Performance Evaluation Report

# Alameda Alliance for Health

July 1, 2011–June 30, 2012

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

June 2013

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# 1. INTRODUCTION

## Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services 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 designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more 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.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, 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.

This report is specific to DHCS's contracted plan, Alameda Alliance for Health ("AAH" or "the plan"), which delivers care in Alameda County, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

## Plan Overview

AAH is a full-scope managed care plan created by the Alameda County Board of Supervisors as an independent, nonprofit, locally operated plan. AAH operates in Alameda County as a local initiative (LI) plan under the Two-Plan Model. In a Two-Plan Model county, DHCS contracts with two managed care plans to provide medical services to Medi-Cal beneficiaries. Most Two-Plan Model counties offer an LI plan and a nongovernmental, commercial health plan.

MCMC beneficiaries in Alameda County may enroll in AAH, the LI plan, or in the alternative commercial plan. AAH became operational in Alameda county to provide MCMC services in 1996. As of June 30, 2012, AAH had 126,054 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

## Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period 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.

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 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

## Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from 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. DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of DHCS's Medi-Cal Managed Care Division (MMCD) have historically worked in conjunction with the Department of Managed Health Care to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or the Department of Managed Health Care. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

No medical performance review has been conducted since the October 2008 review. HSAG reported findings from this audit in the July 1, 2008–June 30, 2009, evaluation report.[4] HSAG also reported that a follow-up monitoring visit was conducted by DHCS in May 2010 and that AAH had implemented activities to ensure the plan addressed the final outstanding deficiency related to the plan monitoring wait time standards.

## Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current medical performance reviews and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

The most recent monitoring review was completed May 2010 covering the review period of July 1, 2008, through April 1, 2010. Details of this monitoring review were included in the plan's 2009–2010 evaluation report and showed that the plan was not fully compliant in the area of prior authorizations and cultural and linguistic requirements; however, the plan adequately addressed these issues as outlined in the plan's 2010–2011 report.[5,6]

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

[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/MMCDQualPerfMsrRpts.aspx.

[6] *Performance Evaluation Report – Alameda Alliance for Health, July 1, 2010 – June 30, 2011*. California Department of Health Care Services. June 2012. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

## Strengths

Based on the information available at the time of this report, AAH is in compliance with all medical performance and MR/PIU review requirements.

## Opportunities for Improvement

HSAG did not identify opportunities for improvement in this area during the review period.

## Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). 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 DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by DHCS for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

## Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the plan's performance in providing quality, accessible, and timely care and services to its MCMC members.

### *Performance Measure Validation*

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[7] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of AAH in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

## Performance Measure Validation Findings

The audit revealed no areas of concern; however, the HSAG audit team made the following two recommendations:

- Consider including HEDIS staff members responsible for HEDIS reporting on the transition team when the plan converts to the new transactional system, Health Suite, to ensure data necessary for HEDIS reporting are included in the new system.
- Research the feasibility of capturing data submitted on PM160 forms for inclusion in HEDIS reporting.

## Performance Measure Results

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

**Table 3.1—Performance Measures Name Key**

| Abbreviation | Full Name of 2012 Performance Measure |
|---|---|
| AAB | *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* |
| ACR | *All-Cause Readmissions (internally developed measure)* |
| AMB–ED | *Ambulatory Care—Emergency Department (ED) Visits* |
| AMB–OP | *Ambulatory Care—Outpatient Visits* |
| AWC | *Adolescent Well-Care Visits* |
| CAP–1224 | *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* |
| CAP–256 | *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* |
| CAP–711 | *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* |
| CAP–1219 | *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* |
| CCS | *Cervical Cancer Screening* |
| CDC–BP | *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* |
| CDC–E | *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* |
| CDC–H8 (<8.0%) | *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)* |
| CDC–H9 (>9.0%) | *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)* |
| CDC–HT | *Comprehensive Diabetes Care—HbA1c Testing* |
| CDC–LC (<100) | *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* |
| CDC–LS | *Comprehensive Diabetes Care—LDL-C Screening* |
| CDC–N | *Comprehensive Diabetes Care—Medical Attention for Nephropathy* |
| CIS–3 | *Childhood Immunization Status—Combination 3* |
| IMA–1 | *Immunizations for Adolescents—Combination 1* |
| LBP | *Use of Imaging Studies for Low Back Pain* |
| MPM–ACE | *Annual Monitoring for Patients on Persistent Medications—ACE* |
| MPM–DIG | *Annual Monitoring for Patients on Persistent Medications—Digoxin* |
| MPM–DIU | *Annual Monitoring for Patients on Persistent Medications—Diuretics* |
| PPC–Pre | *Prenatal and Postpartum Care—Timeliness of Prenatal Care* |

