ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

2017 Quality Improvement Program Evaluation

8/13/18
Date

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BACKGROUND/INTRODUCTION

Alameda Alliance for Health (the Alliance) is a public, not-for-profit managed care health plan committed to making high-quality health care services accessible and affordable to citizens most in need in Alameda County. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for Alameda County residents and reflects the cultural and linguistic diversity of the community. In addition, Alliance providers, employees, and Board of Governors (BOG) live in areas that the health plan serves

The Alliance provides health care coverage to over 265,094 children and adults through the Medicaid (Medi-Cal) and Alliance Group Care (Group Care) product lines. The breakdown of the membership as of December 31, 2017 includes 259,350 Medi-Cal and 5,744 Group Care members. Group Care members represent a safety net population who are low-income and care for family members. The Alliance membership has remained relatively stable over the past year.

Alliance members may choose from a network of over 500 primary care practitioners (PCPs) and 4000 specialists, 13 hospitals, 43 health centers, 46 nursing facilities and more than 200 pharmacies throughout Alameda County. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our first priority.

The Alliance Quality Improvement (QI) Program strives to ensure that members have access to quality health care services.

PURPOSE

The Alliance evaluates its QI Program annually to determine the overall effectiveness in meeting the goals and objectives of the QI Program and Work Plan, identifying improvement opportunities, and assessing progress toward improved network practices. The evaluation includes input from multiple departments. The Alliance uses the annual evaluation to identify goals, objectives, and activities for the QI Program in the coming year.

This evaluation assesses the following elements:

- Effectiveness of the QI structure;
- Overall effectiveness of the QI program;
- Completed and ongoing QI activities;
- Performance measure trends; and
- Analysis of QI initiatives and barriers to improvement.
- Delegated entities' performance.

The annual QI Program Evaluation is reviewed and approved by the Health Care Quality Committee (HCQC) prior to being submitted for review and approval by the BOG. The HCQC and the BOG also review and approve the QI Program Description and Work Plan for the upcoming year.

QI STRUCTURE AND RESOURCES

A. QI Structure

The HCQC is a standing committee of the BOG, which serves as the governing body for the Alliance and retains the ultimate responsibility for the QI Program. The HCQC recommends policy decisions, analyzes and evaluates the QI and Utilization Management (UM) Work Plan activities, and assesses the overall effectiveness of the QI and UM Programs. The HCQC met a total of 5 times in 2017:

- March 9, 2017
- May 25, 2017
- August 24, 2017
- August 31, 2017
- October 12, 2017

On August 24, 2017, the 2016 QI Program Evaluation and the 2017 Program Description and Work Plan were both presented to the HCQC and unanimously approved.

The major committees that support the quality and utilization of care and service include: the HCQC, as well as the Pharmacy and Therapeutics committee, Peer Review and Credentialing Committee, Utilization Management (UM) Subcommittee, Access and Availability Subcommittee, and Internal Quality Improvement Subcommittee (IQIC). Each committee meets at least quarterly, some monthly, and reports directly to the HCQC. Each committee continues to meet the goals set forth in their charters. The HCQC membership includes practitioners, leadership, and staff.

B. QI Resources

The Quality Management Department underwent significant turnover in 2017. The Chief Medical Officer left the organization in early March 2017. A second physician joined the Alliance in the capacity of consulting Chief Medical Officer in March and April 2017. In April 2017, an Interim Chief Medical Officer was in place for the remainder of the year. Throughout 2017, the following changes occurred:

- 2nd Quarter 2017 – one Quality Improvement Project Specialist left the Quality Department and transferred to Compliance.
- 2nd Quarter 2017 – one Quality Improvement Project Specialist left the Alliance.
- 4th Quarter 2017 – the Manager of Performance Improvement and one Quality Project Specialist were moved to Healthcare Analytics to support the transition of the Healthcare Effectiveness Data and Information Set (HEDIS) project form the Quality department to Medical Analytics department for reporting year 2018.
- 4th Quarter 2017 – one Quality Improvement Project Specialist transferred to Vendor Management and one new Quality Improvement Project Specialist was hired.

- Throughout 2017, the Alliance continued the contract with Health Data Decisions. This firm augments internal resources and provides consulting and analytic assistance for HEDIS data and helps address care and reporting gaps.

Throughout 2017, the Director of Accreditation and Health Education remained in the role of Acting Director of Quality. Throughout 2017 the Quality Program was directed by the Chief Medical Officer. Due to tremendous Quality Department and leadership turnover in the Quality Department, many Quality department roles warrant redefinition in 2018.

I. Overall Program Effectiveness

The Alliance's improvement efforts strive to impact the quality of care and service provided to our members and providers. Review of the Alliance's QI activities as described herein demonstrate the ability to successfully achieve the following:

- Improved focus on the importance of prenatal care, chronic condition management, and accessing appropriate care through initiatives to educate and connect with members, work with providers, and enhance our internal operations.
- Improved focus on the analysis of key drivers of access to care and expanded our knowledge of health disparities among all members of Medi-Cal and Group Care.
- Promoted the awareness and concepts of inter-departmental organizational QI to create greater operational efficiency and capacity.
- Invested in quality measurement expertise.
- Exhibited improvement in many HEDIS measures' performance.
- Continued focus on hiring new staff for the QI Department.

The Alliance is heavily invested in a multi-year strategy to ensure that the organization adapts to health plan industry changes occurring now and within the next 3-5 years. An effective QI program with adequate resources is essential to the Alliance's successful adaptation to expected changes and challenges.

II. Serving Members With Complex Conditions

The Alliance continues to identify members in need of supportive services based on complex health conditions. The Alliance links members to Asthma and Diabetes Disease Management, Complex Case Management and Transition of Care.

Members are identified as potential candidates for Asthma Disease Management and are mailed outreach materials explaining their illness and the process to enroll in Disease Management. Disease Management is optional so members who do not pursue Disease Management programs are also provided information related to community resources that support their conditions.

Members are identified as high risk through claims, encounter and referral sources. These members are forwarded to case management for follow up. Complex Case Management staff outreach to high risk members by telephone. When outreach attempts are successful, initial assessments are performed and care plans are developed. Members who agree to care are provided assistance with provision of services and recommendations to support managing their conditions. When outreach is attempted but unsuccessful, the case is closed.

Members are also identified for transition of care assistance. Transition of Care assistance occurs for members who are discharged from Medical or Surgical inpatient care settings.

Case and Disease Management processes and outcomes are provided in the Complex Case Management and Disease Management program documents.

III. Provider Outreach

During 2017, the Provider Services department provided their continued outreach to all PCP, Specialists and Ancillary provider offices via in-person visits and the use of fax blasts. Topics covered in the visits and fax blasts included: use of provider portal, the announcement of the Member Satisfaction survey, review of HEDIS measures, interpretive services, cultural sensitivity, Health Wellness, Provider Dispute Resolution (PDR) policy and procedure, updated drug formulary schedule change, announcement of the acupuncture benefit, instructions on discharging members from provider practices, Fraud Waste and Abuse reporting, Provider Appointment Availability Survey (PASS), the announcement of the Claims Editing System software, tobacco cessation counseling and Pay For Performance and DHCS' final rule impact on managed Medi-Cal plans.

In addition to ongoing quarterly visits, every newly credentialed provider received a new provider orientation within 10 days of becoming effective with the Alliance. This orientation includes a very detailed summary which includes but not limited to:

- Plan review and summary of Alliance programs
- Review of network and contract information
- How to verify eligibility
- Referrals and how to submit prior authorizations
- How to submit claims
- Filing of complaints and the appeal process
- Initial Health Assessment
- Coordination of Care, CCS, Regional Center, WIC program

Overall, there were approximately 1376 provider visits completed during the 2017 calendar year. In April 2017, the Interim Director of Provider Services was appointed as the permanent Director.

IV. Member Outreach and Member Services

The Alliance Member Services (MS) Department has a strong focus on providing high-quality service. Quarterly call center metrics are presented below.

Member Services Dashboard 2017

Blended Customer Service Results – Medi-Cal and Group Care

Alliance Member Services Staff	Q1	Q2	Q3	Q4
Incoming Calls (MS)	48458	41545	40474	36573
Abandoned Rate (MS)	3%	3%	3%	2%
Answered Calls (MS)	47078	40396	39334	35708
Average Speed to Answer (ASA)	00:25	00:25	00:20	00:16
Calls Answered in 30 Seconds (All)	85.0%	86%	87%	90%
Calls Answered in 10 Minutes (goal: 100%)	100.0%	100.0%	100.0%	100.0%
Recordings/Voicemails	**Q1**	**Q2**	**Q3**	**Q4**
Incoming Calls (R/V)	7051	6030	2639	2381
Abandoned Rate (R/V)	0.0%	0.0%	0.0%	0.0%
Answered Calls (R/V)	7051	6030	2639	4081
Calls Answered in 30 Seconds (R/V)	100%	100%	100%	100%
Blended Results	**Q1**	**Q2**	**Q3**	**Q4**
Incoming Calls (R/V)	55599	47575	43113	38954
Abandoned Rate (R/V)	2%	2%	3%	2%
Answered Calls (R/V)	54129	46426	41973	38089
Average Speeed to Answer (ASA)	00:25	00:25	00:20	00:16
Calls Answered in 30 Seconds (R/V)	87%	88%	87%	91%
Targets: To answer 80% or more calls within 30 seconds, and to have an Abandoned Rate of 5% or less.				

In 2017, Member Service staff met target call service metrics to answer 80% or more calls within 30 seconds and experience less than 5% abandonment.

The Alliance also has a Member Advisory Committee (MAC), which meets quarterly. The MAC assists with setting public policy of the Alliance and makes recommendations and reports to the BOG.

The MAC met four times in 2017:

- March 3, 2017
- June 15, 2017
- September 21, 2017
- December 21, 2017

Some of the key topics discussed in 2017 include:

- Cultural and Linguistics Work Plan and Report

- Grievances and appeals
- Behavioral Health grievances
- Health Education materials review
- Provider directory
- Member language capacity comparison
- Quality Improvement and HEDIS results
- New member materials
- Diabetes prevention
- Advance Directives
- Health Risk Assessment
- Community Relations events
- Questions & answers for member concerns.

The Alliance newsletter *Member Alert* was published 2 times in 2017. The newsletter contained a variety of preventive care topics such as Asthma, Chronic Obstructive Pulmonary Disease, exercise, Attention Deficit Hyperactivity Disorder, immunizations, healthy eating, and preventive care visits.

V. Safety of Clinical Care

The Alliance has an organizational focus on maintaining safety of clinical care for its membership.

