Performance Evaluation Report

Alameda Alliance for Health

July 1, 2012–June 30, 2013

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

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Performance Evaluation Report – Alameda Alliance for Health

July 1, 2012 – June 30, 2013

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and

[1] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.

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

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

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Alameda Alliance for Health ("AAH" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

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

AAH became operational in Alameda County to provide MCMC services effective 1996. As of June 30, 2013, AAH had 152,160 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

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

This report section covers 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, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's 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.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits and Member Rights Reviews

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

Member Rights/Program Integrity Unit Monitoring Review

The most recent Member Rights/Program Integrity Unit (MR/PIU) monitoring review for AAH was conducted October 16, 2012, through October 18, 2012, covering the review period of April

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP 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 the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

1, 2010, through August 1, 2012. The purpose of the review was to review AAH's compliance with Medi-Cal contractual requirements relating to the following areas:

- Member Grievances
- Prior Authorization Notification
- Cultural and Linguistic Services
- Marketing
- Program Integrity

A key component of the on-site visit was to review AAH's compliance with SPD competency and sensitivity training, as well as the Facility Site Review (FSR) physical accessibility assessment requirement.

In a letter from MR/PIU dated December 31, 2012, MR/PIU identified the following opportunities for technical assistance:

- In the area of SPD Sensitivity Training, MR/PIU noted that AAH does not have established policies and procedures for tracking and conducting SPD sensitivity training for current staff members, nor does it have training for newly hired staff.
- In the area of Physical Accessibility, MR/PIU noted that AAH does not consistently post its network physical accessibility assessment results on the MCP's provider Web site and directory as required.

AAH is not required to submit a CAP, and MR/PIU will follow up with the MCP to determine if the areas for technical assistance have been addressed.

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

The most recent on-site SPD Enrollment Survey for AAH was conducted October 16, 2012, through October 19, 2012, covering the review period of July 1, 2011, through July 31, 2012. The survey evaluated the following elements specifically related to the care of the SPD population:

- Utilization Management
- Continuity of Care
- Availability and Accessibility
- Member Rights
- Quality Management

DMHC issued the survey report on March 28, 2013. The report indicates that DMHC identified the following potential survey deficiencies:

Access and Availability

- The MCP does not consistently display the level of access and the accessibility indicators for each provider on its Web site and in provider directories.
- The MCP does not ensure that appointments are available within the provider network at the required time frames.

Quality Management

- During the first half of the survey review period, the MCP's governing body did not receive reports from the MCP's Health Care Quality Committee.

Since AAH's response to the identified potential deficiencies and DMHC's follow-up occurred outside the review period for this report, HSAG will provide follow-up information on the MCP's efforts to address the potential deficiencies in AAH's 2013–14 MCP-specific evaluation report.

Department of Managed Health Care Routine Medical Survey

The most recent Routine Medical Survey for AAH was conducted at the same time as the SPD Enrollment Survey—October 16, 2012, through October 19, 2012, covering the review period of July 1, 2011, through July 31, 2012. DMHC assessed the following areas:

- Quality Management
- Grievances and Appeals
- Access and Availability of Services
- Utilization Management
- Continuity of Care
- Access to Emergency Services and Payment
- Prescription (RX) Drug Coverage
- Language Assistance

DMHC issued the final report to the MCP on June 24, 2013. The report indicates that five deficiencies were identified and were in the areas of Quality Management, Access and Availability of Services, Prescription (RX) Drug Coverage, and Language Assistance. At the time the final report was issued, four of the five deficiencies were corrected. The following deficiency in the area of Prescription (RX) Drug Coverage was not corrected:

- The MCP does not consistently include in pharmacy denial letters a clear and concise explanation when denying, delaying, or modifying a request for services based on medical necessity.

In the final report, DMHC noted that sufficient time had not elapsed to assess whether AAH's corrective actions related to the deficiency had been successfully implemented into the MCP's operations. DMHC indicated that it will need to review a sample of pharmacy denial letters during the second quarter of 2013 to confirm the MCP is consistently providing a clear and concise explanation of the MCP's reason for the denial. Additionally, DMHC recommended that AAH consider spelling out an acronym in one of the MCP's pharmacy documents.

