Performance Evaluation Report

Partnership HealthPlan of California

July 1, 2013–June 30, 2014

Managed Care Quality and Monitoring Division
California Department of Health Care Services

April 2015

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Performance Evaluation Report
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1. INTRODUCTION

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)[1] in the State of California through a combination of contracted full-scope and specialty managed care health plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an

[1] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

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

- MCP-specific evaluation reports (July 1, 2013–June 30, 2014). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Partnership HealthPlan of California ("Partnership" or "the MCP"), for the review period July 1, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Health Plan Overview

Partnership is a full-scope MCP delivering services to its MCMC members as a County Organized Health System (COHS). A COHS is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission.

Partnership became operational to provide MCMC services in Solano County in May 1994, in Napa County in March 1998, in Yolo County in March 2001, in Sonoma County in October 2009, and in Marin and Mendocino counties in July 2011. As part of the expansion authority under Section 1115 of the Social Security Act, MCMC expanded into several rural eastern counties of California in 2013. Under the expansion, Partnership contracted with DHCS to provide MCMC services in Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties beginning September 1, 2013. As of June 30, 2014, Partnership had 10,019 MCMC members in Del Norte County; 39,251 in Humboldt County; 22,884 in Lake County; 7,121 in Lassen County; 29,415 in Marin County; 29,861 in Mendocino County; 2,503 in Modoc County; 23,041 in Napa County; 52,512 in Shasta County; 14,682 in Siskiyou County; 89,590 in Solano County; 88,402 in Sonoma County; 3,734 in Trinity County; and 40,262 in Yolo County—for a total of 453,277 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

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

This report section covers review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to evaluate key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

Medical Audits and SPD Medical Surveys

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were

conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

DHCS received authorization "1115 Waiver" from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-COHS counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

Audits & Investigation Division Medical Audit

The most recent medical audit for Partnership was conducted December 2, 2013, through December 13, 2013, covering the review period of September 1, 2012, through August 31, 2013. A&I evaluated the MCP's compliance with its contract and regulations in the areas of:

- Utilization Management
- Case Management and Coordination of Care
- Availability and Accessibility
- Member's Rights
- Quality Management
- Administrative and Organizational Capacity

In the report, issued June 19, 2014, A&I summarized the findings from the medical audit. A&I identified findings in the areas of Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management. A&I found the MCP fully compliant with the requirements reviewed in the area of Administrative and Organizational Capacity.

Audits & Investigation Division State Supported Services Audit

In conjunction with the medical audit, A&I conducted a State Supported Services audit to evaluate Partnership's compliance with its State Supported Services contract and regulations. Partnership was found to be fully compliant with the State Supported Services requirements.

Strengths

During the December 2013 joint medical and State Supported Services audit, A&I identified no findings in the area of Administrative and Organizational Capacity and found Partnership to be fully compliant with the State Supported Services requirements.

Opportunities for Improvement

Partnership has the opportunity to ensure that all findings from the December 2013 medical audit are fully resolved. The findings cut across all three domains of care—quality, access, and timeliness.

Conducting the EQRO Review

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[4] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

Performance Measure Validation

DHCS's 2014 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 32. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[6] of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

In order to report HEDIS measure rates, MCPs must first have members meet continuous enrollment requirements for each measure being reported, which typically means members need to be enrolled in the MCP for 11 of 12 months during the measurement year. No Partnership Medi-Cal members in Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties had continuous enrollment during 2013. Consequently, HSAG did not include these counties in the 2014 NCQA HEDIS Compliance Audit conducted with Partnership, and no data for these counties are included in this report. HSAG will include the expansion counties in the 2015 NCQA HEDIS Compliance Audit process, and rates for the counties will be included in Partnership's 2014–15 MCP-Specific Evaluation Report.

Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for Partnership HealthPlan of California* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that Partnership followed the appropriate specifications to produce valid rates, and no

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

issues of concern were identified. A brief summary of the findings and opportunities for improvement is included below.

- Although Partnership experienced a large increase in membership during the measurement year, the MCP had no backlogs or delays in data processing.
- As Partnership expands into new counties, the MCP is requiring its clinics and providers to report services rendered by using revenue codes. This detail is critical to HEDIS reporting; therefore, any efforts to acquire this information will help to ensure data completeness.
- Partnership successfully transitioned its Healthy Families Program population into MCMC with no impact on member operations (i.e., processes related to enrollment, customer service, member outreach, etc.).
- The HSAG auditor recommended that Partnership implement an ongoing and formal validation process for its supplemental datasets as the NCQA guidelines become stricter. The auditor also recommended that the MCP validate a large percentage of records to ensure that these data are reliable for future reporting. Finally, the auditor recommended that Partnership require all providers to upload into the supplemental database proof-of-service documentation for all services they provided.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 through Table 3.4 present a summary of Partnership's performance measure results for 2011–14. Note that data may not be available for all four years.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 through Table 3.4 show the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

DHCS based the MPLs and HPLs on the NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *CDC–H9 (>9.0 percent)* measure. For the *CDC–H9 (>9.0 percent)* measure, a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

Note: While generally requiring MCPs to report county-level data, DHCS made an exception and allowed Partnership to continue to report Napa, Solano, and Yolo counties as one combined rate.

The reader should note the following regarding Table 3.1 through Table 3.4:

- The *All-Cause Readmissions* measure is a non-HEDIS measure used for the ACR collaborative QIP; therefore, no MPL or HPL is established for this measure.
- For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- The *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures. No MPL or HPL is established for a utilization measure. Additionally, HSAG did not compare performance for these measures.
- Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for 2014:
  - All four *Children and Adolescents' Access to Primary Care* measures.
  - *Cervical Cancer Screening*. Note: MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008; however, due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014. Consequently, HSAG did not include or make comparisons to previous years' rates in this report.
  - *Comprehensive Diabetes Care—LDL-C Control*. (This measure is being eliminated for HEDIS 2015.)
  - *Comprehensive Diabetes Care—LDL-C Screening*. (This measure is being eliminated for HEDIS 2015.)

Table 3.1—Performance Measure Results
Partnership—Marin County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	16.04%	16.45%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	48.34	43.50	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	304.46	342.84	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	**76.74%**	84.90%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	**76.71%**	87.77%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	NA	46.15%	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	74.45%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	78.35%	75.35%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	98.76%	99.10%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	87.69%	90.64%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	**87.25%**	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	**84.18%**	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	60.71%	70.29%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	**42.46%**	49.64%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	87.70%	88.77%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	50.40%	48.91%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	34.13%	40.22%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	71.03%	76.45%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	79.37%	83.70%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	40.08%	43.84%	↔
Controlling High Blood Pressure	Q	—	—	50.65%	64.77%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	67.47%	75.00%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	NA	**43.64%**	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	NA	24.55%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	**57.75%**	67.63%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	**78.17%**	84.89%	↔
Use of Imaging Studies for Low Back Pain	Q	—	—	85.71%	S	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	83.33%	83.70%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	63.89%	68.86%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	44.44%	60.10%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	67.59%	75.83%	↑

