

Performance Evaluation Report  
Partnership HealthPlan of California  
July 1, 2008–June 30, 2009

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

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# Performance Evaluation Report – Partnership HealthPlan of California

## July 1, 2008 – June 30, 2009

### 1. EXECUTIVE SUMMARY

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#### Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.6 million beneficiaries (as of June 2009) in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Plan-specific reports are issued in tandem with the technical report. The plan-specific reports include findings for each plan regarding its organizational assessment and structure, performance measures, and QIPs as they relate to the quality, access, and timeliness domains. This report is unique to the MCMC Program's contracted plan, Partnership HealthPlan of California ("Partnership" or "the plan"), for the review period July 1, 2008, to June 30, 2009. Actions taken by the plan subsequent to June 30, 2009, regarding findings identified within this report will be included in the next annual plan-specific evaluation report.

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

### Quality

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

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

To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPLs indicate low performance, rates at or above the HPLs indicate high performance, and rates at the MPLs or between the MPLs and HPLs demonstrate average performance.

HSAG found that Partnership demonstrated average performance for the quality domain of care. This was based on the plan's 2009 performance measure rates (which reflected 2008 measurement data), QIP outcomes, and compliance review standards related to measurement and improvement.

Most of Partnership's performance measure rates fell between the established MPLs and HPLs. The *Comprehensive Diabetes Care—LDL-C Control (CDC-LC)* measure was above the HPL. No performance measure rates were below the MPLs. Partnership had three measures that were within three percentage points of achieving the HPLs: *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC-Pre)*, *Prenatal and Postpartum Care—Postpartum Care (PPC-Pst)*, and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*.

Partnership has opportunities to further improve the quality of care delivered to MCMC members. The plan had four measures with statistically significant declines between 2008 and 2009. Three of the measures with rates that decreased related to diabetes care and one related to well-child visits in the first 15 months of life.

The plan had partial success with its asthma QIP, showing sustained improvement for two study indicators—the percentage of members with asthma controller medications increased, and access to a specialist following an emergency room visit for an asthma episode also increased. Three additional study indicators did not achieve improvement.

The baseline rate for one of the QIP indicators was 99.1 percent, which left little to no room for actionable improvement. For future QIPs, the plan should determine areas of low and actionable performance that need improvement. For the other two indicators the plan has an opportunity to determine factors that resulted in declined performance. While the interventions were extensive, the plan did not provide rationale to support the addition, modification, or elimination of interventions. In addition, the plan needs to provide a clear description of the specific barriers targeted by the interventions. This will ensure alignment between the barrier and intervention, which can increase the likelihood of success. HSAG also noted that the plan has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs.

For State-specified standards related to quality management and assessed through a joint audit and the Member Rights/Program Integrity Unit (MRPIU) review, Partnership demonstrated that its quality improvement program monitored all aspects of quality care, identified opportunities for improvement, and implemented targeted actions. The plan demonstrated adequate resources dedicated to support its quality management program.

## Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess plans' compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Many performance measures fall under more than one domain. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Partnership demonstrated average performance for the access domain of care based on its 2009 performance measure rates related to access, QIP outcomes that addressed access, and compliance review standards related to the availability of and access to care. All 2009 performance measures related to access fell between the MPLs and HPLs. The plan showed strength in providing prenatal and postpartum care, as evidenced by rates that were within three percentage points of achieving the HPLs. These measures span the quality, access, and timeliness domains of care. Partnership should determine if there are any access-related issues that may have contributed to

the statistically significant decline for its *Comprehensive Diabetes Care—HbA1c Testing (CDC-HT)* measure.

The plan demonstrated statistically significant and sustained improvement for increasing the percentage of members who had an emergency department visit for asthma and a follow-up visit with a primary care provider or asthma/allergy specialist within 21 days. The plan increased its baseline rate of 19.9 percent to 38.3 percent, which demonstrated improved access and coordination of care for members.

