Performance Evaluation Report

AIDS Healthcare Foundation

July 1, 2011–June 30, 2012

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

June 2013

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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, AIDS Healthcare Foundation (previously known as AHF Healthcare Centers and referred to in this report as "AHF" or "the plan"), which delivers care in Los Angeles 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

AHF 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 (i.e., 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, 2012, the plan had 886 MCMC members.[3]

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

[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 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. 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.

As stated in AHF's 2010–11 performance evaluation report, the plan's most recent medical performance review was completed in April 2006. The results of the review were included in the plan's 2008–2009 performance evaluation report.[4] Although a review by the State Controller's Office was conducted in January and February 2011 covering the audit period of October 1, 2009, through September 30, 2010, the results from this audit were not approved by DHCS and are therefore not summarized in this report.

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 MR/PIU review was conducted in June 2010, and covered the review period of January 1, 2008, through April 30, 2010. HSAG reported the findings of this review in AHF's 2010–11 performance evaluation report.

As was previously reported, the review found AHF to be fully compliant with prior authorization notification procedures; marketing; and fraud and abuse prevention, monitoring, and notification requirements. MR/PIU noted findings in the areas of Member Grievances, Cultural and Linguistic

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

Services, and Member Services. AHF was not required to respond to the findings. MR/PIU will follow up with the plan on the findings during its next review. Listed below are the findings:

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

AHF provided information to HSAG regarding actions the plan has taken to address the findings. During the time period July 1, 2011, through June 20, 2012, AHF indicated that the plan:

- Implemented a process where grievances are reviewed and results are reported quarterly to senior management and the Board of Directors and grievance file compliance audits are reported to the Member and Provider and Quality Management committees.
- Conducted four trainings for providers and staff members on appropriate use of the Language Line at high-volume health care centers and a continuing medical education session on HIV treatment for transgender patients.
- Included an article in the plan's newsletter about understanding the needs of limited English proficiency patients.
- Provided resource lists to providers for HIV support groups and cultural community centers in Los Angeles.
- Updated the Language Line poster and distributed it to all plan health care centers.
- Began revising the cultural and linguistic training model to include practical applications of cultural competency concepts to the member demographics based on the 2011 Group Needs Assessment findings.
- Distributed the Industry Collaboration Effort (ICE) Employee Language Skills Self-Assessment Tool to health care centers to help identify and document bilingual capabilities of practitioners and their staff.
- Implemented evaluation and monitoring processes to ensure cultural and linguistic training is effective and providers are adhering to policies, procedures, and guidelines.

Strengths

During the review period of July 1, 2011, through June 20, 2012, AHF appears to have engaged in multiple efforts to address the findings related to cultural and linguistic services. The plan also implemented a process to ensure grievances are managed in accordance with the plan's policies and procedures.

Opportunities for Improvement

Although AHF implemented a process for auditing grievances and reporting results within the plan's structure, specific efforts were not described related to ensuring that the resolution letter is sent within 30 days of receipt of the grievance. AHF should specify the processes it will use to ensure letters are sent within the required time frame and report on the monitoring results to demonstrate whether the plan is meeting the requirements.

HSAG's review of AHF's quality improvement and evaluation documents did not reveal evidence that the plan revised its EOC document to include all required information. Revision of the document will ensure members are provided all required information and that AHF is in compliance with State and federal requirements.

Conducting the Review

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). DHCS requires that plans collect and report EAS rates, which provide a standardized method for objectively evaluating plans' delivery of services.

Due to the small size of specialty plan populations, 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, DHCS requires specialty plans to report only two performance measures. In collaboration with DHCS, a specialty plan may select measures from the Healthcare Effectiveness Data and Information Set (HEDIS®)[5] or design a measure that is appropriate to the plan's population. The measures put forth by the specialty plan are subject to approval by DHCS. 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.

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

AHF reported two HEDIS measures: *Controlling High Blood Pressure* and *Colorectal Cancer Screening*. HSAG performed a HEDIS Compliance Audit™ of AHF in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

Performance Measure Validation Findings

Based on the results of the compliance audit, HSAG found both measures to be reportable and did not identify any areas of concern. During the audit, AHF ran rates from its live repository; and it was recommended during the audit that a process be put in place to freeze data used to create annual HEDIS rates so they can be recreated.

Performance Measure Results

After validating the plan's performance measure rates, HSAG assessed the results.

Table 3.1 presents a summary of AHF'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. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs.

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 percentiles and 90th percentiles, respectively.