A. Pharmacy

The Alliance is in the process of partnering with our providers and other local leaders to develop an Opioid Management Program. Pain has long been difficult to quantify/qualify, as there is no test that can be ordered to assess the amount of pain and amount of medication needed to reduce that pain (i.e., no clear dose/response correlation applicable to all patients). We can however try to ensure that opioids are being used appropriately and only for conditions where the patient will be able to show a day-to-day functional improvement from therapy. We are in the process of implementation of a 3-phase approach with intended goal of reducing inappropriate prescribing of opioids by:

1. Developing a comprehensive opioid educational program and materials for Alliance providers
2. Ensure members have access to alternative medications and therapies to reduce opioid use
3. Establish appropriate use criteria for using over 120 milligrams of morphine per day (or its equivalent dose in other opioids) and subsequent dose increases
4. Ensure appropriate use of long-acting opioids and prevention of inappropriate dose escalation
5. Reduce potentially inappropriate use of multiple long-acting opioids together (possibly from different doctors and/or filled at different pharmacies).
6. Remove/restrict use of medications commonly abused with opioids that have formulary alternatives (e.g., Alprazolam, Carisoprodol)

7. Reduce use of opioids for treatment of low-evidence conditions (e.g., headaches, chronic lower back pain without radiographic evidence of disease, fibromyalgia)

The Pharmacy Department monitors all drug recalls. In 2017 there were six drug recalls. Three of the six recalls were Lot recalls, not affecting any members. All Lot recalls were posted on the website. Two of the six were Class II; a letter was sent to the members impacted. One of the six was a Class III recall, in which patients were contacted directly by pharmacy staff.

The Alliance website has a continuous flow of safety resources for members and providers and includes FDA recalls, Risk Evaluation and Mitigation Strategies, a Patient Safety Resource Center, and Drug Safety Bulletins.

B. Quality of Care

The QI Department investigates all Potential Quality Issues (PQIs). These may be submitted by members, practitioners, or internal staff. When a PQI is identified, it is forwarded to the Quality Department and logged into a database for tracking. Quality Review Nurses investigate the incident and summarize the findings. The Medical Director reviews all PQI summaries where a quality of care issue is identified. A Medical Director will refer cases to the Peer Review and Credentialing Committee (PRCC) for resolution, if found to be a significant quality of care issue (Clinical Severity 3, 4).

Alameda Alliance for Health's Quality department received three hundred sixty-eight (368) Potential Quality Issues (PQIs) during measurement year 2017. The quarterly frequencies are listed in Table1 below:

Table 1

Quarter	Q1	Q2	Q3	Q4	TOTAL
All 2017 PQIs	85	73	111	99	**368**

On average, 92 PQIs were identified per quarter over the year, and there was a slight increase in Q3. When a grievance is identified as a PQI, it is assigned a case file number unique to the member, day and time of complaint and is investigated. Each case file number represents a root PQI.

The investigation process frequently reveals that root PQIs include multiple unique issues, hereafter referred to as "unique PQIs." Each unique PQI is categorized into one of three categories: access PQIs, clinical PQIs, or administrative PQIs. Table 2 below shows the number of unique PQIs in each category:

Table 2

PQI Type	Q1	Q2	Q3	Q4	TOTAL	%
All Access PQIs	22	25	43	35	125	23.8%
All Administrative PQIs	45	46	64	45	200	38%
All Clinical PQIs	41	51	49	60	201	38.1%
Total	108	122	156	140	526	
% of PQIs	20.5%	23.2%	29.7%	26.6%		

In 2017, no PQI leveled higher than 2b. Therefore, no PQIs were sent to PRCC for review and recommendation.

Site Review

Site reviews are another way the QI Department ensures safety within the provider office environment. In 2017, there were 90 site reviews conducted; 26 full scope, 6 initial facility site reviews, 6 initial medical record reviews and 50 mid-cycle reviews. These reviews resulted in 55 corrective action plans and follow-up with the practice sites.

VI. Peer Review and Credentialing Committee (PRCC)

The PRCC met monthly and conducted a comprehensive review of each practitioner before credentialing or recredentialing was complete. If any issues were identified, a thorough review by the committee was completed to ensure that there were not quality or safety issues.

Any practitioner that was not board certified was reviewed by the committee. In 2017, 43 practitioners were reviewed for lack of board certification. If there were complaints about a practitioner's office, facility site reviews were conducted and the outcome was reviewed by the PRCC. There were no site reviews conducted based on complaints in 2017. All grievances, complaints, and PQIs that required investigation were forwarded to this committee for review. In 2017, 30 grievances,

complaints, or PQIs were investigated by the committee. There were no practitioners that required reporting to National Practitioner Data Bank (NPDB).

In 2017, the PRCC granted one year reappointment for three practitioners for grievances filed regarding office procedures. Additionally, one practitioner was denied credentialing based on not meeting criteria due to no admitting arrangement or privileges, lack of board certification, and NPDB. The table below shows evidence of practitioner review by the PRCC prior to re-credentialing decisions.

Count of Practitioners Reviewed for Quality Issues At PRCC In 2017								
PRCC Date	NPDB	Attestation	Malpractice (pending or dismissed)	Facility Site Reviews	Grievance, Complaint, PQI	License Action	Board Certification	**Total**
1/17/2017			2				5	**7**
2/21/2017			2		7		4	**13**
3/21/2017	2		1		4		4	**11**
4/18/2017	1		1		3		5	**10**
5/16/2017	2				1			**3**
6/20/2017	3				2		2	**7**
8/15/2017	3						1	**4**
9/19/2017	2		1		3		5	**11**
10/17/2017	2		1		3		4	**10**
12/19/2017	5				7		13	**25**
	20	**0**	**8**	**0**	**30**	**0**	**43**	**101**

VII. Delegation Oversight

The Alliance conducts quarterly and annual delegation oversight in compliance with Department of Health Care Services (DHCS), DMHC, and the National Committee for Quality Assurance (NCQA) regulations. Annual delegation oversight reviews were conducted in 2017. Results from the reviews are reported to the Compliance Committee. The QI delegation audit results were also reported to the HCQC.

The following delegated groups were audited in 2017:

2017 AAH Delegation Audit Schedule													
	Delegate Name	Service Type	Product Line		Quality Improvement	Utilization Management	Credentialing/ Re-Credentialing	Rights and Responsibilities	Claims	Case Management	Audit Report & CAP Sent	Audit CAP Response Received	Audit CAP Closed
			MCAL	GC									
1	KAISER	Fully Delegated	X		10/25/17	10/25/17	NCQA	10/25/17	10/25/17	10/25/17			
2	BEACON HEALTH STRATEGIES LLC	Mental Health, Partially Delegated	X	X	8/10/17	8/10/17	NCQA	N/A	8/10/17	8/10/17	9/26/17		
3	COMMUNITY HEALTH CENTER NETWORK (CHCN)	Partially Delegated	X	X	N/A	*11/7/2017	N/A	N/A	*11/7/2017	*11/7/2017			
4	CHILDREN'S FIRST MEDICAL GROUP (CFMG)	Partially Delegated	X		N/A	8/28/17	7/01/17	N/A	8/28/17	N/A	10/23/17		
5	PERFORMRX	Pharmacy	X	X	N/A	4/25/17	4/25/17	N/A	4/25/17	N/A	8/03/17	9/15/17	
6	MARCH VISION CARE GROUP, INC.	Vision	X		N/A	N/A	7/01/17	N/A	8/01/17	N/A			
7	CALIFORNIA HOME MEDICAL EQUIPMENT (CHME)	DME	X	X	N/A	9/14/17	N/A	N/A	N/A	N/A			
8	EVICORE	Specialty Radiology	X	X	N/A	8/01/17	N/A	N/A	N/A	N/A			
9	PHYSICAL THERAPY PROVIDER NETWORK (PTPN)	Physical Therapy	X	X	N/A	N/A	4/01/17	N/A	N/A	N/A	N/A	N/A	N/A
10	LUCILLE PACKARD	Medical Group	X	X	N/A	N/A	9/01/17	N/A	N/A	N/A	N/A	N/A	N/A
11	UCSF	Medical Group	X	X	N/A	N/A	10/01/17	N/A	N/A	N/A	N/A	N/A	N/A

*rescheduled from 10/16/2017

The Alliance will continue to conduct oversight of the delegated groups, review thresholds to ensure they are aligned with industry standards, and will issue corrective actions when warranted.

In addition to the annual oversight audits, the Alliance holds quarterly Joint Operations Meetings with delegates (as well as Executive Team meetings with CHNC and AHS Executive Leadership). The Alliance and the delegate contribute to the agenda items. The agenda includes a discussion of claims, information technology, provider relations, member services, quality issues/progress, and new legislation. Also, weekly or biweekly calls are held with the delegates to resolve any immediate concerns. The Alliance places a high degree of importance on problem solving and communicating with delegates.

The Alliance conducted Joint Operations meetings with the delegated groups to review HEDIS performance specific to their group and to identify opportunities for improvement, strategies for improvement of scores, and HEDIS timelines for reporting year 2017.

VIII. Quality Improvement Projects

In 2017, the Alliance cooperated with the Department of Health Care Services (DHCS) to improve the process for three quality measures. The following quality improvement projects were conceived in late 2015 and completed 2017. The projects were based on HEDIS 2015 reporting year data. DHCS encourages plans to adopt the Institute for Health Improvement's (IHI) model for improvement. This approach frames the improvement project to clarify and focus the project before the Plan-Do-Study-Act (PDSA) model is used. The project cycle was 18 months ran through 2017. The outcomes for the quality improvement projects are stated below.

