

Performance Evaluation Report
Alameda Alliance for Health
July 1, 2010–June 30, 2011

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

June 2012



1. INTRODUCTION.....	1
Purpose of Report	1
Plan Overview	2
2. ORGANIZATIONAL ASSESSMENT AND STRUCTURE.....	3
Conducting the Review.....	3
Findings.....	3
Medical Performance Review	3
Medi-Cal Managed Care Member Rights and Program Integrity Review.....	5
Strengths	6
Opportunities for Improvement	6
3. PERFORMANCE MEASURES	7
Conducting the Review.....	7
Findings.....	7
Performance Measure Validation.....	7
Performance Measure Results	8
Performance Measure Result Findings.....	10
HEDIS Improvement Plans	10
Strengths	12
Opportunities for Improvement	12
4. QUALITY IMPROVEMENT PROJECTS.....	13
Conducting the Review.....	13
Findings.....	13
Quality Improvement Projects Conducted.....	13
Quality Improvement Project Validation Findings	14
Quality Improvement Project Outcomes	16
Strengths	17
Opportunities for Improvement	17
5. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS	18
Overall Findings Regarding Health Care Quality, Access, and Timeliness.....	18
Quality	18
Access	19
Timeliness.....	20
Follow-Up on Prior Year Recommendations	20
Conclusions and Recommendations.....	20
APPENDIX A. GRID OF PLAN’S FOLLOW-UP ON EQR RECOMMENDATIONS FROM THE	
JULY 1, 2009–JUNE 30, 2010 PERFORMANCE EVALUATION REPORT.....	A-1

Performance Evaluation Report – Alameda Alliance for Health

July 1, 2010 – June 30, 2011

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 million beneficiaries (as of June 2011)¹ in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- ◆ The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- ◆ Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

¹ *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

This report is specific to the MCMC Program’s contracted plan, Alameda Alliance for Health (“AAH” or “the plan”), which delivers care in Alameda County, for the review period July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

Plan Overview

AAH is a full-scope Medi-Cal managed care plan created by the Alameda County Board of Supervisors as an independent, nonprofit, locally operated plan. AAH serves MCMC members in Alameda County as a local initiative (LI) under the Two-Plan Model. AAH became operational with the MCMC Program in 1996. As of June 30, 2011, AAH had 108,941 MCMC members.²

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

² *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at:
<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

Conducting the Review

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

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

This report section covers the DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about AAH's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

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

HSAG reviewed the most current medical performance audit reports available as of June 30, 2011, to assess plans' compliance with State-specified standards. The most recent audit for AAH was the one conducted by A&I and DMHC in October 2008, which covered the review period of October 1, 2007, through September 30, 2008. HSAG reported findings from this audit in the July 1, 2008–June 30, 2009, evaluation report.³

The audit covered the areas of utilization management (UM), continuity of care, access and availability, member rights, quality management, and administrative and organizational capacity.⁴ As noted in AAH's 2009–2010 evaluation report,⁵ most deficiencies from the October 2008 audit were due to lack of a process for tracking and/or monitoring information such as referrals, the forwarding of information to the primary care provider (PCP), appointment wait times, quality of care concerns within the recertifying files, and new member health assessments.

Also noted in AAH's 2009–2010 evaluation report, the DHCS conducted a monitoring visit in May 2010 to follow up on AAH's progress with its corrective action plan to address the areas of noncompliance from the October 2008 joint audit. A follow-up letter to the plan issued in August 2010 indicated that the plan adequately addressed all areas of noncompliance except for monitoring of wait times. While the plan made a policy change, the DHCS found no evidence that the plan developed a mechanism for monitoring wait times; therefore, this item remained an open issue.