Audit findings showed that the plan was fully compliant in the areas of cultural and linguistic services. The plan demonstrated adequate processes to monitor access and availability of care.

### **Timeliness**

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

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

Based on 2009 performance measure rates for providing timely care and compliance review standards related to timeliness, Partnership demonstrated average performance in the timeliness domain of care. The plan performed within the MCMC-established thresholds for all DHCS-required performance measures in the timeliness domain of care.

The MRPIU review noted findings related to member grievances and prior authorization notifications. A review of grievance files found that a delegated entity did not meet the time frame for sending an acknowledgement letter and another exceeded the resolution time frame. In some instances, prior authorization notifications also exceeded the time frame. Additionally, one file lacked a citation that supported the action taken by the plan, and some files did not contain documentation that a qualified physician reviewed the files.

The joint audit review revealed two areas of outstanding deficiency at the time of the *Medical Audit Close Out Report*. The plan did not have sufficient oversight of entities delegated for grievances.

Additionally, the review found that the plan's policy for claims processing was not compliant with DHCS requirements.

### **Conclusions and Recommendations**

Overall, Partnership demonstrated average performance in providing quality, accessible, and timely health care services to its MCMC members. Performance measure rates for 2009 were primarily between the established MPLs and HPLs. The plan exceeded the HPL for *Comprehensive Diabetes Care—LDL-C Control (CDC-LC)*. The plan also demonstrated strength with its prenatal and postpartum care.

The plan's asthma QIP demonstrated success with two indicators—increasing members receiving controller medications and increasing follow-up after an asthma-related ER visit. The plan had a decline in performance for the additional indicators for specific medications and asthma-related inpatient admissions.

Partnership demonstrated full compliance with DHCS standards for cultural and linguistic services. Opportunities for improvement exist for member grievances, prior authorization notifications, and claims payment policies.

Based on the overall assessment of Partnership in the areas of quality and timeliness of and access to care, HSAG recommends the following:

- ◆ Focus efforts to determine the factors that contributed to the statistically significant decreases for the three diabetes measures and the one well-child visits measure to prevent further decline.
- ◆ Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.
- ◆ Retire the asthma QIP as a formal project since it has progressed through multiple periods of remeasurement, and focus the next project on an area of low and actionable performance in need of improvement.
- ◆ Revise claims payment policies and procedures to comply with State-specified requirements for claims submitted up to 12 months after the date of service.
- ◆ Continue to monitor the performance of delegated entities related to member grievances and prior-authorization notifications to ensure compliance with the DHCS and federal requirements.

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



## Plan Overview

Partnership HealthPlan of California (Partnership) is a full-scope Medi-Cal managed care plan operating in Napa, Solano, and Yolo counties. Partnership delivers care to members as a County Organized Health System (COHS). Partnership began contracting with the MCMC Program in Napa County in March 1998, in Solano County in May 1994 and in Yolo County in March 2001. As of June 30, 2009, Partnership had 96,929 enrolled members under the MCMC Program for all of its contracted counties combined.<sup>1</sup>

In a COHS model, the DHCS contracts with a county-organized and county-operated plan to provide managed care services to all Medi-Cal beneficiaries in the county, except for those in a few select aid codes. These mandatory members do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the DHCS. Beneficiaries enrolled in the COHS plan can choose from a wide range of managed care providers in the plan's network.

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<sup>1</sup> *Medi-Cal Managed Care Enrollment Report, June 2009*. Available at:  
<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>



## Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process to assess plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

## Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about Partnership's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards primarily fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

## Joint Audit Review

The DHCS's Audits and Investigations Division (A&I) works in conjunction with the California Department of Managed Health Care to conduct routine medical surveys (joint audits) of MCMC plans. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A joint audit is conducted for each MCMC plan approximately once every three years. In addition, the A&I periodically conducts non-joint medical audits of five MCMC plans; however, Partnership was not among those plans designated for a non-joint medical audit.

