Performance Evaluation Report

Partnership Health Plan

July 1, 2010–June 30, 2011

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

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 million beneficiaries (as of June 2011)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2011.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Partnership Health Plan ("Partnership" or "the plan"), which delivers care in Napa, Solano, Yolo, and Sonoma counties, for the review period July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

Partnership is a full-scope managed care plan operating in Napa, Solano, Yolo, and Sonoma counties under the MCMC Program. Partnership delivers care to members as a County Organized Health System (COHS).

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

Partnership began services under the MCMC Program beginning in Napa County in March 1998, in Solano County in May 1994, in Yolo County in March 2001, and in Sonoma County in October 2009. As of June 30, 2011, Partnership had 160,056 enrolled members under the MCMC Program across all four counties.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

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

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about the plan's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

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

June 30, 2011, to assess plans' compliance with State-specified standards. The most recent medical performance review was completed in October and November 2007, covering the review period of October 1, 2006, through September 30, 2007. HSAG reported the review findings in the 2008–2009 plan evaluation report for Partnership.[3]

The review showed that Partnership had audit findings in the areas of continuity of care, access and availability, prior authorization, member rights, quality management, and administrative and organizational capacity. DHCS *Medical Audit Close-Out Report* letter dated October 6, 2008, noted that the plan had fully corrected several audit deficiencies; however, some issues remained unresolved at the time of the audit close-out report.

In the category of availability and accessibility, the plan had three outstanding deficiencies and should address three recommendations. First, Partnership must revise its policies and must pay claims submitted beyond the six-month billing limit. Second, it must send misdirected claims to subcontractors within ten working days. Finally, the plan must ensure payment of 100 percent clean claims. In the area of member rights, the outstanding deficiency requires Partnership to include Kaiser grievances as its delegated provider, at least quarterly, for the commission review.

Medi-Cal Managed Care Member Rights and Program Integrity Review

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

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2011.

MRPIU conducted an on-site review of Partnership in April, 2011, covering the review period of November 1, 2008 through January 31, 2011. The scope of the review included grievances, prior authorization notifications, cultural and linguistic services, evidence of coverage, and provider

[3] California Department of Health Care Services. *Performance Evaluation Report, Partnership Health Plan – July 1, 2008 through June 30, 2009*. October 2009. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

compliance with member rights requirements. MRPIU noted findings in the categories of prior authorization and cultural and linguistic services.

In the member grievances category, a review of 47 randomly selected files showed that resolution letters sent to the beneficiaries contained only the last page of the five-page instructions that provide members with guidance over the State Fair Hearing process. Going forward, the plan was advised to include all five pages of the instructions.

In the prior authorization category, MRPIU observed that three of 27 files reviewed contained a Notice of Action (NOA) letter that exceeded the maximum 14-day time frame. Additionally, 10 files used an outdated template for the NOA letter and "Your Rights" attachment. In the cultural and linguistic services category, MRPIU noted that one provider office indicated that the use of family, friends, or minors as translators was not discouraged.

Strengths

In the medical review audit, Partnership was able to close out deficiencies in the areas of continuity of care, prior authorization, quality management, and administrative and organizational capacity through corrective action plans. In the MRPIU audit, Partnership showed strength in the area of evidence of coverage, with no findings in this area.

Opportunities for Improvement

Partnership has the opportunity to strengthen policies and procedures in the areas of prior authorization and cultural and linguistic services. Additionally, as several deficiencies from the medical review audit remain open, Partnership has the opportunity to correct these deficiencies and improve processes in these categories.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about Partnership's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[4] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of Partnership in 2011 to determine whether the plan followed appropriate specifications to produce valid rates. The audit revealed no areas of concern.

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

Performance Measure Results

MCMC requires contracted health plans to calculate and report HEDIS rates at the county level unless otherwise approved by the DHCS; however, exceptions to this requirement were approved several years ago for COHS health plans operating in certain counties. Partnership was one of the COHS health plans approved for combined county reporting for Napa, Solano, and Yolo counties. Table 3.2 reflects combined reporting for those three counties. MCMC requires all existing health plans expanding into new counties to report separate HEDIS rates for each county whenever a new county's membership exceeds 1,000. The DHCS required Partnership to generate county-level reporting for Sonoma County beginning in 2011.

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Tables 3.2 and 3.3.

Table 3.1—HEDIS® 2011 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2011 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Tables 3.2 and 3.3 present a summary of Partnership's HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. The table shows the plan's HEDIS 2011 performance compared to the MCMC-established MPLs and HPLs.