Quality Improvement Activities (QIA)

1. Increase the rate of timely prenatal care. For reporting year 2015 (2014 calendar year data), Alameda Alliance timely prenatal care (hybrid) rate of 66.67% was below the 2015 Minimum Performance Level (MPL) of 25th percentile when measured against Medicaid health plans nationally. Additional analysis showed that the prenatal rate was more than 6% lower for African American mothers than the Alameda Alliance reported rate overall. The goal of the intervention is to increase the administrative of rate of prenatal care among African American women, from 43.24% to 49.24% by June 30, 2017. The intervention focused on creating an obstetric care coordination program (OBCM) to assist newly identified pregnant members to overcome identified barriers to care. The HEDIS measure prenatal rate increased from 66.67% in RY 2015 to 73.97% for all women in RY 2016. This intervention continued into 2017. The final evaluation of timely prenatal care for African American women based on the implementation of an OBCM program was submitted to DHCS in August of 2017. Although the improvement initiative did not conclusively tie the obstetric care program to increased rates, the administrative rate of prenatal screening for African American women increased from 43.24% in RY2015 to 66.18% in RY 2017. The hybrid rate of prenatal screening for African American women increased to 60.67% in RY 2015 to 79.12% in RY 2017.
2. Increase Alameda Alliance overall rate of cervical cancer screening. Alameda Alliance cervical screening rate was below the minimum performance level of 25th percentile when measured against Medical health plans nationally in RY 2015 (53.51%) and RY 2016 (51.09%). Additional analysis showed the screening rate for women assigned to Roots Community Clinic in Oakland was significantly lower than Alameda Alliance rates overall. The focus of the QIA was to increase the cervical cancer rate for women ages 21-64 years, assigned to Roots Community Health Center (RCHC), from 22.37% to 42.10% by 12/31/2016. The intervention is designed to improve the process for identification, appointment scheduling, appointment reminder, and successful screening of women at RCHC, the target site. Intervention progress was reported to DHCS quarterly until August 2017. Although the intervention was unable to impact the cervical cancer screening rates at Roots Community Health Center, the intervention was showcased by DHCS due to commendable adherence to the quality improvement methodology. Cervical cancer screening rates increased from 53.51% in RY 2015 to 60.34% in RY 2017.
3. Managing members on persistent medications. Screening rates for members on persistent medications were below the minimum performance level two years in a row. The rates of screening for members on the following medications: angiotensin converting enzyme (ACE) inhibiters or angiotensin receptor blockers (ARB) and diuretics (DIU) were ACE/ARB= 83.12% in RY 2015 and 84.27% in RY 2016 and DIU= 81.67% in RY 2015 and 83.22% in RY 2016. The intervention was directed toward members assigned to Eastmont Wellness Center due to the volume of members assigned to that clinic. In Q3 2016, 263 members ages 18 and older, assigned to Eastmont Wellness Center and prescribed ACE/ARB and 185 prescribed DIU, who had not been screened were targeted for outreach. The list of members was forwarded to staff at Eastmont Wellness Center. Clinical staff initiated lab requisitions. Once the requisitions were entered, Alameda Alliance outbound call center reached out to members by telephone to encourage them to complete the screening prior to 12/31/2016. This intervention continued through Q1 2017 when Alameda reported to DHCS. The intervention exceeded goal for

Eastmont Wellness Center. The intervention, though successful, was not sufficient in numbers great enough to bring compliance with the measure above the minimum performance level. ACE/ARB rates increased from 84.27% in RY 2015 to 86.06% in RY 2017. DIU 81.67% in RY 2015 to 85.14% in RY 2017.

IX. CLINICAL IMPROVEMENT TRENDS – HEDIS

The Alliance is committed to ensuring the level of care provided to all enrollees meets professionally recognized standards of care and is not withheld or delayed for any reason. The Alliance adopts and evaluates recognized standards of care for preventive, chronic and behavioral health care conditions. The Alliance also approves the guidelines used by delegated entities. Guidelines are approved through the HCQC. Adherence to practice guidelines and clinical performance is evaluated primarily using standard HEDIS measures. HEDIS is a set of national standardized performance measures used to report on health plan performance in preventive health, chronic condition care, access and utilization measures. DHCS requires all Medicaid plans to report a subset of the HEDIS measures. Three years of Medicaid hybrid and administrative rates are noted below. Reporting year is noted and reflects prior calendar year. Minimum Performance Level and High Performance Level are determined by the Medi-Cal Managed Care Division.

Medicaid Hybrid HEDIS Measures

Hybrid/Admin Measure	NCQA Acronym	Rate Method	Measure	Hybrid Final - 2015	Hybrid Final - 2016	Hybrid Final - 2017	2017 MPL	2017 HPL	2017 Target Variance	2017 TARGET 5% Gain from 2016 or 2017 MPL
Hybrid	CCS	H	Cervical Cancer Screening	53.53%	51.09%	60.34%	*48.26%*	*63.70%*	**6.69%**	*53.65%*
	CDC	H	Hemoglobin A1c (HbA1c) Testing	87.10%	83.21%	85.89%	*82.98%*	*89.43%*	**-1.48%**	*87.37%*
	CIS	H	Combination #3	75.91%	66.42%	74.45%	*64.30%*	*75.60%*	**4.71%**	*69.74%*
	PPC	H	Timeliness of Prenatal Care	66.67%	73.97%	84.43%	*74.21%*	*87.56%*	**6.76%**	*77.66%*
	W34	H	Well-Child Visits in the Third, Fourth, Fifth and Six	71.53%	68.61%	73.13%	*64.72%*	*77.57%*	**1.09%**	*72.04%*
	CBP	H	Controlling High Blood Pressure	43.07%	57.66%	65.21%	*47.03%*	*63.87%*	**4.66%**	*60.55%*
	CDC	H	HbA1c Poor Control (>9.0%)	41.85%	40.63%	37.96%	*52.26%*	*36.95%*	**0.64%**	*38.60%*
	CDC	H	HbA1c Control (<8.0%)	41.85%	48.42%	50.12%	*39.80%*	*52.55%*	**-0.72%**	*50.84%*
	CDC	H	Eye Exam (Retinal) Performed	46.23%	49.64%	55.23%	*44.53%*	*61.69%*	**3.11%**	*52.12%*
	CDC	H	Medical Attention for Nephropathy	80.05%	88.08%	88.81%	*88.45%*	*91.97%*	**-3.67%**	*92.48%*
	CDC	H	Blood Pressure Control (<140/90 mm Hg)	40.39%	58.64%	61.56%	*52.26%*	*68.61%*	**-0.01%**	*61.57%*
	IMA	H	Combo 1 Meningococcal, Tdap/Td	74.45%	73.24%	76.40%	*66.03%*	*82.09%*	**-0.50%**	*76.90%*
	IMA	H	Combo 2 Meningococcal, Tdap/Td, HPV	n/a	n/a	30.17%				
	PPC	H	Postpartum Care	55.47%	59.61%	67.15%	*55.47%*	*67.53%*	**4.56%**	*62.59%*
	WCC	H	Counseling for Nutrition Total	57.42%	65.69%	79.56%	*51.84%*	*70.88%*	**10.58%**	*68.98%*
	WCC	H	Counseling for Physical Activity Total	48.42%	60.10%	74.70%	*45.09%*	*63.47%*	**11.59%**	*63.10%*

Medicaid Administrative HEDIS Rates

Hybrid/Admin Measure	NCQA Acronym	Rate Method	Measure	Admin - 2015	Admin - 2016	Admin - 2017	2017 MPL Variance	2017 MPL	2017 HPL
Admin	AAB	A	Avoidance of Antibiotic Treatment in Adults with Ac	34.48%	32.80%	38.05%	15.92%	22.13%	32.33%
	CAP	A	12-24 Months	88.24%	92.61%	92.00%	-1.14%	93.14%	97.28%
	CAP	A	25 Months - 6 Years	81.44%	84.00%	84.40%	-0.43%	84.83%	90.98%
	CAP	A	7-11 Years	84.77%	86.97%	87.19%	-0.72%	87.91%	93.25%
	CAP	A	12-19 Years	81.65%	84.60%	84.75%	-1.09%	85.84%	92.67%
	AMR	A	Total	27.13%	29.36%	60.65%	5.88%	54.77%	65.32%
	LBP	A	Use of Imaging Studies for Low Back Pain	87.33%	83.45%	76.28%	6.40%	69.88%	77.09%
	MPM	A	ACE Inhibitors or ARBs	83.12%	84.27%	86.06%	0.43%	85.63%	89.92%
	MPM	A	Diuretics	81.67%	83.22%	85.14%	-0.05%	85.19%	90.04%

Analysis of HEDIS Medicaid External Accountability Set (EAS)

The above tables represent the Medicaid HEDIS measures where there was comparative data from 2015 through 2017 for the DHCS Accountability measure set. Of the trended measures (including individual sub measures), 23/25 measures showed improvement and 2 showed a minimal decline. The Alliance goal is to increase HEDIS rates by 5% each year. In 2017, the Alliance met the target goal when evaluated in the aggregate. Where the Alliance has failed to meet minimum performance goals, in depth analysis will occur to identify barriers to access and care. Based on the HEDIS data presented, potential focus areas for 2018 may include the following:

- Prioritizing HEDIS interventions based on health disparity data analysis
- Access to care
- Managing Members on Persistent Medications- ACE/ARB and DIU
- Prenatal Care; and
- Postpartum Care

Accreditation Measures

Each year, predetermined subsets of HEDIS measures are evaluated for scoring NCQA health plan accreditation status. The following HEDIS measures were used to score the Alliance for the 2018 accreditation award. Due to increased scoring on many measures, the Alliance earned "Commendable" status by NCQA. Group Care membership does not meet enrollment criteria for annual scoring by NCQA. Medicaid and Group Care accreditation measures are listed below.