**Table 3.1—Performance Measures Name Key**

| Abbreviation | Full Name of 2012 Performance Measure |
|---|---|
| PPC–Pst | *Prenatal and Postpartum Care—Postpartum Care* |
| W-34 | *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* |
| WCC–BMI | *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total* |
| WCC–N | *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total* |
| WCC–PA | *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total* |

Table 3.2 presents a summary of AAH's HEDIS 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

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

**Table 3.2—Comparison of 2011 and 2012 Performance Measure Results for Alameda Alliance for Health—Alameda County**

| Performance Measure[1] | Domain of Care[2] | 2011 HEDIS Rates[3] | 2012 HEDIS Rates[4] | Performance Level for 2012 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| AAB | Q | 35.6% | 31.5% | ★★ | ↔ | 18.8% | 31.6% |
| AMB–ED | ‡ | -- | 42.0 | -- | Not Comparable | -- | -- |
| AMB–OP | ‡ | -- | 315.0 | -- | Not Comparable | -- | -- |
| AWC | Q,A,T | 40.7% | 45.0% | ★★ | ↔ | 39.6% | 64.1% |
| CAP–1224 | A | -- | 94.6% | -- | Not Comparable | -- | -- |
| CAP–256 | A | -- | 85.5% | -- | Not Comparable | -- | -- |
| CAP–711 | A | -- | 85.6% | -- | Not Comparable | -- | -- |
| CAP–1219 | A | -- | 82.0% | -- | Not Comparable | -- | -- |
| CCS | Q,A | 67.7% | 68.4% | ★★ | ↔ | 64.0% | 78.7% |
| CDC–BP | Q | 55.7% | 59.9% | ★★ | ↔ | 54.3% | 76.0% |
| CDC–E | Q,A | 40.0% | 52.6% | ★★ | ↑ | 43.8% | 70.6% |
| CDC–H8 (<8.0%) | Q | 40.0% | 58.9% | ★★ | ↑ | 39.9% | 59.1% |
| CDC–H9 (>9.0%) | Q | 49.9% | 28.5% | ★★★ | ↑ | 52.1% | 29.1% |
| CDC–HT | Q,A | 84.0% | 83.2% | ★★ | ↔ | 77.6% | 90.9% |
| CDC–LC (<100) | Q | 34.1% | 43.6% | ★★ | ↑ | 27.3% | 45.9% |
| CDC–LS | Q,A | 74.3% | 76.9% | ★★ | ↔ | 70.4% | 84.2% |
| CDC–N | Q,A | 81.7% | 83.0% | ★★ | ↔ | 73.9% | 86.9% |
| CIS–3 | Q,A,T | 47.9% | 78.1% | ★★ | ↑ | 64.4% | 82.6% |
| IMA–1 | Q,A,T | -- | 66.7% | -- | Not Comparable | -- | -- |
| LBP | Q | 84.3% | 84.8% | ★★★ | ↔ | 72.3% | 82.3% |
| MPM–ACE | Q | -- | 87.0% | -- | Not Comparable | -- | -- |
| MPM–DIG | Q | -- | 86.4% | -- | Not Comparable | -- | -- |
| MPM–DIU | Q | -- | 84.8% | -- | Not Comparable | -- | -- |
| PPC–Pre | Q,A,T | 64.7% | 88.6% | ★★ | ↑ | 80.3% | 93.2% |
| PPC–Pst | Q,A,T | 58.8% | 61.1% | ★★ | ↔ | 59.6% | 75.2% |
| W-34 | Q,A,T | 68.8% | 77.6% | ★★ | ↑ | 66.1% | 82.9% |
| WCC–BMI | Q | 39.6% | 55.2% | ★★ | ↑ | 19.7% | 69.8% |
| WCC–N | Q | 80.1% | 58.6% | ★★ | ↓ | 39.0% | 72.0% |
| WCC–PA | Q | 55.8% | 41.6% | ★★ | ↓ | 28.5% | 60.6% |

