Section 14
Quality and Performance Improvement Program

The Alliance Quality and Performance Improvement Program (QPIP) exists to assure and improve the quality of care for Alliance members, in fulfillment of state and federal requirements, and incorporates various best practice standards (e.g., National Committee for Quality Assurance [NCQA] standards) as deemed appropriate.

Quality and Performance Improvement Program Goals

The QPIP provides a comprehensive structure to achieve the following goals:

- Ensure all medically necessary covered services are: available and accessible to all members regardless of cultural and ethnic background, race, color, national origin, creed, ancestry, religion, language, age, sex, sexual orientation, gender, gender identity, marital status, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56; and provided in a culturally and linguistically appropriate manner;
- Ensure integration with current community health priorities, standards and public health goals;
- Ensure patient safety;
- Identify and act upon opportunities to address potential quality issues and review trends;
- Identify overuse, misuse and underuse of services;
- Ensure appropriate care for members with complex health needs;
- Ensure that the cultural and linguistic needs of Alliance members are met; and
- Ensure appropriate care for members with behavioral health needs.

The QPIP goals are achieved by employing the following:

- Maintaining accountability of care systems;
- Maintaining continuous quality monitoring utilizing specific quality and performance improvement methods; and
- Analyzing data, incorporating provider feedback and developing interventions.

The Continuous Quality Improvement Committee (CQIC) is the contractually-required quality improvement committee with oversight and performance responsibility of the QPIP – excluding credentialing/recredentialing activities, which are directed by the PRCC. Annually, the CQIC reviews and approves QPIP and Utilization Management Program policies (401-1101 - Quality and Performance Improvement Program and 401-1305) and work plans [the Quality Improvement Work Plan (QIWP) and Utilization Management Work Plan (UMWP)]. Once approved, the CQIC monitors QIWP and UMWP activities

quarterly, ensuring implementation of interventions and re-measurement of performance goals and benchmarks.

For more information about the QPIP, please see Policy 401-1101- Quality and Performance Improvement Program.

Member Satisfaction Surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Consumer Assessment of Healthcare Providers and Systems (CAHPS) was developed by the Agency for Healthcare Research and Quality (AHRQ) to advance understanding of patient experience with healthcare. The Department of Health Care Services (DHCS) conducts the CAHPS survey every three years, but the Alliance contracts with a vendor to conduct the survey every year to have an understanding of our member's satisfaction with healthcare.

CAHPS is considered the national standard for measuring member's experience related to the healthplan and its services. This also includes member's experience with interacting with providers and staff, as well as health care facilities.

The survey is administered in the first quarter of the year and measures child and adult experiences. The child surveys are completed by the parent/guardian on behalf of the child. The survey includes the following measures:

- Rating of the Healthplan
- Getting Needed Care
- Customer Service
- Providing Needed Information
- Ease of Filling out Forms
- How Well Doctors Communicate
- Shared Decision Making
- Health Promotion and Education
- Coordination of Care
- Rating of Personal Doctor
- Rating of Specialist

For additional information on CAHPS please visit the AHRQ website at https://www.ahrq.gov/cahps/about-cahps/index.html. Please refer to the Alliance's Member Satisfaction Tool Kit for additional resource information.

CAHPS Clinician & Group Survey (CG-CAHPS)

The CAHPS Clinician & Group Survey assesses member's experiences with their healthcare providers and staff in the doctors' office. This survey is administered in the fourth quarter of the year to children and adult members, and measures the first six months of the year. Tax IDs with claims from more than 333 unique households will receive the survey.

The child surveys are completed by the parent/guardian on behalf of the child. The results of the survey are broken down by provider (doctor, nurse practitioner, physician assistant, or other provider). The survey includes the following measures:

- Getting Timely Appointments, Care, and Information
- How Well Providers Communicate With Patients
- Providers' Use of Information to Coordinate Patient Care (New to the 3.0 version)
- Helpful, Courteous, and Respectful Office Staff
- Patients' Rating of the Provider

For additional information on the CG-CAHPS please visit the AHRQ website at https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html. If you are interested in receiving your clinic results please email QI@CCAH-Alliance.org or contact your Provider Relations Representative at (800) 700-3874 ext. 5504. Please refer to the Alliance's Member Satisfaction Tool Kit for additional resource information.