Since the DHCS monitoring visit in May 2010, it appears that AAH has implemented activities to monitor wait times. The plan's internal *Quality Improvement and Utilization Management Program Evaluation Report* for the period July 2010–June 2011 indicates that wait times for various appointment types are continuously monitored; and surveys, complaints, and primary care provider requests indicate that wait times fell into acceptable standards. AAH's 2011–2012 Quality Improvement and Utilization Management Work Plan includes an objective about meeting the standards for waiting times and monitoring activities to assess performance toward meeting the objective.

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

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

⁵ *Performance Evaluation Report – Alameda Alliance for Health, July 1, 2009 – June 30, 2010*. California Department of Health Care Services. August 2011. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>.

Medi-Cal Managed Care Member Rights and Program Integrity Review

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

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2011.

The most recent on-site review of AAH was completed in May 2010. The review period covered June 1, 2008–April 1, 2010. HSAG reported findings from this review in the July 1, 2008–June 30, 2009, evaluation report.⁶ The scope of the review included grievances, prior authorization notifications, cultural and linguistic services, marketing, and the False Claims Act. MRPIU's review showed that AAH was fully compliant in the areas of member grievances, marketing and enrollment programs, and program integrity. Findings were noted in the areas of prior authorization and cultural and linguistic services.

The follow-up letter dated August 19, 2010, from MRPIU included a recommendation that the plan confirm that all prior authorization files have the necessary notification letters and that the letters are in compliance with necessary regulations regarding prior authorization notification procedures. The plan's 2011–2012 Quality Improvement and Utilization Management Work Plan includes a monthly activity to train staff on compliance with required denial file/letter components. The monthly training should increase the likelihood that staff will follow the required processes related to prior authorization notification. The August 19, 2010, letter also recommended that the plan ensure that all of its providers have necessary training regarding cultural and linguistic services requirements. The 2011–2012 Quality Improvement and Utilization Management Work Plan includes an ongoing activity to educate providers about the cultural and linguistic services requirements, including language interpreter services, which should help AAH become more compliant with cultural and linguistic service requirements. Adding this activity should help ensure that providers are aware of these requirements.

⁶ *Performance Evaluation Report – Alameda Alliance for Health, July 1, 2008 – June 30, 2009*. California Department of Health Care Services. October 2010. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>.

Strengths

Review of AAH's 2011–2012 Quality Improvement and Utilization Management Work Plan shows that since HSAG's last evaluation report, AAH has established monitoring activities to assess its performance on meeting the standards for wait times. The work plan also includes a monthly activity to train staff on compliance with required denial file/letter components and plans to educate providers about cultural and linguistic services requirements. By adding these activities to its work plan, AAH appears to have taken appropriate action to address the deficiencies noted in the most recent letter from MRPIU. The implementation of these activities provides the opportunity for improvement in members' ability to access available services and helps to ensure that providers offer all appropriate and needed services to members in a timely manner.

Opportunities for Improvement

Although AAH has included in its work plan monitoring activities related to wait times and educating providers about cultural and linguistic services requirements, the time frame for conducting these activities is “ongoing” rather than at specific intervals. Identifying specific intervals for the activities (e.g., monthly, bi-monthly, annually) may result in more effective monitoring of their implementation, making timely improvements, and ensuring the activities are completed.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about AAH's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS[®])⁷ measures; therefore, HSAG performed a HEDIS Compliance Audit[™] of AAH in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. The audit revealed no areas of concern for the plan to report valid rates.

⁷ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

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

Table 3.1—HEDIS® 2011 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2011 Performance Measure
AAB	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
AWC	<i>Adolescent Well-Care Visits</i>
BCS	<i>Breast Cancer Screening</i>
CCS	<i>Cervical Cancer Screening</i>
CDC–BP	<i>Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)</i>
CDC–E	<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>
CDC–H8 (<8.0%)	<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)</i>
CDC–H9 (>9.0%)	<i>Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)</i>
CDC–HT	<i>Comprehensive Diabetes Care—HbA1c Testing</i>
CDC–LC (<100)	<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>
CDC–LS	<i>Comprehensive Diabetes Care—LDL-C Screening</i>
CDC–N	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>
CIS–3	<i>Childhood Immunization Status—Combination 3</i>
LBP	<i>Use of Imaging Studies for Low Back Pain</i>
PPC–Pre	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>
PPC–Pst	<i>Prenatal and Postpartum Care—Postpartum Care</i>
URI	<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>
W34	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
WCC–BMI	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>
WCC–N	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>
WCC–PA	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>

Table 3.2 presents a summary of AAH’s HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. The table shows the plan’s HEDIS 2011 performance compared to the MCMC-established MPLs and HPLs.