Table 3.1—2011–2012 Performance Measure Results for AIDS Healthcare Foundation—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	MMCD's Minimum Performance Level	MMCD's High Performance Level (Goal)
Controlling High Blood Pressure (CBP)							
18–85 years	Q,A	69.6%	68.2%	★★★	↔	47.9%*	67.6%*
Colorectal Cancer Screening (COL)							
50–75 years	Q,A	60.2%	64.2%	★★	↔	57.3%^	74.2%^

[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.
* The minimum performance level (MPL) and high performance level (HPL) for this measure are based on NCQA's national Medicaid 25th and 90th percentiles, respectively.
^ The MPL and HPL for this measure are based on NCQA's national commercial 25th and 90th percentiles, respectively.
★ = Below-average performance relative to the national Medicaid 25th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles).
★★★ = Above-average performance relative to the national Medicaid 90th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

AHF performed above the HPL for the *Controlling High Blood Pressure* measure in 2012. The plan performed above the MPL, but below the HPL, for the *Colorectal Cancer Screening* measure in 2012. AHF's self-report indicates that several activities were implemented during the time period of July 1, 2011, through June 30, 2012, to positively affect the *Colorectal Cancer Screening* measure rate. Activities included providing a screening checklist, screening reminder, and educational information to providers. Although not statistically significant, there was a 4 percentage point increase on the *Colorectal Cancer Screening* measure from 2011 to 2012, which suggests that the plan's colorectal cancer screening activities are improving AHF's performance on this measure.

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.

In 2011, the plan did not have any measures below the MPLs. Therefore, no improvement plans were in place for 2012.

Strengths

This is the second year that AHF's performance on the *Controlling High Blood Pressure* was measured. The plan performed above the HPL, which can likely be attributed to AHF's initiatives to work with members to ensure their blood pressure is under control. Although AHF did not see a statistically significant improvement in performance on the *Colorectal Cancer Screening* measure rate, an increase in the rate suggests that the plan is making progress on ensuring that appropriate colorectal cancer screening occurs.

Opportunities for Improvement

AHF's 2011–12 Quality and Performance Improvement Work Plan includes a goal of attaining the 90th percentile for the *Controlling High Blood Pressure* and *Colorectal Cancer Screening* measures. To assist AHF in meeting this goal, the plan could benefit from assessing which processes are working to assist members in controlling their blood pressure and ensure these processes are being implemented plan-wide. AHF also could benefit from identifying the strategies that are resulting in appropriate colorectal cancer screening so they can be duplicated across all providers to increase screening rates.

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

Quality Improvement Project Objectives

Specialty plans must be engaged in two QIPs at all times. However, because specialty plans serve unique populations that are limited in size, DHCS does not require them 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 one nonclinical QIP and one clinical QIP in progress during the review period of July 1, 2011–June 30, 2012. The first QIP, which fell under the quality domain of care, sought to increase the percentage of members with documentation of advanced care planning. As defined by NCQA, advanced care planning is a discussion about preferences for resuscitation, life-sustaining treatment, and end-of-life care. At the initiation of the QIP, 7.2 percent of the eligible members had an advance directive. AHF's second project fell under both quality and access domains of care

and focused on increasing CD4 and viral load testing. At the start of the QIP, 69.3 percent of eligible members had three or more CD4 tests and 68.9 percent had three or more viral load tests. AHF's project attempted to improve the testing rates by using both member and provider interventions.

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 AIDS Healthcare Foundation—Los Angeles 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]
Internal QIPs				
Advance Care Directives	Annual Submission	77%	82%	*Partially Met*
	Resubmission	97%	100%	*Met*
CD4 and Viral Load Testing	Annual Submission	89%	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, 2011, through June 30, 2012, showed that AHF's initial submission of its *Advance Care Directives* QIP received an overall validation status of *Partially Met* because the plan's definition of the study question was not complete. Since DHCS requires plans to resubmit their QIPs until they achieve an overall *Met* validation status, the plan resubmitted this QIP. The plan achieved an overall *Met* validation status on the resubmission, with 100 percent of critical elements receiving a *Met* score. AHF's initial submission of its *CD4 and Viral Load Testing* QIP received an overall validation status of *Met*.

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

Table 4.2—Quality Improvement Project Average Rates* for AIDS Healthcare Foundation—Los Angeles County (Number = 3 QIP Submissions, 2 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	94%	0%	6%
	II: Clearly Defined, Answerable Study Question(s)	67%	33%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**94%**	**4%**	**2%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection**	91%	4%	4%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**94%**	**3%**	**3%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation**	63%	19%	19%
	IX: Real Improvement Achieved	75%	0%	25%
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		**65%**	**15%**	**20%**

*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.
‡No QIPs were assessed for this activity.