Healthcare Effectiveness Data and Information Set (HEDIS®)

The Alliance is contractually required by the California State Department of Healthcare Services (DHCS) to perform a quality measure audit that complies with DHCS' Managed Care Accountability Set (MCAS). The MCAS aligns with Centers for Medicare and Medicaid Services'(CMS) Child and Adult Core Sets, as well as with the National Committee for Quality Assurances' (NCQA) Healthcare Effectiveness Data Information Set (HEDIS) quality measures. The audit assess how well the Alliance network is providing services to our members, while ensuring accurate and reliable measurement.

The Alliance's Quality Improvement department begins preparations for the upcoming season by reviewing current rates and areas possible target areas for improvement. For more information about HEDIS, please see Policy 401-1607 Healthcare Effectiveness Data and Information Set (HEDIS) Program Management and Oversight.

HEDIS 2020 MCAS Planning

HEDIS has a two phase approach, the first including a review of administrative measures consisting of claims, pharmacy, immunization registry, and supplemental data.

The second phase consists of administrative measures which are subject to medical record review. If these measures are not identified as compliant through administrative data, the Alliance may request specific medical records to establish additional measure compliance.

The 2020 MCAS includes a total of 35 measures. The Alliance is held to the Minimum Performance Level (MPL) for 19 of these measures. DHCS has shifted the MPL from the 25th to the 50th percentile for HEDIS 2020. Should the Alliance fall beneath the 50th percentile in any measures, it will be subject to economic sanctions and corrective action plans.

Please see the comprehensive list of 2020 HEDIS measures that the Alliance is held to MPL:

ABBREVIATION	2020 (MY 2019) Measures Held to MPL	DATA SOURCE
PCR	Plan All-Cause Readmission	Claims
AWC	Adolescent Well-Care Visits	Claims, Medical Record Review
ABA	Adult Body Mass Index (BMI) Assessment	Claims, Provider Submitted Data
AMM-Acute	Antidepressant Medication Management - Acute Phase Treatment	Claims and Pharmacy Data
AMM-Cont	Antidepressant medication Management - Continuation Phase Treatment	Claims and Pharmacy Data
BCS	Breast Cancer Screening	Claims and Pharmacy Data
AMR	Asthma Medication Ratio	Claims and Pharmacy Data
CCS	Cervical Cancer Screening	Claims, Lab Data and Provider Submitted Data, Medical Records
CIS	Childhood Immunization Status (Combo 10)	Immunization Registry, Claims, Provider Submitted Data, and Medical Records
CHL	Chlamydia Screening in Women	Claims
CDC-HT	Comprehensive Diabetes Care: HbA1c Test	Claims, Lab and Pharmacy Data, Provider Submitted Data, and Medical Records
CDC-H9	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	Claims, Lab and Pharmacy Data, Provider Submitted Data, and Medical Records
CBP	Controlling High Blood Pressure	Claims and Medical Records and Provider Submitted Data
PPC-Pre	Timeliness of Prenatal CarePrenatal	Claims and Medical Records
PPC-Post	Postpartum Care	Claims and Medical Records
WCC	Weight Assessment: Body Mass Index (BMI)	Claims, Provider Submitted Data and Medical Records
IMA-2	Immunizations for Adolescents	Immunization Registry, Claims, Provider Submitted Data, and Medical Records
W34	Well-Child Visits in the 3 to 6 Years of Life	Claims and Medical Records

W15	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Claims and Medical Records

The Alliance is required to report the following measures to DHCS in 2020. These measures are currently not held to the MPL, but are expected to in 2021.

ABBREVIATION	2020 MEASURES NOT HELD TO MPL	DATA SOURCE
AMB-ED	Ambulatory Care: Emergency Department (ED) Visits	Claims
ADD-Init	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Initiation Phase	Claims and Pharmacy Data
ADD-C&M	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	Claims and Pharmacy Data
CAP	Children and Adolescents' Access to Primary Care Practitioners: 12 months to 19 years of age	Claims
CCW-MMEC	Contraceptive Care – All Women: Most or Moderately Effective Contraception	Claims and Pharmacy Data
CCW-LARC	Contraceptive Care – All Women: Long Acting Reversible Contraception (LARC)	Claims and Pharmacy Data
CCP-MMEC3	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 3 Days	Claims and Pharmacy Data
CCP-MMEC60	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	Claims and Pharmacy Data
CCW-LARC3	Contraceptive Care – Postpartum Women: LARC - 3 Days	Claims and Pharmacy Data
CCP-LARC60	Contraceptive Care – Postpartum Women: LARC - 60 Days	Claims and Pharmacy Data
DEV	Developmental Screening in the First Three Years of Life	Claims and Provider Submitted Data
HVL	Human Immunodeficiency Virus (HIV) Viral Load Suppression	Claims
MPM-ACE/ARB	Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)	Claims, Supplemental Data and Provider Submitted Data
MPM-Diu	Annual Monitoring for Patients on Persistent Medications: Diuretics	Claims, Supplemental Data and Provider Submitted Data
COB	Concurrent Use of Opioids and Benzodiazepines	Claims and Pharmacy Data
OHD	Use of Opioids at High Dosage in Persons Without Cancer	Claims and Pharmacy Data

CDF	Screening for Depression and Follow-Up Plan	Claims and Pharmacy Data

Please visit the HEDIS Website of the Alliance provider website for additional information on 2020 HEDIS measures and the appropriate billing codes for the measures listed above.

