Performance Evaluation Report

Partnership Health Plan

July 1, 2009–June 30, 2010

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

March 2012

TABLE OF CONTENTS

1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] 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 the 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. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Partnership Health Plan ("Partnership" or "the plan"), which delivers care in Napa, Solano, Yolo, and Sonoma counties, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

Partnership is a full-scope managed care plan operating in Napa, Solano, Yolo, and Sonoma counties under the MCMC Program. Partnership delivers care to members as a County Organized Health System (COHS). Partnership has been Knox-Keene licensed since 2005. Knox-Keene licensure is granted by the Department of Managed Health Care (DMHC) to plans that meet minimum required standards according to the Knox-Keene Health Care Service Plan Act of 1975. The act includes a set of laws that regulates managed care organizations (MCOs).

In a COHS model, the DHCS initiates contracts with county-organized and operated plans to provide managed care services to beneficiaries with designated, mandatory aid codes. In a COHS plan, beneficiaries can choose from a wide network of managed care providers. These beneficiaries do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the plan.

Partnership began services under the MCMC Program beginning in Napa County in March 1998, in Solano County in May 1994, in Yolo County in March 2001, and in Sonoma County in October 2009. As of June 30, 2010, Partnership had 153,338 enrolled members under the MCMC Program across all four counties.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2010*. 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 that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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 fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division often work in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits are conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

HSAG reviewed the most current medical performance review reports available as of June 30, 2010, to assess the plans' compliance with State-specified standards. A&I and DMHC conducted a medical performance review of Partnership in October and November 2007 covering the review period of October 1, 2006, through September 30, 2007.[3] HSAG reported the review findings in the 2008–2009 plan evaluation report for Partnership.

The review noted that Partnership was fully compliant with its utilization management program, processing of appeals, delegation, referrals and follow-up care, access to medical care, access to pharmaceuticals, and management information systems requirements.

The results of the audit noted that Partnership had deficiencies in the following areas, which were considered fully resolved by the time the DHCS close-out letter was released in October 2008:

- Continuity of Care—services for persons with developmental disabilities
- Prior Authorization—treatment authorization request(TAR)denials
- Member Rights—member grievances, monitoring of member grievance system
- Quality Management—potential quality issue identification and resolution procedures
- Administrative and Organizational Capacity—provider training

The close-out letter noted that Partnership had some review findings that remained unresolved in the areas of:

- Availability and Accessibility—emergency service providers/family planning claims processing
- Members' Rights—monitoring of members' grievance system

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's 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 member rights reviews are conducted 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 member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved

[3] *California Department of Health Care Services Medical Review – Northern Section, Audits and Investigations, Partnership Healthplan of California*, April 10, 2008.

compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2010.

MRPIU conducted an on-site review of Partnership in March 2009 covering the review period of November 1, 2007, through October 31, 2008. HSAG reported the findings from the review in the 2008–2009 plan evaluation report.

The MRPIU found Partnership fully compliant with the areas of cultural and linguistic services.

The MRPIU noted deficiencies in the areas of:

- Member grievances—the plan did not always meet the time frame requirements for sending acknowledgement and resolution letters.
- Prior authorizations—issues with exceeding the time frame for notice of action letters, a file with missing citations/regulations to support plan actions taken, and missing documentation of qualified physician review of files.
- Reporting of suspected fraud and/or abuse—although not a formal finding, the plan had not reported any cases and was encouraged to ensure all suspected cases were reported.

Partnership submitted a corrective action plan to MRPIU in December 2009 to address the review findings. The MRPIU will assess compliance with these requirements as well as all other monitoring areas during the next scheduled review.

Strengths

Partnership was fully compliant with many aspects of the State-specified standards. In addition, the plan expeditiously resolved most review findings by the time the medical performance review close-out letter was issued. Partnership also took steps to address the review findings noted by the MRPIU.

Opportunities for Improvement

Partnership has an opportunity for improvement by ensuring that all outstanding review findings have been fully resolved. In addition, the plan should routinely monitor areas that had deficiencies to ensure that the corrective actions were effective in achieving full compliance.

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 provide a standardized method for 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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed a HEDIS Compliance Audit™ of Partnership in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[4] Based on the results of the compliance audit, HSAG found all measures to be reportable. The audit team noted some data entry errors in a supplemental database, although the errors did not result in any bias to any reported measure. The team recommended that Partnership implement monitoring of its supplemental data collection to ensure its accuracy.