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 3.2—Performance Measure Results
Partnership—Mendocino County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	9.81%	11.46%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	57.94	56.02	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	331.59	308.59	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	84.48%	**82.37%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	85.61%	**80.80%**	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	28.57%	48.05%	↑
Cervical Cancer Screening	Q,A	—	—	—	66.18%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	**61.86%**	**61.08%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	**95.45%**	95.80%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	89.15%	88.64%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	88.51%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	88.35%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	57.18%	63.74%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	**38.86%**	**39.34%**	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	92.82%	82.64%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	49.75%	41.32%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	37.38%	29.23%	↓
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	76.73%	**65.71%**	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	78.71%	75.16%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	37.38%	49.67%	▼
Controlling High Blood Pressure	Q	—	—	57.43%	59.55%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	51.46%	**57.65%**	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	NA	62.58%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	NA	32.52%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	69.68%	64.94%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	88.01%	83.33%	↔
Use of Imaging Studies for Low Back Pain	Q	—	—	88.05%	85.48%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	69.91%	77.86%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	55.79%	51.58%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	31.71%	36.98%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	**62.04%**	**63.92%**	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—Performance Measure Results
Partnership—Napa/Solano/Yolo Counties

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	13.25%	15.60%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	47.82	52.33	53.57	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	256.88	312.13	311.38	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**82.13%**	84.46%	89.71%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	**80.88%**	90.48%	94.44%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**82.38%**	**82.35%**	89.42%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	26.08%	42.76%	33.18%	34.31%	↔
Cervical Cancer Screening	Q,A	—	—	—	69.59%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	70.14%	71.93%	68.87%	72.32%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**94.91%**	96.49%	96.81%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**82.91%**	**86.42%**	87.79%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**80.35%**	**83.67%**	**85.84%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**77.25%**	**84.94%**	**83.80%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	60.31%	69.27%	66.67%	65.21%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	54.77%	56.79%	53.42%	60.34%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.04%	86.64%	85.65%	82.48%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	54.77%	60.58%	53.64%	52.31%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	49.89%	49.22%	42.16%	46.96%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	79.38%	78.17%	77.70%	77.86%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	78.49%	83.74%	84.33%	86.86%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	34.59%	28.73%	35.76%	37.47%	↔
Controlling High Blood Pressure	Q	—	—	53.86%	56.72%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	56.81%	65.33%	64.10%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	59.90%	61.68%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	39.41%	40.23%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	69.51%	70.29%	75.92%	68.85%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	89.02%	87.27%	81.41%	80.00%	↔
Use of Imaging Studies for Low Back Pain	Q	88.42%	88.52%	88.95%	89.17%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	57.41%	74.77%	77.44%	69.76%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	49.77%	65.05%	67.91%	65.12%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	42.13%	53.70%	52.79%	54.15%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	67.54%	74.34%	74.26%	73.83%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.

Table 3.4—Performance Measure Results
Partnership—Sonoma County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	13.05%	12.79%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	43.17	44.10	39.40	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	283.01	345.59	354.14	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**71.41%**	**69.27%**	**84.41%**	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	88.57%	**85.29%**	88.89%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**73.94%**	**72.08%**	85.05%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	20.97%	47.47%	27.33%	36.96%	↔
Cervical Cancer Screening	Q,A	—	—	—	72.02%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	71.00%	76.62%	74.01%	79.13%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	95.24%	96.25%	98.23%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**86.47%**	88.58%	90.32%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**83.26%**	**85.70%**	**87.25%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**84.36%**	88.23%	86.73%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	62.22%	76.12%	69.98%	70.56%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	49.56%	54.24%	57.62%	60.10%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	87.33%	90.18%	92.27%	89.05%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	51.78%	59.38%	51.66%	52.55%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	38.44%	43.75%	39.74%	41.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	**68.89%**	74.33%	76.60%	79.81%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	77.33%	80.13%	80.13%	82.24%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	37.11%	27.01%	34.88%	34.55%	↔
Controlling High Blood Pressure	Q	—	—	54.53%	60.69%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	53.01%	65.66%	74.93%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	63.71%	61.42%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	41.62%	44.29%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	67.06%	75.69%	73.73%	74.14%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	88.15%	82.96%	85.97%	89.10%	↔
Use of Imaging Studies for Low Back Pain	Q	90.15%	90.42%	90.32%	90.56%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	77.31%	86.31%	87.15%	85.12%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	54.40%	69.37%	68.46%	65.12%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	47.69%	54.99%	51.64%	56.83%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	71.69%	72.16%	74.43%	81.31%	↑

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[7] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

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

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

The final selected SPD measures are listed below. Following the list of measures are Table 3.5 through Table 3.12, which present a summary of Partnership's 2014 SPD measure results. Table 3.5 through Table 3.8 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[8] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.9 through Table 3.12 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[8] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.5 through Table 3.8.

Table 3.5—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Partnership—Marin County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	17.72%	↔	16.45%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.76%	85.42%	↔	84.90%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.09%	88.65%	↔	87.77%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	99.10%	NA	Not Comparable	99.10%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.78%	83.93%	↔	90.64%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	87.41%	84.15%	↔	87.25%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	85.57%	68.29%	↓	84.18%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	74.70%	68.39%	↔	70.29%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	49.40%	49.74%	↔	49.64%
Comprehensive Diabetes Care—HbA1c Testing	84.34%	90.67%	↔	88.77%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	44.58%	50.78%	↔	48.91%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	30.12%	44.56%	↑	40.22%
Comprehensive Diabetes Care—LDL-C Screening	73.49%	77.72%	↔	76.45%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.11%	86.53%	↔	83.70%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	45.78%	43.01%	↔	43.84%

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

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

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

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

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 3.6—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Partnership—Mendocino County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	13.24%	↔	11.46%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.58%	83.17%	↔	82.37%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.46%	81.52%	↔	80.80%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.78%	NA	Not Comparable	95.80%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.55%	92.98%	↔	88.64%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.58%	87.01%	↔	88.51%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.52%	85.82%	↔	88.35%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.44%	64.73%	↔	63.74%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	31.47%	45.35%	↑	39.34%
Comprehensive Diabetes Care—HbA1c Testing	81.73%	83.33%	↔	82.64%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	35.53%	45.74%	↑	41.32%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	23.86%	33.33%	↑	29.23%
Comprehensive Diabetes Care—LDL-C Screening	62.44%	68.22%	↔	65.71%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	67.51%	81.01%	↑	75.16%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	54.82%	45.74%	↔	49.67%

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

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

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

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

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

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 3.7—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Partnership—Napa/Solano/Yolo Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.48%	16.98%	▼	15.60%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.91%	90.49%	↑	89.71%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	94.90%	Not Comparable	94.44%
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.24%	90.39%	↑	89.42%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.88%	92.31%	↔	96.81%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.88%	85.68%	↔	87.79%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.88%	85.27%	↔	85.84%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.15%	81.25%	↓	83.80%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	69.83%	61.07%	↓	65.21%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.85%	62.04%	↑	60.34%
Comprehensive Diabetes Care—HbA1c Testing	82.24%	83.45%	↔	82.48%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	47.93%	54.50%	↔	52.31%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.98%	48.91%	↑	46.96%
Comprehensive Diabetes Care—LDL-C Screening	75.43%	78.10%	↔	77.86%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.27%	89.54%	↑	86.86%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.61%	35.28%	↔	37.47%

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

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

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

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

Not comparable = A rate comparison could not be made because data were not available for both populations.
NA = A *Not Applicable* audit finding because the MCP’s denominator was too small to report (less than 30).

