Performance Evaluation Report

Alameda Alliance for Health

July 1, 2013–June 30, 2014

Managed Care Quality and Monitoring Division
California Department of Health Care Services

April 2015

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Performance Evaluation Report – Alameda Alliance for Health
July 1, 2013 – June 30, 2014

1. INTRODUCTION

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)[1] in the State of California through a combination of contracted full-scope and specialty managed care health plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and operations,

[1] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

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

- MCP-specific evaluation reports (July 1, 2013–June 30, 2014). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Alameda Alliance for Health ("AAH" or "the MCP"), for the review period July 1, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Health Plan Overview

AAH is a full-scope MCP delivering services to its MCMC members as a "Local Initiative" (LI) MCP under the Two-Plan Model (TPM). In TPM counties, MCMC beneficiaries may choose between two MCPs; typically, one MCP is an LI and the other a commercial plan (CP). DHCS contracts with both plans. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. MCMC beneficiaries may enroll in AAH, the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative CP.

AAH became operational in Alameda County to provide MCMC services effective 1996. As of June 30, 2014, AAH had 203,422 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

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

This report section covers review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to evaluate key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

Medical Audits and SPD Medical Surveys

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were

conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

DHCS received authorization "1115 Waiver" from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-County Organized Health System (COHS) counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

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

The most recent on-site SPD medical survey for AAH was conducted October 16, 2012, through October 19, 2012, covering the review period of July 1, 2011, through July 31, 2012. HSAG summarized the results of the survey in AAH's 2012–13 MCP-specific evaluation report. Three potential survey deficiencies were identified, and following is a summary of the status of each deficiency based on a letter dated September 9, 2013, from DHCS:

Access and Availability

- The MCP does not consistently display the level of access and the accessibility indicators for each provider on its website and in provider directories.
  - DHCS noted in the letter that while AAH has taken action to address this deficiency, in order to be in full compliance, the MCP must provide DHCS its website address demonstrating updates and a copy of the MCP's printed provider directory displaying the level of access information.

- The MCP does not ensure that appointments are available within the provider network at the required time frames.
  - DHCS noted in the letter that AAH has taken action to address the deficiency; however, in order to fully address the deficiency, the MCP needs to send to DHCS the MCP's policies and procedures with a target/goal regarding the monitoring of appointment availability within its provider network.

Quality Management

- During the first half of the survey review period, the MCP's governing body did not receive reports from the MCP's Health Care Quality Committee.
  - DHCS noted in the letter that the MCP has taken adequate corrective action to address the deficiency.

Department of Managed Health Care Routine Medical Survey

The most recent routine medical survey for AAH was conducted at the same time as the SPD medical survey—October 16, 2012, through October 19, 2012, covering the review period of July 1, 2011, through July 31, 2012. HSAG summarized the results of the survey in AAH's 2012–13 MCP-specific evaluation report. One deficiency in the area of Prescription (RX) Drug Coverage remained outstanding at the time the 2012–13 report was written. The deficiency was that the MCP does not consistently include in pharmacy denial letters a clear and concise explanation when denying, delaying, or modifying a request for services based on medical necessity.

In AAH's 2012–13 MCP-specific evaluation report, HSAG indicated that DMHC planned to review a sample of the MCP's pharmacy denial letters during the second quarter of 2013 to confirm the MCP is consistently providing a clear and concise explanation of the MCP's reason for the denial. As part of the process for writing the current report, HSAG received no documentation from DHCS indicating that DMHC reviewed the letters or that the MCP resolved this deficiency. It should be noted that the MCP provided a description of actions it has taken to address this deficiency (See Appendix D). Specifically, the MCP indicated that it implemented new processes to ensure that clear and concise language is used in all denial letters.

Strengths

AAH resolved the deficiency in the area of Quality Management identified during the SPD medical survey and made progress resolving the two deficiencies in the area of Access and Availability. Additionally, the MCP reports taking action to resolve the deficiency in the area of Prescription (RX) Drug Coverage identified during the most recent routine medical survey.

Opportunities for Improvement

The MCP has the opportunity to fully resolve the two deficiencies in the area of Access and Availability identified through the SPD medical survey and to ensure that actions taken to address the deficiency in the area of Prescription (RX) Drug Coverage identified during the routine medical survey meet DMHC's requirements.

Conducting the EQRO Review

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[4] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

Performance Measure Validation

DHCS's 2014 External Accountability Set consisted of 14 HEDIS measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 32. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for Alameda Alliance for Health* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that AAH followed the appropriate specifications to produce valid rates; however, there were issues of concern that caused a minimal impact on the findings. A brief summary of the findings and opportunities for improvement is included below.