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

Performance Measure Results

MCMC 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 COHS health plans operating in certain counties. Partnership Health Plan was one of the COHS health plans approved for combined county reporting for Napa, Solano, and Yolo counties; Table 3.2 reflects combined reporting for those three counties. MCMC is requiring that all existing health plans expanding into new counties report separate HEDIS rates for each county whenever a new county's membership exceeds 1,000. Partnership will be required to generate county-level reporting for Sonoma County beginning in 2011.

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Table 3.2.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of Partnership's HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan's HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national Medicaid 25th percentile and 90th percentile, respectively. For the CDC–H9 (>9.0 percent) measure, a low rate indicates better performance and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the national Medicaid 10th percentile.

Table 3.2—2009–2010 Performance Measure Results for Partnership Health Plan—Napa, Solano, and Yolo Counties*

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	22.4%	27.0%	★★	↔	20.2%	33.4%
AWC	Q,A,T	39.4%	38.7%	★★	↔	37.9%	59.4%
BCS	Q,A	56.1%	49.7%	★★	↓	45.0%	63.0%
CCS	Q,A	66.0%	61.6%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	64.8%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	60.9%	53.8%	★★	↓	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	53.5%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	36.9%	35.2%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	79.0%	82.7%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	42.9%	46.9%	★★★	↔	27.2%	44.7%
CDC–LS	Q,A	78.9%	79.0%	★★	↔	71.5%	82.5%
CDC–N	Q,A	80.7%	80.5%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	72.3%	65.0%	★★	↓	62.4%	80.6%
LBP	Q	‡	88.1%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	88.6%	84.8%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	68.4%	64.8%	★★	↔	57.9%	72.7%
URI	Q	91.8%	93.2%	★★	↑	81.1%	94.5%
W34	Q,A,T	68.0%	73.3%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	50.7%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	43.1%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	35.9%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).

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

[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.

[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.

[6] 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.

[7] 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 DHCS did not require plans to report this measure in 2009.

NA= The DHCS does not establish an MPL/HPL for first year measures.

★ = 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.

↑ = Statistically significant increase.

* Sonoma County's results were not included in this table because Partnership did not expand into this county until October 2009.

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

Performance Measure Result Findings

Partnership demonstrated average performance overall, achieving the HPL for one measure (*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*. All remaining measures fell between the MPL and the HPL.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline steps to improve care.

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

Partnership did not have any 2009 performance measure rates that required an improvement plan.

Strengths

Partnership exceeded the MPL for all of its HEDIS measures and met the HPL for one. The plan attained a statistically significant improvement in the *Appropriate Treatment for Children With Upper Respiratory Infection* measure.

Opportunities for Improvement

Partnership has several opportunities for improvement. For a second consecutive year, the plan experienced a statistically significant decline in the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure. Partnership should conduct a thorough barrier analysis to determine why performance in this measure continues to decline. In addition, the plan should conduct a subgroup analysis (evaluating measure performance using different groupings such as by primary care physician [PCP] or geographic location) to determine if there is an aspect of performance that is impacted by a specific subgroup. The plan can then identify and prioritize what interventions would be most effective in bringing about improvement.

Partnership had two other measures (*Breast Cancer Screening* and *Childhood Immunization Status—Combination 3)* that experienced a statistically significant decline, representing another opportunity for improvement.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas.

HSAG reviews each QIP using the Centers for Medicare & Medicaid Services' (CMS') validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Quality Improvement Projects Conducted

Partnership had two clinical QIPs and one QIP proposal in progress during the review period of July 1, 2009, through June 30, 2010. The first QIP focused on 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. Since Partnership's asthma QIP was closing out, the plan submitted a proposal for an internal QIP that targeted improving the management of chronic obstructive pulmonary disease (COPD) among members 40 years of age and older. All three QIPs fell under the quality domain of care, and the first two projects also fell under the access domain of care.

The plan's ER and COPD QIPs covered in this report included members from Napa, Solano, and Yolo counties but did not include members from Sonoma County. The DHCS requires that plans initiate QIP projects for counties after the plan has been operational in that county for one year; therefore, Partnership will be required to initiate QIP projects for Sonoma County beginning in October 2010. 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.