2017 Measures			2016 Results		2017 Rates					2015 Accreditation Percentiles				
Rate Method	Measure	Population	Admin Final 2016	Hybrid Final 2016	Current Rate	Variance (Prior Year Admin Final to Current Rate)	Variance (2016 Hybrid Final to Current Hybrid Rate)	Current Admin	Current Hybrid	HEDIS 2016 %ile	25th	50th	75th	90th	2017 Est %ile
H	Adult BMI Assessment	Medicaid	45.79%	76.40%	86.23%	10.44%	9.83%	56.23%	86.23%	<25th	77%	84%	89%	93%	50th
H	Controlling High Blood Pressure	Medicaid	0.00%	57.66%	65.21%	0.00%	7.54%	0.00%	65.21%	50th	47%	55%	64%	71%	75th
H	Cervical Cancer Screening	Medicaid	45.60%	51.09%	60.34%	7.90%	9.25%	53.50%	60.34%	25th	48%	56%	64%	70%	50th
H	HbA1c Poor Control (>9.0%)	Medicaid	59.90%	40.63%	37.96%	1.89%	2.67%	58.01%	37.96%	<25th	52%	44%	37%	29%	<25th
H	HbA1c Control (<8.0%)	Medicaid	33.60%	48.42%	50.12%	1.95%	1.70%	35.55%	50.12%	50th	40%	47%	53%	58%	50th
H	Eye Exam (Retinal) Performed	Medicaid	41.50%	49.64%	55.23%	3.39%	5.59%	44.89%	55.23%	25th	45%	53%	62%	68%	50th
H	Medical Attention for Nephropathy	Medicaid	86.33%	88.08%	88.81%	0.48%	0.73%	86.81%	88.81%	<25th	88%	91%	92%	94%	25th
H	Blood Pressure Control (<140/90 mm Hg)	Medicaid	30.49%	58.64%	61.56%	-0.01%	2.92%	30.48%	61.56%	25th	52%	60%	69%	76%	50th
H	Combination #10	Medicaid	35.83%	40.88%	48.18%	4.38%	7.30%	40.21%	48.18%	50th	26%	33%	41%	46%	90th
H	Frequency of Ongoing Prenatal Care	Medicaid	17.87%	35.04%	55.47%	20.09%	20.43%	37.96%	55.47%	<25th	46%	59%	70%	76%	25th
H	Combo 1 Meningococcal, Tdap/Td	Medicaid	71.29%	73.24%	76.40%	1.98%	3.16%	73.26%	76.40%	25th	66%	75%	82%	87%	50th
H	Timeliness of Prenatal Care	Medicaid	50.00%	73.97%	84.43%	22.74%	10.46%	72.74%	84.43%	<25th	74%	82%	88%	91%	50th
H	Postpartum Care	Medicaid	47.39%	59.61%	67.15%	11.18%	7.54%	58.57%	67.15%	25th	55%	61%	68%	74%	50th
H	BMI Percentile Total	Medicaid	35.34%	64.72%	83.21%	15.03%	18.49%	50.37%	83.21%	25th	55%	68%	78%	86%	75th
H	Counseling for Nutrition Total	Medicaid	21.82%	65.69%	79.56%	-0.83%	13.87%	20.99%	79.56%	50th	52%	63%	71%	80%	90th
H	Counseling for Physical Activity Total	Medicaid	18.37%	60.10%	74.70%	1.94%	14.60%	20.31%	74.70%	50th	45%	55%	63%	72%	90th
A	Avoidance of Antibiotic Treatment in Adults	Medicaid	32.80%		38.05%	5.25%		38.05%		75th	22%	26%	32%	39%	75th
A	Initiation Phase	Medicaid	35.51%		37.55%	2.04%		37.55%		25th	34%	42%	50%	55%	25th
A	Continuation and Maintenance (C&M) Pha	Medicaid	34.51%		48.48%	13.97%		48.48%		<25th	41%	52%	63%	67%	25th
A	Effective Acute Phase Treatment	Medicaid	67.12%		66.89%	-0.23%		66.89%		75th	48%	53%	60%	68%	75th
A	Effective Continuation Phase Treatment	Medicaid	51.52%		52.61%	1.09%		52.61%		75th	33%	38%	43%	54%	75th
A	Total	Medicaid	29.36%		60.65%	31.29%		60.65%		<25th	55%	61%	65%	70%	25th
A	Breast Cancer Screening	Medicaid	57.45%		62.52%	5.07%		62.52%		25th	52%	58%	65%	71%	50th
A	Total	Medicaid	55.10%		56.08%	0.98%		56.08%		25th	49%	55%	62%	69%	50th
A	Appropriate Testing for Children with Phary	Medicaid	62.64%		60.27%	-2.37%		60.27%		<25th	63%	72%	81%	87%	<25th
A	30-day follow-up	Medicaid	0.00%		0.00%	0.00%		0.00%		<25th	54%	64%	73%	79%	<25th
A	7-day follow-up	Medicaid	0.00%		0.00%	0.00%		0.00%		<25th	34%	44%	55%	64%	<25th
A	Initiation of AOD Treatment: Total	Medicaid	0.00%		0.00%	0.00%		0.00%		<25th	34%	38%	43%	46%	<25th
A	Engagement of AOD Treatment: Total	Medicaid	0.00%		0.00%	0.00%		0.00%		<25th	7%	10%	13%	17%	<25th
A	Use of Imaging Studies for Low Back Pain	Medicaid	83.45%		76.28%	-7.17%		76.28%		90th	70%	74%	77%	81%	50th
A	Total Medication Compliance 50%	Medicaid	52.53%		64.92%	12.39%		64.92%		25th	50%	56%	62%	72%	75th
A	Total Medication Compliance 75%	Medicaid	30.09%		43.64%	13.55%		43.64%		25th	25%	31%	38%	48%	75th
A	Persistence of Beta-Blocker Treatment Afte	Medicaid	0.00%		83.05%	83.05%		83.05%		<25th	77%	83%	88%	92%	25th
A	Systemic corticosteroid	Medicaid	63.16%		60.88%	-2.28%		60.88%		25th	61%	70%	75%	79%	<25th
A	Bronchodilator	Medicaid	87.58%		84.90%	-2.68%		84.90%		75th	77%	84%	87%	89%	50th
A	Diabetes Screening for People With Schizo	Medicaid	80.00%		80.34%	0.34%		80.34%		25th	77%	81%	84%	87%	25th
A	Appropriate Treatment for Children With U	Medicaid	96.87%		97.14%	0.27%		97.14%		90th	85%	89%	93%	96%	90th

Group Care HEDIS

Below 2016 and 2017 Group Care HEDIS rates are compared. Not all measures have sufficient denominators for accurate benchmarking.

IHSS (Group Care) HEDIS Measures

Hybrid/Admin Measure	NCQA Acronym	Measure	Admin Final 2016	Hybrid Final 2016	Final 2017 Rate
Hybrid	ABA	Adult BMI Assessment	25.91%	80.05%	87.04%
	CBP	Controlling High Blood Pressure	0.00%	59.12%	61.80%
	CCS	Cervical Cancer Screening	56.69%	59.85%	62.77%
	CDC	HbA1c Poor Control (>9.0%)	55.64%	34.31%	31.87%
	CDC	HbA1c Control (<8.0%)	37.92%	59.37%	60.10%
	CDC	Eye Exam (Retinal) Performed	38.28%	46.72%	51.82%
	CDC	Medical Attention for Nephropathy	84.62%	0.00%	86.13%
	CDC	Blood Pressure Control (<140/90 mm Hg)	15.74%	60.34%	63.26%
	COL	Colorectal Cancer Screening	39.10%	44.77%	56.45%
	PPC	Timeliness of Prenatal Care	58.06%	93.10%	83.33%
	PPC	Postpartum Care	19.35%	48.28%	52.78%
Admin	AAB	Avoidance of Antibiotic Treatment in Adults with Acute B	34.72%		39.47%
	ADD	Initiation Phase	0.00%		0.00%
	ADD	Continuation and Maintenance (C&M) Phase	0.00%		0.00%
	AMM	Effective Acute Phase Treatment	56.45%		56.41%
	AMM	Effective Continuation Phase Treatment	40.32%		43.59%
	AMR	Total	29.41%		49.23%
	BCS	Breast Cancer Screening	66.75%		67.65%
	CHL	Total	51.72%		75.86%
	CWP	Appropriate Testing for Children with Pharyngitis	0.00%		0.00%
	FUH	30-day follow-up	0.00%		50.00%
	FUH	7-day follow-up	0.00%		50.00%
	IET	Initiation of AOD Treatment: Total	13.51%		22.89%
	IET	Engagement of AOD Treatment: Total	0.00%		1.20%
	LBP	Use of Imaging Studies for Low Back Pain	76.19%		78.57%
	MMA	Total Medication Compliance 50%	0.00%		61.22%
	MMA	Total Medication Compliance 75%	56.10%		53.06%
	PBH	Persistence of Beta-Blocker Treatment After a Heart Att	80.00%		50.00%
	PCE	Systemic corticosteroid	72.73%		80.77%
	PCE	Bronchodilator	81.82%		84.62%
	URI	Appropriate Treatment for Children With URI	0.00%		0.00%

Analysis of IHSS (Group Care) HEDIS

The above table represents the Group Care HEDIS measures, where there was comparative data between 2016 and 2017. Data from 2015 was not collected. The Alliance goal is to increase by 5% overall each year. On average, Group Care met this goal. The Alliance is cautious to apply commercial product benchmarks to Group Care because the member demographic is vastly different than other Commercial products nationwide. In 2018, further analysis of the Group Care membership is warranted to better define meaningful benchmarks. Based on the data presented, potential focus areas for Group Care in 2018 may include the following:

- Antidepressant medication management; and
- Diabetes Care- Blood Pressure Control.

X. Health Plan Accreditation

In September 2016, Alameda Alliance participated in the triennial reaccreditation survey for Health Plan Accreditation (HPA) sponsored by NCQA. NCQA HPA is a voluntary recognition program consisting of a triennial desktop review of program materials, policies and procedures and on-site file review. The standards evaluate Quality Improvement, Utilization Management, Pharmacy, Rights and Responsibilities, Credentialing, Network Management and Member Related Services. Annually, the score and award are reevaluated based on the fixed survey standards score and an annual reevaluation of audited HEDIS and CAHPS scores. NCQA grants the following decisions: Excellent (90-100 points), Commendable (80-89.99 points), Accredited (65-79.99 points), Provisional (55-64.99 points), and Denied (less than 54.99 points).

Both Medicaid and Group Care products were brought forward for evaluation in 2017. Based on increased HEDIS and CAHPS scores, Medicaid earned “Commendable” status.

Medicaid

The total points earned by Medicaid were 81.23/100 points.
Standards score earned by Medicaid were 46.23/50. Medicaid HEDIS scores were 26.6/37 points, and CAHPS scores were 8.4/13 points. In 2018, HEDIS and CAHPS scores will be submitted for annual NCQA reevaluation and added to the Standards score of 46.23.

Group Care


NCQA
Measuring quality. Improving health care.
National Committee for Quality Assurance
has awarded
Alameda Alliance for Health Joint Powers Authority
Commercial HMO
ACCREDITED
CHAIR, BOARD OF DIRECTORS
PRESIDENT
CHAIR, REVIEW OVERSIGHT COMMITTEE
October 18, 2016
DATE GRANTED
October 18, 2019
EXPIRATION DATE

In 2017, Group Care had insufficient membership to participate in an evaluation of HEDIS and CAHPS scores. Under these circumstances, the award is based on a 50 point scale and the maximum award is Accredited. Therefore, the Accredited award is based on a standards score of 46.02/50 points. If Group Care has sufficient membership in 2018, HEDIS and CAHPS will undergo review. Potentially, the award for Group Care will stay in effect until the next triennial standards survey scheduled for July 23, 2019.

XI. Quality of Service and Access to Care

A. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Alliance utilizes the CAHPS survey to assess member experience with health care services. In 2017, the Alliance contracted with SPH Analytics to field the survey using the NCQA approved CAHPS survey methodology. The Alliance's goal is to improve 2% each year for all global composite ratings for Adult and Child surveys.

The data for the CAHPS Survey was collected and analyzed by SPH Analytics using a mixed phone and mail methodology. The sample was generated in accordance with NCQA protocol for Medicaid plans and the minimum required sample size used, oversampling where necessary to improve response rates in an effort to yield a reportable number of survey responses. The required

sample size for the Medicaid and Commercial Adult surveys is 1,350, and 1,650 for the Medicaid Child survey. The Alliance chose to oversample by 25% for the Medicaid Child survey for a total of 2,063 members selected. Response rates generated only include members that met the eligible respondent criteria. The Medicaid Adult response rate was 26.1%, Medicaid Child 19.5%, and Commercial Adult 31.6%.

Medicaid Adult CAHPS Survey

The CAHPS Composite Ratings, shown below, display the overall scores for the composite areas in 2017 compared to the Alliance's 2015 scores and the 2016 national mean. SPH Analytics Book of Business (BOB) mean is also shown below. The Alliance goal is to increase by 2% each year.