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

Table 3.2—2010–2011 Performance Measure Results for Partnership Health Plan—Napa, Solano, and Yolo Counties

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	27.0%	26.1%	★★	↔	19.7%	35.9%
AWC	Q,A,T	38.7%	39.6%	★★	↔	38.8%	63.2%
BCS	Q,A	49.7%	52.9%	★★	↑	46.2%	63.8%
CCS	Q,A	61.6%	68.0%	★★	↔	61.0%	78.9%
CDC–BP	Q	64.8%	60.3%	★★	↔	53.5%	73.4%
CDC–E	Q,A	53.8%	54.8%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	53.5%	54.8%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	35.2%	34.6%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	82.7%	84.0%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	46.9%	49.9%	★★★	↔	27.2%	45.5%
CDC–LS	Q,A	79.0%	79.4%	★★	↔	69.3%	84.0%
CDC–N	Q,A	80.5%	78.5%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	65.0%	70.1%	★★	↔	63.5%	82.0%
LBP	Q	88.1%	88.4%	★★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	84.8%	89.0%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	64.8%	69.5%	★★	↔	58.7%	74.4%
URI	Q	93.2%	93.6%	★★	↔	82.1%	94.9%
W34	Q,A,T	73.3%	67.5%	★★	↔	65.9%	82.5%
WCC–BMI	Q	50.7%	57.4%	★★	↑	13.0%	63.0%
WCC–N	Q	43.1%	49.8%	★★	↑	34.3%	67.9%
WCC–PA	Q	35.9%	42.1%	★★	↔	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.3—2010–2011 Performance Measure Results for Partnership Health Plan—Sonoma County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	NA	21.0%	★★	NC	19.7%	35.9%
AWC	Q,A,T	NA	36.3%	★	NC	38.8%	63.2%
BCS	Q,A	NA	NA	NA	NC	46.2%	63.8%
CCS	Q,A	NA	60.3%	★	NC	61.0%	78.9%
CDC–BP	Q	NA	62.2%	★★	NC	53.5%	73.4%
CDC–E	Q,A	NA	49.6%	★★	NC	41.4%	70.1%
CDC–H8 (<8.0%)	Q	NA	51.8%	★★	NC	38.7%	58.8%
CDC–H9 (>9.0%)	Q	NA	37.1%	★★	NC	53.4%	27.7%
CDC–HT	Q,A	NA	87.3%	★★	NC	76.0%	90.2%
CDC–LC (<100)	Q	NA	38.4%	★★	NC	27.2%	45.5%
CDC–LS	Q,A	NA	68.9%	★	NC	69.3%	84.0%
CDC–N	Q,A	NA	77.3%	★★	NC	72.5%	86.2%
CIS–3	Q,A,T	NA	71.0%	★★	NC	63.5%	82.0%
LBP	Q	NA	90.1%	★★★	NC	72.0%	84.1%
PPC–Pre	Q,A,T	NA	88.2%	★★	NC	80.3%	92.7%
PPC–Pst	Q,A,T	NA	67.1%	★★	NC	58.7%	74.4%
URI	Q	NA	97.0%	★★★	NC	82.1%	94.9%
W34	Q,A,T	NA	71.7%	★★	NC	65.9%	82.5%
WCC–BMI	Q	NA	77.3%	★★★	NC	13.0%	63.0%
WCC–N	Q	NA	54.4%	★★	NC	34.3%	67.9%
WCC–PA	Q	NA	47.7%	★★	NC	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
NA = The DHCS does not establish an MPL/HPL for first year measures.
NC = Not comparable with the previous year.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

Partnership demonstrated average performance overall. Five measures scored above the MPLs, and only three measures scored below the MPLs in 2011. For Napa/Solano/Yolo counties, three measures had statistically significant increases and there were no measures with a statistically significant decrease. There were no HEDIS results for Sonoma County in 2010; therefore, no comparison could be made for the 2011 measurement period.

HEDIS Improvement Plans

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

For measures requiring a 2010 improvement plan, HSAG used 2011 HEDIS scores to evaluate progress during the year. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or develop new improvement plans.

In 2010, the plan did not have any measures below MPLs. Therefore, no improvement plans were in place for 2011.

Strengths

Across all counties, Partnership exceeded the MPL for a majority of its HEDIS measures and exceeded the HPL in five measures. *Use of Imaging Studies for Low Back Pain* was the top-performing indicator across all counties, as it performed above the HPL. There were no measures with a statistically significant decrease, and three measures had a statistically significant increase.