- AAH had procedures in place to process data timely; therefore, no backlogs occurred in 2013.
- The Healthy Families Program population transitioned into MCMC during the measurement year, and there were some concerns regarding the MCP's ability to thoroughly account for each member due to system limitations. During the audit, AAH provided further documentation and it was determined there was no impact to the measures. The auditor recommended the MCP work with its vendor to correct the system limitations.
- AAH's vendor did not provide timely responses to the auditor's requests, which negatively affected the preliminary rate review process.
- The HSAG auditor recommended that AAH use industry standard codes for the *Prenatal and Postpartum Care* measures to ensure inclusion of all claims.

- As of January 1, 2014, AAH will use a new system for capturing claims and encounters. The auditor recommended that the MCP address any concerns or issues regarding this transition in next year's documentation.
- For future reporting purposes, the auditor recommended that AAH work with the Live Birth Vital Statistics and hospital staff to improve documentation of the first prenatal visit.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of AAH's performance measure results for 2011–14. Note that data may not be available for all four years.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 shows the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

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

The reader should note the following regarding Table 3.1:

- The *All-Cause Readmissions* measure is a non-HEDIS measure used for the ACR collaborative QIP; therefore, no MPL or HPL is established for this measure.
- For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- The *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures. No MPL or HPL is established for a utilization measure. Additionally, HSAG did not compare performance for these measures.
- Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for 2014:
  - All four *Children and Adolescents' Access to Primary Care* measures.
  - *Cervical Cancer Screening*. Note: MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008; however, due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014. Consequently, HSAG did not include or make comparisons to previous years' rates in this report.

- *Comprehensive Diabetes Care—LDL-C Control.* (This measure is being eliminated for HEDIS 2015.)
- *Comprehensive Diabetes Care—LDL-C Screening.* (This measure is being eliminated for HEDIS 2015.)

Table 3.1—Performance Measure Results
AAH—Alameda County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.66%	17.42%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	42.02	47.24	29.28	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	315.03	297.17	240.12	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	87.05%	84.40%	**83.78%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	**86.41%**	94.08%	93.43%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	84.78%	**81.92%**	84.34%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	35.61%	31.53%	38.09%	40.90%	↔
Cervical Cancer Screening	Q,A	—	—	—	59.85%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	**47.92%**	78.10%	79.08%	67.40%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**94.63%**	**92.32%**	**94.34%**	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**85.48%**	**83.91%**	**85.10%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**85.61%**	**85.06%**	**87.07%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**82.03%**	**84.64%**	**83.24%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	55.65%	59.85%	59.61%	57.66%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	**40.00%**	52.55%	48.91%	45.26%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.00%	83.21%	83.45%	81.75%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	40.00%	58.88%	51.58%	48.18%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	34.09%	43.55%	36.74%	29.20%	↓
Comprehensive Diabetes Care—LDL-C Screening	Q,A	74.26%	76.89%	77.62%	71.29%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	81.74%	82.97%	82.97%	80.05%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	49.91%	28.47%	37.47%	51.82%	▼
Controlling High Blood Pressure	Q	—	—	53.53%	**45.99%**	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	66.67%	76.40%	79.08%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**43.88%**	**41.69%**	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**24.23%**	**17.80%**	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	58.84%	61.07%	**57.18%**	**49.39%**	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**64.65%**	88.56%	80.54%	**79.56%**	↔
Use of Imaging Studies for Low Back Pain	Q	84.26%	84.76%	87.07%	88.58%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	39.58%	55.23%	55.23%	59.61%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	80.09%	58.64%	64.72%	71.29%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	55.79%	41.61%	46.23%	61.31%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	68.75%	77.62%	71.53%	70.80%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[5] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures).

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

Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

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

The final selected SPD measures are listed below. Following the list of measures are Table 3.2 and Table 3.3, which present a summary of AAH's 2014 SPD measure results. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[6] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[6] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.2.