Strengths

During the MR/PIU monitoring review, no findings or concerns were identified in the areas of Member Grievances, Prior Authorization Notifications, Cultural and Linguistic Services, Marketing, or Program Integrity. During the DMHC SPD Enrollment Survey, no potential deficiencies were identified in the areas of Utilization Management, Continuity of Care, and Member Rights. During the DMHC Routine Medical Survey, no deficiencies were identified in the areas of Grievances and Appeals, Utilization Management, Continuity of Care, and Access to Emergency Services and Payment. Additionally, AAH fully corrected four of the five deficiencies identified during the Routine Medical Survey.

Opportunities for Improvement

AAH has the opportunity to make improvements in the areas of SPD Sensitivity Training, Physical Accessibility, Access and Availability, Quality Management, and Prescription (RX) Drug Coverage. These areas impact the quality of and access to care for MCMC beneficiaries.

Conducting the EQRO Review

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for Alameda Alliance for Health* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that AAH followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A review of the MCP's HEDIS audit report revealed the following observations:

- Consistent with the 2012 HEDIS audit findings, the auditor recommended that MCP staff members responsible for HEDIS reporting be included on the transition team when the MCP converts to the new transactional system, Health Suite, to ensure data necessary for HEDIS reporting are included in the new system.

Documentation provided by AAH as part of the MCP's response to recommendations made in the MCP's 2011–12 MCP-specific evaluation report indicates that AAH's quality staff members have been working with the Health Suite implementation team to ensure that data necessary for HEDIS reporting will be included in the new system.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

Table 3.1—Name Key for Performance Measures in External Accountability Set

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions*‡
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient 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)*
CBP	*Controlling High Blood Pressure*
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*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MMA–75	*Medication Management for People with Asthma—Medication Compliance 75% Total*
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*
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*

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.

‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Table 3.2 below presents a summary of AAH's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.2 shows the MCP's 2013 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 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 2012 and 2013 Performance Measure Results
AAH—Alameda County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	31.53%	38.09%	★★★	↑	18.98%	33.33%
ACR	Q, A	--	14.66%	--	Not Comparable	--	--
AMB–ED	‡	42.02	47.24	‡	Not Comparable	‡	‡
AMB–OP	‡	315.03	297.17	‡	Not Comparable	‡	‡
CAP–1224	A	94.63%	92.32%	★	↓	95.56%	98.39%
CAP–256	A	85.48%	83.91%	★	↓	86.62%	92.63%
CAP–711	A	85.61%	85.06%	★	↔	87.56%	94.51%
CAP–1219	A	82.03%	84.64%	★	↑	86.04%	93.01%
CBP	Q	--	53.53%	--	Not Comparable	--	--
CCS	Q,A	68.37%	65.21%	★★	↔	61.81%	78.51%
CDC–BP	Q	59.85%	59.61%	★★	↔	54.48%	75.44%
CDC–E	Q,A	52.55%	48.91%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	58.88%	51.58%	★★	↓	42.09%	59.37%
CDC–H9 (>9.0%)	Q	28.47%	37.47%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	83.21%	83.45%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	43.55%	36.74%	★★	↓	28.47%	46.44%
CDC–LS	Q,A	76.89%	77.62%	★★	↔	70.34%	83.45%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
AAH—Alameda County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
CDC–N	Q,A	82.97%	82.97%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	78.10%	79.08%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	66.67%	76.40%	★★	↑	50.36%	80.91%
LBP	Q	84.76%	87.07%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	43.88%	--	Not Comparable	--	--
MMA–75	Q	--	24.23%	--	Not Comparable	--	--
MPM–ACE	Q	87.05%	84.40%	★★	↓	83.72%	91.33%
MPM–DIG	Q	86.41%	94.08%	★★	↑	87.93%	95.56%
MPM–DIU	Q	84.78%	81.92%	★	↓	83.19%	91.30%
PPC–Pre	Q,A,T	88.56%	80.54%	★★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	61.07%	57.18%	★	↔	58.70%	74.73%
W-34	Q,A,T	77.62%	71.53%	★★	↓	65.51%	83.04%
WCC–BMI	Q	55.23%	55.23%	★★	↔	29.20%	77.13%
WCC–N	Q	58.64%	64.72%	★★	↔	42.82%	77.61%
WCC–PA	Q	41.61%	46.23%	★★	↔	31.63%	64.87%

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[8] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

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

The final selected SPD measures are listed below. Following the list of measures are Tables 3.3 and 3.4, which present a summary of AAH's 2013 SPD measure results. Table 3.3 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.4 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*

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

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.3.

- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Table 3.3—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
AAH—Alameda County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	10.47%	15.86%	▼	14.66%
CAP–1224	92.41%	85.71%	↔	92.32%
CAP–256	83.84%	85.99%	↔	83.91%
CAP–711	85.00%	86.15%	↔	85.06%
CAP–1219	84.99%	80.59%	↓	84.64%
CDC–BP	59.37%	62.29%	↔	59.61%
CDC–E	48.91%	52.07%	↔	48.91%
CDC–H8 (<8.0%)	51.58%	53.53%	↔	51.58%
CDC–H9 (>9.0%)	37.47%	34.55%	↔	37.47%
CDC–HT	83.45%	84.43%	↔	83.45%
CDC–LC (<100)	36.74%	38.20%	↔	36.74%
CDC–LS	77.62%	78.10%	↔	77.62%
CDC–N	82.97%	83.21%	↔	82.97%
MPM–ACE	77.54%	85.99%	↑	84.40%
MPM–DIG	NA	94.30%	Not Comparable	94.08%
MPM–DIU	73.16%	84.07%	↑	81.92%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

Table 3.4—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
AAH—Alameda County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
240.90	40.42	481.81	69.61

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

Performance Measure Result Findings

Overall, AAH performed average on its measures in 2013. Two measures had rates above the HPLs, and six measures had rates below the MPLs. Four measures had rates with statistically significant improvement from 2012 to 2013, and nine measures had statistically significant decline in rates.

The two measures with rates above the HPLs were:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Use of Imaging Studies for Low Back Pain*

AAH has performed above the HPL for the *Use of Imaging Studies for Low Back Pain* measure since 2011, and 2013 is the first year the MCP has performed above the HPL for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure.

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

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Prenatal and Postpartum Care—Postpartum Care*

Three of the measures with rates below the MPLs had a statistically significant decline in their rates from 2012 to 2013. These measures were:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

In addition to the three measures identified above with rates below the MPLs, the following six measures had rates that had statistically significant decline from 2012 to 2013:

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rates for the following four measures had statistically significant improvement from 2012 to 2013:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Immunizations for Adolescents—Combination 1*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*

Seniors and Persons with Disabilities Findings

The following SPD rates were significantly higher than the non-SPD rates:

- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The SPD rate for the *All-Cause Readmissions* measure was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population. Additionally, the SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* measure was significantly lower than the non-SPD rate for this measure, meaning fewer members aged 12–19 year of age in the SPD population were seen by their primary care practitioner than members in the non-SPD population.

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

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

Since AAH did not have any rates below the MPLs during 2012, no IPs were required. The MCP will be required to submit IPs for the following measures that had rates below the MPLs in 2013:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Prenatal and Postpartum Care—Postpartum Care*

Although AAH's rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures were below the MPLs in 2013, the MCP will not be required to submit IPs for these measures. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact.

Strengths

Documentation provided by AAH as part of the MCP's response to recommendations made in the MCP's 2011–12 MCP-specific evaluation report indicates that AAH's quality staff members have been working to ensure that data necessary for HEDIS reporting will be included in the MCP's new system.

AAH demonstrated statistically significant improvement on four measures. Two measures had rates above the HPLs, and the rates for four measures had statistically significant improvement from 2012 to 2013.

Opportunities for Improvement

AAH has an opportunity to improve its rates by focusing on the four *Children and Adolescents' Access to Primary Care Practitioners* measures, the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure, and the *Prenatal and Postpartum Care—Postpartum Care* measure, which all had rates below the MPLs. Additionally, the MCP has the opportunity to improve its rates by focusing on the measures that had statistically significant decline in their rates from 2012 to 2013. The MCP has the opportunity to assess the factors that have caused AAH to have poor performance on these measures and identify interventions to be implemented that will result in improvement on these measures' rates.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[10] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

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

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

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

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

Quality Improvement Project Objectives

AAH participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2012–June 30, 2013.

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

Table 4.1—Quality Improvement Projects for AAH
July 1, 2012, through June 30, 2013

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

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

Prior to initiation of the statewide collaborative QIP, AAH had a 30–day readmission rate of 13.29 percent among Medi-Cal beneficiaries. AAH also found that the readmission rate for the SPD population was 14.46 percent, which was higher than the 10.93 percent rate for the non-SPD population.