Proper diagnostic testing and medication are critical for COPD management. Emergency room readmissions for COPD are an indicator of poorly controlled COPD and suboptimal care. Partnership's project attempted to improve the quality of care delivered to members with COPD.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for Partnership Health Plan—Napa, Solano, and Yolo Counties July 1, 2009, through June 30, 2010

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	68%	60%	*Partially Met*
	Resubmission	98%	100%	*Met*
Internal QIPs				
Asthma Management	Annual Submission	76%	80%	*Partially Met*
	Resubmission 1	82%	90%	*Partially Met*
	Resubmission 2	84%	100%	*Met*
Improving Care and Reducing Acute Readmissions for People With COPD	Proposal	70%	50%	*Partially Met*
	Resubmission	100%	100%	*Met*

[1] **Type of Review**—Designates the QIP review as a new proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met, Partially Met,* or *Not Met*. In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that the annual submission by Partnership of its three QIPs received an overall validation status of *Partially Met*. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted the *Asthma Management* QIP twice and the *Improving Care and Reducing Acute Readmissions for People With COPD* and *Reducing Avoidable ER Visits* QIPs once. Upon subsequent validation, all three QIPs achieved an overall *Met* validation status.

Table 4.2 summarizes the validation results for the three Partnership's QIPs across the CMS protocol activities during the review period. The validation scores presented in Table 4.2 reflect the last submission validated before June 30, 2010.

Table 4.2––Quality Improvement Project Average Rates*
for Partnership Health Plan—Napa, Solano, and Yolo Counties
(Number = 3 QIP Submissions, 3 QIP Topics)
July 1, 2009, through June 30, 2010

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	93%	7%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total †		**95%**	**5%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	88%	6%	6%
	IX: Real Improvement Achieved†	25%	38%	38%
	X: Sustained Improvement Achieved	0%	100%	0%
Outcomes Total		**64%**	**20%**	**16%**

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

† The sum may not equal 100 percent due to rounding.

Partnership submitted Remeasurement 1 data for the *Reducing Avoidable Emergency Room Visits* QIP and HSAG validated Activities I through IX. For the *Asthma Management* QIP, the plan reported Remeasurement 5 data and HSAG validated Activities I though X. Partnership accurately conducted the activities of the design and implementation stages. Conversely, for the outcomes stage, Partnership scored lower in Activity VIII for the plan's incomplete interpretation of results for its *Asthma Management* QIP. Not all of the study indicators for the *Reducing Avoidable Emergency Room Visits* QIP and the *Asthma Management* QIP demonstrated statistically significant improvement; therefore, the plan received a score of 25 percent for Activity IX, Achieving Real Improvement. Additionally, only one study indicator for the *Asthma Management* QIP demonstrated sustained improvement. Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3—Quality Improvement Project Outcomes for Partnership Health Plan—Napa, Solano, and Yolo Counties July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable	17.7%	18.9%*	‡	‡

QIP #2—Asthma Management							
QIP Study Indicator	**Baseline Period 1/1/03–12/31/03**	**Remeasurement**					**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%	89.7%	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%*	83.1%*	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%*	86.2%*	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%*	96.8%*	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%*	No

QIP #3—Improving Care and Reducing Acute Readmissions for People With COPD				
QIP Study Indicator	**Baseline Period 7/1/08–6/30/09**	**Remeasurement 1 7/1/09–6/30/10**	**Remeasurement 2 7/1/10–6/30/11**	**Sustained Improvement¥**
1. Percentage of members 40 years of age and older with at least one claim/ encounter for spirometry in the 730 days before the Index Episode Start Date (IESD) to 180 days after the IESD	‡	‡	‡	‡
2a. Percentage of members 40 years of age and older with events (discharges, ED encounters) where a systemic corticosteroid was dispensed within 14 days 2b. Percentage of members 40 years of age and older with events (discharges, ED encounters) where a bronchodilator was dispensed within 30 days	‡	‡	‡	‡
3. Percentage of members 40 years of age and older with all-cause inpatient hospital discharges with an inpatient hospital readmission within 30 days of discharge date for COPD members	‡	‡	‡	‡

¥ Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

* A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05)

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

For the ER statewide collaborative QIP, Partnership reported an increase in the percentage of avoidable ER visits. This decline in performance was statistically significant. Partnership implemented a stepped intervention in addition to the statewide collaborative interventions to reduce avoidable ER visits. Since collaborative interventions were not initiated until 2009, HSAG cannot evaluate the effectiveness of those interventions.