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance’s (NCQA’s) national Medicaid 25th percentile and 90th percentile, respectively. For the CDC–H9 (>9.0 percent) measure, a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the national Medicaid 10th percentile.

Table 3.2—2010–2011 Performance Measure Results for Alameda Alliance for Health—Alameda County

Performance Measure ¹	Domain of Care ²	2010 HEDIS Rates ³	2011 HEDIS Rates ⁴	Performance Level for 2011	Performance Comparison ⁵	MMCD's Minimum Performance Level ⁶	MMCD's High Performance Level (Goal) ⁷
AAB	Q	29.8%	35.6%	★★	↔	19.7%	35.9%
AWC	Q,A,T	38.7%	40.7%	★★	↔	38.8%	63.2%
BCS	Q,A	59.6%	58.0%	★★	↔	46.2%	63.8%
CCS	Q,A	62.1%	67.7%	★★	↔	61.0%	78.9%
CDC–BP	Q	57.1%	55.7%	★★	↔	53.5%	73.4%
CDC–E	Q,A	25.5%	40.0%	★	↑	41.4%	70.1%
CDC–H8 (<8.0%)	Q	36.9%	40.0%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	54.3%	49.9%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	77.5%	84.0%	★★	↑	76.0%	90.2%
CDC–LC (<100)	Q	29.5%	34.1%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	70.3%	74.3%	★★	↔	69.3%	84.0%
CDC–N	Q,A	72.2%	81.7%	★★	↑	72.5%	86.2%
CIS–3	Q,A,T	71.3%	47.9%	★	↓	63.5%	82.0%
LBP	Q	87.1%	84.3%	★★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	60.5%	64.7%	★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	50.9%	58.8%	★★	↑	58.7%	74.4%
URI	Q	94.9%	96.2%	★★★	↔	82.1%	94.9%
W34	Q,A,T	69.9%	68.8%	★★	↔	65.9%	82.5%
WCC–BMI	Q	37.0%	39.6%	★★	↔	13.0%	63.0%
WCC–N	Q	83.8%	80.1%	★★★	↔	34.3%	67.9%
WCC–PA	Q	60.4%	55.8%	★★	↔	22.9%	56.7%

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).

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

³ HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

⁴ HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.

⁵ Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.

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

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

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, AAH had average performance results across the spectrum of HEDIS measures. Three measures performed above the national Medicaid 90th percentile while three measures fell below the national Medicaid 25th percentile. Four measures had a statistically significant increase over their respective 2010 performance, while only one measure (*Childhood Immunization Status—Combination 3*) had a statistically significant decrease in 2011.

HEDIS Improvement Plans

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

For plan measure rates that required a 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with the plan's 2011 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

Based on AAH's 2010 performance measure rates, the DHCS required the plan to submit HEDIS improvement plans for six measures:

- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Comprehensive Diabetes Care—LDL Screening*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Of the six measures, three were repeat measures that fell below the MPL in 2009. HSAG reviewed AAH's 2010 HEDIS improvement plans using HEDIS 2011 rates and assessed whether the plan improved its performance in 2011. HSAG provides the following analysis of the plan's 2010 HEDIS improvement plans.

Prenatal Care

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

AAH's plan for improving the *PPC–Pre* measure's rate does not significantly differ from past years' improvement plans, which is a cause for concern in achieving real improvement. The plan intends to take a three-prong approach to improvement, including: general member outreach, supplemental data expansion more reflective of the population, and data completeness enhancement.