Table 3.8—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Partnership—Sonoma County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.54%	14.00%	↔	12.79%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.70%	85.94%	↑	84.41%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	87.88%	Not Comparable	88.89%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.87%	86.11%	↔	85.05%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.27%	NA	Not Comparable	98.23%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.28%	91.75%	↔	90.32%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	87.13%	89.15%	↔	87.25%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	86.68%	87.34%	↔	86.73%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	78.80%	66.42%	↓	70.56%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.61%	59.37%	↔	60.10%
Comprehensive Diabetes Care—HbA1c Testing	91.58%	87.59%	↔	89.05%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	50.82%	54.01%	↔	52.55%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	40.49%	41.61%	↔	41.12%
Comprehensive Diabetes Care—LDL-C Screening	80.16%	78.10%	↔	79.81%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.80%	83.45%	↔	82.24%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	36.14%	36.25%	↔	34.55%

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

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

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

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

Not comparable = A rate comparison could not be made because data were not available for both populations.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.9—2014 Non-SPD and SPD Rates for Ambulatory Care Measures Partnership—Marin County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
308.78	40.32	538.03	61.72

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

Table 3.10—2014 Non-SPD and SPD Rates for Ambulatory Care Measures Partnership—Mendocino County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
267.41	50.11	586.07	95.80

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

Table 3.11—2014 Non-SPD and SPD Rates for Ambulatory Care Measures Partnership—Napa/Solano/Yolo Counties

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
240.94	45.79	565.93	81.68

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

Table 3.12—2014 Non-SPD and SPD Rates for Ambulatory Care Measures Partnership—Sonoma County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
319.83	34.76	597.96	72.33

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

Performance Measure Result Findings

Across all counties, 17 rates were above the HPLs. Marin and Sonoma counties each had seven measures with rates that improved significantly from 2013 to 2014. Napa/Solano/Yolo counties

had five measures with rates that improved significantly, and the rates for three measures for Mendocino County showed significant improvement. Although DHCS did not hold the MCPs accountable to meet the MPLs for some measures in 2013, across all counties 10 rates improved from below the MPLs in 2013 to above the MPLs in 2014.

Across all counties, 14 rates were below the MPLs. Mendocino County had the most measures with rates below the MPLs (seven) and the most measures with rates that declined significantly from 2013 to 2014 (five). Additionally, Mendocino County was the only county with rates that moved from above the MPLs in 2013 to below the MPLs in 2014 (four). Marin County had three measures with rates below the MPLs, and Napa/Solano/Yolo and Sonoma counties each had two measures with rates below the MPLs. Napa/Solano/Yolo counties had four measures with rates that were significantly worse in 2014 when compared to 2013, and the rate for one measure in Sonoma County declined significantly from 2013 to 2014. No measures for Marin County had rates that were significantly worse in 2013 when compared to 2014.

Seniors and Persons with Disabilities Findings

Across all counties, 11 SPD rates were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of this population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The SPD rates were significantly worse than the non-SPD rates for the following measures:

- *All-Cause Readmissions* for Napa/Solano/Yolo counties
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* for Marin and Napa/Solano/Yolo counties
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* for Napa/Solano/Yolo and Sonoma counties

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

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to

develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act cycle . DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates (measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid cycle approach (including the Plan-Do-Study-Act cycle) to strengthen these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

Assessment of MCP's Improvement Plans

Partnership was required to submit new IPs for the following measures in 2013:

- All three *Annual Monitoring for Patients on Persistent Medications* measures for Sonoma County
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* for Napa/Solano/Yolo Counties

For all IPs, Partnership identified the following barriers to the rates being above the MPLs:

- Data gaps

- Lack of provider education

The MCP identified the following interventions to address the barriers:

- The MCP held monthly internal data workgroup meetings.
- The quality improvement team worked directly with contracted lab vendors to improve the quality of the encounter data.
- The MCP built a supplemental database for the *Annual Monitoring for Patients on Persistent Medications* measures.
- The MCP worked directly with Kaiser, one of the MCP's medical groups, to improve data quality.
- Partnership added the *Annual Monitoring for Patients on Persistent Medications* measures to the pay-for-performance program.
- The MCP hosted webinars for providers on the *Annual Monitoring for Patients on Persistent Medications* measures.

Partnership's efforts resulted in the following:

- The rates for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure in Napa/Solano/Yolo and Sonoma counties improved significantly from 2013 to 2014, resulting in the rates moving from below the MPLs in 2013 to above the MPLs in 2014.
- The rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure in Sonoma County improved significantly; however, the rate remained below the MPL for the third consecutive year.
- The rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure in Sonoma County improved by more than 3 percentage points; and although the improvement was not statistically significant, the rate moved from below the MPL in 2013 to above the MPL in 2014.

Partnership will work with DHCS to prioritize quality improvement activities and interventions, and DHCS will require the MCP to submit an IP and/or use a rapid cycle approach (including the Plan-Do-Study-Act cycle) to address Partnership's poor performance related to the following measures:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* for Mendocino and Sonoma counties
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* for Mendocino County
- *Childhood Immunization Status—Combination 3* for Mendocino County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Mendocino County
- *Immunizations for Adolescents—Combination 1* for Mendocino County

- *Medication Management for People with Asthma—Medication Compliance 50% Total* for Marin County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* for Mendocino County

Strengths

Although Partnership experienced a large increase in membership during the measurement year, the MCP had no backlogs or delays in data processing. Additionally, Partnership successfully transitioned its Healthy Families Program population into MCMC with no impact on member operations.

Across all counties, Partnership had 17 rates above the HPLs, 22 rates that improved significantly from 2013 to 2014, and 10 rates that improved from below the MPLs in 2013 to above the MPLs in 2014.

Opportunities for Improvement

The HSAG auditor recommended that Partnership implement an ongoing and formal validation process for its supplemental datasets as the NCQA guidelines become stricter. The auditor also recommended that the MCP validate a large percentage of records to ensure that these data are reliable for future reporting. Finally, the auditor recommended that Partnership require all providers to upload into the supplemental database proof-of-service documentation for all services they provided.

Partnership has the opportunity to assess the factors leading to several measures having rates below the MPLs. Mendocino County has the most opportunities for improvement, since it had had the most measures with rates below the MPLs (seven) and the most measures with rates that declined significantly from 2013 to 2014 (five). Additionally, Mendocino County was the only county with rates that moved from above the MPLs in 2014 to below the MPLs in 2013 (four). Partnership also has the opportunity to continue to assess the factors leading to five SPD rates being significantly worse than the non-SPD rates to ensure that the MCP is meeting the needs of the SPD population. While Partnership provided information on the MCP's assessment of the differences in rates (see Appendix D), HSAG recommends the MCP continue to monitor data to ensure that processes are in place to address the SPD population's needs.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[9] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

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

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

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

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

Quality Improvement Project Objectives

Partnership participated in the statewide collaborative QIP and had three internal QIPs in progress during the review period of July 1, 2013–June 30, 2014.

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

Table 4.1—Quality Improvement Projects for Partnership
July 1, 2013, through June 30, 2014

QIP	Counties	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Marin, Mendocino, Napa/Solano/Yolo, and Sonoma	Clinical	Q, A
Childhood Immunization Status—Combo 3	Mendocino	Clinical	Q, A, T
Improving Access to Primary Care for Children and Adolescents	Napa/Solano/Yolo, and Sonoma	Clinical	A
Improving the Timeliness of Prenatal and Postpartum Care	Marin	Clinical	Q, A, T

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

The *Childhood Immunization Status* QIP targeted beneficiaries who will turn 2 years of age during the measurement year. The administration of immunizations has dramatically decreased the occurrence of many diseases including diphtheria, tetanus, pertussis, and small pox. However, due to either misconceptions about immunizations' side effects or lack of access, the number of children who have not received immunizations has increased. By understanding why children are not receiving life-saving vaccines, Partnership hopes to increase the number of children who receive the recommended immunizations.