Opportunities for Improvement

Partnership's biggest opportunity for improvement is for the newly added Sonoma County to benchmark against the HEDIS success that Partnership is experiencing in Napa, Solano, and Yolo counties. Sonoma County had three measures (*Adolescent Well-Care Visits*, *Cervical Cancer Screening*, and *Comprehensive Diabetes Care—LDL-C Screening*) that performed below the MPLs and will be required to submit HEDIS improvement plans to address these areas of low performance until it achieves DHCS established MPLs. Overall, the majority of measures were between the MPLs and HPLs, with no statistically significant change. The plan may consider how to elevate rates at or above the HPLs and how to promote statistically significant change in the upcoming year.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Quality Improvement Projects Conducted

Partnership had two clinical QIPs in progress during the review period of July 1, 2010–June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of DHCS's statewide collaborative QIP project. Partnership's second project, an internal QIP, targeted improving the management of chronic obstructive pulmonary disease (COPD) among members 40 years of age and older. Both QIPs fell under the quality domain of care, and the first project also fell under the access domain of care.

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

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

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

Quality Improvement Project Validation Findings

The table below summarizes the validation results for both QIPs across CMS protocol activities during the review period. HSAG validated

Table 4.1—Quality Improvement Project Validation Activity for Partnership Health Plan—Napa, Solano, and Yolo Counties July 1, 2010, through June 30, 2011

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	84%	100%	*Met*
Internal QIPs				
Improving Care and Reducing Acute Readmissions for People With COPD	Annual Submission	74%	80%	*Partially Met*
	Resubmission 1	87%	90%	*Partially Met*
	Resubmission 2	92%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that Partnership's annual submission of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*, with 84 percent all evaluation elements and 100 percent of critical elements receiving a *Met* score. For its *Improving Care and Reducing Acute Readmissions for People With COPD* QIP annual submission, Partnership received a *Partially Met* validation status. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted this QIP; however, the plan still did not provide accurate or complete statistical testing documentation, so the score remained *Partially Met*. The plan resubmitted this QIP for a second time and, upon subsequent validation, achieved an overall *Met* validation status.

Table 4.2 summarizes the validation results for both of Partnership's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates*
for Partnership Health Plan—Napa, Solano, and Yolo Counties
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2010, through June 30, 2011

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	92%	8%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**97%**	**3%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	90%	10%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**94%**	**6%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved†	25%	38%	38%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**72%**	**12%**	**16%**

* The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.
† The sum may not equal 100 percent due to rounding.

Only the *Reducing Avoidable Emergency Room Visits* QIP had a second remeasurement period and was assessed through Activity X. The *Improving Care and Reducing Acute Readmissions for People With COPD* QIP was assessed through Activity IX.

Partnership successfully applied the QIP process for the design and implementation stages, scoring 100 percent *Met* on all applicable evaluation elements for four of the seven applicable activities. For the outcomes stage, the plan was scored down for not demonstrating statistically significant improvement for the *Reducing Avoidable Emergency Room Visits* QIP outcome and the third study indicator for the *Improving Care and Reducing Acute Readmissions for People With COPD* QIP. Additionally, in Activity X, the plan was scored down for not achieving sustained improvement for the *Reducing Avoidable Emergency Room Visits* QIP outcome. Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

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

Table 4.3—Quality Improvement Project Outcomes for Partnership Health Plan—Napa, Solano, and Yolo Counties (Number = 2 QIP Submissions, 2 QIP Topics) July 1, 2010, through June 30, 2011

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable	17.7%	18.9%*	21.5%*	No
QIP #2—Improving Care and Reducing Readmissions for People With COPD				
QIP Study Indicator	**Baseline Period 7/1/08–6/30/09**	**Remeasurement 1 7/1/09–6/30/10**	**Remeasurement 2 7/1/10–6/30/11**	**Sustained Improvement¥**
1) Percentage of members 40 years of age and older with at least one claim/encounter for spirometry in the 730 days before the Index Episode Start Date to 180 days after the IESD	21.4%	23.6%*	‡	‡
2) Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter who were dispensed :				
a) Systemic corticosteroid within 14 days of the event	37.6%	66.7%*	‡	‡
b) Bronchodilator within 30 days of the event	46.6%	88.9%*	‡	‡
3) Percentage of all-cause inpatient hospital discharges with an inpatient hospital readmission within 30 days of discharge date for COPD members	28.0%	36.3%*	‡	‡

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

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

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

The plan documented an increase in avoidable ER visits between the first and second remeasurement periods, reflecting a decline in performance. The plan did not achieve sustained improvement from baseline to Remeasurement 2. Collaborative interventions were initiated in 2009; however, they did not correlate with any improvement in the QIP outcome.