The plan's *Asthma Management* QIP used five study indicators to measure improvement. Study Indicators 2, 3, and 4 demonstrated real (statistically significant) improvement between Remeasurement 4 and Remeasurement 5. Study Indicator 1 achieved sustained improvement over the entire study period demonstrating that Partnership was able to improve and sustain the percentage of members with asthma who received controller medications. The plan was not successful in improving the outcome for the fifth study indicator of the QIP. Instead, there was a statistically significant decline between Remeasurement 4 and Remeasurement 5.

Partnership had not progressed to the point of reporting results for its *Improving Care and Reducing Acute Readmissions for People With COPD* QIP.

Strengths

Partnership successfully applied the documentation requirements for the activities in both the design and implementation stages. The plan had partial success with its *Asthma Management* QIP showing statistically significant improvement for three of its study indicators and sustained improvement for one study indicator (increasing the percentage of members with asthma controller medications).

Opportunities for Improvement

Partnership should not rely on the ability to resubmit QIPs. The plan should be able to apply the lessons learned, and recommendations were provided regarding future submissions of ongoing QIPs and future QIP topics.

The plan implemented the collaborative interventions for the *Reducing Avoidable Emergency Room Visits* QIP and some plan-specific interventions; however, the plan needs to incorporate methods, such as subgroup analyses, to evaluate the efficacy of the interventions and to facilitate improved study outcomes.

Partnership did not show statistically significant improvement for two of its *Asthma Management* 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 Management* 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.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan surveys.[5]

The administration of the CAHPS surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS surveys be administered to both adult members and the parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

The Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about Partnership's performance in providing quality, accessible, and timely care and services to its MCMC members. The DHCS did not require HSAG to conduct a CAHPS survey for members in Sonoma County during the review period. Sonoma County's plan members will be surveyed in subsequent years that the CAHPS survey is administered. HSAG evaluated data on the four CAHPS global rating measures and five composite measures as follows:

CAHPS Global Rating Measures:

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

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

CAHPS Composite Measures:

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

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance (NCQA)'s HEDIS® benchmarks and thresholds or NCQA's national Medicaid data, when applicable. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 5.1.

Table 5.1—Star Ratings Crosswalk

Stars	Adult Percentiles	Child Percentiles
★★★★★	≥ 90th percentile	≥ 80th percentile
★★★★	75th percentile–89th percentile	60th percentile–79th percentile
★★★	50th percentile–74th percentile	40th percentile–59th percentile
★★	25th percentile–49th percentile	20th percentile–39th percentile
★	< 25th percentile	< 20th percentile

Table 5.2—Partnership Health Plan—Napa, Solano, and Yolo Counties Medicaid County-Level Global Ratings

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★★★	★★★	★★★
Child	★★	★★★	★★★★★	★★★+

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Table 5.3—Partnership Health Plan—Napa, Solano, and Yolo Counties
Medi-Cal Managed Care County-Level Composite Measures

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Adult	★★	★★	★★	★★+	★★★
Child	★★	★★	★★	★+	★★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Strengths

Partnership's child members expressed high levels of satisfaction in the *Rating of Personal Doctor* category. Partnership also achieved higher satisfaction results for both adults and children in the *Rating of All Health Care* and *Rating of Specialist Seen Most Often* global ratings and the *Shared Decision Making* composite measure for adults. These findings suggest that Partnership's providers are effective at building a strong patient-provider relationship.

Opportunities for Improvement

Partnership's CAHPS results showed primarily poor performance for the global *Rating of Health Plan* rating category and all composite scores for both adults and children (except *Shared Decision Making* for adults). HSAG conducted an analysis of key drivers of satisfaction that focused on the three highest priorities based on the plan's CAHPS results. The purpose of the analysis was to help decision-makers identify specific aspects of care that are most likely to benefit from quality improvement activities. Based on the key driver analysis, HSAG identified the following measures as Partnership's highest priorities: *Rating of Health Plan, Customer Service,* and *Getting Needed Care.* The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 Partnership CAHPS Plan-Specific Report.* Areas for improvement spanned the quality, access, and timeliness domains of care.

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 the results of performance measures and quality improvement projects (QIPs) 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. Finally, some member satisfaction measures relate to quality of care.

Partnership showed average performance based on its 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, member satisfaction survey results, and the results of the medical performance and member rights reviews as they related to quality. Partnership either fully met contract requirements that relate to quality (under the measurement and improvement area standards) or was able to resolve any deficiencies prior to the close-out period. For most performance measures, the plan's rates were between the MPL and the HPL. Partnership had one measure above the HPL for two consecutive years, one with a statistically significant improvement, and three with a statistically significant decline. All of the performance measures addressed quality.