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a $p$ value of <0.05.
[6] DHCS'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] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

## Performance Measure Result Findings

Overall, AAH had average performance results across the spectrum of HEDIS measures. Two measures performed above the HPLs, while no measures fell below the MPLs. An impressive eight measures had statistically significant increases over their respective 2011 performance, while only two measures had a statistically significant decrease in 2012.

## HEDIS Improvement Plans

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

HSAG compared the plan's 2011 IP (if one was required) with the plan's 2012 HEDIS rate for that measure 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 2011 performance measure rates, DHCS required the plan to submit HEDIS improvement plans for three measures:

- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Two of the three measures (eye exam and prenatal care) were on improvement plans from the previous year, and childhood immunization was a new improvement plan for 2011. HSAG reviewed AAH's 2011 HEDIS improvement plans using HEDIS 2012 rates and assessed whether the plan improved its performance in 2012. HSAG provides the following analysis of the plan's 2011 HEDIS improvement plans.

### Childhood Immunization

AAH's 2011 improvement plan for *Childhood Immunization Status—Combination 3* was very effective as the rate jumped more than 30 percentage points in 2012, which was a statistically significant increase. The rate was approximately four percentage points away from reaching the HPL.

AAH indicated that two strategies were employed to ensure data completeness, which the plan cited as the primary reason this performance measure plummeted from 2009 to 2010. One strategy

was that AAH obtained California Immunization Registry data timely to use as supplemental data in the plan's HEDIS calculations. AAH also replaced its previous HEDIS vendor with a new HEDIS vendor. The new vendor was able to use the supplemental data and provide improved information to the plan on where to pursue medical record review. The plan reported that internal resources were previously lacking to provide feedback to providers on members that were in need of immunizations; and beginning in 2012, the vendor provided member lists that were shared with providers quarterly. The reports also were used for Interactive Voice Response (IVR) calls to member homes reminding parents to have their children immunized. Based on its 2012 performance measure rate, AAH will not be required to submit an improvement plan for the *Child Immunization Status—Combination 3* measure.

### Diabetes Care

Only one diabetes measure fell below the MPL in 2011, *Comprehensive Diabetes Care—Eye Exam (Retinal)*. In 2012 the measure had a statistically significant increase and performed above the MPL. This increase in performance can be attributed to the effectiveness of AAH's improvement plan. The plan continued strategies begun as part of its 2010 improvement plans which included sending member and provider reminders and enhancing data completeness. In AAH's self-report of actions implemented to address performance on this measure, the plan attributed the improvement in the measure to member and provider outreach and data mapping improvements.

Based on its 2012 performance measure rates, the plan will not need to continue the improvement plan for the *Comprehensive Diabetes Care—Eye Exam (Retinal)* measure.

### Prenatal Care

In the past, AAH struggled to improve its performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* measure. However, continued focus and 2011's improvement plan helped AAH surpass the MPL and have a statistically significant increase in performance in 2012.

AAH continued to conduct member outreach through its member newsletters. Additionally, the plan worked with quality improvement nurses to improve the medical record review logic used to identify the most likely provider of prenatal care.. The plan also offered gift cards to members who obtained a prenatal care visit within their first trimester. Finally, using the expanded birth record from the county's Vital Statistics Department as supplemental data and working with the new HEDIS vendor improved the accuracy of data and helped to improve performance.

Based on its 2012 rate for this measure, AAH will not need to continue the performance improvement plan for the *Timeliness of Prenatal Care (PPC-Pre)* measure.