Table 3.2—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for AAH—Alameda County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	13.64%	19.54%	▼	17.42%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.91%	84.69%	↑	83.78%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	92.80%	Not Comparable	93.43%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.90%	85.18%	↑	84.34%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.25%	100.0%	↔	94.34%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	85.07%	86.01%	↔	85.10%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	87.03%	87.57%	↔	87.07%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	83.59%	79.65%	↓	83.24%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	61.63%	56.93%	↔	57.66%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	44.06%	43.55%	↔	45.26%
Comprehensive Diabetes Care—HbA1c Testing	77.48%	84.43%	↑	81.75%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	44.80%	54.74%	↑	48.18%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.47%	30.90%	↔	29.20%
Comprehensive Diabetes Care—LDL-C Screening	63.86%	78.10%	↑	71.29%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.76%	85.16%	↑	80.05%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	55.20%	45.26%	▲	51.82%

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

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

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

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

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—2014 Non-SPD and SPD Rates for Ambulatory Care Measures AAH—Alameda County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
212.26	24.72	387.05	53.35

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

Performance Measure Result Findings

The rate for the *Use of Imaging Studies for Low Back Pain* measure was above the HPL for the fourth consecutive year and the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was above the HPL for the second consecutive year. The rates for the following measures improved significantly from 2013 to 2014:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics*, resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014.
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months, 25 Months to 6 Years, and 7 to 11 Years*; however, the rates for these measures remained below the MPLs for the third consecutive year.
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total.*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total.*

The rates for 10 measures were below the MPLs in 2014 and the rates for nine measures were significantly worse in 2014 when compared to 2013. The rates for the following measures moved from above the MPLs in 2013 to below the MPLs in 2014:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Controlling High Blood Pressure*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Seniors and Persons with Disabilities Findings

The SPD rates for seven measures were significantly better than the non-SPD rates and the SPD rates for the *All-Cause Readmissions* and *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measures were significantly worse than the non-SPD rates.

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

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act cycle. DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates (measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid cycle approach (including the Plan-Do-Study-Act cycle) to strengthen these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates

below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

Assessment of MCP's Improvement Plans

Based on 2013 rates, AAH was required to submit IPs for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* and *Prenatal and Postpartum Care—Postpartum Care* measures. Following is a summary of each IP and HSAG's assessment of the progress the MCP made toward improving the rates for the measures.

Annual Monitoring for Patients on Persistent Medications—Diuretics

AAH identified the following barriers to the rate for this measure being above the MPL:

- Lack of member outreach
- Lack of member awareness of the need for testing
- Incomplete lab data

The MCP implemented the following interventions to address the barriers:

- Had the pharmacy department make interactive voice response calls to inform members who are taking diuretics to get a lab test
- Published a newsletter to inform providers about the importance of annual lab monitoring for patients on diuretics
- Had the information technology department perform monthly monitoring of lab files

AAH's efforts resulted in the rate for this measure improving significantly and moving from below the MPL in 2013 to above the MPL in 2014. The MCP will not be required to submit an IP for this measure in 2014.

Prenatal and Postpartum Care—Postpartum Care

AAH submitted information to DHCS indicating that, due to financial constraints, the MCP was unable to implement planned interventions to address the rate for this measure being below the MPL in 2013. Since the rate for this measure was still below the MPL in 2014 and the rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure was below the MPL in 2014, the MCP will submit an IP that includes both of these measures.

Other Measures Requiring an Improvement Plan in 2014

AAH will be required to submit IPs for the following measures that had rates below the MPLs in 2014:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Controlling High Blood Pressure*
- Both *Medication Management for People with Asthma* measures
- Both *Prenatal and Postpartum Care* measures

Strengths

The rates for two measures were above the HPLs in 2014, and the rates for six measures improved significantly from 2013 to 2014. The MCP's improvement efforts resulted in the rate for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure moving from below the MPL in 2013 to above the MPL in 2014.

AAH provided documentation of actions the MCP has taken to improve performance on measures with rates below the MPLs in 2013 (See Appendix D). Although the rates for seven measures remained below the MPLs in 2014, the rate for one measure improved from below the MPL in 2013 to above the MPL in 2014, and the rates for three measures improved significantly from 2013 to 2014.

Opportunities for Improvement

AAH has the opportunity to assess the factors leading to the poor performance on several measures and identify improvement strategies that have the potential to result in positive outcomes. Additionally, to ensure AAH is meeting the needs of the SPD population, the MCP has the opportunity to assess the factors leading to the SPD rates for the *All-Cause Readmissions* and *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measures being significantly worse than the non-SPD rates. Although AAH documented actions the MCP has taken to reduce readmissions rates (See Appendix D), the efforts did not result in fewer readmissions. Instead, readmissions increased significantly from 2013 to 2014.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[7] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

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

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

HSAG organized, aggregated, and analyzed AAH's validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

Quality Improvement Project Objectives

AAH participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2013–June 30, 2014.