AAH indicated that the largest barrier to improvement was the short time frame for improvement. The plan anticipates a new core data system in 2012, which would allow for better tracking of pregnancy measures.

Most of the improvement actions, however, are standard procedures for ensuring data integrity and accuracy and are repeated from previous years' improvement plans. While these efforts are necessary, they will not improve the delivery of prenatal care services to the plan's members. The data issues should be resolved expeditiously so that stronger improvement efforts can be implemented that improve the rate of women receiving timely prenatal care.

Based on its 2011 rate for this measure, the plan will need to continue the performance improvement plan in 2012.

Postpartum Care

AAH performed below the MPL for the *Postpartum Care* measure in 2010 and thus was required to create and implement an improvement plan. The plan's *Postpartum Care* improvement plan did not differ from its *Timeliness of Prenatal Care* plan, which shows the plan may have been trying to meet compliance with documenting the improvement plan versus taking appropriate action to improve the rate. HSAG's review of the improvement plan showed a lack of attention to detail as the *Postpartum Care* performance standard and goal were exactly the same as those for the *Timeliness of Prenatal Care* measure's improvement plan. Despite the lack of documentation in the improvement plan, AAH achieved a statistically significant increase between 2010 and 2011. Additionally, the plan achieved the MPL.

Diabetes Care

AAH had four measures related to diabetes care that fell below the MPL in 2010, but only one remained below the MPL in 2011: *Eye Exam (Retinal) Performed*.

AAH's improvement plans were very similar for all four measures. They mainly consisted of general member outreach, disease-specific interventions, and data completeness enhancement. For the member outreach portion, AAH continued to supplement the member newsletter with diabetes-specific messages. For the disease-specific interventions, the plan requested that its pharmacy vendor engage in an intervention to improve diabetes care, which included case management. To enhance data completeness, AAH established a comprehensive HEDIS reporting

system. The plan believes that this new reporting mechanism will improve all laboratory-driven measures for the CDC series of measurements.

Regarding barriers that impeded performance, AAH stated that the biggest barrier was the short time frame in which to implement its improvement plans.

Although AAH had a statistically significant improvement in its rate for the *Eye Exam (Retinal) Performed* measure between 2010 and 2011, the plan will need to continue its improvement efforts for this measure.

Strengths

AAH was able to perform above the HPL for three measures: *Use of Imaging Studies for Low Back Pain*, *Appropriate Treatment for Children With Upper Respiratory Infection*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*. Additionally, the plan reduced the total number of measures requiring a HEDIS Improvement Plan from six in 2010 to three in 2011.

Opportunities for Improvement

AAH must resolve its data capture issues that for several years have been identified as a barrier. The plan has had adequate time to make the appropriate changes to address this barrier, and HSAG expects to see this issue no longer listed as a barrier in 2012. If this issue remains a barrier, then HSAG expects the plan to provide additional documentation regarding the project timeline and reasons for the delay in resolution.

The plan also has an opportunity to improve documentation in its HEDIS improvement plans to better support the identified barriers and ensure that interventions are aligned appropriately. As part of its 2011 improvement plans, AAH needs to include an update of all actions outlined in the 2009 and 2010 improvement plans—specifically, the results and analyses of the interventions. Finally, the plan should explore the drastic reduction in its childhood immunization rate.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Quality Improvement Projects Conducted

AAH had two clinical QIPs in progress during the review period of July 1, 2010–June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of DHCS' statewide collaborative QIP project. AAH's second project, an internal QIP, aimed to decrease return ER visits for asthmatic exacerbations in children 2–18 years of age.