Partnership's performance on member satisfaction survey results was mixed for both adults and children. Performance results were highest for *Rating of Personal Doctor* for children. The global *Rating of All Health Care* and *Rating of Specialist Seen Most Often* for both adults and children, and the *Shared Decision Making* composite measure for adults also have higher satisfaction scores. The plan showed poorer performance; however, in other measures of quality, including the global *Rating of Health Plan*, *How Well Doctors Communicate,* and *Customer Service.*

QIP results showed that the plan did well with documenting the QIP study design and implementation phases. The plan experienced a decline in performance in the collaborative QIP, although results for Remeasurement 2 are not yet available. The other QIP, aimed at improving asthma management, achieved statistically significant improvement in three indicators and sustained improvement in another. Although the plan had a decline in performance in the fifth study indicator, overall, the findings suggest that the QIP was successful toward improving the quality of care provided to plan members with asthma.

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 a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

The plan demonstrated average to below-average performance based on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results. While performance measure results showed that Partnership performed between the MPL and HPL for most access-related measures, three measures had a statistically significant decline.

The collaborative QIP showed a decline in performance for the first remeasurement period.

Member satisfaction results related to access were low in the *Getting Needed Care* composite and *Rating of Health Plan* measure for both adults and children.

For access-related compliance standards, while Partnership met or addressed most deficient areas, the plan had one unresolved finding related to processing of emergency service and family planning claims.

Timeliness

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

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.

Partnership exhibited average to below-average performance in the timeliness domain of care based on 2010 performance measure rates for providing timely care, medical performance and member rights reviews related to timeliness, and member satisfaction results related to timeliness.

Performance measure rates showed a statistically significant decline in the *Childhood Immunization Status* measure, which relates to timeliness. Other measures of timeliness, including prenatal care and well-child care visits, demonstrated average performance, exceeding the MPL but not achieving the HPL.

Member satisfaction results showed that the plan experienced poor performance in the *Getting Care Quickly* category for both adult and child populations as well as for other satisfaction measures assessing timeliness. This suggests that members perceive that they do not always receive care as quickly as they would like.

The MRPIU review noted issues related to time frame requirements in sending prior authorization notice of action letters and grievance acknowledgement and resolution letters.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. Partnership's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, Partnership showed average performance in providing quality health care services to its MCMC members, and average to below-average performance in providing care that is accessible and timely. The plan has many opportunities for improvement.

Findings suggest that Partnership may have issues with access to care, given the decline in some performance measures related to access and lower member satisfaction results.

The plan demonstrated success with its *Asthma Management* QIP and its *Improving Care and Reducing Acute Readmissions for People With COPD* shows promise. The second remeasurement period for its *Reducing Avoidable Emergency Room Visits* QIP will reflect additional plan interventions aimed at improving performance.

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

- As the *Improving Care and Reducing Acute Readmissions for People With COPD* QIP progresses, evaluate the effectiveness of the interventions. If improvements are not made, conduct subgroup analysis to identify specific barriers to improving care for members with COPD and adjust interventions to address these barriers.
- Ensure that all open findings from the medical performance and MRPIU reviews are fully addressed, and that corrective action plans were effective in addressing deficiencies.
- Implement a formal process to assess performance measures that show declining performance, particularly focusing on the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.* Conduct a thorough analysis to determine what factors are contributing to lower performance and implement targeted improvement interventions.
- Review the 2010 plan-specific CAHPS results report and develop strategies to address the *Rating of All Health Care, Rating of Health Plan,* and *Getting Care Quickly* priority areas.

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

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
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.	**Provider incentive:** Inclusion of diabetes indicators and W34 in PHC's QIP (P4P) program. **Decision Support tools for providers:** Providers can now access lists of members needing services in these two areas via managedcare.com.
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.	Began using new QIP summary form as required for new QI activities
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.	Retired asthma as QIP in 2009. PHC has received approval from HSAG and the DHCS to begin COPD as new topic and has successfully submitted project on new QIP Summary Form.
Revise claims payment policies and procedures to comply with State-specified requirements for claims submitted up to 12 months after the date of service.	Partnership submitted a proposal to DHCS-MMCD on modifying our billing limit policy.
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.	Plan monitors member grievances and prior-authorization delegate reports on a quarterly basis. Details are reported through PHC's Internal Quality Improvement Committee along with corrective action status. Plan monitors any deficiencies.