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. A joint audit of Partnership was conducted in October and November 2007, covering the review period of October 1, 2006, through September 30, 2007. The scope of the audit covered the areas of utilization management (UM), continuity of care, availability and accessibility, member rights, quality management, and administrative and

organizational capacity. Results from the audit showed strengths as well as opportunities for improvement.

For the UM category of review, Partnership demonstrated that it developed and implemented a UM program, which included criteria for determining medical necessity. The plan also reviewed data to monitor for under- and overutilization of services. Findings under this area of review showed that Partnership allowed non-physician staff to authorize denials for treatment authorization requests (TARs) based on administrative criteria, which was not consistent with contract requirements. Additionally, the plan was not compliant with timely notification requirements to members for deferred and denied TARs or with the content and format requirements. The final audit report noted that Partnership had successfully resolved both of these findings with corrective action plans.

Standards reviewed related to continuity of care found that the plan had the necessary policies and procedures in place to coordinate care for its members. Partnership demonstrated the use of member and provider complaints and grievances, appeal and transfer data analysis, and member and provider survey responses for monitoring and assessing aspects of continuity and coordination of care. Although Partnership had policies and procedures to ensure that members received an initial health assessment (IHA) and an initial health education behavioral assessment (IHEBA) within 120 days of enrollment, the audit showed that Partnership had low completion rates for both IHAs and IHEBAs, a repeat finding from the prior audit period. Additionally, the audit found that while there was collaboration between the plan and the regional center for coordinating services for members with disabilities, the plan had not fully implemented a process to identify all members with disabilities to ensure that medically necessary services were provided. The final audit report indicated DHCS's acceptance of Partnership's corrective action plan for the low rates of health assessments. The DHCS's October 2008 *Medical Audit Close Out Report* indicated that the plan corrected issues related to the identification of members with disabilities.

Audit results related to availability and accessibility standards found adequate policies and procedures for monitoring provider availability and capacity. The plan also had written standards for office and telephone wait times. The audit noted noncompliance in the area of claims, including procedures for processing out-of-network claims to meet contract timeliness requirements, a mechanism to ensure payment of redirected claims within required time frames, and the plan's policy for claims reimbursement up to 12 months after the date of service.

For the member rights category, the review showed that Partnership had a grievance and appeals system in place; however, the plan did not have adequate monitoring of grievances for its delegated entities. Additional findings related to the plan's privacy policies and procedures, which lacked the required reporting requirements for notifying the DHCS within the appropriate time frames of actual or suspected breaches of protected health information. The final audit report noted that Partnership revised its policies and procedures to comply with privacy requirements;

however, evidence of monitoring grievances for its delegated entities remained as an outstanding issue.

A review of State-specified standards for quality management showed that the plan had a quality management program that employed a variety of mechanisms to identify and take action to improve potential quality of care and patient safety issues. One finding in this category indicated that Partnership's policy for identifying and resolving potential quality of care issues did not clearly identify the staff responsible for determining if a quality of care concern exists, the procedures for involving the medical director, and the criteria used in determining further action. The final audit report noted that the plan corrected all deficiencies in this area.

Under the administrative and organizational capacity category, Partnership demonstrated adequate staffing and information system resources to support the delivery of the quality management program. The audit showed one finding in this area because the plan lacked a process for monitoring the delegation of provider training. In addition, not all new providers received training by the plan within the required 10 days. The plan corrected both issues, as noted in the DHCS's *Medical Close Out Report*.

### ***Member Rights and Program Integrity Monitoring Review***

The Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These reviews are done before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2009.

MRPIU conducted an on-site review of Partnership in March 2009 covering the review period of November 1, 2007, through October 31, 2008. The review covered member grievances, prior authorization notifications, cultural and linguistic services, and False Claims Act requirements. MRPIU auditors noted that:

- ◆ The plan was fully compliant in the areas of cultural and linguistic services.