Table 4.1 below lists AAH's QIPs and indicates whether the QIP is clinical or nonclinical and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

Table 4.1—Quality Improvement Projects for AAH
July 1, 2013, through June 30, 2014

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members, leading to improved health outcomes.

AAH's *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP measures the percentage of members with a diagnosis of hypertension and compares it against national data to determine if there may be underreporting of the condition. To determine rates of medication adherence for members diagnosed with hypertension, the MCP measures the percentage of members who filled a prescription for their hypertensive medications. Hypertension is a risk factor for heart disease and stroke. Both the identification of high blood pressure and the management of the condition are important to prevent more serious complications.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Validation Activity
AAH—Alameda County
July 1, 2013, through June 30, 2014

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Annual Submission	63%	86%	*Partially Met*
	Annual Resubmission 1	63%	86%	*Partially Met*
	Annual Resubmission 2	69%	86%	*Partially Met*
	Annual Resubmission 3	100%	100%	*Met*
Internal QIPs				
Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension	Annual Submission	54%	57%	*Not Met*
	Annual Resubmission 1	62%	71%	*Partially Met*
	Annual Resubmission 2	62%	71%	*Partially Met*
	Annual Resubmission 3	77%	86%	*Partially Met*
	Annual Resubmission 4	85%	100%	*Met*

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

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that AAH's annual submission of its *All-Cause Readmissions* QIP received an overall validation status of *Partially Met*. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, AAH resubmitted the QIP and, after the third resubmission, achieved an overall *Met* validation status with 100 percent of evaluation elements (critical and noncritical) receiving a met score. The *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP annual submission received an overall status of *Not Met*. AAH resubmitted its QIP and, upon the fourth resubmission, achieved an overall *Met* validation status, with 85 percent of the evaluation elements and 100 percent of the critical elements receiving a met score.

Table 4.3 summarizes the aggregated validation results for AAH's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
AAH—Alameda County
(Number = 9 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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)	89%	11%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection**	89%	6%	6%
Design Total		**95%**	**3%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	48%	21%	30%
	VIII: Appropriate Improvement Strategies	57%	43%	0%
Implementation Total**		**51%**	**28%**	**22%**
Outcomes	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**25%**	**0%**	**75%**

*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 stage and/or activity totals may not equal 100 percent due to rounding.

HSAG validated Activities I through VIII for AAH's *All-Cause Readmissions* QIP annual submission and Activities I through IX for the MCP's *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP annual submission.

AAH demonstrated a strong application of the Design stage, meeting 95 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP did not document its data analysis plan for the *All-Cause Readmissions* QIP, resulting in a lower score for Activity VI. For the *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP, the MCP did not clearly define the study question and did not document a process for collecting baseline and remeasurement data, resulting in lower scores for Activities II and VI.

Both QIPs progressed to the Implementation stage during the reporting period. AAH struggled with its application of the Implementation stage for both QIPs, meeting 51 percent of the

requirements for all applicable evaluation elements within the study stage. The *All-Cause Readmissions* and *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIPs had multiple implementation issues, resulting in lower scores for Activities VII and VIII. HSAG held a technical assistance call with AAH to discuss ways the MCP could improve upon the implementation of the QIPs and address the deficiencies. AAH corrected the deficiencies in the resubmissions, resulting in both QIPs achieving an overall *Met* validation status.

Only the *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP progressed to the Outcomes stage during the reporting period. The QIP received a lower score in Activity IX because the rates for Study Indicator 1 and 2 declined from the baseline period to the first remeasurement period. This QIP was not assessed for sustained improvement (Activity X) since it had not yet progressed to that stage.

Quality Improvement Project Outcomes and Interventions

The *All-Cause Readmissions* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP's interventions for the *All-Cause Readmissions* QIP:

- The Mobile Medical Examination Service conducts home visits. The purpose of the home visit is to:
  - Assess and compile clinical and diagnostic data from the member for the purposes of care coordination, disease management, and education.
  - Provide members with guidance related to specific issues to discuss with the primary care physician.
  - Identify urgent health problems or health risks.
  - Optimize the Centers for Medicare & Medicaid Services Hierarchical Condition Categories scoring through appropriate documentation of medical records and submission of all relevant ICD-9 diagnostic codes identified during the home visit.
  - Follow up with members who were readmitted to assess the cause and effect of the readmission.

Outcome information for the *All-Cause Readmissions* QIP will be included in AAH's 2014–15 MCP-specific evaluation report.