AHF included baseline data for the *Advance Care Directives* QIP, so it was validated through Activity VIII. The *CD4 and Viral Load Testing* QIP included Remeasurement 1 data, so HSAG validated Activities I through IX. AHF demonstrated an appropriate application of the design and implementation stages, scoring over 90 percent on all applicable evaluation elements for five of the six activities. In Activity II for the *Advance Care Directives* QIP, the plan did not address the recommendations provided in the prior year's validation and once again omitted the definition for "provider" in its study question, resulting in a lowered score.

For the outcomes stage of the *CD4 and Viral Load Testing* QIP, the plan did not identify whether there were factors that affected the ability to compare measurement periods. Additionally, HSAG was unable to replicate the reported *p* value for one of the study indicators. The plan was scored lower for not achieving statistically significant improvement from baseline to the first remeasurement period. Neither QIP included a second remeasurement period; therefore, HSAG could not assess for sustained improvement. 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 AIDS Healthcare Foundation—Los Angeles County (Number = 2 QIP Topics) July 1, 2011, through June 30, 2012

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 evidence of advanced care planning or have had a discussion regarding advanced care planning with their provider	7.2%	‡	‡	‡
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	69.3%	69.7%	‡	‡
Percentage of eligible members receiving at least three Viral Load lab tests	68.9%	73.4%	‡	‡

¥ 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.

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

Advance Care Directives QIP

For the *Advance Care Directives* QIP, the plan's initial goal was to achieve 10 percent of the eligible members with evidence of advanced care planning or having had a discussion regarding advanced care planning with their provider. At baseline, the plan was below its goal, having documented only 7.2 percent of the members with evidence of advanced care planning.

A critical analysis of the plan's improvement strategy identified the following:

- The plan conducted brainstorming sessions to identify barriers and develop interventions. Based on these sessions, the plan implemented system, provider, and member interventions to improve the percentage of members with advanced care planning. The plan provided a fishbone diagram but did not provide any data-driven rationale for the selection of the interventions. The plan did not conduct any subgroup analyses to identify providers with the lowest performance.
- The plan did not include an evaluation plan for each of its interventions. With the implementation of any intervention and especially for multiple interventions, 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 which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

CD4 and Viral Load Testing QIP

For the *CD4 and Viral Load Testing* QIP, the plan set the project objective as a five percent increase annually. From baseline to the first remeasurement period, the plan did not achieve statistically significant improvement for either outcome. An analysis of the plan's improvement strategy identified some weaknesses which may have led to the lack of improvement in outcomes:

- Initially, the plan's interventions consisted of member and provider newsletters. Not until October 2011 did the plan begin providing monthly trend and member non-adherence reports to the providers quarterly. The plan may have achieved better results if it had developed a method to evaluate whether the provider reports are effective in increasing the percentage of members with appropriate testing.

The plan identified additional barriers such as incomplete documentation in the Case Management Tracking System and lack of coordination of appointments; however, the provider reports do not address these barriers. The plan should directly link the prioritized barriers with interventions that address the barriers.

Strengths

AHF accurately documented the QIP process as evidenced by a *Met* validation status for the annual submission of the *CD4 and Viral Load Testing* QIP.

Opportunities for Improvement

AHF should improve the documentation of the barrier analysis, providing the data and the rationale for how the barriers are prioritized.

The implemented interventions should address the high-priority barriers. There should be a direct link between the barrier and intervention. The plan should document a method to evaluate each intervention, as well as provide the results of the interventions' evaluations 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.

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.

AHF showed overall average performance in the quality domain of care based on the plan's 2012 performance measure rates (which reflect 2011 measurement data), QIP validation results, and the MR/PIU review. The plan reported above-average performance on the *Controlling High Blood Pressure* measure and average performance for the *Colorectal Cancer Screening* measure. QIP results showed that the plan performed well on the study design and implementation stages for the *Advance Care Directives* QIP and the *CD4 and Viral Load Testing* QIP.

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.

AHF showed average performance in the access domain of care based on the plan's 2012 performance measure rates (which reflect 2011 measurement data), QIP validation results, and the MR/PIU review. AHF reported that the plan engaged in multiple efforts to address findings noted in the 2010 MR/PIU review related to cultural and linguistic services. The efforts should result in improved member access to appropriate health care services that meet the member's specific needs. HSAG's review of AHF's quality improvement documents did not reveal evidence that the plan had revised its EOC document to include all required information.

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.

AHF exhibited average performance in the timeliness domain of care based on member rights reviews related to timeliness.

As a follow-up to a finding noted in the plan's June 2010 MR/PIU review related to resolution letters not being sent within the required time frame, AHF reported that the plan implemented a process to review grievances and report results quarterly through its management and committee structures.