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

Quality Improvement Project Validation Findings

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

Table 4.2—Quality Improvement Project Validation Activity
AAH—Alameda County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension	Annual Submission	76%	71%	*Partially Met*
	Annual Resubmission 1	100%	100%	*Met*

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

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by AAH of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 90 percent of evaluation elements met. AAH received a *Partially Met* validation status for its *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* annual submission. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on the validation feedback, the MCP resubmitted its QIP and upon subsequent validation, achieved an overall *Met* validation status with 100 percent of both the critical and evaluation elements being met.

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

Table 4.3—Quality Improvement Project Average Rates*
AAH—Alameda County
(Number = 3 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	75%	25%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection**	83%	8%	8%
Design Total		**88%**	**9%**	**3%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	88%	0%	13%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**92%**	**0%**	**8%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

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

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

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

AAH demonstrated a strong application of the Design stage, meeting 88 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. Although AAH scored well in the Design stage, the MCP showed opportunities for improvement related to providing the required documentation. For its *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP, AAH did not provide objective or clearly defined study indicators in Activity III, which resulted in a lower score. The MCP also did not provide a complete data analysis plan for either QIP, which resulted in a lower score for Activity VI.

AAH demonstrated a strong application of the Implementation stage, meeting 92 percent of the requirements for all applicable evaluation elements with the study stage for the *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP. In the initial QIP submission, the MCP did not indicate if there were any factors that threatened the validity of the baseline data, resulting in a lower score for Activity VII. The MCP corrected all noted deficiencies in the QIP resubmission.

HSAG did not score either QIP for the Outcomes stage since neither of these QIPs had progressed to the Outcomes stage during this reporting period.

Quality Improvement Project Outcomes and Interventions

Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

Since neither of the MCP's QIPs progressed to the implementation or Outcomes stage during the reporting period, only the baseline rates are included in the table. The MCP's 2013–14 MCP-specific evaluation report will include outcomes and intervention information.

Table 4.4—Quality Improvement Project Outcomes for AAH—Alameda County July 1, 2012, through June 30, 2013

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

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.
‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Strengths

AAH excelled at defining the study questions, correctly identifying the study population, and implementing the appropriate improvement strategies for both the *All-Cause Readmissions* and *Improving Anti-Hypertensive Medication Fills Among Members with Hypertension* QIPs. Additionally, the MCP completed a causal/barrier analysis for the *Improving Anti-Hypertensive Medication Fills Among Members with Hypertension* QIP and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process. The documentation included system interventions that were likely to have a long-term effect.

Opportunities for Improvement

AAH has the opportunity to improve documentation of its data analysis plans for each QIP. The MCP should refer to the QIP Completion Instructions prior to submitting its QIPs to ensure completeness of the data and documentation. Providing clearly defined and documented information will likely improve the MCPs QIP validation score and eliminate the need for resubmissions.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

AAH's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about AAH's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

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

CAHPS Global Rating Measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

CAHPS Composite Measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

Table 5.1—CAHPS Measures Domains of Care

Measure	Domains of Care
Rating of Health Plan	Q
Rating of All Health Care	Q
Rating of Personal Doctor	Q
Rating of Specialist Seen Most Often	Q
Getting Needed Care	Q, A
Getting Care Quickly	Q, T
How Well Doctors Communicate	Q
Customer Service	Q
Shared Decision Making	Q

National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

Star Rating	Adult and Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or above the 75th and below the 90th percentiles
★★★ Good	At or above the 50th and below the 75th percentiles
★★ Fair	At or above the 25th and below the 50th percentiles
★ Poor	Below the 25th percentile

Table 5.3 through Table 5.4 present the star ratings for the global ratings and composite measures for AAH's adult and child Medicaid populations.[15]

Table 5.3—Medi-Cal Managed Care County-Level Global Ratings
AAH—Alameda County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★★	★★★
Child	★★	★★	★★★★	★★★+
+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.				