CAHPS Medicaid Adult Survey Trend							
Composite	2015	2016	2017	% Variance 2016 to 2017	SPH Book of Business (Mean)	Goal	Goal Variance
Getting Needed Care	70.3%	66.3%	75.3%	9.0%	81.3%	68.3%	7.0%
Getting Care Quickly	68.0%	66.0%	70.3%	4.3%	80.6%	68.0%	2.3%
How Well Doctors Communicate	86.1%	87.9%	90.3%	2.4%	91.0%	89.9%	0.4%
Rating of Health Care	63.5%	71.5%	66.2%	-5.3%	73.7%	73.5%	-7.3%
Rating of Personal Doctor	74.8%	79.6%	74.0%	-5.6%	80.6%	81.6%	-7.6%
Rating of Specialist	76.9%	81.9%	86.1%	4.2%	81.5%	83.9%	2.2%
Rating of Health Plan	63.9%	72.0%	69.3%	-2.7%	76.2%	74.0%	-4.7%

Medicaid Child CAHPS Survey

CAHPS Medicaid Child Survey Trend							
Composite	2015	2016	2017	% Variance 2016 to 2017	SPH Book of Business (Mean)	Goal	Goal Variance
Getting Needed Care	79.0%	81.0%	81.7%	0.7%	83.9%	83.0%	-1.3%
Getting Care Quickly	80.0%	79.0%	83.6%	4.6%	88.4%	81.0%	2.6%
How Well Doctors Communicate	94.4%	90.8%	90.5%	-0.3%	93.5%	92.8%	-2.3%
Rating of Health Care	83.1%	83.1%	90.1%	7.0%	86.9%	85.1%	5.0%
Rating of Personal Doctor	87.6%	89.3%	92.9%	3.6%	89.6%	91.3%	1.6%
Rating of Specialist	86.6%	81.4%	88.7%	7.3%	86.4%	83.4%	5.3%
Rating of Health Plan	83.1%	82.3%	88.4%	6.1%	86.1%	84.3%	4.1%

The Alliance's goal is to improve 2% each year. In 2017 all composites, with the exception of "How Well Doctors Communicate" improved significantly.

Group Care Adult Survey

CAHPS Commercial Adult Survey Trend							
Composite	2015	2016	2017	% Variance 2016 to 2017	SPH Book of Business (Mean)	Goal	Goal Variance
Getting Needed Care	N/A	67.9%	65.0%	-2.9%	86.3%	69.9%	-4.9%
Getting Care Quickly	N/A	68.5%	65.5%	-3.0%	84.6%	70.5%	-5.0%
How Well Doctors Communicate	N/A	86.7%	84.6%	-2.1%	95.2%	88.7%	-4.1%
Rating of Health Care	N/A	63.3%	62.2%	-1.1%	78.2%	65.3%	-3.1%
Rating of Personal Doctor	N/A	76.6%	71.9%	-4.7%	85.1%	78.6%	-6.7%
Rating of Specialist	N/A	79.5%	70.4%	-9.1%	85.4%	81.5%	-11.1%
Rating of Health Plan	N/A	62.1%	63.4%	1.3%	68.2%	64.1%	-0.7%

Group Care respondents indicate less satisfaction with specialists than in the prior year. Further analysis is warranted in 2018.

Asian Language Augment

In 2016, Alameda Alliance for Health conducted the Group Needs Assessment (GNA) which is conducted every five years and looks at the needs of various sub groups within the Alliance's membership. Information obtained through the GNA results prompted the Alliance to field an augmented survey for its Asian threshold languages. These languages are Cantonese and Vietnamese. The goal was to capture the experience of respondents who may not otherwise get captured through the standard English/Spanish CAHPS survey. The Vietnamese and Cantonese surveys were sampled using NCQA protocol (1350 members) that selected a preferred language of Vietnamese or Cantonese. Response rates for the augmented surveys were 46% for Vietnamese and 41% for Cantonese. This percentage far exceeds the response rates for the standard Medicaid Adult, Medicaid Child, and Commercial Adult surveys.

CAHPS Medicaid Adult Language Comparison			
Composite	2017 AAH Summary Rate	Vietnamese Augment	Cantonese Augment
Getting Needed Care	75.3%	57.5%	27.0%
Getting Care Quickly	70.3%	55.6%	34.5%
How Well Doctors Communicate	90.3%	81.8%	64.8%
Rating of Health Care	66.2%	69.4%	66.4%
Rating of Personal Doctor	74.0%	77.8%	72.7%
Rating of Specialist	86.1%	74.7%	73.8%
Rating of Health Plan	69.3%	74.4%	59.8%

Results

Alliance Medicaid Adult, Vietnamese language preferred members show lower satisfaction rates than the overall population in composites Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Rating of Specialist. The Vietnamese language preferred members rated Rating of Health Care, Rating of Personal Doctor, and Rating of Health Plan higher than the overall population rating.

Alliance Medicaid Adult, Cantonese language preferred members show lower satisfaction rates than the overall population in composites Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Rating of Specialist, Rating of Personal Doctor, and Rating of Health Plan. The Cantonese language preferred members rated Rating of Health Care, higher than the overall population rating.

In 2018, Quality Management will partner with Health Education and Cultural and Linguistic services to formulate interventions based on the findings noted above.

Barriers contributing to CAHPS Results

The Quality Improvement and Member Services Departments have experienced vacancies and need to add administrative capacity to better serve the needs of Alameda Alliance members. High turnover and high vacancies for some of these positions delayed the implementation of new programs in 2017. Quality and Member Services are working collaboratively with Human Resources to recruit and retain resources in these departments.

Medicaid Grievance and Appeals

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan in an effort to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into two processes, exempt grievances and non-exempt grievances. In both instances, the details of the member's complaints are collected, processed, and reviewed and actions are taken to resolve the issue.

An **Exempt Grievance** is a complaint that is not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the close of the next business day following receipt. These complaints are exempt from the requirement to send a written acknowledgment and response.

A **Non Exempt Grievance** is a written or oral expression of dissatisfaction regarding the Plan and/or provider, including quality of care concerns, and may include a complaint, dispute, or a request for reconsideration or appeal made by a Member or the Member's authorized representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it will be considered a grievance.

Exempt Grievances are tracked within our HealthSuite system, whereas Non Exempt Grievances are processed and tracked in our Grievance and Appeals Application. Below are the Alliance combined findings from the examination of both exempt and non-exempt grievance issues reported by Alliance members or their representatives concerning both Medicaid Adult and Medicaid Child members and the Complaint Volume Report below.

Issues and Recommendations

Appeals

- During 2017, the Alliance identified that the overturn rate of prior authorization appeals filed against our radiology vendor eviCore was well above our benchmark of 45.0%. The annual overturn rate was 75.9% for eviCore, this initiated a review of the original decision making process of prior authorization by our vendor. The Utilization Management Department have been conducting monthly audits of prior authorization files and have been meeting with eviCore monthly to discuss audit findings and other issues identified with their current UM process.

Grievances:

- The Alliance initiated an update to our exempt grievance process during the year. We identified that in addition to not reporting exempt grievances to Committee for review we were grossly under reporting exempt grievances in general. Exempt grievances are now being reporting with standard grievance up to our internal sub-committees and our Health Care Quality Committee for tracking and trending purposes beginning in the third quarter of 2017. There has also been a significant increase of grievances throughout the quarters which can be attributed to staff training in addition to updated workflows with Member Services with regards to capturing all expressions of dissatisfaction. The Alliance will continue to conduct training on a regular basis.
- The Alliance identified through exempt grievance data an issue with regards to accessibility at our Alameda Heath System's clinics. The exempt grievances were captured under PCP changes; members who were initially auto assigned to an AHS clinic were calling to change their PCP because they were not able to secure an appointment in a timely manner. We have notified AHS of this issue and are currently working with them on a solution.
- The Alliance processed 84 grievances with regards to Kaiser's enrollment process during the year. Grievances were filed against Kaiser in response to the denial of the members request to be enrolled in the Kaiser Network; members were not informed that they are not automatically enrolled when they select Kaiser on their Medi-Cal Choice Form. The Alliance's Call Center Outbound Unit proactively conducts weekly calls to the members who selected Kaiser on their form to educate the member that they will still need to meet criteria for Kaiser assignment prior

to being enrolled. This effort has decreased our number of grievances for this issue throughout the quarters of 2017.

An analysis of 2017 Grievance and Appeal data is attached in Addendum 1.

B. Access to Care

The Alliance QI Department and Health Education Manager conduct an annual assessment of the Alliance's membership cultural and linguistic makeup as well as the provider network with respect to member accessibility. The assessment is meant to enhance the Alliance's ability to provide access to high quality healthcare to our members and focuses on the following areas:

- Cultural and Linguistic needs of members;
- PCP availability;
- Specialty Care Practitioner availability;
- Appointment access to providers; and
- Member Services access.

I. Cultural and Linguistic Needs of Members

The Alliance strives to ensure members have access to a PCP who can speak their language or to appropriate interpreters. For members who have not chosen a PCP upon enrollment, the Alliance will assign a member to a PCP based on characteristics, including language. In 2017, the Alliance identified the following threshold languages.

Plan	Threshold Languages		
Medi-Cal 259,235	English	157,238	61%
	Spanish	50,404	19%
	Chinese	25,016	10%
	Vietnamese	8,572	3%
Group Care 5,744	English	3,499	61%
	Chinese	1,199	21%
	Spanish	287	5%

Member Ethnicity by product

MEDI-CAL	Prior Year	YTD		% Change		Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2017	Jan - Jan 2018		% YTD Membership in Jan - Jan 2018 (minus) % of Membership in Jan - Dec 2017		Jan 2018	Jan 2018 %
Hispanic	28.87%	28.83%		-0.04%		74,734	28.83%
Black	19.59%	19.42%		-0.17%		50,355	19.42%
Other Asian / Pacific Islander	12.39%	12.22%		-0.17%		31,677	12.22%
Other	11.49%	11.85%		0.36%		30,730	11.85%

White	11.30%	10.99%		-0.31%	28,495	10.99%
Chinese	10.77%	10.95%		0.18%	28,398	10.95%
Vietnamese	4.29%	4.34%		0.05%	11,242	4.34%
Unknown	1.00%	1.11%		0.11%	2,872	1.11%
American Indian Or Alaskan Native	0.29%	0.28%		-0.01%	732	0.28%
Total Members					**259,235**	

Medi-Cal Ethnicity Discussion: Slight changes in ethnicities as a percent of the Medi-Cal membership. White continues to decline while Other continues to increase.