## Strengths

AAH performed above the HPLs for two measures: *Use of Imaging Studies for Low Back Pain* and *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*, and there were no measures that fell below the MPLs. The plan also exhibited strength in its HEDIS improvement plans, as all of the measures that were on an improvement plan in 2011 had statistically significant improvements in 2012. The plan will not need to continue improvement plans for any of these measures.

## Opportunities for Improvement

Despite the plan's solid performance in 2012, AAH still has some opportunities to improve in 2013. The plan had statistically significant decrease in performance for two measures:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total.*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total.*

The plan should assess factors contributing to the decline in performance. Based on the results of the assessment, a strategy should be implemented to improve performance on these measures.

## 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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* provides an overview of the objectives and methodology for conducting the EQRO review.

## Validating Quality Improvement Projects and Assessing Results

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

AAH had two statewide collaborative QIPs and two internal QIPs in progress during the review period of July 1, 2011–June 30, 2012. All four QIPs had a clinical focus and fell under the quality and access domains of care.

The first collaborative QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of DHCS's statewide collaborative QIP project. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative QIP, which focused on reducing readmissions for members aged 21 years and older.

The current 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. At the initiation of the QIP, AAH had identified 5,184 ER visits that were avoidable,

which was 7.9 percent of the plan's ER visits. AAH's objective was to reduce this rate by using both member and provider improvement strategies. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

The new statewide collaborative proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members leading to improved health outcomes.

AAH's first internal QIP aimed to decrease return ER visits for asthmatic exacerbations in children 2–18 years of age. This QIP was completed during the review period; therefore, AAH submitted a second internal QIP proposal targeting hypertensive members. The hypertension QIP focused on improving the identification of members with hypertension and anti-hypertensive medication management.

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. At the start of AAH's decreasing return asthmatic ER visits QIP, the plan identified 111 children (17.5 percent) who had two or more ER visits during the measurement year. AAH's project attempted to improve the quality of care delivered to children with asthma by using an ATTACK Asthma Clinic located within the ER in a children's hospital.

Hypertension is a risk factor for heart disease and stroke. Both the identification of high blood pressure and the management of the condition are important to prevent more serious complications. AAH's hypertension project will measure the percentage of members with a diagnosis of hypertension and compare it against national data to determine if there may be underreporting of the condition. For members diagnosed with hypertension, the plan will measure the percentage of members who filled a prescription for their hypertensive medications to determine rates of medication adherence.

## Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status 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, 2011, through June 30, 2012**

| Name of Project/Study | Type of Review[1] | Percentage Score of Evaluation Elements *Met*[2] | Percentage Score of Critical Elements *Met*[3] | Overall Validation Status[4] |
|---|---|---|---|---|
| **Statewide Collaborative QIP** | | | | |
| *Reducing Avoidable Emergency Room Visits* | Annual Submission | 97% | 100% | *Met* |
| *All-Cause Readmissions** | Proposal | Not Applicable | Not Applicable | *Pass* |
| **Internal QIPs** | | | | |
| *Decrease Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age* | Annual Submission | 89% | 100% | *Met* |
| *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* | Proposal | 65% | 50% | *Partially Met* |
| | Proposal Resubmission | 100% | 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*.

*During the review period, the *All-Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that both the annual submission by AAH of its *Reducing Avoidable Emergency Room Visits* QIP and its *Decreasing Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age* QIP received an overall validation status of *Met* with 100 percent of critical elements receiving a *Met* score. AAH received a *Partially Met* validation status for its *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* proposal submission. As of July 1, 2009, DHCS has required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted the proposal and upon subsequent validation, achieved an overall *Met* validation status. For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