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.
[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.
[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

Table 5.4—Medi-Cal Managed Care County-Level Composite Measures
AAH—Alameda County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★	★
Child	★	★	★★	★

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Strengths

AAH received a *Very Good* rating for the *Rating of Personal Doctor* measure for the child population and a *Good* rating for the *Rating of Specialist Seen Most Often* measure for both the adult and child populations. Since the MCP had fewer than 100 respondents for the child *Rating of Specialist Seen Most Often* measure, caution should be exercised when evaluating these results. AAH was able to improve its performance on all three of these measures since the previous survey in 2010.

Opportunities for Improvement

AAH's CAHPS results showed below-average performance for the majority of the child and adult global ratings and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as AAH's highest priorities: *Customer Service, Getting Needed Care,* and *Getting Care Quickly*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 AAH CAHPS MCP-Specific Report.* Areas for improvement spanned the quality, access, and timeliness domains of care.

Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[16] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[16] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

AAH's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

Encounter Data Validation Findings

Review of Encounter Systems and Processes

AAH's processes for aggregating and submitting claims and encounter data files adhere to industry best practices. Vision, Behavioral Health, and Pharmacy claims and encounters that are processed by delegated entities, along with the claims processed by the MCP, are stored in AAH's data warehouse in preparation for submission. AAH aggregates and submits all claims and encounter data to DHCS. After identifying a higher-than-expected error percentage, AAH began the process of building a more robust data warehouse, improving data collection methodologies, and developing specific policies and procedures to handle encounters. Part of AAH's process-related changes include requiring delegated partners to use the standard version 5010, 837 format when submitting capitated encounter data in order to standardize encounter data collection.

Record Completeness

AAH's record omission rates varied across the three claim types. The Pharmacy claim type had the lowest record omission rate of 0.8 percent while the Hospital/Inpatient claim type had the highest record omission rate of nearly 25 percent. The record omission rates for the Medical/Outpatient and Hospital/Inpatient claim types were worse than the statewide rates by 2.4 percentage points and 14.5 percentage points, respectively. For the Hospital/Inpatient records in the MCP's data but omitted from DHCS's data, more than half of the records had beginning dates of service between July 1 and September 30, 2010. The majority of the omitted Medical/Outpatient records were from specific *Provider Types* such as Optometrists, Durable Medical Equipment, and Clinical

Laboratories. AAH's record surplus rates were all below 4 percent, which were better than the respective statewide record surplus rates. Overall, AAH had low record omission and record surplus rates for the Medical/Outpatient and Pharmacy claim types, indicating relatively complete data when comparing DHCS's data and the encounter data extracted from AAH's data system for this study.

Data Element Completeness

AAH primarily had element omission rates of 0.0 percent across the claim types. The only two data elements with element omissions were *Provider Specialty* for the Medical/Outpatient claim type and *Drug/Medical Supply* for the Pharmacy claim type. The *Provider Specialty* element omission rate of 53.1 percent was worse than the statewide rate by 49.4 percentage points. The majority of the records with *Provider Specialty* element omission occurred for the *Provider Types* where the provider specialty was not required based on the Encounter Data Element Dictionary. However, the *Drug/Medical Supply* omission rate for the Pharmacy data was slightly better than the statewide rate of 1.0 percent. The *Drug/Medical Supply* omissions were all due to the additional *Drug/Medical Supply* value "9999MZZ" populated in AAH's data and not in DCHS's data. AAH had no element surplus for any of the key data elements.

Data Element Accuracy

AAH had reasonable accuracy rates that were greater than 93 percent for all key data elements across the three claim types. The Pharmacy claim type had accuracy rates greater than 99.0 percent, and the Hospital/Inpatient claim type generally had element accuracy rates of 100.0 percent except for the *Referring/Prescribing/Admitting Provider Number* and *Revenue Code* elements. Although AAH had relatively high element accuracy rates, there were a few patterns in the fields with differing values. The MCP's data contained alphanumeric *Provider Specialty* codes instead of two-digit codes and included additional information (i.e., city name) in the *Referring/Prescribing/Admitting Provider Number*. DHCS truncated some of the *Rendering Provider Number* to six or ten digits. Overall, only the *Provider Specialty, Header Service From Date,* and *Header Service To Date* fields in the Medical/Outpatient claim type and the *Revenue Code* field in the Hospital/Inpatient claim type had element accuracy rates that were below the statewide rates. The relatively low element accuracy for the *Revenue Code* was mainly caused by the gap in line numbers in the MCP's data and the line numbers without gaps in DHCS's data.