GROUP CARE	**Prior Year**	**YTD**		**% Change**		**Current Month**	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	**Jan - Dec 2017**	**Jan - Jan 2018**		**% YTD Membership in Jan - Jan 2018 (minus) % of Membership in Jan - Dec 2017**		**Jan 2018**	**Jan 2018 %**
Unknown	45.36%	43.23%		-2.13%		2,483	43.23%
Other Asian / Pacific Islander	22.95%	24.60%		1.65%		1,413	24.60%
Black	10.39%	10.58%		0.19%		608	10.58%
Chinese	9.67%	9.85%		0.18%		566	9.85%
Other	4.18%	4.25%		0.06%		244	4.25%
Hispanic	2.92%	2.99%		0.07%		172	2.99%
Vietnamese	2.55%	2.58%		0.03%		148	2.58%
White	1.85%	1.81%		-0.04%		104	1.81%
American Indian Or Alaskan Native	0.12%	0.10%		-0.01%		6	0.10%
Total Members						**5,744**	

Group Care Ethnicity Discussion:

- The percent of Group Care members with unknown ethnicity continues to decline, although still higher than desired..
- The largest group who identified their ethnicity was the Other Asian/Pacific Islander, at almost one-fourth of the Group Care membership, of which 21% are of Asian Indian ethnicity.

Member and Provider Languages Spoken

MEDI-CAL	**Prior Year**	**YTD**		**% Change**		**Current Month**	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	**Jan - Dec 2017**	**Jan - Jan 2018**		**% YTD Membership in Jan - Jan 2018 (minus) % of Membership in Jan - Dec 2017**		**Jan 2018**	**Jan 2018 %**
English	61.26%	60.65%		-0.61%		157,238	60.65%
Spanish	19.26%	19.44%		0.19%		50,404	19.44%
Chinese	9.46%	9.65%		0.19%		25,016	9.65%

Unknown	4.39%	4.49%		0.10%	11,644	4.49%
Vietnamese	3.24%	3.31%		0.07%	8,572	3.31%
Other Non-English	1.73%	1.77%		0.04%	4,599	1.77%
Farsi	0.67%	0.68%		0.01%	1,762	0.68%
Total Members					**259,235**	

Medi-Cal Language Discussion: This month we continue to see a continued slight rise in Spanish and Chinese speakers and drop in English speakers.

GROUP CARE	**Prior Year**	**YTD**		**% Change**		**Current Month**	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	**Jan - Dec 2017**	**Jan - Jan 2018**		**% YTD Membership in Jan - Jan 2018 (minus) % of Membership in Jan - Dec 2017**		**Jan 2018**	**Jan 2018 %**
English	61.26%	60.92%		-0.34%		3,499	60.92%
Chinese	20.47%	20.87%		0.40%		1,199	20.87%
Unknown	5.37%	5.22%		-0.15%		300	5.22%
Spanish	4.87%	5.00%		0.13%		287	5.00%
Vietnamese	3.38%	3.38%		0.00%		194	3.38%
Other Non-English	2.75%	2.82%		0.07%		162	2.82%
Farsi	1.90%	1.79%		-0.11%		103	1.79%
Total Members						**5,744**	

Practitioner Language Capacity

During 2017, the Alliance's Provider Relations staff conducted in-person surveys during provider office visits to verify languages spoken by providers. The chart below is a comparison of identified languages spoken by the plan's members to its provider network at the end of Quarter 4 2017. Please note, multi-lingual providers are counted for each language spoken by the individual.

Provider & Member Language Spoken Comparison (Q4 2017)							
				Change from Q3 – Q4 2017			
Language	**PCPs**	**Members**	**Ratio PCPs: Members Q4 2017**	**# PCPs**	**% PCPs**	**# Members**	**% Members**

English	501	135,124	1:269	9	2%	-881	-1%
Spanish	113	45,571	1:403	-4	-3%	-264	-1%
Chinese	47	23,701	1:504	-1	-2%	-122	-1%
Vietnamese	16	8,289	1:518	0	0%	7	0%
Other Non-English	133	2,212	1:16	-1	-1%	-7	-0%
Arabic	2	2,069	1:1,034	0	0%	23	1%
Farsi	6	1,656	1:276	0	0%	15	1%
Total	**825**	**229,440**					

After reviewing the Plan's provider network at the end of 2017, the following results were identified:

- Ratio of Providers speaking a non-English language to number of members preferring the language range from 1:269 for English to 1:1,034 for Arabic.
    - 269 English-speaking members per English-speaking PCP
    - 504 Chinese-speaking members per Chinese-speaking PCP
    - 403 Spanish-speaking members per Spanish-speaking PCP
    - 518 Vietnamese-speaking members per Vietnamese-speaking PCP
    - 1034 Arabic-speaking members per Arabic-speaking PCP
    - 276 Farsi-speaking members per Farsi-Speaking PCP

In 2017, the Alliance began to track its Arabic and Farsi speaking members as well. The Alliance identified a substantially lower ratio of Arabic-speaking providers to members than for other languages.

The Alliance also identified and reviewed significant changes and trends related to provider language capacity. In 2017 the Plan experienced overall improvement in the ratios of members per provider for all threshold languages (English, Chinese, Spanish and Vietnamese) except for Chinese where the ratio lowered, but not to a level of concern.

Threshold Language Change in Provider to Member Ratio Q4 2016 to Q4 2017

Language	Ratio 4th Quarter 2016	Ratio 4th Quarter 2017
English	1:280	1:269
Chinese	1:432	1:504
Spanish	1:546	1:403
Vietnamese	1:630	1:518

To address the less favorable ratio of Arabic speaking members to provider, the Alliance has done the following:

1. Evaluated data regarding where our Arabic-speaking members live to better understand where in the county it would be preferable to contract with Arabic speaking providers.
2. Informed Alliance Provider Contracting that adding one or two Arabic-speaking providers would benefit this population.

In addition, the Alliance continues to monitor provider language capacity levels and trends quarterly though the following:

1. Review of provider and member spoken language capacity comparison
2. Review of grievance cases related to provider language capacity
3. Review standard grievances related to provider language capacity
4. Monitoring of interpreter services provided

In the absence of a practitioner who speaks a member's preferred language, the Alliance ensures the provision of interpreter services at the time of appointment. In order to meet the language demand increase in 2017, the Alliance contracted with a second interpreter vendor. In 2017, the Alliance scheduled over 18,000 requests for interpreter services at the time of appointment. This represents over 99.5% fulfillment with prescheduled interpreter requests.

Provider Capacity

The Alliance reviews network capacity reports monthly to determine whether primary care providers are reaching network capacity standards of 1:2000. In 2017, no providers exceeded the 2,000 member threshold. The Network Validation department flags the provider at 1900 and above to ensure member assignment does not reach the 2,000 capacity standard. If a provider is close to the threshold, the plan reaches out to confirm if the provider intends to recruit other providers. If not, the panel is closed to new assignment. During this time the plan and the provider are in communication of such changes.

Geo Access

The geographic access reports are reviewed quarterly to ensure that the plan is meeting the geographic access standards for provided services in Alameda County. In 2017, the rural areas near Livermore and the southern border of Alameda were the only areas in which the plan is facing geographic access issues for certain specialties. These areas are in need of access to a hospital which will enable them to meet the geographic access standards for both lines of business (IHSS and Medi-Cal). The plan's IHSS members often time live outside the plan's service area even though they are workers/caregivers for persons living inside of Alameda County. When reviewing the geographic access maps and data, it is evident the issue stems from the fact the member's residence address is used to map the distance from the provider versus the member's work address which would be in Alameda County. In the past due to the lack of hospitals located in the rural area, plan submitted an alternative access standard proposal to the Department of Managed Health Care which has been approved for a distance of 25 miles for both Medi-Cal and IHSS networks.

The Alliance is very close to finalizing a physician and hospital contract agreement with a local and major health system that will provide geographic access for those members residing in the Livermore and Pleasanton areas. The target completion plan is during the 2nd quarter of 2018.

Provider Appointment Availability

The Alliance annual Provider Appointment Availability Survey for MY2017 was used to review appointment wait times for the following provider types:

- Primary Care Physicians
- Specialists:
    - Allergists
    - Cardiologists
    - Endocrinologists
    - Gastroenterologists
    - Psychiatrists
    - Child & Adolescent Psychiatrists
- Non-Physician Mental Health Providers (PhD-level and Masters-level)
- Ancillary Providers offering Mammogram, MRI and/or Physical Therapy appointments

The Alliance reviewed the results of its annual Provider Appointment Availability Survey for MY2017 in order to identify areas of deficiency and areas of potential improvement. The Alliance defines *deficiency* as a provider group scoring less than seventy-five percent (75%) for the compliance rate on any of the survey questions related to appointment wait times.

Review of Survey Results

The Alliance focused its review on the provider groups, including Alameda Health System (AHS), Children First Medical Group (CFMG), Community Health Center Network (CHCN), and its individually contracted network as a whole. The Alliance categorizes these groups as high volume; these four groups account for more than seventy-five percent (75%) of the Alliance's surveyed providers and more than eighty-percent (80%) of the membership are assigned to providers belonging to the previously mentioned groups. For the review of specific specialty-types, the Alliance reviewed groups that held the largest amounts of the network for each particular specialty type surveyed. The Alliance analyzed results for Alameda County, as the vast majority of members live and receive care in Alameda County, the Alliance's service area.

Primary Care Physicians (PCP):

Below are the compliance rates for the Alliance's largest provider groups surveyed for PCP appointment availability:

MY 2017 Rate of Compliance for PCPs

Provider Group	Urgent Appt. w/o PA (48 Hour Standard) 2017 Compliance Rate	Routine Appt. (10 Business Day Standard) 2017 Compliance Rate
AHS	Medi-Cal: 100% Commercial: 100%	Medi-Cal: 100% Commercial: 100%
Asian Health Services	Medi-Cal: 100% Commercial: 100%	Medi-Cal: 100% Commercial: 100%

CFMG	Medi-Cal:98% Commercial: N/A	Medi-Cal: 90% Commercial: N/A
La Clinica De La Raza, Inc.	Medi-Cal: 100% Commercial: 100%	Medi-Cal: % 100% Commercial: % 100%
Lifelong Medical Care	Medi-Cal: 100% Commercial: 100%	Medi-Cal: 100% Commercial: 100%
Individually Contracted Provider	Medi-Cal: 84% Commercial: 90%	Medi-Cal: 87% Commercial: 90%

CFMG held the majority of PCPs within the network and had both urgent and routine appointments available over 90% of the time. AHS is the second largest supplier of PCP and had no deficiencies in both lines of business. The Alliance's Individually Contracted Providers are the third largest group of PCPs. ICP were able to provide urgent and routine appointments for Medi-Cal members more than 80% of the time with commercial members faring a bit better at 90%. Asian Health Services, La Clinica De La Raza and Lifelong Medical Care have a moderate amount of PCPs and showed no deficiencies in appointment availability in both lines of business.