Table 4.4 summarizes the *Improving Anti-Hypertensive Medication Fills Among Members with Hypertension* QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

Table 4.4—Quality Improvement Project Outcomes for AAH—Alameda County July 1, 2013, through June 30, 2014

QIP #1—Improving Anti-Hypertensive Medication Fills Among Members with Hypertension			
Study Indicator 1: The percentage of members 18–85 years of age continuously enrolled as of December 31 of each measurement year, with a diagnosis of hypertension in the first 6 months of the measurement year who filled at least one anti-hypertensive medication.			
Baseline Period 1/1/11–12/31/11	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**	**Sustained Improvement¥**
65.6%	64.0%	‡	‡
Study Indicator 2: The percentage of members 18–85 years of age continuously enrolled as of December 31 of each measurement year, with a diagnosis of hypertension in the first 6 months of the measurement year and taking at least 1, 2, or 3 antihypertensive medications who had a fill rate of at least 40% during the measurement year.			
Baseline Period 1/1/11–12/31/11	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**	**Sustained Improvement¥**
53.9%	48.3%*	‡	‡

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

* A statistically significant difference between the measurement period and the prior measurement period (*p* value <0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Improving Anti-Hypertensive Medication Fills Among Members with Hypertension

AAH's objective for the *Improving Anti-Hypertensive Medication Fills Among Members with Hypertension* QIP was to achieve a 5 percent improvement for each indicator every year. From baseline to Remeasurement 1, this QIP did not achieve the project objective for either study indicator. The rates for both study indicators decreased during the reporting period, with the decrease for Study Indicator 2 being statistically significant. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- AAH did not provide complete and/or accurate information throughout the QIP Summary Form and had to resubmit the QIP four times.
- Initially, AAH did not provide its causal/barrier analysis or an evaluation plan for the implemented interventions; however, the MCP provided this information in its resubmissions.
- Although the interventions were not successful in improving the QIP outcomes, following is a brief description of the interventions implemented by AAH:
  - Continue to share information with providers about the *Controlling High Blood Pressure* measure, and provide a report to providers about their patients who have hypertension but no hypertension medications (to encourage improving hypertensive prescriptions).
  - Continue to encourage antihypertensive medication adherence among hypertensive members by providing targeted outreach through case management and disease management as well as reminder letters and tools that empower members to take their medications.

- Conduct outreach programs through interactive voice response (IVR) calls, case and disease management, and medication adherence reminder letters.

Strengths

AAH demonstrated an excellent application of the QIP Design stage for both the *All-Cause Readmissions* and *Improving Anti-Hypertensive Medication Fills Among Members with Hypertension* QIPs.

Opportunities for Improvement

Since AAH required multiple QIP resubmissions before receiving a *Met* validation status for both QIPs, the MCP has the opportunity to make improvements in its documentation on the QIP Summary Form. To ensure data completeness, the MCP should refer to the QIP Completion Instructions and previous QIP validation tools prior to submitting the QIPs.

Since AAH's *Improving Anti-Hypertensive Medication Fills Among Members with Hypertension* QIP has not been successful in improving the indicators' rates, the MCP should conduct a new causal/barrier analysis and assess if it needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.

Conducting the EQRO Review

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Please note that when a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[8]

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

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

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

HSAG reviewed AAH's 2014 quality improvement program description, which includes details of the MCP's quality program structure. Additionally, the MCP includes goals and objectives designed to ensure that quality care is provided to its MCMC members.

The rates for the following quality performance measures were above the HPLs:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* for the second consecutive year
- *Use of Imaging Studies for Low Back Pain* for the fourth consecutive year

The rates for the following quality measures improved significantly from 2013 to 2014:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics*, resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*

The rates for the following quality measures were below the MPLs:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Controlling High Blood Pressure*
- Both *Medication Management for People with Asthma* measures
- Both *Prenatal and Postpartum Care* measures

Additionally, the rates for eight quality measures declined significantly from 2013 to 2014.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and the SPD rates for seven of the measures were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to more monitoring of care. The SPD rates for the *All-Cause Readmissions* measure, which falls into the quality domain of care, was significantly worse than the non-SPD rate, meaning that significantly more members in the SPD population (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than members in the non-SPD population.

Both of AAH's QIPs fell into the quality domain of care. Only the *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP progressed to the Outcomes

stage during the reporting period. The QIP did not show improvement, suggesting that the MCP has opportunities for improvement in the quality of care being provided to members with hypertension.

Overall, AAH showed below-average performance related to the quality domain of care.

