Performance Evaluation Report

AHF Healthcare Centers

July 1, 2010–June 30, 2011

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

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 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*, at http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, AHF Healthcare Centers ("AHF" or "the plan"), which delivers care in Los Angeles County, for the review period 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

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

AHF became operational with the MCMC Program in April 1995. As of June 30, 2011, the plan had 806 MCMC members.[2]

Due to the plan's unique membership, some of AHF's contract requirements have been modified from the MCMC Program's full-scope health plan contracts.

[2] *Medi-Cal Managed Care Enrollment Report —June 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 AHF's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

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. HSAG reported the April 2006 results, which reflect the review period of April 1, 2005, through March 31, 2006, in the plan's 2008–2009 performance evaluation report[3]. The State Controller's Office conducted a medical audit in January/February of 2011 covering the audit period of October 1, 2009, through September 30, 2010. The final audit report was not available for review; therefore, results from this audit will be included in the next annual evaluation report.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, , 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.

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

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

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

[3] California Department of Healthcare Services. *AHF Healthcare Centers Performance Evaluation Report: July 1, 2008 – June 30, 2009.*

- Under member services, the plan's evidence of coverage document provided to members was missing various required information.

Strengths

In the June 2010 MRPIU review, AHF was fully compliant with several areas evaluated by the MRPIU, including prior authorization notification, marketing functions, and fraud and abuse. The plan resolved most of the grievance deficiencies that were identified during the previous MRPIU review conducted in May 2008.

Opportunities for Improvement

AHF must address its ongoing deficiency related to notification letter requirements for processing grievances. The plan has an opportunity to implement an internal audit process on a frequent basis to ensure that it is meeting grievance notification requirements.

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

Conducting the Review

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

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 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 AHF's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under two domains of care—quality and access.

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

Performance Measure Validation

AHF reported two HEDIS measures; therefore, HSAG performed an NCQA HEDIS Compliance Audit™[5] in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern. The auditors recommended that AHF prepare flow diagrams covering key data processing functions, including claims/encounter data, enrollment data, and provider data as a means to further validate measure calculations.

Performance Measure Results

AHF Healthcare Centers' 2011 performance measures were the HEDIS measures *Controlling High Blood Pressure* and *Colorectal Cancer Screening*. *Controlling High Blood Pressure* is the measure used to assess the percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than or equal to 140/90 mm Hg) during the measurement year. This is the first year that AHF reported the *Controlling High Blood Pressure* measure; therefore, the MPL and HPL are not applicable. The *Colorectal Cancer Screening* measure calculates the percentage of adults 50 to 75 years of age who had appropriate screening for colorectal cancer.

Table 3.1 presents a summary of AHF's HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared with HEDIS 2010 performance measure results (based on CY 2009 data). In addition, the table shows the plan's HEDIS 2011 performance compared with MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

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

Table 3.1—2010–20011 Performance Measure Results for AHF Healthcare Centers—Los Angeles 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]
Controlling High Blood Pressure (CBP)							
18–85 years	Q,A	NA	69.6%	NA	NA	NA	NA
Colorectal Cancer Screening (COL)							
50–75 years	Q,A	64.2%	60.2%	★★	↔	56.1%	72.3%

[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 COL measure, the MPL is based on the national Commercial 25th percentile since no Medicaid benchmark exists for this measure.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the COL measure, the HPL is based on the national Commercial 90th percentile since no Medicaid benchmark exists for this measure.
★ = Below-average performance relative to the national Medicaid/Commercial 25th percentile.
★★ = Average performance relative to national Medicaid/Commercial percentiles (between the 25th and 90th percentiles).
★★★ = Above-average performance relative to the national Medicaid/Commercial 90th percentile.
NA = Not applicable due to the plan's denominator being too small to report a valid rate (less than 30).
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

AHF performed above the MPL, but below the HPL, for the *Colorectal Cancer Screening* measure in 2011. There was a four percentage point decline from 2010 to 2011; however, it was not statistically significant.

HEDIS Improvement Plans

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

For measure rates requiring a 2010 improvement plan, HSAG used 2011 HEDIS scores to evaluate progress during the year. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans. In 2010, the plan did not have any measures below MPLs. Therefore, no improvement plans were in place for 2011.

Strengths

AHF selected *Controlling High Blood Pressure* as a new 2011 performance measure to replace the *Adults' Access to Preventive/Ambulatory Health Services* measure, which achieved high levels of performance in prior years. This new selection has allowed the plan to focus on a performance measure area in need of improvement.

Opportunities for Improvement

Although the decrease in the *Colorectal Cancer Screening* measure's rate was not statistically significant, AHF has an opportunity to improve performance on the measure.