Due to unique, one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

Table 4.2 summarizes the aggregate validation results for 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 = 4 QIP Submissions, 3 QIP Topics) July 1, 2011, through June 30, 2012**

| QIP Study Stages | Activity | *Met* Elements | *Partially Met* Elements | *Not Met* Elements |
|---|---|---|---|---|
| Design | I: Appropriate Study Topic | 96% | 0% | 4% |
| | II: Clearly Defined, Answerable Study Question(s) | 75% | 25% | 0% |
| | III: Clearly Defined Study Indicator(s) | 88% | 12% | 0% |
| | IV: Correctly Identified Study Population | 100% | 0% | 0% |
| **Design Total**** | | **91%** | **7%** | **1%** |
| 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 | 83% | 0% | 17% |
| **Implementation Total** | | **94%** | **0%** | **6%** |
| Outcomes | VIII: Sufficient Data Analysis and Interpretation | 100% | 0% | 0% |
| | IX: Real Improvement Achieved | 57% | 0% | 43% |
| | X: Sustained Improvement Achieved | 50% | 0% | 50% |
| **Outcomes Total** | | **84%** | **0%** | **16%** |

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

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

AAH submitted Activities I through IV for its *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* proposal submission. AAH submitted Remeasurement 3 data for its *Reducing Avoidable Emergency Room Visits* QIP and its *Decreasing Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age* QIP; therefore, HSAG validated Activity I through Activity X for these two QIPs. AAH demonstrated a strong understanding of the design and implementation stages, scoring over 90 percent for all applicable evaluation elements within the two study stages. Only the *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP was scored down for study design activities. The plan had incorrectly defined the study question and study indicators. HSAG provided technical assistance and the plan corrected these deficiencies.

For the outcomes stage, AAH was scored lower in Activity IX for not demonstrating statistically significant improvement from the second to the third remeasurement period for its *Decreasing Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age* QIP. In Activity X, the plan was scored lower for its inability to achieve sustained improvement for its *Reducing Avoidable Emergency Room Visits* QIP. 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 and Interventions

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 = 3 QIP Topics) July 1, 2011, through June 30, 2012**

| 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 | Remeasurement 3 1/1/10–12/31/10 | Sustained Improvement¥ |
| Percentage of avoidable ER visits | 11.4%^ | 23.0%* | 19.9%* | 17.6%* | 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 7/1/09–6/30/10 | Remeasurement 3 7/1/10–6/30/11 | 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%* | 14.3% | Yes |

**Table 4.3—Quality Improvement Project Outcomes for Alameda Alliance for Health—Alameda County (Number = 3 QIP Topics) July 1, 2011, through June 30, 2012**

| QIP #3—Improving Anti-Hypertensive Medication Fills Among Members with Hypertension | | | | |
|---|---|---|---|---|
| QIP Study Indicator | Baseline Period 1/1/11–12/31/11 | Remeasurement 1 1/1/12–12/31/12 | Remeasurement 2 1/1/13–12/31/13 | Sustained Improvement¥ |
| The percentage of members 18-85 years of age continuously enrolled as of December 31 of each measurement year with a diagnosis of hypertension in the first 6 months of the measurement year who filled at least four anti-hypertensive medications | ‡ | ‡ | ‡ | ‡ |

¥ 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 did not progress to this phase during the review period and could not be assessed.
^Rate may have been miscalculated since claims data was used instead of reported HEDIS rates.

### *Reducing Avoidable Emergency Room Visits* QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, AAH set an overall objective to decrease the rate of ER visits designated as avoidable by 10 percent. For this project outcome, a lower rate demonstrates improved performance. While the plan did not meet its overall objective, it was able to reduce the percentage of avoidable ER visits by a statistically significant amount from the first remeasurement period to the second remeasurement period (3.1 percentage points) and then again from the second to the third remeasurement period (2.3 percentage points). However, the third remeasurement period remained above baseline, demonstrating a lack of sustained improvement for the project.

While the plan did achieve statistically significant improvement for two remeasurement periods, there was an initial decline in performance from baseline to the first remeasurement period; the rate of avoidable ER visits increased by a statistically significant amount. A critical analysis of the plan's improvement strategy identified the following:

- The plan did not incorporate data analysis as part of the barrier analysis until June 2009 due to data system, information technology, and staffing limitations.