For the *Improving Care and Reducing Acute Readmissions for People With COPD* QIP, the plan was able to demonstrate statistically significant improvement for spirometry testing and the dispensing of corticosteroids and bronchodilators. The plan reported a statistically significant increase in the readmissions for COPD members, which represented a decline in performance. The plan did not clearly document the barrier analysis results or how interventions were evaluated. However, the plan did implement a care transition plan in June 2010 to address readmissions, which may affect the Remeasurement 2 results.

Strengths

Partnership accurately documented the design and implementation stages for both QIPs, scoring 100 percent *Met* for all applicable evaluation elements in four of the six activities. Additionally, the plan achieved a statistically significant improvement in providing spirometry tests and dispensing systemic corticosteroids and bronchodilators for members with COPD.

Opportunities for Improvement

Partnership has an opportunity to improve its QIP documentation in order to increase compliance with the validation requirements. HSAG recommends that Partnership use HSAG's QIP Completion Instructions, which will help the plan address all required elements within the activities. In addition to addressing deficient evaluation element scores of *Partially Met* or *Not Met*, the plan should also address all elements scored *Met* with a *Point of Clarification* in order to avoid these scores from being lowered to a *Partially Met* or *Not Met* score in a subsequent validation.

The plan has an opportunity to improve its intervention strategies to order to achieve sustained improvement of its QIP outcomes. At a minimum, barrier analysis should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone.

Partnership should include a plan to evaluate the efficacy of the interventions—specifically, using subgroup analysis to determine if the initiatives are affecting the entire study population in the same way. The plan should evaluate the outcomes by gender, age, provider, and/or other selected groupings, which will enable the plan to address, through the development of plan-specific interventions, any disparities that may exist in the study population in relationship to the study outcomes. The evaluation of the interventions should be clearly documented. Based on the

evaluation results, the plan should make appropriate revisions or implement new interventions, if necessary. If the intervention evaluation demonstrates that an intervention is successful, the plan should clearly document the process used to monitor and standardize the intervention in the QIP.

The plan must initiate two QIPs for its Sonoma County membership to meet DHCS requirements for having two QIPs in progress after October 1, 2010.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

Partnership had average performance based on its 2011 performance measure rates (which reflect 2010 measurement data), QIP outcomes, medical performance, and member rights reviews.

The plan resolved several deficiencies relating to previous medical performance findings and scored well on compliance reviews. However, Partnership will need to ensure 100 percent payment of clean claims. In the area of member rights, this outstanding deficiency requires Partnership to submit Kaiser grievances, at least quarterly, for commission review.

The MRPIU review of 47 randomly selected grievance files describes resolution letters sent to beneficiaries that contained only the last page of a five-page guidance document on the State Fair Hearing process. The plan was advised to include all five pages of instructions moving forward.

The plan had average scores for performance measures in the quality domain. Five measures scored above the MPLs, and only three measures scored below the MPLs in 2011. For Napa/Solano/Yolo Counties, three measures had statistically significant increases, and there were no measures with a statistically significant decrease.

Partnership had average results for QIP performance in 2010–2011. The plan did well documenting QIP study design and implementation phases. Both QIPs, *Reducing Avoidable*

Emergency Room Visits and *Improving Care and Reducing Acute Readmissions for People With COPD*, fell within the quality domain of care. Although the plan did not achieve statistically significant improvement for its *Reducing Avoidable Emergency Room Visits* QIP*,* it achieved statistically significant improvement in two of the three study indicators (providing spirometry tests and dispensing systemic corticosteroids and bronchodilators for members with COPD).

Access

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

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

Relating to accessibility to care, the plan demonstrated below-average performance based on a review of 2011 performance measure rates related to access, QIP outcomes, medical performance, and member rights reviews.

While Partnership met, or addressed, most deficiencies in access-related compliance standards, the plan had an unresolved finding for cultural and linguistic services. MRPIU describes one provider office failing to discourage use of family, friends, or minors as translators.