Having a primary care provider (PCP) can improve a child's health by providing the opportunity for him/her to receive immunizations and preventive care. Partnership's *Improving Access to Primary Care for Children and Adolescents* QIP aims to increase the rate at which children and adolescents access their PCP, since increasing access to PCPs may positively affect health. Partnership is

focusing on four different age groups for this QIP: 12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12 to 18 years.

Partnership's *Improving the Timeliness of Prenatal and Postpartum Care* QIP focused on improving the care women receive during and post pregnancy. Being able to maintain regular prenatal care visits throughout a pregnancy can help identify and treat any problems that may arise. Providing postpartum care is also an essential factor that can lead to a successful health outcome.

Quality Improvement Project Validation Findings

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

Table 4.2—Quality Improvement Project Validation Activity
Partnership—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties
July 1, 2013, through June 30, 2014

Name of Project/Study	County	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	All counties received the same score.	Annual Submission	81%	86%	*Partially Met*
		Annual Resubmission 1	100%	100%	*Met*
Internal QIPs					
Childhood Immunization Status—Combo 3	Mendocino	Study Design Submission	83%	83%	*Not Met*
		Study Design Resubmission 1	100%	100%	*Met*
Improving Access to Primary Care for Children and Adolescents	Napa/Solano/Yolo	Annual Submission	92%	100%	*Met*
	Sonoma	Annual Submission	84%	100%	*Met*
Improving the Timeliness of Prenatal and Postpartum Care	Marin	Study Design Submission	75%	83%	*Not Met*
		Study Design Resubmission 1	100%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that Partnership's annual submission of its *All-Cause Readmissions* QIP received an overall validation status of *Partially Met* for all counties. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, Partnership resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of evaluation elements (critical and noncritical) receiving a met score. The *Childhood Immunization Status* QIP study design submission for Mendocino County received an overall validation status of *Not Met*. Partnership resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of evaluation elements (critical and noncritical) receiving a met score. The *Improving Access to Primary Care for Children and Adolescents* QIP annual submission achieved an overall validation status of *Met*, with 92 percent of the evaluation elements and 100 percent of the critical elements receiving a met score for Napa/Solano/Yolo counties and 84 percent of the evaluation elements and 100 percent of the critical elements receiving a met score for Sonoma County. Finally, the *Improving the Timeliness of Prenatal and Postpartum Care* QIP study design submission for Marin County received an overall validation status of *Not Met*. Partnership resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of evaluation elements (critical and noncritical) receiving a met score.

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

Table 4.3—Quality Improvement Project Average Rates*
Partnership—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties
(Number = 14 QIP Submissions, 4 QIP Topics)
July 1, 2013, through June 30, 2014

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%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection**	83%	13%	5%
Design Total		**93%**	**5%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	88%	4%	8%
	VIII: Appropriate Improvement Strategies	82%	18%	0%
Implementation Total**		**86%**	**9%**	**6%**
Outcomes	IX: Real Improvement Achieved	75%	25%	0%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**75%**	**25%**	**0%**

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

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

HSAG validated Activities I through VIII for Partnership's *All-Cause Readmissions* QIP annual submission, Activities I through VI for the MCP's *Improving the Timeliness of Prenatal and Postpartum Care* and *Childhood Immunization Status* QIPs study design submissions, and Activities I through IX for the MCP's *Improving Access to Primary Care for Children and Adolescents* QIP annual submission.

Partnership demonstrated a strong application of the Design stage, meeting 93 percent of the requirements for all applicable evaluation elements within the study stage for all four QIPs. For both the *All-Cause Readmissions* and *Improving Access to Primary Care for Children and Adolescents* QIPs, the MCP did not fully describe its data analysis plan, resulting in a lower score for Activity VI. For both the *Childhood Immunization Status* and *Improving the Timeliness of Prenatal and Postpartum Care* QIPs, Partnership did not provide the process for collecting manual data and did not provide the manual data collection tool. Additionally, for the *Improving the Timeliness of Prenatal and Postpartum Care* QIP, the MCP did not submit the qualifications of the staff members who would be collecting the manual data, resulting in a lower score for Activity VI. Partnership corrected these deficiencies in the resubmissions, resulting in the QIPs each achieving an overall *Met* validation status.

Both the *All-Cause Readmissions* and *Improving Access to Primary Care for Children and Adolescents* QIPs progressed to the Implementation stage during the reporting period. The MCP demonstrated an adequate application of the Implementation stage, meeting 86 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. In the initial submission of the *All-Cause Readmissions* QIP, Partnership did not indicate if there were any factors that threatened the internal or external validity of the findings and did not provide the process used to evaluate the effectiveness of the interventions, resulting in a lower score for Activities VII and VIII. Partnership corrected the deficiencies in its resubmission, resulting in the QIP achieving an overall *Met* validation status. For the *Improving Access to Primary Care for Children and Adolescents* QIP, Partnership did not utilize the same statistical testing throughout its data analysis, resulting in a lower score for Activity VII. The QIP achieved an overall *Met* validation status on its first submission; therefore, the MCP was not required to correct the deficiency.

Only the *Improving Access to Primary Care for Children and Adolescents* QIP progressed to the Outcomes stage during the reporting period. The score for Activity IX was lowered because Study Indicator 1 for Sonoma County did not achieve statistically significant improvement over baseline. This QIP was not assessed for sustained improvement (Activity X) since it had not yet progressed to that activity. Sustained improvement will be assessed during the next review period for all counties with indicators that achieved statistically significant improvement over baseline at Remeasurement 1.

Quality Improvement Project Outcomes and Interventions

The *Childhood Immunization Status* and *Improving the Timeliness of Prenatal and Postpartum Care* QIPs did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information is included in this report.

The *All-Cause Readmissions* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP's interventions for the *All-Cause Readmissions* QIP:

- Provided quarterly reports to all PCPs showing their readmissions rates and, when requested, a drill-down at the patient level.
- Increased the number of hospitals reporting readmissions rates electronically, thereby reducing delays in the MCP being notified of hospitalizations.
- Tested with three primary care sites an e-mail notification system designed to provide timely alerts of a patient hospitalization.
- Implemented a pay-for-performance program.
- Hired a care transition nurse to work in the Sonoma region to reach more members who need these services.
- Increased the case load for the care transition nurse by testing and improving the referral system for identifying members at risk for readmissions.
- Enrolled into care transitions and case management the top five patients with the most readmissions within a 12-month period.

Outcome information for the *All-Cause Readmissions* QIP will be included in Partnership's 2014–15 MCP-specific evaluation report.