Access

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

HSAG's review of AAH's 2014 quality improvement program description found documentation of processes, goals, and objectives designed to ensure members' access to care. The MCP's 2013 quality improvement program evaluation document describes access-related issues that were identified through causal/barrier analyses and planned activities to address the causes/barriers.

The MCP has two outstanding deficiencies from its DMHC SPD medical survey and one outstanding deficiency from its routine medical survey that could affect access to care for MCMC members. Two deficiencies are in the area of Access and Availability, and one is in the area of Prescription (RX) Drug Coverage.

No access performance measures had rates above the HPLs, and the following access measures had rates below the MPLs:

- All four *Children and Adolescents' Access to Primary Care Practitioners* measures for the third consecutive year. Note: The rates for the *12 to 24 Months*, *25 Months to 6 Years*, and *7 to 11 Years* indicators improved significantly from 2013 to 2014.
- Both *Prenatal and Postpartum Care* measures, with the rate for the *Postpartum Care* indicator being below the MPL for the second consecutive year.

The rates for the following access measures declined significantly from 2013 to 2014:

- *All-Cause Readmissions*
- *Childhood Immunization Status—Combination 3*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Prenatal and Postpartum Care—Postpartum Care*

Nine of the performance measures stratified for the SPD population fall into the access domain of care. The SPD rates for three of these measures were significantly better than the non-SPD rates. The SPD rates were significantly worse than the non-SPD rates for the following measures:

- *All-Cause Readmissions*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Both of AAH's QIPs fell into the access domain of care. Only the *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP progressed to the Outcomes stage during the reporting period. The QIP did not show improvement, suggesting that the MCP has opportunities for improvement in ensuring access to needed services for members with hypertension.

Overall, AAH showed below-average performance related to the access domain of care.

Timeliness

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

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

AAH's 2013 quality improvement program evaluation document indicates that it delegates the utilization management function and that all delegates achieved 100 percent compliance. In the

MCP's 2014 quality improvement program description, AAH also describes activities related to its grievance system and processes.

No timeliness measures had rates above the HPLs; and the rates for both *Prenatal and Postpartum Care* measures, which fall into the timeliness domain of care, were below the MPLs in 2014. The rate for the *Postpartum* indicator declined significantly from 2013 to 2014, and the rate was below the MPL for the second consecutive year. Additionally, the rate for the *Childhood Immunization Status—Combination 3* measure, which falls into the timeliness domain of care, declined significantly from 2013 to 2014.

Overall, AAH showed average performance related to the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2012–13 MCP-specific evaluation report. AAH's self-reported responses are included in Appendix D.

Recommendations

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

- Fully resolve the two deficiencies in the area of Access and Availability from the SPD medical survey.
- Ensure that the actions the MCP has taken to address the deficiency identified during the routine medical survey in the area of Prescription (RX) Drug Coverage meet DMHC's requirements.
- Since the MCP had 10 measures with rates below the MPLs and nine measures with rates that were significantly worse in 2014 when compared to 2013, work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once. AAH may want to focus efforts on the following measures first since the MCP is required to submit IPs for each of them in 2014:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
  - *Controlling High Blood Pressure*
  - Both *Medication Management for People with Asthma* measures
  - Both *Prenatal and Postpartum Care* measures

- Assess the factors leading to the SPD rates for the *All-Cause Readmissions* and *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measures being significantly worse than the non-SPD rates to ensure that the MCP is meeting the needs of the SPD population.
- Refer to the QIP Completion Instructions and previous QIP validation tools prior to submitting QIPs to ensure data completeness.
- Since AAH's *Improving Anti-Hypertensive Medication Fills Among Members with Hypertension* QIP has not been successful at improving the indicators' rates, conduct a new causal/barrier analysis and assess if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.

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

Table A.1 provides two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table A.1—HEDIS 2014 SPD Trend Table
AAH—Alameda County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	15.86%	19.54%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	69.61	53.35	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	481.81	387.05	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.99%	84.69%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	94.30%	92.80%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.07%	85.18%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	85.71%	100.0%	↑
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	85.99%	86.01%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	86.15%	87.57%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	80.59%	79.65%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.29%	56.93%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.07%	43.55%	↓
Comprehensive Diabetes Care—HbA1c Testing	84.43%	84.43%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	53.53%	54.74%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.20%	30.90%	↓
Comprehensive Diabetes Care—LDL-C Screening	78.10%	78.10%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.21%	85.16%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	34.55%	45.26%	▼