Comparison of Compliance Rate for MY 2016 and MY 2017 for PCPs

Provider	Urgent Appt. w/o PA (48 Hour Standard) 2016 Compliance Rate	Urgent Appt. w/o PA (48 Hour Standard) 2017 Compliance Rate	Routine Appt. (10 Business Day Standard) 2016 Compliance Rate	Routine Appt. (10 Business Day Standard) 2017 Compliance Rate
AHS	Medi-Cal:0% Commercial: 0%	Medi-Cal: 100% Commercial: 100%	Medi-Cal: 0% Commercial: 0%	Medi-Cal: 100% Commercial: 100%
Individually Contracted Provider	Medi-Cal: 63% Commercial: 64%	Medi-Cal:84% Commercial: 90%	Medi-Cal: 75% Commercial: 74%	Medi-Cal: 87% Commercial: 90%

AHS and Individually Contracted Providers experienced a significant improvement in compliance with timely access requirements. In MY 2016, AHS had a compliance rate of 0% for urgent and routine appointments for both lines of business. This year, AHS increased their rate by 100%. Individually Contracted Providers improved compliance for urgent appointments over 20% and routine appointments over 10% for both lines of business. Thus, Individually Contracted Providers reached the compliance threshold set by the Alliance.

Provider Satisfaction Survey Overview

Alameda Alliance for Health (AAH) contracted with SPH Analytics to conduct two Provider Satisfaction Surveys for measurement year 2017.

In March 2017, AAH provided SPH with a database of 9,201 Primary Care Physicians, Specialists and Behavioral Health Care Practitioners. The database was cleaned by removing any records with duplicate NPIs. From the database of unique providers, a sample of 815 records was drawn based on specialty. A total of 241 surveys were completed (91 mail, 29 internet and 121 phone), yielding a response rate of 15.3% for the mail/internet component and 28.9% for the phone data component.

In December 2017, AAH provided SPH with a database of 5,102 Primary Care Physicians, Specialists and Behavioral Health Care Practitioners. The database was cleaned by removing any records with duplicate NPIs. From the database of unique providers, a sample of 815 records was

drawn based on specialty. A total of 253 surveys were completed (186 mail and 67 phone), yielding a response rate of 24.3% for the mail component and 11.6% for the phone data component.

Provider Satisfaction Survey Results

Below is an overview of the survey results broken down by provider satisfaction composites (i.e. Finance Issues, UM/QM, Network/Coordination of Care, Pharmacy, Health Plan Call Center Staff, Provider Relations, and Overall Satisfaction) and access to care and interpreter services measures.

Composite Scores

Area of Questioning	Measurement Year 2017 (December) Result	Measurement Year 2017 (May) Result	Measurement Year 2015 Result	Increase / Decrease
Overall Satisfaction	79.1%	74.2%	58.8%	increase
Finance Issues	47.2%	35.6%	26.3%	Significant increase
Utilization and Quality Management	46.6%	39.7%	33.2%	increase
Network/ Coordination of Care	35.6%	32.8%	34.1%	increase
Pharmacy	34.2%	26.7%	19.4%	increase
Health Plan Call center Service Staff	55.4%	47.7%	37.5%	increase
Provider relations	54.8%	54.8%	42.0%	No significant change

Although not statistically significant in all instances, AAH realized an increase for all but one of the composite scores. The composite score for financial issues demonstrated a statistically significant increase in providers' satisfaction with consistency of reimbursement fees, accuracy and timeliness of claims processing and resolutions of claims payment problems.

Quality Program Barriers

The Alliance has identified the challenges and barriers to improvement throughout the 2017 QI Evaluation. Recommended activities and interventions for the upcoming year consider these challenges and barriers in working towards success and achievement of the Alliance's goals in 2018.

Some of the challenges encountered throughout 2016 included, but are not limited to:

- Significant vacancies in the QI Department and employee turnover throughout the organization.
- Changes in the Grievance and Appeals system.
- Significant reliance on HEDIS for outcome measurement and performance improvement activities. Annual data collection impedes rapid and strategic PDSA cycles.
- The Alliance's members are transient and do not always contact the Alliance to inform the plan of address or phone number changes.
- Mixed results in member experience as measured through CAHPS and grievances.

Successes

Some successful outcomes for 2017 include:

- Robust Health Education and Cultural and Linguistic Programs.
- Improved HEDIS performance for some measures.
- Enhanced focus on provider education, including more frequent visits and regular meetings with network and delegated providers that resulted in increased provider satisfaction.
- Continued focus on health promotion and education that resulted in some of the higher CAHPS scores.
- Cost effective approach to quality and safety by utilizing community resources such as:
    - Early Start Program that serves infants and toddlers who have significant developmental delays.
    - California WIC Program that helps pregnant, breastfeeding or postpartum women and children.
    - Partnering with the Breastfeeding Coalition and Black Infant Health
- Improved Member Services processes and hiring new staff, resulting in improved telephone response times.
- Comprehensive monitoring of all practitioners during credentialing/recredentialing to ensure high quality network.

Addendum 1

Grievance and Appeals Report	
To:	Health Care Quality Committee
Date:	April 12, 2018
From:	Jennifer Karmelich – Director, Complaints and Resolutions
Reporting Period:	Resolved 2017

Purpose:

To track and trend all grievance and appeals resolved during the reporting period in order to identify opportunities for quality improvement.

Standards/Benchmark:

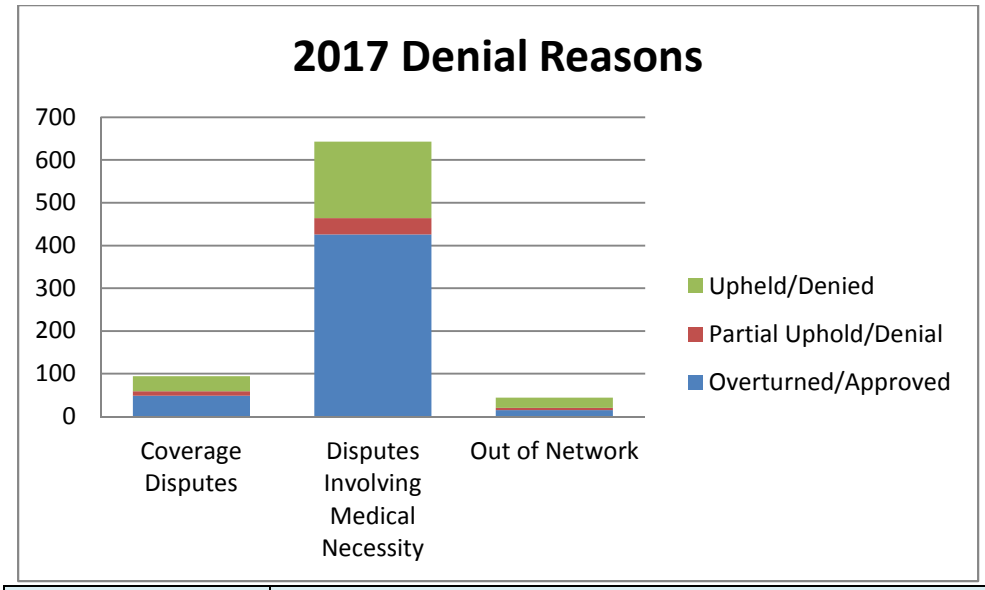
AAH G&A	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,218	30 Calendar Days	95% compliance within standard	1,216	100%	
Expedited Grievance	76	3 Calendar Days	95% compliance within standard	76	100%	
Exempt Grievance	575	Next Business Day	95% compliance within standard	575	100%	
Standard Appeal	645	30 Calendar Days	95% compliance within standard	645	100%	
Expedited Appeal	136	3 Calendar Days	95% compliance within standard	136	100%	
2017 Annual Total Cases:**	2,650		95% compliance within standard	2,648	100%	0.82

*Goal is to have less than 1 complaint per 1,000 members, (calculation: the sum of all grievances for the quarter divided by the sum of all enrollment for the quarter multiplied by 1000.)

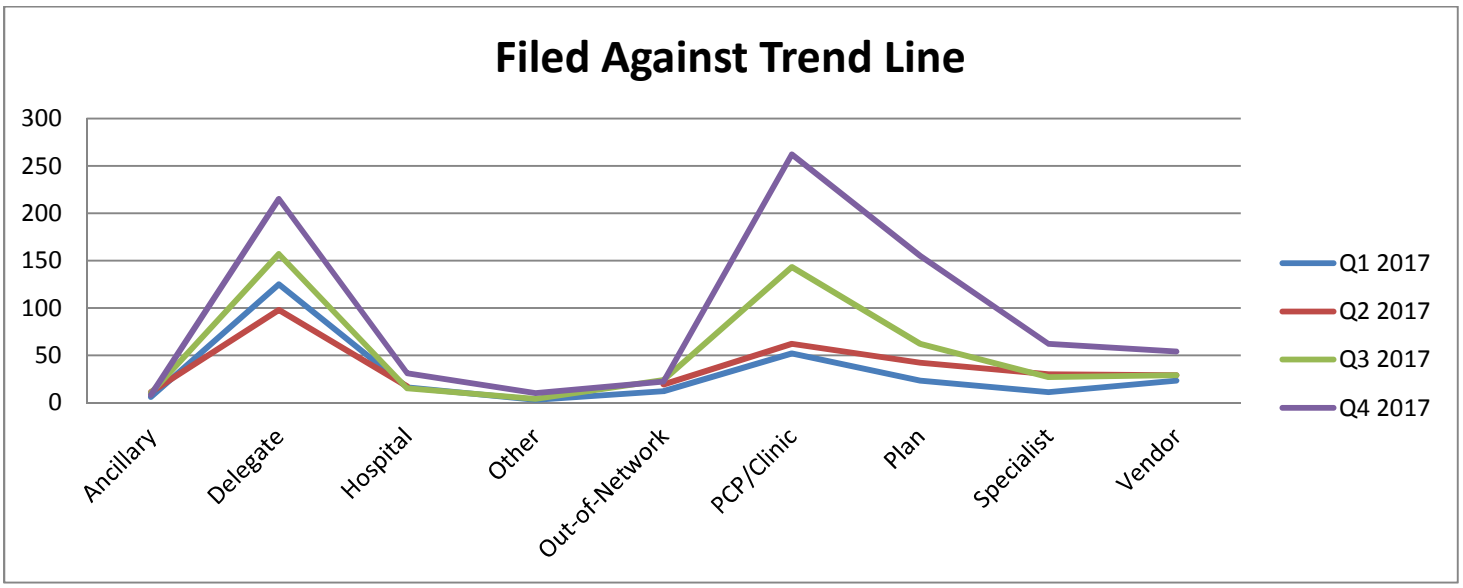
**Exempt grievances were not counted for until Q3 2017

Data/Analysis:

Prior Authorization Appeals	Filed Against:					Overturned %:
	Beacon	CFMG	CHCN	EviCore	Plan	
Inpatient Appeal					31	**51.6%**
Outpatient Appeal	1		38	284	104	**66.0%**
Pharmacy Appeal					299	**58.9%**
Retro Appeal			1	11	12	**66.7%**
Grand Total:	**1**	**0**	**39**	**295**	**446**	**781**
Overturned %:	**0.0%**	**0.0%**	**38.5%**	**75.9%**	**56.3%**	**62.7%**