Provider's Role

The role of the provider is very important in promotion of the health of Alliance members. The Alliance encourages providers to assist in facilitating the HEDIS process by:

- Providing appropriate care within the designated time frames defined by HEDIS
- Clearly documenting all care provided in the patient's medical record
- Accurately coding all claims (see 2020 HEDIS Code Set on the HEDIS Website)
- Responding promptly and accurately to medical records requests (within five to seven business days of request)
- Providing the Alliance and its HEDIS vendor access to your electronic health record (EHR) system to reduce the impact on your medical records team, as well more accurately report your clinic's performance.

HIPAA Statement

All providers are contractually obligated to provide the Alliance with medical records upon request. A patient release form is not necessary. HEDIS data collection and release of information is permitted under HIPAA since the disclosure of records is part of quality assessment and improvement activities. Please be assured that with providing the QI team and the Alliance's HEDIS vendor EHR access Alliance members' personal health information is maintained in accordance of federal and state laws.

Continuous Quality Monitoring

The QPIP uses a variety of mechanisms to identify potential quality of service issues, ensure patient safety, and ensure compliance with standards of care across the care continuum (i.e. preventative health services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services). These mechanisms include, but are not limited to:

- External quality review using the MCAS and NCQA's HEDIS® measure calculation to evaluate the quality of care provided to our members and for comparison against national or regional benchmarks.
- Site reviews of PCP facilities for criteria such as: patient safety, physical accessibility, infection control and quality of medical records.
- Disease surveillance and reporting public health authorities, as applicable.
- Provider contracting, credentialing and recredentialing processes, including peer review activities.

- Timely access monitoring to ensure the provision of covered services in a timely manner.
- Member satisfaction monitoring including analysis of member satisfaction surveys, complaints and appeals.
- Provider satisfaction surveys.
- Medical and pharmaceutical claim/encounter data analysis to identify sentinel events, variations in practice and potential fraud, waste and/or abuse.
- Potential quality issue investigation and resolution processes, to ensure that services provided to members meet established standards, and address any patient safety concerns.
- Monitoring of over/under utilization of services to ensure appropriate, high quality, cost-effective utilization of health care resources and that these resources are available to all members.
- Population Needs Assessment to evaluate the health education and cultural and linguistic needs of Medi-Cal members.
- Seniors and persons with disabilities activity studies to ensure coordination and continuity of care, availability and access to care, and the provision of case management services.
- Stratified data studies to evaluate population(s) as needed.
- Development and annual review of the QIWP and UMWP.
- Routine and ad-hoc monitoring of QI activities, behavioral health services and delegate oversight.

Communicating Results of QI Activities

Using a variety of communication methods (e.g., Provider Portal, newsletters, special mailings, educational sessions, and/or site reviews), QPIP activities are communicated to Alliance staff, the Alliance Board, oversight and advisory committees, regulatory agencies, providers, and members. The content of these communications may include:

- Listings of members who need specific services;
- Listings of members who need intervention based on pharmacy indicators;
- Comparison of practitioner/provider performance to average plan-wide performance;
- Reports showing practitioner/provider deviation from a benchmark or threshold;
- Recommended interventions to improve performance;
- Barrier analyses and intervention plans/timelines;
- Plan-sponsored training directed at improving performance;
- Incentives for improved or above average performance in quality of care or service;
- Requests for Corrective Action Plans to correct deficiencies

For more information about our QPIP, please see the following policies.

401-1101- Quality and Performance Improvement Program

401-1201 - Continuous Quality Improvement Committee

401-1301 - Potential Quality Issue Review Process

401-1508 - Facility Site Review Process

401-1510 – Medical Record Review and Requirements

401-1509 – Timely Access to Care

401-1515 - Nurse Midwife Guidelines

401-1523 - Non-Physician Medical Practitioner Guidelines

401-1306 - Corrective Action Plan for Quality Issues