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

Table 4.4—Quality Improvement Project Outcomes for Partnership Napa/Solano/Yolo and Sonoma Counties July 1, 2013, through June 30, 2014

QIP #1—Improving Access to Primary Care for Children and Adolescents				
Study Indicator 1: Percentage of 12-to-24-month-old members with one or more visits with a PCP during the measurement year				
County	**Baseline Period 1/1/11–12/31/11**	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**	**Sustained Improvement¥**
Napa/Solano/Yolo	94.9%	96.5%*	‡	‡
Sonoma	95.2%	96.3%	‡	‡
Study Indicator 2: Percentage of 25-month-to-6-year-old members with one or more visits with a PCP during the measurement year				
County	**Baseline Period 1/1/11–12/31/11**	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**	**Sustained Improvement¥**
Napa/Solano/Yolo	82.9%	86.4%*	‡	‡
Sonoma	86.5%	88.6%*	‡	‡
Study Indicator 3: Percentage of 7-to-11-year-old members with one or more visits with a PCP during the measurement year or the year prior to the measurement year				
County	**Baseline Period 1/1/11–12/31/11**	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**	**Sustained Improvement¥**
Napa/Solano/Yolo	80.4%	86.4%*	‡	‡
Sonoma	83.3%	85.7%*	‡	‡
Study Indicator 4: Percentage of 12-to-19-year-old members with one or more visits with a PCP during the measurement year or the year prior to the measurement year				
County	**Baseline Period 1/1/11–12/31/11**	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**	**Sustained Improvement¥**
Napa/Solano/Yolo	77.3%	84.9%*	‡	‡
Sonoma	84.4%	88.2%*	‡	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement from the baseline period (p value < 0.05).

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

Improving Access to Primary Care for Children and Adolescents QIP

Partnership was able to achieve statistically significant improvement at Remeasurement 1 for all study indicators except for Study Indicator 1 for Sonoma County for the *Improving Access to Primary Care for Children and Adolescents* QIP. Sonoma County's Study Indicator 1 demonstrated improvement over baseline; however, the improvement was not statistically significant. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- HSAG noted some documentation errors and recommended that the MCP correct the errors in the next QIP submission.

- Partnership completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through the data analysis and a quality improvement process. The documentation included system interventions likely to have a long-term effect and described problem-solving techniques using data analysis to identify possible causes and solutions.
- The new interventions listed in the QIP Summary Form did not appear to be interventions, but steps that Partnership planned to take to perform additional data analysis and develop new interventions.
- The following interventions were successful at improving the QIP outcomes:
  - Continued patient reminder calls.
  - Gathered data at the individual provider level, and identified which providers and members may benefit most from interventions.
  - Interviewed providers and members to identify specific areas of improvement, and proposed solutions to implement interventions.

Strengths

Partnership demonstrated an excellent application of the QIP process for the Design stage for all QIPs. Additionally, the MCP achieved an overall *Met* validation status on the first submission for the *Improving Access to Primary Care for Children and Adolescents* QIP.

Partnership excelled at developing and implementing interventions that positively affected the rates for the *Improving Access to Primary Care for Children and Adolescents* HEDIS measures. The MCP took advantage of the QIP process to improve these measures' outcomes and to affect organizational processes.

Opportunities for Improvement

Partnership has the opportunity to ensure all required documentation is included in the QIP Summary Form since the MCP had several instances of incomplete data. The MCP should reference the QIP Completion Instructions and QIP validation tools to ensure that all documentation requirements for each activity have been addressed prior to submission.

For the *Improving Access to Primary Care for Children and Adolescents* QIP, the MCP has the opportunity to determine the factors that resulted in Study Indicator 1 for Sonoma County not achieving statistically significant improvement. HSAG recommends that Partnership assess whether existing interventions should be modified or new interventions with the potential to result in positive outcomes should be identified.

Conducting the EQRO Review

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Please note that when a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[10]

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

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

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

Partnership's 2014 strategic plan for its quality and performance improvement department and quality improvement program description contain descriptions of activities and processes designed to ensure that quality care is provided to the MCP's members.

During the December 2013 A&I medical audit, A&I identified findings in the area of Quality Management, which could affect the quality of care provided to the MCP's Medi-Cal members.

Across all counties, 16 rates for measures falling into the quality domain of care were above the HPLs and 16 rates improved significantly from 2013 to 2014. Additionally, the rates for the following quality measures improved from below the MPLs in 2013 to above the MPLs in 2014:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* for Marin County
- *Annual Monitoring for Patients on Persistent Medications—Digoxin* for Sonoma County
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* for Marin, Napa/Solano/Yolo, and Sonoma counties
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Marin County
- *Prenatal and Postpartum Care—Postpartum Care* for Marin County
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Marin County

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

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* for Mendocino and Sonoma counties, with the rate in Sonoma county being below the MPL for the third consecutive year
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* for Mendocino County
- *Childhood Immunization Status—Combination 3* for Mendocino County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Mendocino County
- *Comprehensive Diabetes Care—LDL-C Screening* for Mendocino County
- *Immunizations for Adolescents—Combination 1* for Mendocino County
- *Medication Management for People with Asthma—Medication Compliance 50% Total* for Marin County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* for Mendocino County

The rates for the following quality measures were significantly worse in 2014 when compared to 2013:

- *All-Cause Readmissions* for Napa/Solano/Yolo counties

- *Comprehensive Diabetes Care—HbA1c Testing* for Mendocino County
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* for Mendocino County
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* for Mendocino County
- *Comprehensive Diabetes Care—LDL-C Screening* for Mendocino County
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* for Mendocino County
- *Prenatal and Postpartum Care—Postpartum Care* for Napa/Solano/Yolo counties
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* for Napa/Solano/Yolo counties

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care. Across all counties, 11 SPD rates (associated with six measures) were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of this population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. The SPD rates were significantly worse than the non-SPD rates for the following quality measures:

- *All-Cause Readmissions* for Napa/Solano/Yolo counties
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* for Napa/Solano/Yolo and Sonoma counties

Partnership's *All-Cause Readmissions*, *Childhood Immunization Status—Combo 3*, and *Improving the Timeliness of Prenatal and Postpartum Care* QIPs fell into the quality domain of care. Since none of these QIPs progressed to the Outcomes stage, HSAG was not able to assess the QIPs' success at improving the quality of care delivered to the MCP's MCMC members.

Overall, Partnership showed average performance related to the quality domain of care.

Access

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

access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HSAG reviewed Partnership's available quality improvement information and found that the MCP included processes to monitor and evaluate member access to care.

During the December 2013 A&I medical audit, A&I identified findings in the areas of Case Management and Coordination of Care and Access and Availability of Care, which could affect access to care for the MCP's Medi-Cal members.

The rates for the following access performance measures were above the HPLs:

- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* for Marin County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* for Napa/Solano/Yolo counties
- *Prenatal and Postpartum Care—Postpartum Care* for Sonoma County

The rates for the following access measures improved significantly from 2013 to 2014:

- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* for Sonoma County
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* for Marin, Napa/Solano/Yolo, and Sonoma counties, with the improvement for Napa/Solano/Yolo counties resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* for Napa/Solano/Yolo and Sonoma counties; however, the rates remained below the MPLs for the third consecutive year for both counties
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Napa/Solano/Yolo counties
- *Immunizations for Adolescents—Combination 1* for Sonoma County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* for Marin and Sonoma Counties

In addition to the rate for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure in Napa/Solano/Yolo counties improving from below the MPL in 2013 to above the MPL in 2014, the rates for the following access measures improved from below the MPLs in 2013 to above the MPLs in 2014:

- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* for Mendocino County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Marin County
- *Prenatal and Postpartum Care—Postpartum Care* for Marin County
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Marin County

In addition to the rates for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measures for Napa/Solano/Yolo and Sonoma counties being below the MPLs, the rates for the following access measures were below the MPLs:

- *Childhood Immunization Status—Combination 3* for Mendocino County
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* for Marin County
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* for Marin and Napa/Solano/Yolo counties
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Mendocino County
- *Comprehensive Diabetes Care—LDL-C Screening* for Mendocino County
- *Immunizations for Adolescents—Combination 1* for Mendocino County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* for Mendocino County