Partnership had three access measures below the MPLs, with zero measures above the HPLs. The three measures below MPLs were in Sonoma County: *Adolescent Well-Care Visits, Cervical Cancer Screening, and Comprehensive Diabetes Care—LDL-C Screening.*

For the *Improving Care and Reducing Acute Readmissions for People With COPD* QIP, the plan was able to demonstrate statistically significant improvement for spirometry testing and the dispensing of corticosteroids and bronchodilators. The *Reducing Avoidable Emergency Room Visits* QIP failed to reduce emergency room admissions, particularly for avoidable or unnecessary visits.

Timeliness

The timeliness domain of care relates to a plan's ability to make timely utilization decisions based on clinical urgency, disruptions to care, and efficient delivery of service after a need is identified.

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans compliance with standards in enrollee rights and protections, grievance system, continuity/coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care are under the timeliness domain of care because they quantify health care delivery within a recommended period of time.

Partnership exhibited average performance in the timeliness domain of care based on 2011 performance measures for timely care, medical performance, and member rights reviews.

The October-November 2007 Medical Performance Review noted issues with time frame requirements in sending prior authorization notice of action letters and grievance acknowledgement and resolution letters. First, Partnership must revise policies and pay claims submitted beyond the six-month billing limit. Second, they must forward misdirected claims to subcontractors within 10 working days.

MRPIU notes three of 27 files reviewed contained a Notice of Action (NOA) letter exceeding the maximum 14-day time frame. It was noted that all 10 Woodland Health Care files reviewed contained the outdated template used for the NOA letter and the "Your Rights" attachment.

Performance rates indicate *Adolescent Well-Care Visits* did not achieve the MPL. Other measures of timeliness, including prenatal care and well-child care visits, demonstrated average performance, exceeded MPLs but fell short of the HPLs.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 plan-specific evaluation report. Partnership's self-reported responses are included in Appendix A.

Conclusions and Recommendations

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

Similar to previous year findings, Partnership's members may have issues with access to care, given the decline in compliance, performance measures, and QIP results.

Based on the overall assessment of quality, timeliness, and accessibility of care, HSAG recommends that the plan do the following:

- Revise the plan policy for payment of claims submitted beyond the six-month billing limit. Send misdirected claims to subcontractors within 10 working days.
- Include grievances from Kaiser, at least quarterly, for commission review.
- Include all five pages of State Fair Hearing instructions, providing members with complete guidance on the hearing process.
- Sonoma County should benchmark with Partnership's HEDIS scores in Napa, Solano, and Yolo counties.
- Use HSAG's QIP Completion Instructions to help the plan's compliance with all required elements.
- Improve intervention strategies to sustain improvements in QIP outcomes. At a minimum, barrier analysis should be performed to identify and prioritize challenges in each measurement period. More frequent analyses may allow the plan to identify trends not evident in annual analysis alone.
- Include a plan to evaluate interventions—specifically, using subgroup analysis to determine if initiatives improve the entire study population in the same way. The plan should evaluate the outcomes by gender, age, provider, and/or other selected groupings to address any disparities in the study population.
- Initiate two QIPs for Sonoma County to meet DHCS requirements since the plan has been operational for one year.

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

APPENDIX A. GRID OF PLAN'S FOLLOW-UP ON EQR RECOMMENDATIONS FROM THE JULY 1, 2009–JUNE 30, 2010 PERFORMANCE EVALUATION REPORT

for **Partnership Health Plan**

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with Partnership's self-reported actions that address the recommendations. Neither Health Services Advisory Group, Inc. (the external quality review organization for Medi-Cal Managed Care) nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table A.1—Grid of Partnership's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	Partnership's Self-Reported Actions That Address the EQR Recommendation
As the *Improving Care and Reducing Acute Readmissions for People With COPD* QIP progresses, evaluate the effectiveness of the interventions. If improvements are not made, conduct subgroup analysis to identify specific barriers to improving care for members with COPD and adjust interventions to address these barriers.	For measurement year 2011 (calendar year 2010 data), PHC improved rates in all indicators monitored; however, only improvement for one rate was statistically significant, the lower readmission rate. PHC attributes this improvement to the addition of our Care Transitions Program which became effective in July 2010 and focuses on providing care support for members post discharge. Although the program is not specific to COPD, COPD members meet the criteria for the program. This program demonstrated a positive ROI (3.8); and in comparing members in the program versus those that did not participate, the readmission rate was 10.2 for participants versus 18.6 for non-participants. Again, these data are not specific to COPD. In addition, the visiting nurse home program that started in 2007 continues to be an effective approach. Other interventions that were completed in 2010 included: PHC's COPD newsletter distributed to members twice a year and also a provider toolkit given to providers during site reviews and audits. PHC identified that use of office-based spirometry to diagnose COPD is limited. As a result, PHC received a grant to train providers on using spirometry and interpreting results accurately. If this training program is successful, PHC will spread it to more than the initial four pilot sites in 2012.
Ensure that all open findings from the medical performance and MRPIU reviews are fully addressed, and that corrective action plans were effective in addressing deficiencies.	***Finding: The plan did not always meet the time frame requirements for sending acknowledgement and resolution letters.*** *Response:* PHC has implemented an electronic mechanism designed to streamline processes and better document and execute timely distribution of acknowledgement and resolution letters. The process is monitored regularly to ensure compliance. ***Finding: Issues with prior authorizations exceeding the time frame for notice of action letters, a file with missing citations/regulations to support plan actions taken, and missing documentation of qualified physician review of files.*** *Response*: PHC has implemented additional electronic processes to ensure that all documents are maintained as required. Staff training/retraining has occurred to include the required regulatory citations to support the actions taken. PHC continues to have a physician review any denial and physicians are required to document their findings on a work sheet that is kept with the case and/or in an electronic format. Statistical reports are reviewed quarterly and interrater reliability studies are performed regularly to monitor compliance.