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

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

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for Alameda Alliance for Health—Alameda County July 1, 2010, through June 30, 2011

Name of Project/Study	Type of Review ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Overall Validation Status ⁴
Statewide Collaborative QIP				
<i>Reducing Avoidable Emergency Room Visits</i>	Annual Submission	97%	100%	<i>Met</i>
Internal QIPs				
<i>Decrease Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age</i>	Annual Submission	100%	100%	<i>Met</i>
¹ Type of Review —Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG’s validation criteria to receive an overall <i>Met</i> validation status. ² Percentage Score of Evaluation Elements <i>Met</i> —The percentage score is calculated by dividing the total elements <i>Met</i> (critical and noncritical) by the sum of the total elements of all categories (<i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i>). ³ Percentage Score of Critical Elements <i>Met</i> —The percentage score of critical elements <i>Met</i> is calculated by dividing the total critical elements <i>Met</i> by the sum of the critical elements <i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i> . ⁴ Overall Validation Status —Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> .				

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that the annual submission by AAH of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met* with 97 percent of all evaluation elements and 100 percent of critical elements receiving a *Met* score. Additionally, AAH received a *Met* validation status for its *Decreasing Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age* QIP submission. One hundred percent of all elements and 100 percent of critical elements received a *Met* validation score. Neither QIP required a resubmission.

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

**Table 4.2—Quality Improvement Project Average Rates*
for Alameda Alliance for Health—Alameda County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2010, through June 30, 2011**

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		100%	0%	0%
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		100%	0%	0%
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		96%	0%	4%
*The activity average rate represents the average percentage of applicable elements with a <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> finding across all the evaluation elements for a particular activity.				

AAH submitted Remeasurement 2 data for both QIPs; therefore, HSAG validated Activity I through Activity X. AAH demonstrated an excellent understanding of the design and implementation stages, scoring 100 percent on all applicable evaluation elements. Conversely, for the outcomes stage, AAH was scored lower in Activity X for the plan’s inability to achieve sustained improvement for its *Reducing Avoidable Emergency Room Visits* QIP. The *Decreasing Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age* QIP required an additional measurement period before sustained improvement could be assessed. Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period’s results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

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

Table 4.3—Quality Improvement Project Outcomes for Alameda Alliance for Health—Alameda County (Number = 2 QIP Submissions, 2 QIP Topics) July 1, 2010, through June 30, 2011

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	Baseline Period (1/1/07–12/31/07)	Remeasurement 1 (1/1/08–12/31/08)	Remeasurement 2 (1/1/09–12/31/09)	Sustained Improvement*
Percentage of avoidable ER visits	11.4%^	23.0%*	19.9%*	No
QIP #2—Decrease Return ER Visits for Asthmatic Exacerbations in Children				
QIP Study Indicator	Baseline Period (7/1/07–6/30/08)	Remeasurement 1 (7/1/08–6/30/09)	Remeasurement 2 (07/1/09–06/30/10)	Sustained Improvement*
Percentage of children 2 through 18 years of age who have more than two ER visits for asthma in one year	17.5%	20.7%	12.0%*	‡
† Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period’s results must reflect improvement when compared to the baseline results. *A statistically significant difference between the measurement period and prior measurement period (p value < 0.05). ‡The QIP requires an additional measurement period to assess for sustained improvement since the first remeasurement period rate demonstrated a decline in performance from baseline. ^Rate may have been miscalculated since claims data was used instead of reported HEDIS rates.				

AAH reported an improvement in performance for both QIP study indicators between Remeasurement 1 and Remeasurement 2. The decrease in the avoidable ER visits indicator outcome was statistically significant. A decrease for this measure reflects an improvement in performance. Collaborative interventions were initiated in early 2009 and potentially correspond to the improvement in performance. While the plan demonstrated improvement from Remeasurement 1 to Remeasurement 2, the plan did not demonstrate overall improvement from Baseline to Remeasurement 2. The plan will have to maintain the recent improvement in a subsequent measurement period in order to achieve sustained improvement. For the collaborative QIP only, an exception was made for the assessment of sustained improvement. All plans were assessed for sustained improvement after they reported Remeasurement 2 data, regardless of their performance from Baseline to the second remeasurement period.