The rates for the following access measures were significantly worse in 2014 when compared to 2013:

- *All-Cause Readmissions* for Napa/Solano/Yolo counties
- *Comprehensive Diabetes Care—HbA1c Testing* for Mendocino County
- *Comprehensive Diabetes Care—LDL-C Screening* for Mendocino County
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* for Napa/Solano Yolo and Sonoma counties
- *Prenatal and Postpartum Care—Postpartum Care* for Napa/Solano/Yolo counties

Nine of the performance measures stratified for the SPD population fall into the access domain of care. The SPD rates were significantly better than the non-SPD rates for the following measures:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Mendocino and Napa/Solano Yolo counties
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* for Mendocino and Napa/Solano Yolo counties

As indicated above, the better rates in the SPD population are likely a result of this population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. The SPD rates were significantly worse than the non-SPD rates for the following access measures:

- *All-Cause Readmissions* for Napa/Solano/Yolo counties
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* for Marin and Napa/Solano/Yolo counties

All four of Partnership's QIPs fell into the access domain of care. Only the *Improving Access to Primary Care for Children and Adolescents* QIP progressed to the Outcomes stage. Overall, the QIP was successful in improving access to primary care for members aged 12 months to 19 years, with significantly more members in the targeted age groups being seen by a PCP one or more times from Baseline to Remeasurement 1 in all counties except Sonoma for the 12-to-24-months age group.

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

Timeliness

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

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

HSAG reviewed Partnership's available quality improvement information and found descriptions of the MCP's structure that support monitoring the timeliness of health care services provided to members.

During the December 2013 A&I medical audit, A&I identified findings in the areas of Utilization Management and Member's Rights, which could affect the timeliness of care provided to the MCP's Medi-Cal members.

The rate for Sonoma County for the *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the timeliness domain of care, was above the HPL, and the rates for the following timeliness measures improved significantly from 2013 to 2014:

- *Immunizations for Adolescents—Combination 1* for Sonoma County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* for Marin and Sonoma counties

The rates for both *Prenatal and Postpartum Care* measures for Marin County improved from 2013 to 2014, and although not statistically significant, the improvement resulted in the rates moving from below the MPLs in 2013 to above the MPLs in 2014.

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

- *Childhood Immunization Status—Combination 3* for Mendocino County
- *Immunizations for Adolescents—Combination 1* for Mendocino County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* for Mendocino County

The rate for Napa/Solano/Yolo counties for the *Prenatal and Postpartum Care—Postpartum Care* measure declined significantly from 2013 to 2014.

Partnership's *Childhood Immunization Status—Combo 3* and *Improving the Timeliness of Prenatal and Postpartum Care* QIPs fell into the timeliness domain of care. Since neither of the QIPs progressed to the Outcomes stage, HSAG was unable to assess the QIPs' success at improving the timeliness of care delivered to the MCP's MCMC members.

Overall, Partnership showed below-average performance related to the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2012–13 MCP-specific evaluation report. Partnership's self-reported responses are included in Appendix D.

Recommendations

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

- Ensure that all findings from the December 2013 medical audit are fully resolved. The areas with findings are Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management.
- Regarding the use of supplemental data:
  - Implement an ongoing and formal validation process for supplemental datasets.
  - Validate a large percentage of records to ensure that these data are reliable for future reporting.
  - Require all providers to upload into the supplemental database proof-of-service documentation for all services they provided.
- Assess the factors leading to several measures having rates below the MPLs. Specifically, work with DHCS to prioritize quality improvement activities and interventions and, based on DHCS's requirements, submit an IP and/or use a rapid cycle approach (including Plan-Do-Study-Act cycle) to address the MCP's poor performance related to the following measures:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* for Mendocino and Sonoma counties
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* for Mendocino County
- *Childhood Immunization Status—Combination 3* for Mendocino County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* for Mendocino County
- *Immunizations for Adolescents—Combination 1* for Mendocino County
- Medication *Management for People with Asthma—Medication Compliance 50% Total* for Marin County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* for Mendocino County

- Continue to assess the factors leading to five SPD rates being significantly worse than the non-SPD rates to ensure that the MCP is meeting the needs of the SPD population. While Partnership provided information on the MCP's assessment of the differences in rates (See Appendix D), HSAG recommends that the MCP continue to monitor the data to ensure processes are in place to address the SPD population's needs.
- Ensure all required documentation is included in the QIP Summary Form. The MCP should reference the QIP Completion Instructions and QIP Validation Tools to ensure that all documentation requirements for each activity have been addressed prior to QIP submission.
- For the *Improving Access to Primary Care for Children and Adolescents* QIP, determine the factors that resulted in Study Indicator 1 for Sonoma County not achieving statistically significant improvement. HSAG recommends that Partnership assess whether existing interventions should be modified or new interventions with the potential to result in positive outcomes should be identified.

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

Table A.1 through Table A.4 provide two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the tables:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲ ▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table A.1—HEDIS 2014 SPD Trend Table
Partnership—Marin County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	18.83%	17.72%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	62.43	61.72	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	441.02	538.03	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	79.13%	85.42%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	79.43%	88.65%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	77.97%	83.93%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	84.15%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	68.29%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.77%	68.39%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	43.10%	49.74%	↔
Comprehensive Diabetes Care—HbA1c Testing	89.08%	90.67%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	55.17%	50.78%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	35.63%	44.56%	↔
Comprehensive Diabetes Care—LDL-C Screening	73.56%	77.72%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.33%	86.53%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	35.63%	43.01%	↔

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

Table A.2—HEDIS 2014 SPD Trend Table
Partnership—Mendocino County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	10.68%	13.24%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	94.82	95.80	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	589.67	586.07	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.52%	83.17%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.14%	81.52%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	NA	92.98%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	87.01%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	85.82%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	54.51%	64.73%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	43.44%	45.35%	↔
Comprehensive Diabetes Care—HbA1c Testing	90.98%	83.33%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	52.87%	45.74%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	40.57%	33.33%	↔
Comprehensive Diabetes Care—LDL-C Screening	77.87%	68.22%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.61%	81.01%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	35.66%	45.74%	▼

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

Table A.3—HEDIS 2014 SPD Trend Table
Partnership—Napa/Solano/Yolo Counties

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	15.67%	16.98%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	79.44	81.68	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	503.87	565.93	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.70%	90.49%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	91.07%	94.90%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.26%	90.39%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	86.79%	92.31%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	82.56%	85.68%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	84.64%	85.27%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	81.91%	81.25%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	61.95%	61.07%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.54%	62.04%	↑
Comprehensive Diabetes Care—HbA1c Testing	85.62%	83.45%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	54.65%	54.50%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	43.81%	48.91%	↔
Comprehensive Diabetes Care—LDL-C Screening	77.88%	78.10%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	88.72%	89.54%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	33.19%	35.28%	↔

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

Table A.4—HEDIS 2014 SPD Trend Table
Partnership—Sonoma County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	15.38%	14.00%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	74.66	72.33	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	577.11	597.96	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	69.54%	85.94%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	84.38%	87.88%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	75.51%	86.11%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	94.74%	91.75%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	84.06%	89.15%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.04%	87.34%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	67.77%	66.42%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	59.60%	59.37%	↔
Comprehensive Diabetes Care—HbA1c Testing	93.38%	87.59%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.07%	54.01%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.58%	41.61%	↔
Comprehensive Diabetes Care—LDL-C Screening	77.04%	78.10%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	84.33%	83.45%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	30.91%	36.25%	↔