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

Quality Improvement Projects Conducted

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

AHF had two clinical QIP proposals in progress during the review period of July 1, 2010–June 30, 2011. The first QIP, which fell under the quality domain of care, sought to increase the percentage of members with an advance directive. AHF's second project focused on increasing CD4 and viral load testing, fell under both quality and access domains of care.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for AHF Healthcare Centers—Los Angeles County July 1, 2010, through June 30, 2011

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]
Internal QIPs				
Advance Directive	Proposal	63%	50%	*Partially Met*
	Resubmission 1	75%	63%	*Partially Met*
	Resubmission 2	100%	100%	*Met*
CD4 and Viral Load Testing	Proposal	94%	100%	*Met*

[1] **Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Validation results during the review period of July 1, 2010, through June 30, 2011 showed that AHF's initial submission of its *Advance Directive* QIP proposal received an overall validation status of *Partially Met*. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. The plan's definition of the study population, the study question, and the study indicators did not align. The first resubmission did not address the deficiencies noted in the validation feedback. HSAG provided technical assistance, and the plan resubmitted this QIP for a second time and upon subsequent validation, achieved an overall *Met* validation status, with 100 percent of all evaluation elements and 100 percent of critical elements receiving a *Met* score. AHF's initial submission of its *CD4 and Viral Load Testing* QIP proposal received an overall validation status of *Met*.

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

Table 4.2—Quality Improvement Project Average Rates* for AHF Healthcare Centers—Los Angeles County (Number = 2 QIPs, 2 QIP Topics) July 1, 2010, through June 30, 2011

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	91%	9%	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		**97%**	**3%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	‡	‡	‡
	VI: Accurate/Complete Data Collection	‡	‡	‡
	VII: Appropriate Improvement Strategies	‡	‡	‡
Implementation Total		‡	‡	‡
Outcomes	VIII: Sufficient Data Analysis and Interpretation	‡	‡	‡
	IX: Real Improvement Achieved	‡	‡	‡
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		‡	‡	‡

*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.
‡ No QIPs were assessed for this activity/evaluation element.

AHF's two proposals included only the design stage activities for both QIPs; therefore, HSAG validated through Activity IV. AHF demonstrated the proper application of the design stage, scoring 100 percent on three of the four activities. In Activity I, the plan was scored lower for not correctly defining the study population for the *CD4 and Viral Load Testing* QIP. The technical assistance provided by HSAG should assist the plan in how to correctly define and document the study population in Activity I for all future QIP topics, if properly applied.

Quality Improvement Project Outcomes

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

Table 4.3—Quality Improvement Project Outcomes for AHF Healthcare Centers—Los Angeles County (Number = 2 QIPs, 2 QIP Topics) July 1, 2010, through June 30, 2011

QIP #1—Advance Care Directives				
QIP Study Indicator	**Baseline Period 1/1/10–12/31/10**	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement**
Percentage of eligible members that have an advance directive or have had a discussion regarding advance directives with their provider	‡	‡	‡	‡
QIP #2—CD4 and Viral Load Testing				
QIP Study Indicator	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement**
Percentage of eligible members receiving at least three CD4 lab tests	‡	‡	‡	‡
Percentage of eligible members receiving at least three Viral Load lab tests	‡	‡	‡	‡
‡ The QIP had not progressed to this stage of reporting study indicator results.				

AHF had not progressed to the point of reporting baseline data for either QIP.

Strengths

AHF selected two QIP topics that are specific and important to the specialty Medi-Cal managed care population with HIV/AIDS. Additionally, AHF demonstrated an understanding of the design stage and received *Met* scores for three of the four activities. AHF did not require a resubmission for the *CD4 and Viral Load Testing* QIP, indicating the ability to adequately document the design stage within the QIP validation process.

Opportunities for Improvement

AHF has an opportunity to improve its QIP documentation to meet the validation requirements. Additionally, the plan should comply with the recommendations provided to eliminate the need for multiple submissions to achieve an overall *Met* validation score for its QIPs. Before progressing to the implementation and outcomes stages of its QIPs, AHF should request technical assistance from HSAG if there are any questions with the required documentation.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. Specialty plans are required to administer an annual consumer satisfaction survey to their members to evaluate member satisfaction with care and services.

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

Findings

AHF reported the survey results within its internal quality evaluation for fiscal year 2010, covering the time period of January 1, 2010, through December 31, 2010.[6] HSAG reviewed the survey description, survey results, and AHF analysis. The survey results fell under the quality and timeliness domains.

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

AHF's survey also evaluated the AHF pharmacy performance. Areas evaluated included an overall rating, courtesy/respect from staff and pharmacist, helpfulness, dispensing of medications in a timely manner, dispensing medications correctly, and responses to concerns/complaints. In the 2010 survey, all indicators had results above, or equal to, 5.4 with no areas of low performance.

[6] AHF Healthcare Foundation. *Quality Management Annual Evaluation – Fiscal Year 2010, January 1, 2010 through December 31, 2010.*

Similar to the results for the healthcare centers, the plan achieved improvement across all indicators over the past five years.

AHF also evaluated the overall plan rating. AHF achieved a rating of 5.5 in 2010, representing very good performance.