- ◆ The plan had two areas of deficiency under member grievances. Not all files met the time frame for sending an acknowledgement letter. One of 40 grievance files reviewed had a resolution letter that exceeded the 30-day time frame.
- ◆ Under prior authorization notifications, several notice of action letters exceeded the 14-day time frame and/or were missing a date. One file reviewed lacked the required citation or regulations supporting the action taken by the plan. Additionally, several files did not contain documentation that a qualified physician reviewed the files.
- ◆ The plan had not reported any suspected fraud and/or abuse cases. While this was not a formal finding, the plan was encouraged to ensure it reported this information.

## Strengths

Based on the information available, Partnership demonstrated compliance with many State-specified standards assessed as part of the joint audit and MRPIU review. The plan was fully compliant with cultural and linguistic service requirements. In addition, the plan demonstrated that its quality improvement program monitored all aspects of quality care, identified opportunities for improvement, and implemented targeted action.<sup>2</sup> While the joint audit revealed several areas of deficiency, the plan demonstrated that it corrected all but two concerns at the time of the *Medical Close Out Report*.

## Opportunities for Improvement

The plan has an opportunity to continue monitoring its delegated entities to ensure compliance with prior-authorization notifications and member grievances. The plan needs to revise its claims processing procedures to comply with contract requirements.

<sup>2</sup> Partnership Health Plan of California. *Quality Monitoring and Improvement & Utilization Management Program Evaluation*. Program Year January 2008 – December 2008.

## Conducting the Review

The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provides for a standardized method of objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its EAS-specific performance measures when calculating rates.

## Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about Partnership's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

### *Performance Measure Validation*

HSAG performed a HEDIS<sup>®</sup> Compliance Audit<sup>TM3</sup> of Partnership in 2009. HSAG found all measures to be reportable and that Partnership's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

Recommendations from the audit included continuation of plan efforts to work with providers to increase the percentage of auto-adjudication rates. In addition, the plan should investigate ways to collect LOINC codes for laboratory services to reduce the need for medical record review for lab

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<sup>3</sup> HEDIS<sup>®</sup> refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS Compliance Audit<sup>TM</sup> is a trademark of the NCQA.

results. The plan should implement a formal process to track and trend vendor data volume to identify expected volumes and address any data issues or possible losses.

### *Performance Measure Results*

The table below presents a summary of Partnership's county-level HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measures results (based on calendar year 2007 data). In addition, the table shows the plan's HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs.

The MCMC Program requires contracted health plans to calculate and report HEDIS rates at the county level unless otherwise approved by the DHCS. However, exceptions to this requirement were approved several years ago for health plans operating in certain counties. Partnership was one of the plans approved for combined county reporting for Napa, Solano, and Yolo counties; therefore, Table 4.1 reflects combined reporting for those three counties.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the NCQA's national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—a low rate indicates better performance and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

Due to significant methodology changes for the *Comprehensive Diabetes Care—HbA1c Control (< 7.0 Percent)* measure, the MCMC Program was unable to compare 2008 and 2009 performance results for this measure.

Appendix A includes a performance measure name key with abbreviations contained in the following table.

**Table 4.1—2008–2009 Performance Measure Results for Partnership HealthPlan of California  
Napa, Solano, and Yolo Counties**