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

Table B.1 through Table B.4 provide two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the tables:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table B.1—HEDIS 2014 Non-SPD Trend Table
Partnership—Marin County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	3.70%	S	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	45.40	40.32	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	275.93	308.78	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	67.24%	82.76%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	65.91%	84.09%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.75%	99.10%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.92%	90.78%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	87.41%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	85.57%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.82%	74.70%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.03%	49.40%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.62%	84.34%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	39.74%	44.58%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	30.77%	30.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	65.38%	73.49%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	70.51%	77.11%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	50.00%	45.78%	↔

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

Table B.2—HEDIS 2014 Non-SPD Trend Table
Partnership—Mendocino County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.03%	S	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	51.97	50.11	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	289.83	267.41	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	79.55%	80.58%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.57%	78.46%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.44%	95.78%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.08%	88.55%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	88.58%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	88.52%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	61.25%	62.44%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	31.88%	31.47%	↔
Comprehensive Diabetes Care—HbA1c Testing	95.63%	81.73%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.00%	35.53%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.50%	23.86%	↔
Comprehensive Diabetes Care—LDL-C Screening	75.00%	62.44%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	71.25%	67.51%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	40.00%	54.82%	▼

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

Table B.3—HEDIS 2014 Non-SPD Trend Table
Partnership—Napa/Solano/Yolo Counties

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	6.84%	7.48%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	47.01	45.79	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	274.50	240.94	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	78.93%	84.91%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	74.90%	83.24%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.69%	96.88%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	86.57%	87.88%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	83.59%	85.88%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	85.36%	84.15%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	69.54%	69.83%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.54%	50.85%	↔
Comprehensive Diabetes Care—HbA1c Testing	87.64%	82.24%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	49.67%	47.93%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.75%	36.98%	↔
Comprehensive Diabetes Care—LDL-C Screening	78.15%	75.43%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.12%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	37.75%	41.61%	↔

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

Table B.4—HEDIS 2014 Non-SPD Trend Table
Partnership—Sonoma County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.01%	9.54%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	38.92	34.76	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	306.38	319.83	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	68.61%	80.70%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	62.90%	81.87%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.29%	98.27%	↑
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.48%	90.28%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.78%	87.13%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.24%	86.68%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	73.95%	78.80%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.99%	57.61%	↔
Comprehensive Diabetes Care—HbA1c Testing	90.12%	91.58%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.50%	50.82%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.43%	40.49%	↔
Comprehensive Diabetes Care—LDL-C Screening	78.14%	80.16%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.04%	78.80%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	37.72%	36.14%	↔

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

Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[11] This process allows HSAG to evaluate each MCP's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.1through Table 3.4)

Quality Domain

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

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

Access and Timeliness Domains

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

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Some, but not all, study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

Appendix D. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

for **Partnership HealthPlan of California**

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with Partnership's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table D.1—Partnership's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

2012–13 External Quality Review Recommendation Directed to Partnership	Actions Taken by Partnership During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Ensure that all changes to the MCP's claims and encounter processes that occur as a result of the system upgrade are documented in the MCP's 2014 Roadmap, including any backlogs or issues that arise due to the transition.	The Amysis system was upgraded from version 3 to version 6 from May 1, 2013 to January 17, 2014. All changes to the claims and encounter processes that occurred due to the system upgrade were documented in the 2014 roadmap and discussed during HSAG's on-site visit. No issues were identified due to the upgrade.
2. Since Partnership had 18 measures with rates below the MPLs in 2013 and 9 measures with rates that were significantly worse in 2013 when compared to 2012, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.	Partnership HealthPlan of CA (PHC) worked with DHCS to identify two priority measures for improvement and focused efforts. PHC selected two additional three-year QIP's: *Improving Timeliness of Prenatal Care* in Marin County and *Childhood Immunization Status-Combo 3* in Mendocino. In reviewing our measurement year (MY) 2012 rates, PHC also identified the *Annual Monitoring for Patients on Persistent Medications* (MPM) measure for improvement. This was a measure that also required an improvement plan by DHCS. PHC's Quality Improvement Team identified two barriers in the MPM measure performance: 1. Incomplete lab data 2. Lack of provider education on the importance of the measure and the specific guidelines **Incomplete lab data:** In an attempt to improve MPM performance between HEDIS MY 2012 and HEDIS MY 2013, PHC initiated a provider outreach project. PHC sent lists to Primary Care Providers (PCP) of members who were eligible but noncompliant for one or more of the MPM submeasures. Where the service did not occur (according to the PCP's records), PHC encouraged the provider to send patients for lab tests. If the service did occur (according to the PCP's records), PHC requested that the provider send a copy of the lab report.

<table>
<tr><th>2012–13 External Quality Review Recommendation Directed to Partnership</th><th>Actions Taken by Partnership During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation</th></tr>
<tr><td></td><td>The MPM Provider Outreach Project revealed a pervasive gap in our Quest and Kaiser lab data. We received hundreds of faxed lab reports from both organizations for which we had no corresponding service date within our lab encounter data. Many of the reports were from early in the reporting year, so the absence from our administrative data could not be explained by claims lag. We also ran Kaiser-specific MPM rates and found their rates were lower than our PHC averages, further supporting our assumption that we're missing data from Kaiser.

To address the data gap, PHC took a number of steps in 2013:
1) To improve HEDIS MY2013 rates, we built a supplemental database of all records received via the MPM Provider Outreach Project. The database helped us see some improvement in our Eastern region, but no improvement in Sonoma. The impact of the database was limited by provider response rate to our outreach. Some of our largest providers did not respond to our request for records.
2) In the summer of 2013, PHC developed an internal data workgroup specific to HEDIS measures. Part of that work includes reaching out to Quest and Kaiser to obtain missing data. To date, we have signed an agreement with Quest that will enable PHC to access patient-level lab data through Quest's online portal. We are simultaneously developing improved internal quality assurance processes to more closely monitor the quality of the monthly encounter files we receive from both Quest and Kaiser. We are paying particularly close attention to the quality of data in Sonoma County, where rates are lower, potentially indicating a worse data gap in this region.
3) To ensure we closed the data gap for HEDIS 2014, PHC built a supplemental database in January 2014 for date of service January 1, 2013 through December 31, 2013. We used the Quest portal and outreach lists to Kaiser to find the records required to build the database. With access to the Quest portal and ability to look up member records without disrupting our provider network, we saw a significant improvement in our HEDIS MPM rates in both our Eastern region and in Sonoma County.
4) Lastly, PHC has initiated a conversation with Kaiser regarding improvements to their annual HEDIS supplemental data files (Kaiser provides care for approximately 10 percent of our Eastern and Sonoma members). We have requested a lab file, which we hope will also improve rates in both regions. Early in the HEDIS season, we will run Kaiser-specific MPM rates and request additional data if the rates look low.</td></tr>
</table>