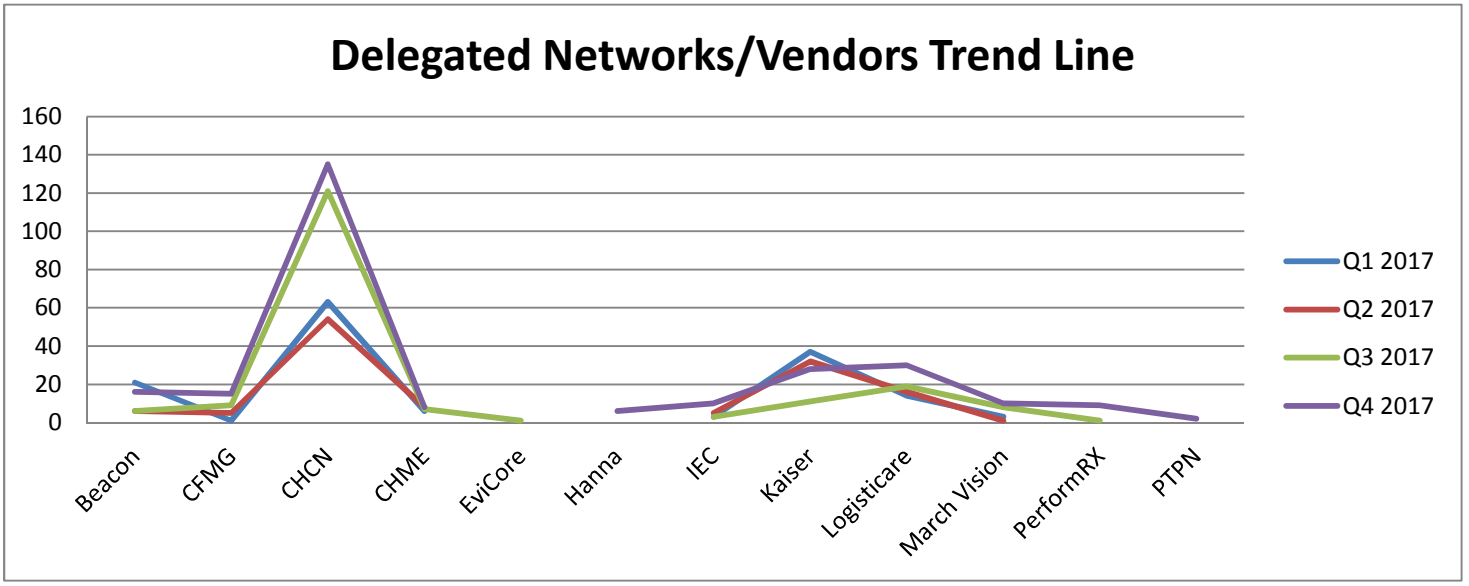


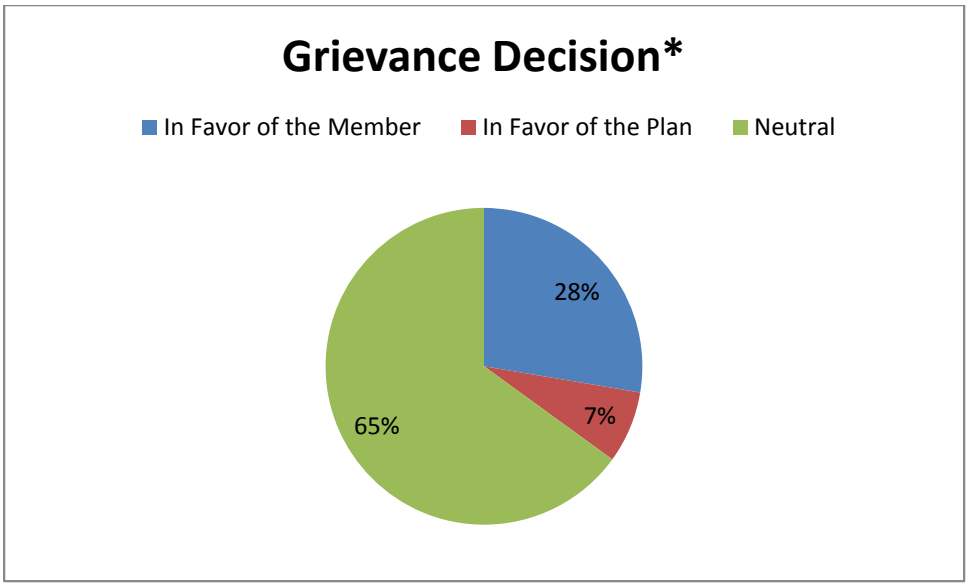
Filed Against:	Grievance Type					Grand Total
	Accessibility	Benefits/Coverage	Other	Quality of Care/Service	Referral	
Ancillary	2	6	1	22	4	35
Delegate	127	51	118	238	61	595
Hospital	8	25	5	34	7	79
Other	1	3	8	4	1	17
Out-of-Network	3	57	1	12	4	77
PCP/Clinic	197	9	20	247	46	519
Plan	33	89	69	63	28	282
Specialist	29	7	8	77	9	130
Vendor	67	6	4	50	8	135
Grand Total	467	253	234	747	168	1,869



Grievances filed against our Delegated Networks/Vendors:

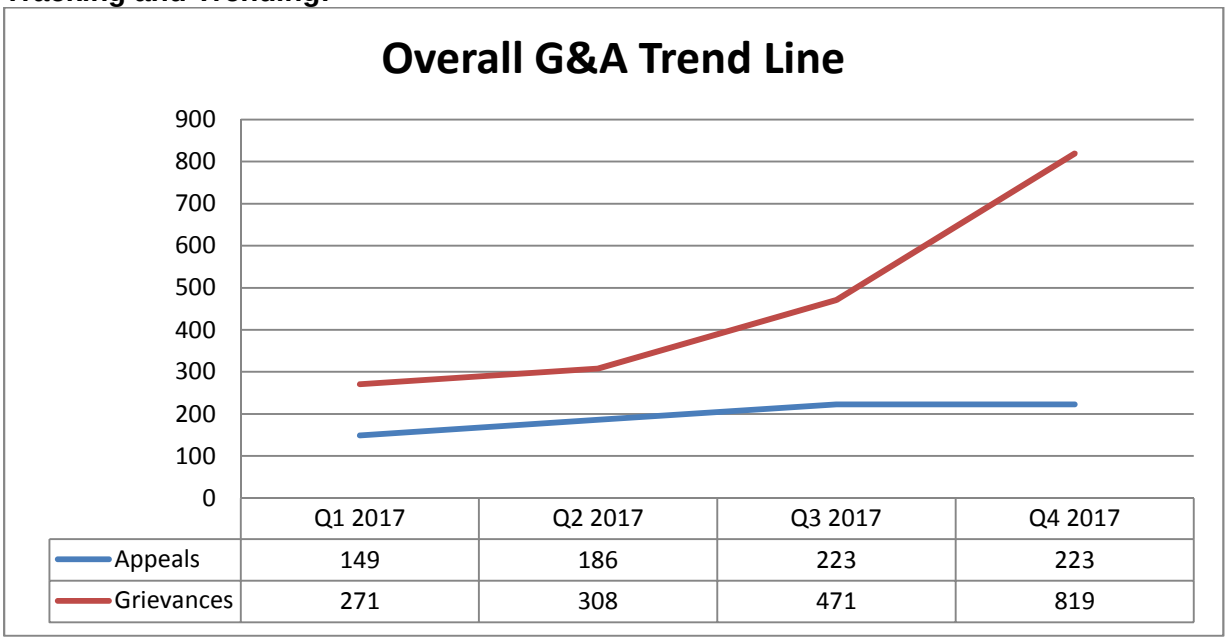
Filed Against:	Grievance Type					Grand Total
	Accessibility	Benefits/Coverage	Other	Quality of Care/Service	Referral	
Beacon	19	3	8	15	4	49
CFMG	8	4	2	14	2	30
CHCN	96	16	24	182	53	371
CHME	7	2	2	11	6	28
eviCore		1				1
Hanna	5			1		6
IEC	13			8		21
Kaiser	2	9	84	12	1	108
Logisticare	41	4	2	30	2	79
March Vision		15		9	1	25
PerformRX	1	3		5	1	10
PTPN	1			1		2
Grand Total	**193**	**57**	**122**	**288**	**70**	**730**





*Neutral decisions are decided when it is a he/she said complaint and the complaint cannot be substantiated either way.

Tracking and Trending:



	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Appeals	149	186	223	223
Grievances	271	308	471	819

Issues/Recommendations:

Appeals

- During 2017, the Alliance identified that the overturn rate of prior authorization appeals filed against our radiology vendor eviCore was well above our benchmark of 45.0%. The annual overturn rate was 75.9% for eviCore, this initiated a review of the original decision making process of prior authorization by our vendor. The Utilization Management Department have been conducting monthly audits of prior authorization files and have been meeting with eviCore monthly to discuss audit findings and other issues identified with their current UM process.

Grievances:

- The Alliance initiated an update to our exempt grievance process during the year. We identified that in addition to not reporting exempt grievances to Committee for review we were grossly

under reporting exempt grievances in general. Exempt grievances are now being reporting with standard grievance up to our internal sub-committees and our Health Care Quality Committee for tracking and trending purposes beginning in the third quarter of 2017. There has also been a significant increase of grievances throughout the quarters which can be attributed to staff training in addition to updated workflows with Member Services with regards to capturing all expressions of dissatisfaction. The Alliance will continue to conduct training on a regular basis.

- The Alliance identified through exempt grievance data an issue with regards to accessibility at our Alameda Heath System's clinics. The exempt grievances were captured under PCP changes; members who were initially auto assigned to an AHS clinic were calling to change their PCP because they were not able to secure an appointment in a timely manner. We have notified AHS of this issue and are currently working with them on a solution.
- The Alliance processed 84 grievances with regards to Kaiser's enrollment process during the year. Grievances were filed against Kaiser in response to the denial of the members request to be enrolled in the Kaiser Network; members were not informed that they are not automatically enrolled when they select Kaiser on their Medi-Cal Choice Form. The Alliance's Call Center Outbound Unit proactively conducts weekly calls to the members who selected Kaiser on their form to educate the member that they will still need to meet criteria for Kaiser assignment prior to being enrolled. This effort has decreased our number of grievances for this issue throughout the quarters of 2017.

Action Items:

Action Item:	Responsible Party:	Completed:
Continue to audit eviCore Prior Authorization files and meet with them on a routine basis to discuss areas of improvement	Utilization Management	
Continue to conduct training on how to identify a grievance on a routine basis	Member Services	
Meet with Alameda Health System to discuss grievances with regards to access issues	Grievance and Appeals, Member Services and Operations	
Continue to conduct outbound calls to members who request assignment to Kaiser to educate on our Kaiser enrollment process	Member Services	