From Remeasurement 1 to Remeasurement 2, the multiple ER visits for asthma indicator outcome demonstrated statistically significant improvement. Improvement for this QIP may correlate with AAH’s continuation of its ATTACK Clinic at Children’s Hospital in Oakland, which connected

members to their medical home and provided families with tools/training to manage asthma at home. Since the most recent measurement period was the first time the plan documented a reduction of members with multiple ER visits for asthma, the plan will have to maintain this improvement in a subsequent measurement period in order to achieve sustained improvement.

Strengths

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

Additionally, AAH documented statistically significant improvement in the outcomes from the first to the second remeasurement period for both QIPs, which demonstrated improvement in reducing avoidable ER visits and multiple ER visits for asthma.

Opportunities for Improvement

AAH has an opportunity to improve its intervention strategies to order to achieve sustained improvement of its QIP outcomes. At a minimum, barrier analysis should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone.

Additionally, HSAG recommends that AAH implement a method to evaluate the effectiveness of each intervention. Based on the evaluation results, the plan can make appropriate revisions or implement new interventions, if necessary. If the intervention evaluation demonstrates that an intervention is successful, the plan should clearly document the process and how it was used to monitor and standardize the intervention in the QIP.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

AAH showed average performance in the quality domain. The plan was able to perform above the HPLs for three HEDIS measures; however, it performed below the MPLs for three measures. Comparison of 2011 performance to 2010 performance shows that AAH had no statistically significant change in 16 measures, statistically significant increases in four measures, and a statistically significant decrease in one measure.

Review of AAH's 2010 HEDIS improvement plans reveals many opportunities for improvement. The plan will need to continue performance improvement plans in 2012 for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* and *Eye Exam (Retinal) Performed* measures. AAH will also need to initiate a new improvement plan for its childhood immunization measure, which had a statistically significant decline in performance. Additionally, the plan needs to fully resolve its long-standing data capture issues as it has had multiple years to address this identified barrier.

AAH shows excellent understanding of QIP design and implementation stages. Statistically significant improvement in the outcomes from the first to the second remeasurement period for the statewide and individual QIPs was demonstrated; however, sustained improvement has not yet been achieved. HSAG recommends that the plan identify ways to improve its intervention strategies in order to achieve sustained improvement of QIP outcomes.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the Medi-Cal Managed Care Program.

Medical Performance Reviews/MRPIU, performance measures, and QIP outcomes are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

AAH demonstrated below-average performance in the access domain based on review of 2011 performance measure rates related to access, QIP outcomes, and results of the medical performance and member rights reviews in the area of access. The plan performed average for eight measures and below average for three. While there was a statistically significant increase in performance on the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure, the plan's performance is still below the MPL.

One outstanding issue remains related to the 2008 medical performance review. After a monitoring visit in May 2010, the DHCS documented in a letter dated August 2010 that there was no evidence that the plan had developed a mechanism for monitoring wait times; however, a review of AAH's July 2010–June 2011 *Quality Improvement and Utilization Management Program Evaluation Report* and 2011–2012 *Quality Improvement and Utilization Management Work Plan* show that the plan appears to be implementing strategies to better monitor wait times. Additionally, MRPIU review showed an opportunity to improve cultural and linguistic services requirements. The plan appears to be attempting to address this issue in that its 2011–2012 *Quality Improvement and Utilization Management Work Plan* includes activities to educate providers about cultural and linguistic services requirements, which should increase the potential that all members will have access to appropriate and needed services.

Timeliness

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

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

AAH demonstrated average performance in the timeliness domain of care. The 2011 performance measure rates for providing timely care show below-average performance for two measures in the timeliness domain, with one showing a statistically significant decrease from 2010 to 2011 (*Childhood Immunization Status—Combination 3*). The plan shows a statistically significant increase from 2010 to 2011 for the *Prenatal and Postpartum Care—Postpartum Care* measure and a change in performance level for this measure from below average to average.