2012–13 External Quality Review Recommendation Directed to Partnership	Actions Taken by Partnership During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
3. Assess the factors leading to the SPD rates for five measures being significantly worse than the non-SPD rates to ensure the MCP is meeting the needs of the SPD population.	PHC saw lower performance among SPDs for the following measures: a. Marin: ACR, CAP-256 b. Napa/Solano/Yolo: ACR, CAP-1224, CAP-256, CAP-1219, CDC-BP c. Sonoma: ACR d. Mendocino: None In response to the Readmissions measure, PHC believes the higher rate is due to the higher complexity and acuity of patients in the SPD population compared to those in the non-SPD population. This complexity is not controlled for in the readmission rate analysis. For the CAP measure, we don't believe the differences are significant due to the very small population of SPDs in this measure. In Marin for example, there were only 56 members in the SPD denominator, compared to 2550 members in the non-SPD denominator. According to the tables produced by our auditing firm, HSAG, the confidence intervals (CIs) for the SPD and non-SPD rates overlapped. The 95% CI for SPDs (CAP-256 in Marin) was 83.93%–94.44% and the confidence interval for the non-SPDS was 90.78%–91.93%. With overlapping confidence intervals, we concluded the differences were not statistically significant and therefore not worth additional investigation. CDC-BP performance is lower among our SPDs in Napa/Solano/Yolo, compared to our non-SPDs. This is the only CDC submeasure in the Eastern region where non-SPD performance is higher than SPD performance. Blood pressure control may be more difficult to achieve in the SPD population given the higher complexity of this patient population. Since all other CDC submeasures revealed higher performance among SPDs than non-SPDs, PHC is confident that our SPD population is getting comparable diabetes care, compared to our non-SPD population.
4. Since the MCP has shown success at improving rates for some measures and sustaining acceptable rates on others, the MCP should consider duplicating applicable successful strategies when approaching improvement efforts on measures with declining rates or rates below the MPLs.	When approaching improvement efforts on measures with declining rates or rates below the MPLs, PHC continually reflects on successful strategies previously and presently implemented. On measures where we have sustained and/or improved, PHC's Quality Improvement workgroup considers duplicating successful interventions where applicable.
5. Ensure documentation on the QIP Summary Form is complete and accurate. Partnership should reference the QIP Completion Instructions to ensure understanding of all information required to be included on the QIP Summary Form.	Partnership HealthPlan ensured documentation on the QIP summary form was complete and accurate and that the QIP completion instructions were referenced. Partnership HealthPlan submitted three QIPs in 2013 that cover Eastern, Sonoma, Marin, and Mendocino Counties. **Eastern and Sonoma—*Improve Access to Primary Care for Children and Adolescents* (HEDIS CAP Measure)** PHC successfully submitted our Remeasurement 1 data during this time frame.

<table>
<tr><th>2012–13 External Quality Review Recommendation Directed to Partnership</th><th>Actions Taken by Partnership During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation</th></tr>
<tr><td></td><td>Based on the analysis of Remeasurement 1 to baseline, the interventions showed a positive effect on visits with primary care providers. The QIP was successful in meeting PHC's goal of being at or above the 25th percentile across all indicators but one—Sonoma County CAP indicator 12 to 24 months. This indicator did improve in rate; however, not enough to meet our goal and did not reflect a statistical significance. Due to the success of the QIP during the re-measurement 1 period, PHC's follow-up activities planned and implemented July 1, 2013, through June 30,2014, were the following:
1. Continue with the robo-call intervention providing a reminder call to all homes with children between the ages of 1 to 19 to follow up with their primary care physician for routine visits with suggested improvements from PHC's Quality Improvement Team.
• Two robo-call scripts: (1) Referencing one child in the home between the ages of 1 to 19, and (2) Referencing multiple children in the home between the ages of 1 to 19.
• Create two files that will be sent to our vendor, Care Calls, which will be executing the robo-calls: (1) File representing one child in the home, and (2) File representing multiple children at the same address and phone number.
• Execute calls by October 31, 2013—one month earlier than our previous year's intervention timeline.

<u>Marin—Improve Timeliness of Prenatal and Postpartum Access to Care (HEDIS PPC measure)</u>
PHC successfully submitted our baseline data during this time frame. Activities PHC planned and implemented July 1, 2013, through June 30, 2014, were the following:
• Stratified plan level data which allowed PHC to identify gaps in care and where interventions may be appropriate.
• Convened an internal improvement workgroup to share data and complete a causal/barrier analysis using a fishbone diagram.
• Prioritized barriers and potential solutions based on the following criteria: potential to use evidence-based interventions to address the barriers, resources available, and feasibility for collecting data to measure the effects of the interventions.
PHC's Quality Improvement Team focused on prioritized barriers and will be summarizing prioritized barriers, success of interventions, and data analysis in the August 29, 2014, QIP submission.</td></tr>
</table>

2012–13 External Quality Review Recommendation Directed to Partnership	Actions Taken by Partnership During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	<u>Mendocino—*Improve Timeliness of Prenatal and Postpartum Access to Care* (HEDIS PPC measure)</u> PHC successfully submitted our baseline data during this time frame. Activities PHC planned and implemented July 1, 2013 through June 30, 2014, were the following: • Stratified plan level data by key demographic variables such as age, sex, ethnicity, and language spoken. • Convened an internal improvement workgroup to share data and complete a causal/barrier analysis using a fishbone diagram. • Prioritized barriers and potential solutions. PHC's Quality Improvement Team focused on prioritized barriers and will be summarizing prioritized barriers, success of interventions, and data analysis in the August 29, 2014, QIP submission.
6. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the *Rating of Health Plan, Rating of All Health Care,* and *Getting Needed Care* priority areas.	PHC analyzed the results and presented them at our Internal Quality Improvement Committee and Quality and Utilization Advisory Committee meetings in April 2014. We compared our performance to State and national benchmarks and discussed the significant correlates of low performance identified in the HSAG report. The major driver of low performance across our priority areas was access to specialty care. To address this gap, PHC has formed a Specialty Access workgroup to understand and improve access to specialty care across our diverse network.
7. Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.	PHC reviewed the MCP-Specific Encounter Data Validation Study Report addressing the recommendations to ensure accurate and complete encounter data. PHC identified, responded, and implemented the following: 1. "Provider Data Quality" tab: • "Referring/Prescribing/Admitting Provider Number" is frequently unpopulated. The use of National Provider Identification is also quite low. **Response:** The current 35C process is pulling the claims data from our core payment system, which does not store additional provider information such as the referring, attending, and prescribing; hence, the process is not reporting those data. **Implemented:** The new 837 process will be created to look into additional data sources to pull data not available in our core payment system. Efforts are made in our current inbound 837 transactions to capture these types of provider data to meet

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

2012–13 External Quality Review Recommendation Directed to Partnership	Actions Taken by Partnership During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	the requirements of projects such as the State's Economic Development and Community Training (EDCT). Efforts will be made to include these data for the EDCT project. 2. The second tab, "Procedure and Diagnosis, "reveals that local procedure codes are an issue in outpatient and Medical/Allied claim types. **Response:** PHC is currently following the State requirements on the use of local codes within our payment processing. We will closely watch what comes out of the plan workgroup on reporting of these codes for the EDCT project. **Next Steps:** PHC will try to adopt the crosswalk created by the plan workgroup if there is one; otherwise, PHC will come up with our own to meet the EDCT project requirements. PHC has added a unit within the IT department that includes data quality analysts whose job is specifically to ensure completeness and accuracy of data. These analysts will develop specific report templates that ensure: (1) all data are submitted by direct and indirect submitters each month, (2) data fields are complete and with appropriate values, and (3) encounter data are complete by comparing data to internal and external benchmarks (TBD). In addition, a specific task will be to work with our pharmacy benefit manager, Claims Department, and IT to understand gaps in the pharmacy data and propose solutions to closing those gaps. The goal will be to monitor data monthly for completeness and quality.