The all-element accuracy rates were fairly high, with rates above 91 percent for the Hospital/Inpatient and Pharmacy claim types. Both of these claim types exceeded the statewide rates by at least 20 percentage points. However, due to the high element omission for the *Provider Specialty*, the Medical/Outpatient claim type had the lowest all-element accuracy rate of 43.0 percent, which was below the statewide rate by 21 percentage points.

Recommendations

Based on its review, HSAG recommends the following:

- For DHCS's data and the data AAH submitted to HSAG, there were no LTC records based on the data element *Claim Type*. However, AAH's response to HSAG's preliminary file review results indicated that it had some LTC records (approximately 1,300) and they were submitted with the Hospital/Inpatient records. AAH used place of service codes 31 and 32 to identify LTC records in its data system. AAH should clarify with DHCS whether the LTC records should be submitted with the value "L" for the data element *Format Code* so that the LTC records can be separated from the Hospital/Inpatient records.
- AAH should investigate the high record omission rate for the Hospital/Inpatient claim type and create strategies for future improvement on the record omission rate for the Hospital/Inpatient claim type.
- Although the record omission rate for the Medical/Outpatient claim type was not very high (6.5 percent), the majority of the omitted Medical/Outpatient records were from specific *Provider Types* such as Optometrists, Durable Medical Equipment, and Clinical Laboratories. In the data submission document, AAH stated that the vision and transportation encounters were not submitted to DHCS prior to the data extract for the EDV study and AAH will refine its data submission process to include vision and transportation services in future submissions. AAH should continue its efforts and investigation so that it will improve the encounter completeness and accuracy for the Medical/Outpatient claim type.
- For the Medical/Outpatient claim type, the *Provider Specialty* data element had a very high element omission rate of 53.1 percent, which was worse than the statewide rate by 49.4 percentage points. However, the majority of the *Provider Specialty* omissions had *Provider Types*, such as Clinical Laboratories or Community Hospital Inpatient, for which the *Provider Specialty* values were not required based on the Encounter Data Element Dictionary. AAH should investigate the high element omission rate for the *Provider Specialty* data element and evaluate whether there is room for improvement.
- AAH had relatively high element accuracy rates that were greater than 93 percent for all key data elements across the three claim types. However, the causes for the inaccuracy should be addressed so that AAH can improve its rates in the future. For example, AAH should try to submit the provider's 10-digit National Provider Identifier (NPI) whenever possible for the data elements *Referring/Prescribing/Admitting Provider Number* and *Rendering Provider Number* so that the respective provider numbers stored in the DHCS data warehouse will not be truncated. Similarly, the *Provider Specialty* data element should have a length of two characters to avoid truncation. AAH should also investigate the inaccuracy for the data elements *Header Service From Date* and *Header Service To Date* in the Medical/Outpatient encounters and the *Revenue Code* in the Hospital/Inpatient encounters.

- Although the element omission rate for the *Drug/Medical Supply* was relatively good, AAH should investigate the *Drug/Medical Supply* value of "9999MZZ," which was populated in the file that AAH submitted to HSAG but which did not appear in the DHCS file.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[17]

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

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

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

HSAG reviewed AAH's 2013 Quality Improvement Program Description, which provides an outline of the MCP's quality improvement program goals and objectives. AAH includes a description of the MCP's structure, which outlines the responsibilities of quality committees and staff members. The program description reflects a commitment to ensuring that quality care is provided to the MCP's members.

When conducting the SPD Enrollment Survey in October 2012, DMHC found that AAH's governing body had not received reports from the MCP's Health Care Quality Committee during the first half of the survey review period. Not receiving this information could lead to the MCP's governing body not being able to adequately assess the quality of care being delivered to the MCP's members. Additionally, while conducting the monitoring review with the MCP in October 2012, MR/PIU noted that AAH does not have established policies and procedures for tracking and conducting SPD sensitivity training for staff members. Not providing staff members with this training could negatively impact the quality of care provided to members in the SPD population.

The following two measures falling into the quality domain of care had rates above the HPLs:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Use of Imaging Studies for Low Back Pain*

Two quality measures had rates below the MPLs:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Prenatal and Postpartum Care—Postpartum Care*

Three quality measures had rates with statistically significant improvement from 2012 to 2013, and the rates for seven quality measures were significantly worse in 2013 when compared to 2012.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and two of these measures had rates that were better than the non-SPD rates. These measures were:

- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The better rates for these two measures may be a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The rate for the *All-Cause Readmissions* measure, which is in the quality domain of care, was worse than the non-SPD rate, showing that more of the MCP's members in the SPD population (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than members in the non-SPD population.

