal requirements.	The plan has already corrected the Grievance and Appeals policy. This correction was presented to the State auditors during the onsite audit in April 2010.
Incorporate all areas of noncompliance, including repeat areas of noncompliance, into the quality improvement work plan to ensure they are resolved and monitored.	The plan has a robust QI work plan, conducts an annual analysis to identify areas for improvement, and monitors the progress of improvement activities and performance.
Consider categorizing grievance and appeal data to track and trend patterns of concern for targeted action.	The plan has already started categorizing grievance and appeals. In addition to that the plan tracks and trends grievances on a quarterly basis. The QI Team is involved in implementing activities to address areas for improvement.