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

Recommendations

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

- Specify the processes the plan will use to ensure resolution letters are sent within the required time frame and report on the monitoring results to demonstrate whether AHF is meeting the requirements.
- Revise the plan's evidence of coverage document to include all required information.
- Implement a data collection process to freeze data used to create annual HEDIS rates so they can be recreated.
- Assess the processes that are working to assist members in controlling their blood pressure and ensure the processes are being implemented plan-wide.
- Identify the strategies that are resulting in appropriate colorectal cancer screening so the plan can duplicate the strategies across all providers.
- Provide documentation of the QIP barrier analysis, providing the data and the rationale for how the barriers are prioritized.
- Document how QIP interventions address high-priority barriers.
- Document the method that will be used to evaluate each QIP intervention and provide the results of the interventions' evaluations for each measurement period.

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, 2010–June 30, 2011 Performance Evaluation Report

for **AIDS Healthcare Foundation**

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with AHF'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 A.1—Grid of AHF's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	AHF's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Implement an internal audit process on a frequent basis to ensure that the plan is meeting grievance notification requirements.	Activities and/or interventions that were initiated during the time period of July 1, 2011, through June 30, 2012: 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 and Quality Management committees (underway).
Educate providers regarding the cultural and linguistic requirements and services available.	Activities and/or interventions that were initiated during the time period of July 1, 2011, through June 30, 2012: <u>Training</u> 1. Implemented provider and staff training on appropriate use of Language Line at high-volume health care centers (completed). • 8/19/11 Downtown • 8/16/11 Valley • 9/14/11 Hollywood • 8/23/11 Westside 2. Continuing Medical Education: HIV Treatment for Transgender Patients (completed 5/2/12). <u>Education</u> 1. Provided resource lists for HIV support groups and cultural community centers in Los Angeles with health care center providers and staff (completed). • 8/16/11 Valley • 8/19/11 Downtown • 8/23/11 Westside • 9/14/11 Hollywood 2. Updated Language Line poster distributed to all Plan health care centers (8/15/11) (completed). 3. Published an article, "Understanding the Needs of Limited English Proficiency Patients" in the Winter 2011 issue of *Positive Practice* (Provider Newsletter) (completed 1/10/12). <u>Program Improvements</u> 1. Revised the C & L training module to include practical applications of cultural competency concepts specific to the member demographics based on the 2011 Group Needs Assessment findings (underway). 2. Distributed the Industry Collaboration Effort (ICE) Employee Language Skills Self-Assessment Tool to health care centers to help identify and document bilingual capabilities of practitioners and their staff (completed 8/26/11).

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

2010–2011 EQR Recommendation	AHF's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Implement a formal monitoring process to ensure cultural and linguistic training is effective and providers are adhering to policies, procedures, and guidelines.	Activities and/or interventions that were initiated during the time period of July 1, 2011, through June 30, 2012: <u>Evaluation</u> 1. 2011 Group Needs Assessment completed with recommendations from participating members integrated into the 2012 Cultural and Linguistics Program (completed 10/2011). 2. Effectiveness of cultural and linguistic training conducted with post-test immediately following training (ongoing) and annually as part of the evaluation of the Quality and Performance Improvement Program (completed 6/25/12). 3. Population analysis completed to collect plan and geographic specific age, gender, and race/ethnicity data to inform development or improvement of programs for people living with HIV/AIDS (completed 4/24/12). <u>Monitoring</u> 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, reported on a 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).
Identify opportunities to improve the *Colorectal Cancer Screening* measure rates.	Activities and/or interventions that were initiated during the time period of July 1, 2011, through June 30, 2012: 1. Protocol included in Screening Checklist in each issue of *Positive Practice* (provider newsletter); 6/28/11, 1/10/12, 6/8/12 (completed). 2. 9/8/11: Screening reminder included in Prevention Points in each issue of *Positive Outlook* (member newsletter); 9/8/11, 11/30/11, 2/13/12, 4/23/12 (completed). 3. 2/13/12: Article in Winter 2011 *Positive Outlook* (member newsletter) regarding colon cancer screening (completed). 4. 6/8/12: Clinical Update article in Spring 2012 *Positive Practice* (provider newsletter) regarding colon cancer screening (completed).
Improve QIP documentation to increase compliance with the validation requirements.	1. HSAG feedback reflected in most QIPs. AHF received "Met" standards with validation on most recent review. 2. Continue quality improvement projects to improve the rates of CD4 and Viral Load Testing and Advance Care Directives (underway).
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.	1. AHF will request technical assistance if there are any questions on documentation (underway). 2. QIP teams are formed for improvement projects with multiple levels of review during formulation, implementation, and analysis of outcomes (underway).