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

Table B.1 provides two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table B.1—HEDIS 2014 Non-SPD Trend Table
AAH—Alameda County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	10.47%	13.64%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	40.42	24.72	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	240.90	212.26	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	77.54%	80.91%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	73.16%	81.90%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	92.41%	94.25%	↑
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.84%	85.07%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.00%	87.03%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.99%	83.59%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.37%	61.63%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.91%	44.06%	↔
Comprehensive Diabetes Care—HbA1c Testing	83.45%	77.48%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	51.58%	44.80%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.74%	28.47%	↓
Comprehensive Diabetes Care—LDL-C Screening	77.62%	63.86%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.97%	73.76%	↓
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	37.47%	55.20%	▼

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

Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[9] This process allows HSAG to evaluate each MCP's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.1)

Quality Domain

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

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

Access and Timeliness Domains

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

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Some, but not all, study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

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

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

APPENDIX D. MCP'S SELF-REPORTED FOLLOW-UP ON EXTERNAL QUALITY REVIEW RECOMMENDATIONS FROM THE JULY 1, 2012–JUNE 30, 2013 PERFORMANCE EVALUATION REPORT

for **Alameda Alliance for Health**

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with AAH's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table D.1—AAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

2012–13 External Quality Review Recommendation Directed to AAH	Actions Taken by AAH During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Ensure all findings and deficiencies from the MR/PIU and DMHC surveys are fully addressed. Specifically:	
a. Develop and implement policies and procedures to ensure that SPD sensitivity training is provided to existing and newly hired staff and that the MCP has a mechanism in place to track the training.	The Alliance did not implement SPD training programs for new hires in Fiscal Year (FY) 2013–14.
b. Ensure that the MCP's network physical accessibility assessment results are consistently reflected on the AAH provider website and directory.	No activities occurred during FY 2013–14 to ensure improved provider access and availability indicators.
c. Ensure that level of access and accessibility indicators for each provider are consistently displayed for each provider on the AAH website and in provider directories.	No activities occurred during FY 2013–14 to ensure improved provider access and availability indicators.
d. Ensure that appointments are available within the provider network at the required time frames.	Appointment availability is not formally monitored at this time. Member complaints to the Grievance Unit about access are reviewed quarterly to identify trends with specific providers, specialties, and geographic areas. Actionable information is forwarded to the Member and Provider Services departments for follow-up with specific members and on larger network issues. Specific provider issues are also forwarded to the Peer Review and Credentialing Committee, as appropriate.
e. Ensure that AAH's governing body receives all reports from the MCP's Health Care Quality Committee.	In February and March of calendar year 2013, the Board of Governors meeting minutes included an Alliance Health Care Quality Committee (HCQC) update and the annual Quality Improvement and Utilization Management plans. Additionally, the January 2014 Board of Governors meeting included a HCQC summary.

2012–13 External Quality Review Recommendation Directed to AAH	Actions Taken by AAH During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
f. Consistently include in pharmacy denial letters a clear and concise explanation when denying, delaying, or modifying a request for services based on medical necessity.	Alameda Alliance's pharmacy staff has created a list of denial rationales that are commonly used for denied cases. There are currently 17 denial rationales in use. A pharmacist who reviews outpatient pharmacy authorization requests uses this list routinely to write the denial reason on the member's denial letter. A team of Alliance pharmacists continually review and revise the denial rationales. In preparation for our Pharmacy Benefit Manager (PBM) transition in January 2014, the Alliance reviewed and updated the standard denial letter language to simplify, clarify, and achieve consistency in the denial reasons for all denials, including medical necessity denials. • Since June 2013, the Alliance has implemented new processes to consistently provide clear and concise language in denial letters based on medical necessity. The current processes performed by Alliance pharmacists are identified below: o Routinely define complex medical terms necessary in denial letters to increase understanding by the member. o Regularly cite guidelines as source of requirements for medical necessity. o Use the updated denial reason template to increase consistency and understanding of medical necessity denial reason. o Review medical necessity denial language with another pharmacist for readability and clarity prior to letter generation.
2. Assess the factors that are leading to overall poor performance on the four *Children and Adolescents' Access to Primary Care Practitioners* measures, the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure, and the *Prenatal and Postpartum Care—Postpartum Care* measure, and identify interventions to be implemented that will result in an improvement on performance. **Note:** Since the rate for the *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* measure had statistically significant improvement from 2012 to 2013, the MCP may benefit from duplicating successful strategies used with members in the 12-to-19-year-old population with the other populations assessed for access to primary care practitioners (as applicable).	Three health education articles published in the Fall 2013 issue of the 'Member Alert' newsletter highlighted different children's health concerns and encouraged parents to schedule regular primary care provider (PCP) visits for their children. Three actions were taken to improve performance for the diuretics measure: • Interactive Voice Response (IVR) calls were made to members reminding them to get their lab tests. • The spring 2014 member newsletter had reminders in it for members to get their lab tests. • The spring 2014 provider newsletter had statements to notify providers to remind their patients about keeping up with their diuretic lab testing.