Performance Measure <sup>1</sup>	Domain of Care <sup>2</sup>	2008 HEDIS Rates <sup>3</sup>	2009 HEDIS Rates <sup>4</sup>	Performance Level for 2009	Performance Comparison <sup>5</sup>	MMCD's Minimum Performance Level <sup>6</sup>	MMCD's High Performance Level (Goal) <sup>7</sup>
AAB	Q	20.7%	22.4%	★★	↔	20.6%	35.4%
ASM	Q	89.5%	89.7%	★★	↔	86.1%	91.9%
AWC	Q,A,T	37.7%	39.4%	★★	↔	35.9%	56.7%
BCS	Q,A	57.9%	56.1%	★★	↔	44.4%	61.2%
CCS	Q,A	63.1%	66.0%	★★	↔	56.5%	77.5%
CDC–E	Q,A	68.8%	60.9%	★★	↓	39.7%	67.6%
CDC–H7 (<7.0%)	Q	40.6%	37.3%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	34.5%	36.9%	★★	↔	52.5%	32.4%
CDC–HT	Q,A	86.3%	79.0%	★★	↓	74.2%	88.8%
CDC–LC (<100)	Q	47.5%	42.9%	★★★	↔	25.1%	42.6%
CDC–LS	Q,A	81.6%	78.9%	★★	↔	66.7%	81.8%
CDC–N	Q,A	86.8%	80.7%	★★	↓	67.9%	85.4%
CIS–3	Q,A,T	75.4%	72.3%	★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	86.8%	88.6%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	64.7%	68.4%	★★	↔	54.0%	70.6%
URI	Q	91.0%	91.8%	★★	↔	79.6%	94.1%
W15	Q,A,T	69.5%	61.7%	★★	↓	44.5%	73.7%
W34	Q,A,T	70.0%	68.0%	★★	↔	59.8%	78.9%

<sup>1</sup> DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for full name of each HEDIS measure.

<sup>2</sup> HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

<sup>3</sup> HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.

<sup>4</sup> HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.

<sup>5</sup> Performance comparisons are based on the z test of statistical significance with a p value of <0.05.

<sup>6</sup> The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.

<sup>7</sup> The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

†The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

Not Comparable = Performance could not be compared due either to significant methodology changes between years or because the rate was not reported.



## Performance Measure Result Findings

Partnership demonstrated average performance for 16 of the 17 measures, falling between the MPLs and HPLs for its reported performance measures in 2009. The plan exceeded the MCMC goal for the *Comprehensive Diabetes Care—LDL-C Control (CDC-LC)* measure. The plan did not have below-average performance in any area.

## HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. Plans that have rates below these minimum levels must submit an improvement plan to the DHCS for each area of deficiency, outlining the steps they will take to improve care.

Partnership did not have any measures in 2008 or 2009 that were below the MPLs. Therefore, the DHCS did not require the plan to submit improvement plans for any measure for either year.

## Strengths

Partnership performed above the MCMC Program goal and the national Medical 90th percentile on the *Comprehensive Diabetes Care—LDL-C Control (CDC-LC)* measure, which falls under the quality domain of care. In addition, the plan's performance for three measures—*Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC-Pre)*; *Prenatal and Postpartum Care—Postpartum Care (PPC-Pst)*; and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*—is within 3 percentage points of the HPLs (2.8, 2.2, and 2.3 percentage points, respectively).

## Opportunities for Improvement

Partnership had four measures with statistically significant decreases between the 2008 to 2009 HEDIS rates. Three were *Comprehensive Diabetes Care (CDC)* measures—*Eye Exam (Retinal) Performed (CDC-E)*, *HbA1c Testing (CDC-HT)*, and *Medical Attention for Nephropathy (CDC-N)*—and one was the pediatric measure *Well-Child Visits in the First 15 Months of Life (W15)*. The rate for the *Comprehensive Diabetes Care—HbA1c Testing (CDC-HT)* measure decreased 7.3 percentage points and was only 4.8 percentage points above the MPL in 2009.

### Conducting the Review

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

### Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about Partnership's performance in providing quality, accessible, and timely care and services to its MCMC members. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

### Quality Improvement Projects Conducted

Partnership had two clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted the reduction of avoidable ER visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP project. Partnership's second project, an internal QIP, aimed to improve asthma management. Both QIPs fell under the quality and access domains of care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

Proper medication and provider follow-up are essential in asthma management. Emergency room visits and hospitalizations for asthmatic exacerbations are an indicator of poorly controlled asthma and suboptimal care. These visits also may indicate limited access to PCPs for asthma care.

Partnership's project attempted to improve the quality of care delivered to members with asthma.

**Quality Improvement Project Validation Findings**

The DHCS contracted with HSAG as its new EQRO in the second half of 2008. HSAG began validation for QIPs submitted by the plans after July 1, 2008.