- A project team identified barriers and developed interventions; however, the results were not documented. The plan did not provide a list of the identified barriers or the rationale for how they were prioritized.
- The plan implemented very limited plan-specific provider and member interventions to reduce avoidable ER visits.
- The plan did report some success with the collaborative interventions. AAH reported that 99.6 percent of ER visit data was received from the participating hospital within five days. The plan did not report how many members were contacted after receiving the data.

Interventions were documented without a specific evaluation plan for each intervention. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

### *Decrease Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age* QIP

For the *Decreasing Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age* QIP, the plan's objective was to reduce the percentage of children with more than two ER visits for asthma by 10 percent each year. While the plan did not meet its overall objective, it was able to reduce the percentage of children with more than two ER visits by a statistically significant amount from the first remeasurement period to the second remeasurement period (8.7 percentage points). The third remeasurement period results remained improved over baseline, demonstrating sustained improvement for the project.

While the plan did achieve overall improvement, there were two time periods without measureable improvement in the outcome. A critical analysis of the plan's improvement strategy identified the following:

- The plan conducted a planning session to identify barriers and develop interventions. The plan did not provide any specific results of the barrier analysis or any data-driven rationale for the selection of the intervention.
- The plan implemented the ATTACK asthma clinic, located inside an ER in a children's hospital, to provide education to members; however, the plan did not provide any data to support the success of the clinic.
- The plan did not conduct annual barrier analyses. Additionally, it did not change or modify its improvement strategy over the course of the project.

The plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine whether to modify or discontinue existing interventions, or implement new ones, thereby reducing the likelihood of achieving project objectives and improving performance.

## Strengths

AAH accurately documented the QIP process as evidenced by a *Met* validation status for the annual submissions of both the *Reducing Avoidable ER Visits* QIP and the *Decreasing Return ER Visits for Asthmatic Exacerbations in Children 2–18 Years of Age* QIP.

The plan was able to reduce the percentage of children with more than two ER visits for asthmatic exacerbations and sustain that improvement through the final remeasurement period.

## Opportunities for Improvement

AAH should conduct an annual barrier analysis, at minimum. The plan should improve the documentation of the barrier analysis, providing the data, the identified barriers, and the rationale for how the barriers are prioritized.

The interventions implemented should address the high-priority barriers. A method to evaluate the effectiveness of each intervention should be documented, as well as the results of the intervention's evaluation for each measurement period.

## Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care. A more detailed description of HSAG's scoring process is included in Appendix A.

### *Quality*

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

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries 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, 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 of care. This assessment was based on AAH's 2012 performance measure rates (which reflect 2011 measurement data), QIP validation and outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

Eight measures that are in the quality domain of care had a statistically significant increase from 2011 rates; however, only one of these eight measures performed above the HPL. Two measures in the quality domain of care had a statistically significant decrease in performance but remained above the MPLs.

AAH demonstrated success with the three 2012 HEDIS improvement plans it was required to submit. All three improvement plans resulted in a statistically significant increase from 2011 rates and the rates exceeding the MPLs.

AAH received a *Met* validation status for the annual submissions of two QIPs, showing an understanding of how to thoroughly and accurately document the QIP process.

## 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 MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and 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. Medical performance reviews, MR/PIU reviews, 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

AAH demonstrated overall average performance in the access domain of care based on review of 2012 performance measure rates and QIP validation and outcomes. The plan's performance was average for all measures assigned to the access domain of care; however, 4 of the 10 access measures had statistically significant increase in performance from 2011 rates.

AAH was able to reduce the percentage of children with more than two ER visits for asthmatic exacerbations and sustain that improvement through the final remeasurement period, which suggests members are accessing services through their primary care providers rather than through the ER.

## 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.

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 overall average performance in the timeliness domain of care. Five measures are assigned to the timeliness domain of care and the plan's performance was average on all of these measures. Three of the timeliness measures had statistically significant improvement from 2011 rates.

## Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. AAH's self-reported responses are included in Appendix B.