All CAHPS measures fall into the quality domain of care. Most measures had a *Fair* or *Poor* rating, with the exception of the *Rating of Personal Doctor* measure, which received a *Very Good* rating for the child population and the *Rating of Specialist Seen Most Often* measure, which received a *Good* rating for both the adult and child populations.

Both of AAH's QIPs fall into the quality domain of care. Neither of the QIPs progressed to the Outcomes stage, so HSAG was not able to assess the QIPs' success at improving the quality of care delivered to the MCP's members.

Overall, AAH showed average performance in the quality domain of care.

Access

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

HSAG's review of AAH's 2013 Quality Improvement Program Description found documentation of goals, objectives, and processes designed to ensure members' access to care.

The MR/PIU monitoring review, DMHC SPD Enrollment Survey, and DMHC Routine Medical Survey—all conducted in October 2012—identified findings in areas that impact access. These areas included Physical Accessibility, Access and Availability, and Prescription (RX) Drug Coverage.

The following two access measures had rates with statistically significant improvement from 2012 to 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Immunizations for Adolescents—Combination 1*

The following access measures had rates below the MPLs in 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Prenatal and Postpartum Care—Postpartum Care*

The following access measures had rates that significantly declined from 2012 to 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and two of these measures had SPD rates that were worse than the non-SPD rates:

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

AAH performed below average on the access-related CAHPS measure, *Getting Needed Care*, receiving a *Poor* rating for both the adult and child populations.

Both of AAH's QIPs fall into the access domain of care. As stated above, neither of the QIPs progressed to the Outcomes stage; therefore, HSAG was not able to assess the QIPs' success at improving the access to needed services for MCP's members.

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

Timeliness

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

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

HSAG reviewed AAH's 2013 Work Plan and found an objective related to improving the time to process authorization requests. The MCP has a goal of processing 100 percent of routine requests within five days. Additionally, the MCP has an objective to improve compliance with required denial file/letter components, with a goal of achieving 90 percent compliance on each required component for the calendar year.

The rate for the *Immunizations for Adolescents—Combination 1* measure, which falls into the timeliness domain of care, had statistically significant improvement from 2012 to 2013. Rates for the following timeliness measures declined significantly from 2012 to 2013:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure was below the MPL.

The CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. This measure received a *Poor* rating for both the adult and child populations.

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

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-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 to the MCP:

- Ensure all findings and deficiencies from the MR/PIU and DMHC surveys are fully addressed. Specifically:
  - Develop and implement policies and procedures to ensure that SPD sensitivity training is provided to existing and newly hired staff and that the MCP has a mechanism in place to track the training.
  - Ensure that the MCP's network physical accessibility assessment results are consistently reflected on the AAH provider Web site and directory.
  - Ensure that level of access and accessibility indicators for each provider are consistently displayed for each provider on the AAH Web site and in provider directories.
  - Ensure that appointments are available within the provider network at the required time frames.
  - Ensure that AAH's governing body receives all reports from the MCP's Health Care Quality Committee.
  - Consistently include in pharmacy denial letters a clear and concise explanation when denying, delaying, or modifying a request for services based on medical necessity.
- Assess the factors that are leading to overall poor performance on the four *Children and Adolescents' Access to Primary Care Practitioners* measures, the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure, and the *Prenatal and Postpartum Care—Postpartum Care* measure and identify interventions to be implemented that will result in an improvement on performance.
  - Since the rate for the *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* measure had statistically significant improvement from 2012 to 2013, the MCP may benefit from duplicating successful strategies used with members in the 12-to-19-year-old population with the other populations assessed for access to primary care practitioners (as applicable).
- Since AAH had nine measures with rates that were significantly worse in 2013 when compared to 2012, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.
- Assess the factors that are leading to a significantly higher rate of readmissions for the SPD population when compared to the non-SPD population to ensure the MCP is meeting the needs of the SPD population.
- Ensure thorough documentation of the data analysis plans for each QIP. The MCP should refer to the QIP Completion Instructions prior to submitting its QIPs to ensure completeness of the

data and documentation. Providing clearly defined and documented information will likely improve the MCP's QIP validation score and prevent the need for QIP resubmissions.

- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Customer Service, Getting Needed Care,* and *Getting Care Quickly* priority areas.
- Review the *2012–13 MCP-Specific Encounter Data Validation Study Report* and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

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

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

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

Access and Timeliness Domains

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

CAHPS Survey Measures

(Refer to Tables 5.3 through 5.4)

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

Quality Domain

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

Access Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

Timeliness Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Not all study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

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 and Medi-Cal Managed Care Division reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures, CAHPS measures, and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the encounter data validation (EDV) study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

Appendix B. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

for Alameda Alliance for Health

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with AAH's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table B.1—AAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	AAH's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. Consider including HEDIS staff members responsible for HEDIS reporting on the transition team when the plan converts to the new transactional system, HealthSuite, to ensure data necessary for HEDIS reporting are included in the new system.	The Quality Improvement Department is responsible for HEDIS reporting. The Alliance is moving to a new transaction data platform effective January 1, 2014. Quality staff has been working with the HealthSuite implementation team to ensure that data necessary for HEDIS reporting will be included in the new system.
2. Research the feasibility of capturing data submitted on PM160 forms for inclusion in HEDIS reporting.	The Alameda Alliance CMO is working with the COO to capture and use these data without interrupting our current business practices.
3. 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:	
a. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total.*	The Alliance saw a decrease in performance in this measure because of the changes made to the measure specifications. Improvement initiatives take a significant amount of time to plan, test, launch, and measure impact. Too many changes year over year impact our ability to launch and evaluate effective improvement initiatives. The Alliance posted a HEDIS summary sheet for providers on the Alliance Web site informing them of the specifications for the WCC measure including appropriate codes. Quality staff will continue to monitor data available on this measure.

Table B.1—AAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	AAH's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
b. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total.*	The Alliance saw a decrease in performance in this measure because of the changes made to the measure specifications. Improvement initiatives take a significant amount of time to plan, test, launch, and measure impact. Too many changes year over year impact our ability to launch and evaluate effective improvement initiatives. The Alliance posted a HEDIS summary sheet for providers on the Alliance Web site informing them of the specifications for the WCC measure including appropriate codes. Quality staff will continue to monitor data available on this measure.
4. 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.	An annual barrier/root cause analysis was performed by the Hypertension project team to identify the causes for low medication adherence among members with hypertension. Information was gathered from various research studies and from health plan experience. These barriers were then prioritized based on the impact the resolution would have on our members with hypertension; those barriers with a higher impact were approached first. The project team consisted of representatives from the following departments: Quality Improvement, Medical Services, Member Services, Health Education, and Pharmacy Services. The top 2 barriers identified for the *Controlling High Blood Pressure (CBP)* measure were: 1) provider unawareness of the CBP HEDIS Measure, and 2) members forgetting to refill their medications or not having time to pick up their medications every month. An annual barrier analysis was also conducted and documented for the *All-Cause Readmissions* project. The barriers were identified and prioritized based on the impact the resolution would have on our readmission rates; those barriers with a higher impact were approached first. The top 2 barriers identified for the *All-Cause Readmissions* project were: 1) patient does not have an assigned PCP, and 2) patient failed to understand the importance of his/her role in preventing readmissions, e.g., following discharge instructions, taking medications as directed.

Table B.1—AAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	AAH's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
5. 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.	The following examples describe how QIP interventions addressed high-priority barriers and evaluated the effectiveness of each intervention. In regard to the Hypertension project barriers, the Alliance sent a fax blast to all providers about the availability of the hypertension clinical practice guidelines and that they will also be receiving a list of members who have been identified as having hypertension but who do not have any pharmacy claims of antihypertensive medications. This intervention aimed at educating providers about the hypertension guidelines. In addition, the Alliance also did IVR calls to hypertensive members reminding them to take their antihypertensive medications as prescribed and other wellness tips to control their blood pressure. This intervention reminds members to refill their prescriptions and adhere to their prescribed medications. In regard to the *All-Cause Readmissions* project, one of the interventions implemented by the Alliance was the Mobile Medical in-home visits where Mobile Medical sends a physician to conduct an in-home visit with members recently discharged from the hospital. This intervention provides the member with a physician visit post-discharge and also helps members understand their discharge instructions.