The table below summarizes the validation results for both of Partnership’s QIPs across CMS protocol activities during the review period.

**Table 5.1—QIP Validation Results for Partnership HealthPlan of California (N=2 QIPs)  
Napa, Solano, and Yolo Counties**

Activity		Percentage of Applicable Elements		
		Met	Partially Met	Not Met
I.	Appropriate Study Topic	92%	8%	0%
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	57%	29%	14%
IV.	Correctly Identified Study Population	0%	50%	50%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	38%†	46%†	15%†
VII.	Appropriate Improvement Strategies	50%	33%	17%
VIII.	Sufficient Data Analysis and Interpretation	19%	31%	50%
IX.	Real Improvement Achieved	25%†	38%†	38%†
X.	Sustained Improvement Achieved	0%	100%	0%
<b>Percentage Score of Applicable Evaluation Elements Met</b>		<b>40%</b>		
<b>Validation Status</b>		<b>Not Applicable*</b>		
* QIPs were not given an overall validation status during the review period.				
† The sum may not equal 100 percent due to rounding.				

During the period covered by this report, HSAG’s application of the CMS validation requirements was more rigorous than previously experienced by the MCMC plans. As a result, many plans had difficulty complying fully with these requirements during the first cycle of QIP validations by HSAG. This was the case with Partnership’s QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided Partnership, as well as other plans, with an overall validation status of “Not Applicable” for both QIPs. This allowed time for plans to receive technical assistance and training with HSAG’s validation requirements without holding up the ongoing progress of QIPs that were already underway.

### *Quality Improvement Project Outcomes*

Table 5.2 shows Partnership's data for its QIPs. For the ER collaborative QIP, Partnership's goal was to reduce the overall rate of avoidable ER visits by 10 percent from baseline. The plan's first remeasurement year data will be submitted in time to be included in the next performance evaluation report (July 1, 2009, through June 30, 2010), at which time HSAG will assess for real improvement.

The *Improving Asthma Management* QIP began with one study indicator in 2002 and subsequently added four other indicators the next year. Study Indicator 1 was a HEDIS measure—*Use of Appropriate Medications for People With Asthma (ASM)*. Study Indicators 2 through 4 were considered HEDIS-like. The plan did not conduct any statistical testing between measurement periods for any of its asthma study indicators. HSAG performed Chi-square tests to determine if any rate changes were statistically significant and included those results in Table 5.2.

**Table 5.2—QIP Outcomes for Partnership HealthPlan of California  
Napa, Solano, and Yolo Counties**

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	Remeasurement Period		Sustained Improvement
		1 1/1/08–12/31/08	2 1/1/09–12/31/09	
Percentage of ER visits that were avoidable	17.7%	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Improving Asthma Management <sup>^</sup>							
QIP Study Indicator	Baseline Period 1/1/03–12/31/03	Remeasurement Period					Sustained Improvement
		1 1/1/04–12/31/04	2 1/1/05–12/31/05	3 1/1/06–12/31/06	4 1/1/07–12/31/07	5 1/1/08–12/31/08	
1) Percentage of persistent asthmatics age 5–56 with one or more controller medications dispensed during the measurement year	85.1%	84.9%	86.6%	88.9%	89.5%	‡	Yes
2) Percentage of persistent asthmatics age 5–56 with <9 canisters of beta agonist medication dispensed during the measurement year	88.6%	86.4%	85.5%	90.8%*	78.8%¥	‡	No
3) Percentage of persistent asthmatics age 5–56 with 0 ED visits for asthma during the measurement year	85.4%	85.7%	88.5%	86.3%	82.5%¥	‡	No
4) Percentage of persistent asthmatics age 5–56 with 0 inpatient discharges for asthma during the measurement year	99.1%	99.0%	97.8%¥	97.2%	94.8%¥	‡	No
5) Percentage of ED visits for asthma during the measurement year with a follow-up visit with a PCP or asthma/allergy specialist within 21 days	19.9%	22.2%	29.1%*	30.9%	45.7%*	38.3%¥	Yes
<sup>^</sup> The first four study indicators were initiated during calendar year 2003, while the fifth study indicator was initiated in calendar year 2002. * Designates statistically significant improvement over the prior measurement period. ¥ Designates statistically significant decline in performance over the prior measurement period. ‡ The QIP did not progress to this phase during the review period and could not be assessed.							