## Recommendations

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

- Consider including HEDIS staff members responsible for HEDIS reporting on the transition team when the plan converts to the new transactional system, Health Suite, to ensure data necessary for HEDIS reporting are included in the new system.
- Research the feasibility of capturing data submitted on PM160 forms for inclusion in HEDIS reporting.
- Assess the reasons for a decrease in performance and, based on the results of the assessment, implement a strategy to improve performance on the following measures:
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total.*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total.*
- At minimum, conduct an annual barrier analysis for QIPs and thoroughly document the analysis, providing the data, the identified barriers, and the rationale for how the barriers are prioritized.
- Document how QIP interventions address the high-priority barriers, including methods for evaluating the effectiveness of each intervention and the results of the intervention's evaluation for each measurement period.

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

## Quality, Access, and Timeliness

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

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

## Performance Measure Rates

*(Refer to Table 3.2)*

### *Quality Domain*

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) greater than negative three, if there are two or less measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than three.
3. To be considered ***Below Average***, a plan will have three or more measures below the MPLs than it has above the HPLs.

### Access Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus and the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

### Timeliness Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

## Quality Improvement Projects (QIPs)

*(Refer to Tables 4.1 and 4.3)*

- **Validation** *(Table 4.1)*: For each QIP submission and subsequent resubmission(s), if applicable.
  - **Above Average** is not applicable.
  - **Average** = *Met* validation status.
  - **Below Average** = *Partially Met* or *Not Met* validation status.
- **Outcomes** *(Table 4.3)*: Activity IX, Element 4—**Real Improvement**
  - **Above Average** = All study indicators demonstrated statistically significant improvement.
  - **Average** = Not all study indicators demonstrated statistically significant improvement.
  - **Below Average** = No study indicators demonstrated statistically significant improvement.

- **Sustained Improvement** *(Table 4.3)*: Activity X—**Achieved Sustained Improvement**
  - **Above Average =** All study indicators achieved sustained improvement.
  - **Average =** Not all study indicators achieved sustained improvement.
  - **Below Average =** No study indicators achieved sustained improvement.

## Calculating Final Quality, Access, and Timeliness Scores

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

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

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

Medical performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain.

# *Appendix B.* Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

*for* **Alameda Alliance for Health**

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with AAH's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

**Table B.1—Grid of AAH's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report**

| 2010–2011 EQR Recommendation | AAH's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation |
|---|---|
| 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. | The Alliance submitted 2011 HEDIS improvement plans for the following measures: *Comprehensive Diabetes Care – Eye Exam (CDC-E)*, *Timeliness of Prenatal Care (PPC-Pre)*, and *Childhood Immunizations (CIS)*.<br><br>The Alliance has continued to improve rates for the CDC-E measure, as shown in the substantial improvement in the rates from 2010 to 2011 (25.52% to 40.00%). The strategies implemented as part of improvement plans submitted in 2010, in particular, member and provider reminders as well as enhancing data completeness, have helped to improve the rates. In addition, the Alliance has continued these interventions throughout 2011 and 2012 and improvements in rates have been achieved. The HEDIS 2012 rate for CDC-E was 52.55%, a significant improvement from the HEDIS 2011 rate of 40%. The improvements are attributed to member and provider outreach and improving the mapping of data.<br><br>In 2012, the Alliance has conducted IVR calls to members needing eye exams and has sent providers lists of members still needing diabetic eye exams and other diabetic testing for outreach.<br><br>The Alliance has seen improvements in the PPC-Pre measure with the rates improving from 60.49% in HEDIS 2010 to 64.65% in HEDIS 2011 to 88.6% in HEDIS 2012. Only a small increase in rates was seen from HEDIS 2010 to HEDIS 2011 due to not having enough time to implement the interventions and vendor issues. However, for HEDIS 2012, a new vendor was utilized and the Alliance was able to improve data collection methods through improved chase logic during chart reviews and acquisition of supplemental data from the Vital Statistics Department. The Alliance is continuing to educate members on the importance of prenatal care and improving data collection for this measure.<br><br>The CIS rates have also improved dramatically since HEDIS 2011. It was clear that there was a data issue since the rates plummeted from 2009 to 2010. Therefore, the strategies that were employed to improve the rates focused on ensuring data completeness. The Alliance obtained the California Immunization Registry data earlier and ensured the ability to use this supplemental data in the calculations. The Alliance also contracted with a new HEDIS vendor who was able to utilize the supplemental data and provided improved chase logic. These strategies contributed to the Alliance achieving a rate of 78.10% for HEDIS 2012, resulting in the Alliance reaching the national Medicaid 75th percentile. In addition, the Alliance has worked with the new HEDIS vendor in 2012 to produce reports to identify members missing vaccines. Reminder cards were mailed to these members beginning in 2012. The Alliance expects the CIS rates to continue to improve due to these strategies. |