One recommendation made by the MRPIU was related to prior authorization files. The plan appears to be attempting to address this issue in that its 2011–2012 Quality Improvement and Utilization Management Work Plan includes activities to train staff on compliance with required denial file/letter components, which will potentially improve the timeliness and thoroughness with which prior authorization files are initiated and maintained.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 plan-specific evaluation report. AAH's self-reported responses are included in Appendix A.

Conclusions and Recommendations

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

Comparison of 2010 and 2011 performance shows nonstatistically significant change in performance on most HEDIS measures, statistically significant increase in performance for four measures, and a statistically significant decrease in performance for one measure. The plan has

opportunities to improve documentation related to HEDIS improvement plans and increase attention to detail. HSAG recommends that the plan continue to identify strategies that will result in improvements in its HEDIS performance.

AAH was generally compliant with requirements related to QIPs and State and federal requirements; however, it continues to experience challenges with improving actual health outcomes for MCMC members.

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

- ◆ Submit 2011 HEDIS improvement plans that include an update on all actions outlined in the 2009 and 2010 improvement plans, including the result and analysis of interventions.
- ◆ Submit a project timeline to address any unresolved data capture issues.
- ◆ Conduct barrier analysis to identify and prioritize barriers for each QIP measurement period.
- ◆ Implement a method to evaluate the effectiveness of each QIP intervention and make appropriate revisions or implement new interventions, if necessary.
- ◆ Identify ways to improve intervention strategies in order to achieve sustained improvement of QIP outcomes.

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

APPENDIX A. GRID OF PLAN'S FOLLOW-UP ON EQR RECOMMENDATIONS FROM THE
JULY 1, 2009–JUNE 30, 2010 PERFORMANCE EVALUATION REPORT

for Alameda Alliance for Health

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with Alameda Alliance for Health's self-reported actions that address the recommendations. Neither Health Services Advisory Group, Inc. (the external quality review organization for Medi-Cal Managed Care) nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table A.1— Grid of AAH's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	AAH's Self-Reported Actions That Address the EQR Recommendation
<p>Implement a mechanism to monitor appointment wait times.</p>	<p>The Alliance informs providers about our access standards through the provider manual as well as provider orientation and re-orientation.</p> <p>The Alliance monitored appointment wait times through various methods July 2010 to June 2011:</p> <ol style="list-style-type: none"> 1. Analysis of grievances about access 2. Member switching PCP due to wait times 3. Analysis of CAHPS survey questions on access 4. Delegation oversight audits of delegated groups regarding compliance with access standards 5. Timely access survey for two of the largest delegated medical groups; surveys were administered to members and providers and assessed satisfaction with access to care in 2011 (e.g., nonurgent, urgent, specialty, ancillary care) <p>Further work is planned to systematically monitor appointment wait times including conducting secret shopper calls.</p>
<p>Conduct periodic, internal, prior-authorization file audits to ensure compliance with the required documentation.</p>	<p>A few different methods were utilized to monitor compliance with required documentation in prior-authorization files. First, a daily authorization audit was performed by the UM manager from July 2010 through January 2011 using a file review checklist of the required documents. Files not in compliance were returned back to the UM staff to fix. In late December 2010, a UM denial file audit was performed. Results were shared with the UM staff and denial letters were corrected to be in compliance.</p> <p>The Alliance continues to conduct periodic, internal, prior-authorization file audits to ensure compliance with the required documentation. The UM staff utilizes a document checklist form to prepare the denial files. On a weekly basis, the UM manager reviews authorization denial files.</p>