Strengths

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

Opportunities for Improvement

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

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

The DHCS uses the results of performance measures and quality improvement project (QIP) to assess care delivered to members 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 supporting the delivery of quality care, such as practice guidelines, a quality assessment and performance improvement program, and health information systems.

The plan showed average performance based on AHF's 2011 performance measure rates (which reflect 2010 measurement data) and QIP validation and outcomes and medical performance reviews. The plan reported average performance for the *Colorectal Cancer Screening* measure. QIP results showed that the plan did well with documenting the study design for the *Advance Directive* QIP and the *CD4 and Viral* Load Testing QIP. In the MRPIU review, the plan's evidence of coverage document provided to members was missing various required information.

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

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure availability of, and access to, all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access and 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, availability of services, coordination/continuity of care, and covered services under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, member satisfaction results, and medical performance reviews are used to evaluate access to care. Measures dealing with topics 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/availability of these services to receive care according to generally accepted clinical guidelines.

The plan showed average performance based on AHF's 2011 performance measure rates (which reflect 2010 measurement data), QIP outcomes, and medical performance reviews. The plan had acceptable performance for QIPs and performance measures; however, medical performance audit results showed that the plan had an opportunity to improve its contracted providers' awareness of linguistic services requirements.

Timeliness

The timeliness domain of care relates to a plan's ability to make timely utilization decisions based on clinical urgency, disruptions to care, and efficient delivery of service 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 standards in enrollee rights and protections, grievance system, continuity/coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care are under the timeliness domain of care because they quantify health care delivery within a recommended period of time.

AHF exhibited average performance in the timeliness domain of care based on medical performance and member rights reviews related to timeliness, and member satisfaction results related to timeliness.

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

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

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

Conclusions and Recommendations

Overall, AHF had average performance in providing quality, accessible, and timely healthcare services to its MCMC members.

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

- Implement an internal audit process on a frequent basis to ensure that the plan is meeting grievance notification requirements.
- Educate providers regarding the cultural and linguistic requirements and services available.
- Implement a formal monitoring process to ensure cultural and linguistic training is effective and providers are adhering to policies, procedures, and guidelines.
- Identify opportunities to improve the *Colorectal Cancer Screening* measure rates.
- Improve QIP documentation to increase compliance with the validation requirements.
- Before progressing to the implementation and outcomes stages of its QIPs, AHF should request technical assistance from HSAG for questions about required documentation.

In the next annual review, HSAG will evaluate AHF'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 AHF Healthcare Centers

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with AHF'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 that the plan self-reported in the grid.

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

2009–2010 EQR Recommendation	AHF's Self-Reported Actions That Address the EQR Recommendation
Conduct periodic internal grievance file audits to ensure compliance with the DHCS's standards.	Activities and/or interventions that were initiated during the time period of July 1, 2009 through June 30, 2010. 1. All grievances are reviewed quarterly and results reported to Senior Management and the Board of Directors on a quarterly basis (underway). 2. Grievance file compliance audits reported to the Member and Provider Committee (underway).
Focus efforts on educating providers on cultural and linguistic services and conduct routine monitoring to ensure compliance with policies and procedures.	Activities and/or interventions that were initiated during the time period of July 1, 2009 through June 30, 2010. Policies and Procedures 1. Revised and implemented Policy and Procedure 91006 Interpreter Services (6/17/10). 2. The QMC approved the CLAS implementation (2009-4th quarter). 3. Health Education Manager completed needs assessment to identify high priority areas for improvement (2010). 4. Member Demographic Reports generated (2010; underway). Education and Training 1. C&L Training provided to all AHF Staff via on-line training (2010; underway). 2. Providers updated about C & L plan via Provider Newsletters (2010). 3. Increased awareness throughout the organization on use of Language Line services (2010). a. Staff completed basic self-assessment of language skills during Facility Site Review audit. b. Focus group sessions were held to review and revise member educational materials. Monitoring 1. Complaint and grievance monitoring for C & L used to assess compliance with AHF policies and procedures (underway). 2. Analysis of utilization data from Language Line (underway and reported on quarterly basis to the Member and Provider Committee). 3. Compliance rate on member satisfaction survey questions pertaining to receiving culturally sensitive health care and receiving health care services in a language the patient can understand (underway).

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

2009–2010 EQR Recommendation	AHF's Self-Reported Actions That Address the EQR Recommendation
Identify an alternative performance measure that assesses quality, access, and/or timeliness of care provided to AHF members.	Performance measures assessed during the time period of July 1, 2009 through June 30, 2010. Access (underway) 1. Call center performance 2. Routine, Urgent and Emergent Care 3. Specialty Care 4. After-Hours Care Clinical Quality (underway) 1. Colorectal Cancer Screening 2. Comprehensive Diabetes Care 3. Controlling High Blood Pressure 4. Cholesterol Screening
Develop and implement two new QIPs targeting areas that need performance improvement.	Activities and/or interventions that were initiated during the time period of July 1, 2009 through June 30, 2010. 1. Viral Load and CD 4 Testing (underway) 2. Advance Directives Colorectal Cancer Screening (underway)