**Table B.1—Grid of AAH's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report**

| 2010–2011 EQR Recommendation | AAH's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation |
|---|---|
| | In addition, the Alliance is continuing to improve data collection system-wide through working with the various trading partners to submit standardized file submission format and changing our core transaction system by March 2013 which will help across measures. The Alliance has also worked on creating a provider repository that improves the provider data that are collected and received from other sources. This will help to ensure that we have the most accurate data to identify the correct specialty types for data mapping. |
| Submit a project timeline to address any unresolved data capture issues. | The QI Department created a timeline in September 2011 to use for the HEDIS 2012 reporting year to ensure that data capturing issues were addressed. This timeline was shared with various internal departments including IT, Business Operations, Provider Services, and Quality Management. Since the Alliance contracted with a new vendor in September 2011, the Alliance was able to re-run the HEDIS 2011 rates with the new vendor to compare rates against the old vendor to identify any data capturing issues. Data gaps were investigated. Special emphasis was placed on improving specialty mapping. All of these efforts resulted in significant improvements on the majority of HEDIS measures for HEDIS 2012 reporting. |
| Conduct barrier analysis to identify and prioritize barriers for each QIP measurement period. | A barrier analysis was conducted to identify and prioritize barriers for the last QIP measurement period. However, going forward, a barrier analysis will be conducted for each QIP measurement period.<br><br>The barriers encountered in the Asthma QIP included difficulty in enrolling children into the ATTACK clinic. Since the program was very limited in that it was only available at Children's Hospital Oakland, the Alliance has since developed an Asthma Disease Management program beginning in June 2012 available to children with asthma. This program is comprehensive and includes mailing of educational materials, health coaching, and case management if indicated for children with asthma. In addition, the Alliance Asthma Disease Management program staff work closely with the ATTACK clinic to encourage members to enroll in the ATTACK clinic and to coordinate care with the member's PCP.<br><br>The barriers encountered in the ER Collaborative QIP included not having the staff resources to support some of the interventions. In addition, the Alliance encountered resistance from providers on receiving reports on members who were in the ER. Subsequently, the Alliance has decided to focus on sending providers a quarterly list of members who frequently use the ER and has continued this activity since October 2011. This report has become automated so that the amount of staff resources required to produce these reports is minimized. Additional analyses are underway in identifying the characteristics of the members who frequent the ER. |

**Table B.1—Grid of AAH's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report**

| 2010–2011 EQR Recommendation | AAH's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation |
|---|---|
| Implement a method to evaluate the effectiveness of each QIP intervention and make appropriate revisions or implement new interventions, if necessary. | The Alliance is currently instituting continuous quality improvement within each QIP by assessing the impact of each strategy and revising as necessary. The Alliance recognizes that in order to evaluate the effectiveness of each intervention, we need to include interventions that are measureable. In addition, more frequent analyses will allow the Alliance to identify if any changes to the interventions are necessary. |
| Identify ways to improve intervention strategies in order to achieve sustained improvement of QIP outcomes. | The Alliance has tried to implement strategies that are more active versus passive (i.e., high-touch versus low-touch) to attempt to achieve sustained improvement of QIP outcomes. For instance, the new QIPs that are being implemented in 2012 have incorporated more direct physician and member outreach. However, some barriers in achieving sustained improvement include budget limitations and limited resources at the plan. Therefore, efforts are made to incorporate interventions that could be built into existing workflows and job duties of staff. |