Table A.1— Grid of AAH's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	AAH's Self-Reported Actions That Address the EQR Recommendation
<p>Re-educate providers on the cultural and linguistic service requirements, including the grievance process and language interpreter services.</p>	<p>The Alliance Provider Services Department reviews a PowerPoint presentation with providers that includes information on language interpreter services and the grievances/appeals process as part of new provider orientation and reorientation for existing providers.</p> <p>Quarterly provider bulletins also include the telephone number for language interpreter services and the following statement: "The Alliance strongly discourages use of family or friends as interpreters for Alliance members. Using an untrained interpreter may cause miscommunication of medical information, embarrassment when discussing sensitive topics, and compromise quality of care. If a member declines interpreter services, the state of California requires the provider to document this in the medical record."</p> <p>The Alliance also shares with providers a one-page "Cultural and Linguistics Quick Reference Guide" which includes a Q & A on interpreter services and what to do if a member has a complaint.</p> <p>In addition, in June 2010, a fax blast was distributed to all providers that included information for a free Webinar on June 30, 2010: "Enhancing Language Access: Communication with Limited English Proficient Patients."</p> <p>The Alliance also participates in the Alameda County Provider Training Collaborative which holds CME conferences and seminars throughout the year on various topics. All CMEs are required to include a cultural competency objective. Providers were invited to all of these events.</p> <p>The provider manual includes information about the Alliance grievance process and language interpreter services and is available on the Alliance Web site for all providers.</p>
<p>Incorporate data capture issues into the quality improvement program's work plan as a mechanism to track and monitor progress.</p>	<p>Data capturing issues were not incorporated into the quality improvement program's work plan in 2010–2011. However, the Alliance has taken steps to improve data integration and capture throughout 2010 and 2011 by analyzing and standardizing delegated medical groups and vendor encounter data and claims and ensuring timely receipt and completeness. In addition, the 2011–2012 quality improvement work plan includes activities for investigating and addressing data capturing issues.</p>

Table A.1— Grid of AAH's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	AAH's Self-Reported Actions That Address the EQR Recommendation
<p>Submit 2010 HEDIS improvement plans that include an update on all actions outlined in the 2009 improvement plans, including the result and analysis of interventions.</p>	<p>The 2010 HEDIS improvement plan was submitted on January 4, 2011. The interventions listed in the 2009 improvement plans were primarily based on improving data completeness from delegated medical groups and data integration into the data warehouse. Although these data enhancement activities were in effect, it was too soon to affect the HEDIS Measurement Year 2009 rates. An improvement plan was requested for HEDIS 2010 for the same measures (CDC HbA1c poor control and CDC eye exam). However, the HEDIS 2011 rates showed improvement in these two measures probably as a result of continuing 2–3 interventions from the 2009 improvement plan as well as implementing new strategies.</p>
<p>Review, rewrite, and resubmit the <i>Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)</i> HEDIS improvement plan to better align barriers and interventions.</p>	<p>The HEDIS improvement plan for the <i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)</i> measure was resubmitted on March, 2, 2011. The Alliance rate for this measure for Measurement Year 2010 improved and was above the MPL.</p>
<p>Conduct annual causal-barrier and subgroup analyses to determine why and for what groups current QIP interventions did not produce improvement between measurement periods.</p>	<p>The two QIPs were completed in 2011. The Alliance did not conduct subgroup analyses July 2010–June 2011; however, the Alliance plans to incorporate this process in the next QIP.</p>
<p>Review the 2010 plan-specific CAHPS results report and develop strategies to address the following priority areas: <i>Getting Needed Care, Customer Service, and Rating of All Health.</i></p>	<p>The Alliance reviewed the 2010 CAHPS results report and evaluated the recommendations for feasible strategies. The Alliance has been working on improving its provider repository which feeds information to the provider directories. Additional information such as language spoken and provider gender will also be displayed on the Alliance Web site for members. This may help members choose a physician that will meet their needs. In addition, the customer service department has implemented an auditing and training process to ensure that the staff is providing accurate information about the plan. Further work is underway to implement additional strategies through a member satisfaction workgroup.</p>