For the ER statewide collaborative QIP, Partnership implemented a stepped intervention in addition to the statewide collaborative interventions to reduce avoidable ER visits. Reducing avoidable ER visits was added as a bonus quality indicator in May 2008. The plan recognized the importance of educating and training providers regarding the incentive. Training on the indicator was held initially in three counties and then expanded to 62 primary care sites.

The plan's QIP, *Improving Asthma Management*, used five study indicators to measure improvement. Study Indicators 2 and 5 demonstrated real (statistically significant) improvement between any two measurement periods, and Study Indicators 1 and 5 achieved sustained improvement over the entire study period. Partnership was able to improve and sustain the percentage of members with asthma who received controller medications. Additionally, the plan increased and sustained the percentage of members with asthma who accessed the emergency department and then were seen by an asthma or allergy specialist within 21 days of discharge. Both indicators represent an improved quality of care.

The plan was not successful with improving three of its study indicators for the asthma QIP. All three showed a statistically significant decline between Remeasurement 3 and Remeasurement 4.

## Strengths

Partnership demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data. The plan had partial success with its asthma QIP showing sustained improvement for two study indicators. One indicator showed an increase in the percentage of members with asthma controller medications, and the other showed an increase in the access to a specialist following an ER visit for an asthma episode.

## Opportunities for Improvement

The plan has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with the DHCS requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

Partnership did not show improvement for three of its asthma QIP's five study indicators. The plan should provide a more detailed description of the interventions implemented and a clear description of the specific barriers that each intervention targets. Partnership's selection of interventions to increase asthma management was extensive, but the plan did not provide rationale to support the addition, modification, or elimination of interventions.

One of the asthma QIPs' study indicators measured the percentage of asthmatics with no inpatient discharges within the measurement year. The plan's baseline rate was 99.1 percent, which

left very little opportunity for actionable improvement. While this indicator may be important in determining the plan's overall management of asthmatics, future projects should focus study indicators on an actionable area of performance. Despite a decrease to 94.8 percent over the initial baseline period and no improvement, the high rate at baseline and fairly stable performance over a four-year period would suggest that the plan is managing this aspect of care well. The plan has an opportunity to determine factors that led to the decline in performance for the other two study indicators.



The table below provides abbreviations of HEDIS performance measures used throughout this report.

**Table A.1—HEDIS® Performance Measures Name Key**

<b>Abbreviation</b>	<b>Full Name of HEDIS® Performance Measure</b>
AAB	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
ASM	<i>Use of Appropriate Medications for People With Asthma</i>
AWC	<i>Adolescent Well-Care Visits</i>
BCS	<i>Breast Cancer Screening</i>
CCS	<i>Cervical Cancer Screening</i>
CDC-E	<i>Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed</i>
CDC-H7	<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (&lt; 7.0 Percent)</i>
CDC-H9	<i>Comprehensive Diabetes Care—HbA1c Poor Control (&gt; 9.0 Percent)</i>
CDC-HT	<i>Comprehensive Diabetes Care—HbA1c Testing</i>
CDC-LC	<i>Comprehensive Diabetes Care—LDL-C Control</i>
CDC-LS	<i>Comprehensive Diabetes Care—LDL-C Screening</i>
CDC-N	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>
CIS-3	<i>Childhood Immunization Status—Combination 3</i>
PPC-Pre	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>
PPC-Pst	<i>Prenatal and Postpartum Care—Postpartum Care</i>
URI	<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>
W15	<i>Well-Child Visits in the First 15 Months of Life (Six or More Visits)</i>
W34	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>