Table A.1—Grid of Partnership's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	Partnership's Self-Reported Actions That Address the EQR Recommendation
Implement a formal process to assess performance measures that show declining performance, particularly focusing on the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.* Conduct a thorough analysis to determine what factors are contributing to lower performance and implement targeted improvement interventions.	In reviewing the data, PHC identified the following reasons for lower eye exam rate: 1) The State limited the benefit for adults where adult members could not get glasses and annual eye exams, except for diabetics, where an annual exam is covered. Although annual eye exams are covered for diabetics, members were confused about the change; and this was gleaned from member calls to PHC. 2) Beginning 2008–2009, PHC no longer provided financial incentives to providers for providing annual eye exams to diabetic members. A diabetes multi-disciplinary work group was convened in 2009 to identify interventions for improving eye exam rates. As a result of that work group, PHC had several phone calls with VSP, our members' vision provider, to explore ways to improve access to eye exams. VSP began sending out reminders to diabetics who have not had a dilated eye exam; however, this intervention had limited success. The plan is now exploring other interventions where we would partner with providers to identify members who need an exam and work with them to determine barriers to access (i.e., use retinal cameras in the office). Adding the eye exam to PHC's provider incentive program is under consideration for the 2012–2013 fiscal year.
Review the 2010 plan-specific CAHPS results report and develop strategies to address the *Rating of All Health Care, Rating of Health Plan,* and *Getting Care Quickly* priority areas.	In order to better understand the drivers for lower satisfaction rates in the three areas identified by HSAG, the Member Services Department obtained input from our members through focus groups conducted in 2010 and the Consumer Advisory Committee. The focus groups highlighted access issues, especially with access to specialists as well as communication between specialists and primary care providers as top concerns. In addition, feedback from Member Services staff on how to improve members' perception of their health plan uncovered the need to focus on training of customer service staff. With these drivers identified, the following interventions were implemented in 2010/2011: ◆ Provide customer service training at least annually to customer service staff. • Status: 2010 training completed; activity is ongoing. Training focuses on active listening, dealing with difficult members, demonstrating empathy, and scripts for opening and closing calls. The closing states, "Did I meet your service expectations today?"

Table A.1—Grid of Partnership's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	Partnership's Self-Reported Actions That Address the EQR Recommendation
	◆ Questions specific to PHC's Member Services Department were added to the 2010 Cultural &Linguistics survey that included open-ended questions to better understand member concerns with service provided by Member Services and where they believe access issues are present. • Status: Survey fielded in October/November 2010, where access to well exams was identified as a big issue. Beginning in 2012, a communication packet was developed to encourage providers to do well exams annually per AAP guidelines. ◆ New Call Center System was developed to enable Member Services staff to better respond to member and provider calls and reduce the number of transfers. • Status: Completed implementation of call system in 2010. ◆ Management monitors five calls per month, per rep, and provides feedback to staff. • Status: Completed and ongoing. Performance on the phone is part of an employee's annual performance review and is measured by specific standards. ◆ Currently telemedicine is only a benefit for a select group of specialties. In 2010, PHC leadership explored the feasibility of providing reimbursement and expanding the use of telemedicine and setting up a benefit structure to support its use in more specialty areas. Meetings with UC Davis occurred; and beginning in 2012, access to more specialties will be available.