2012–13 External Quality Review Recommendation Directed to AAH	Actions Taken by AAH During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
3. Since AAH had nine measures with rates that were significantly worse in 2013 when compared to 2012, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.	The Alliance followed DHCS guidance by developing and implementing HEDIS Improvement Plans (IP) to improve performance on the PPC-Postpartum (PP) and MPM-Diuretics measures. Based on HEDIS 2014 reports, the MPM-Diuretic measure rate scored above the Minimum Performance Level (MPL). As a result, the Diuretic IP was successfully closed after a final report was submitted to DHCS. Regrettably, the PPC-PP 2014 HEDIS rate remained below the MPL. The IP will be continued for another year.

4. Assess the factors that are leading to a significantly higher rate of readmissions for the SPD population when compared to the non-SPD population to ensure the MCP is meeting the needs of the SPD population.	Readmission rates for the entire FY 2013–14 are not available for SPD and non-SPD members. The Chief Medical Officer (CMO) implemented an initiative in FY 2013–14 to reduce inpatient costs for all members. The initiative is monitored using ALOS, Admits/K, and Days/K rates. These rates are tracked for both SPD and non-SPD members. The assumption is that reducing the above rates for all members will also result in a readmission rate reduction. The following actions were implemented to decrease inpatient costs:
	• Starting July 2012 and concluding February 2014, Concurrent Review (CCR) nurses were located on-site at the plan's five highest volume inpatient acute hospitals.
	• Starting in December 2011 and continuing through August 2014, members at high risk for readmission are contacted by the home visit vendor and encouraged to accept a post-discharge home visit from a primary care practitioner (vendor).
	• Effective January 2014, Medical Director and CCR staff focused on reducing ICU stay lengths for patients able to move to a lower level of care.
	• Effective February 2014, Transition of Care (TOC) staff initiated short-term support for the first 30 days after a member's discharge to prevent unnecessary readmissions.
	• Effective April 2014:
	  o Medical Director and CCR staff analyzed delegate provider readmissions each month and discussed results with delegated representatives.
	  o CCR nurse on-call weekend coverage was established to facilitate early review of approval/denial decisions for new admissions.
	  o The CMO began evaluating readmission data by primary diagnosis and modified TOC and case management (CM) program strategies with the goal of reducing readmissions for the target diagnoses.

2012–13 External Quality Review Recommendation Directed to AAH	Actions Taken by AAH During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
5. Ensure thorough documentation of the data analysis plans for each QIP. The MCP should refer to the QIP Completion Instructions prior to submitting its QIPs to ensure completeness of the data and documentation. Providing clearly defined and documented information will likely improve the MCP's QIP validation score and prevent the need for QIP resubmissions.	AAH completed and submitted its QIPs to DHCS. The QIPs were accepted after resubmission with recommended changes and clarifications.
6. Review the 2013 MCP-specific CAHPS®[10] results report and develop strategies to address the *Customer Service, Getting Needed Care,* and *Getting Care Quickly* priority areas.	DHCS has not yet released the FY 2013–14 CAHPS report. AAH did not develop any new strategies for FY 2013–14.
7. Review the *2012–13 MCP-Specific Encounter Data Validation Study Report* and identify strategies to address the recommendations to ensure accurate and complete encounter data.	Alameda Alliance has converted a majority of inbound encounter data submissions to the 5010 format. These data are contained within our new data warehouse. Alameda Alliance expects to complete this process for the two remaining trading partners in this calendar year (2014). Alameda Alliance has worked to ensure the accuracy and completeness of the 5010/837 data. Previous proprietary encounter data are being reconciled against the 5010/837 data for history. During FY 2013–14, trading partners were actively engaged to update their 837 data to improve their data quality. Additionally, the Alliance is working to produce outbound 997 and 999/5010 transactions based on edits already in place. These edits are also being updated to improve the data quality. As the above work continues, work is underway to send historic 5010/837 data to DHCS on October 1, 2014. Alameda Alliance plans to update its new data warehouse to meet the October 1 deadline.

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