# Performance Evaluation Report

# Partnership HealthPlan of California

## July 1, 2011–June 30, 2012

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

June 2013

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# 1. Introduction

## Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans 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 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 designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more 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.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[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.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, 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.

This report is specific to DHCS's contracted plan, Partnership HealthPlan of California ("Partnership" or "the plan"), which delivers care in Napa, Solano, Yolo, and Sonoma counties, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, 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 Marin, Mendocino, Napa, Solano, Sonoma, and Yolo counties. Partnership delivers care to members as a County Organized Health System (COHS) model. In a COHS model, DHCS initiates contracts with county-organized and county-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.

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 of June 30, 2012, Partnership had 201,692 MCMC members across all six counties.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

## Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period 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.

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 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

## Assessing Structure and Operations

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

### *Medical Performance Review*

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

The most recent completed medical performance review with Partnership was conducted in November 2007, covering the review period of October 1, 2006, through September 30, 2007. HSAG initially reported the review findings in Partnership's 2008–2009 plan-specific evaluation report.[4] The DHCS *Medical Audit Close-Out Report* letter dated October 6, 2008, indicated that the plan had fully corrected deficiencies in the areas of Continuity of Care, Quality Management, and Administrative and Organizational Capacity, and two of the three identified deficiencies in the area of Member's Rights. The letter also indicated that unresolved deficiencies remained in the areas of Availability and Accessibility and Member's Rights.

A medical review by the State Controller's Office was conducted in December 2010 covering the period January 1, 2009, through December 31, 2009; however, the State Controller's Office did not issue the final audit report. Therefore, the results are not summarized in this report.

Since the November 2007 medical performance audit was conducted more than three years prior to the review period for this report, HSAG includes a summary of the findings in this report for historical purposes of the most recent audit; however, HSAG does not include these outdated results when assessing overall plan performance during the review period. As part of the development of this report, HSAG reviewed documentation from the plan to determine what actions it has taken to resolve the outdated deficiencies and, when applicable, HSAG has included a description of those actions. Listed below are the unresolved deficiencies followed by actions the plan appears to have taken to resolve the deficiencies.

## Deficiencies

### *Availability and Accessibility*

Partnership's policies and procedures in the areas of Emergency Service Providers and Family Planning were not in compliance with California Welfare and Institutions (W&I) Code, which allows providers to submit a Medi-Cal claim for payment beyond the 6-month billing limit in specified situations.

**Plan Response:**

- Partnership's self-report indicates that the plan revised its policy on payment of claims beyond the 6-month billing limit. Furthermore, the plan is sending misdirected claims to subcontractors within 10 working days.

[4] 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.

***Member's Rights***

In the area of Monitoring of Member's Grievance System, Partnership did not submit adequate documentation that the plan is sufficiently monitoring and following up with a delegate that had processed 8 of 52 issues outside the contracted and/or mandated timelines.

**Plan Response:**

- Partnership's self-report indicates that the delegate's grievances are included in board member meetings for review, which occur bimonthly. Partnership did not provide evidence that the plan followed up with the delegate regarding the identified concerns.

## Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current medical performance reviews and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

MR/PIU conducted an on-site review of Partnership in April 2011, covering the review period of November 1, 2008 through January 31, 2011. HSAG initially reported the findings from this review in Partnership's 2010–11 plan-specific evaluation report. Findings were identified in the areas of Prior Authorization Notification and Cultural and Linguistic Services, and MR/PIU identified one opportunity for technical assistance in the area of Member Grievances. Partnership

was not required to respond to the findings. MR/PIU will follow up with the plan on the findings during its next review. Listed below are the findings:

## Findings

### Prior Authorization Notification

- Review of 27 prior authorization notification files identified three files that contained a Notice of Action (NOA) letter that was sent outside the 14-day time frame requirement.
- MR/PIU reviewed 10 files from one of Partnership's providers, and all 10 used an outdated NOA letter template and "Your Rights" attachment.

### Cultural and Linguistic Services

- One staff member in five provider offices visited indicated that the use of family, friends, or minors as translators was not discouraged.

HSAG found the following information regarding actions the plan has taken that appear to address the finding in the area of Cultural and Linguistic Services:

- Partnership submitted the plan's Quality & Performance Improvement Program Evaluation report for program years January 2010–December 2011. This report was not available at the time HSAG wrote Partnership's 2010–11 plan-specific evaluation report. Partnership's Quality & Performance Improvement Program Evaluation report indicates that the plan conducted a cultural and linguistic survey in October and November 2010. The survey revealed that 20 percent of respondents indicated that a family member interpreted for them because they did not know interpreter services were available. To improve member awareness of interpreter services, the plan focused on educating members and providers through member and provider newsletters about the availability of interpreter services. Additionally, the plan emphasized the availability of interpreter services in provider trainings.

### Area of Technical Assistance

In the area of Member Grievances, a review of 47 randomly selected files and Partnership's grievances policies and procedures identified no areas of concern; however, one observation was identified. The grievance files showed that the resolution letters sent to the beneficiaries contained only the last page of the five-page instructions that provide members with guidance about the State Fair Hearing process.

Partnership provided information to HSAG as part of the process for producing this report that indicates that since expanding to Marin and Mendocino counties, the plan cross-checks all resolution letters to ensure all five pages of the State Fair Hearing instructions are included.

## Strengths

Partnership provided documentation that demonstrated efforts to resolve some of the findings identified during the medical performance and MR/PIU reviews.

## Opportunities for Improvement

The plan has the opportunity to ensure all findings are fully resolved to ensure compliance with all State requirements.

## Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). 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 DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by DHCS for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

## Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the plan's performance in providing quality, accessible, and timely care and services to its MCMC members.

### *Performance Measure Validation*

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of Partnership in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

## Performance Measure Validation Findings

HSAG auditors determined that Partnership followed the appropriate specifications to produce valid rates, and no issues were identified.

## Performance Measure Results

MCMC requires contracted health plans to calculate and report HEDIS rates at the county level unless otherwise approved by 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 is requiring that all existing health plans expanding into new counties report separate HEDIS rates for each county whenever a new county's membership exceeds 1,000. DHCS required Partnership to generate county-level reporting for Sonoma County beginning in 2011. Additionally, since Marin and Mendocino counties were added in July 2011, the first year Partnership will be required to submit data for these counties will be 2013 for calendar year 2012.

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

**Table 3.1—Performance Measures Name Key**

| Abbreviation | Full Name of 2012 Performance Measure |
|---|---|
| AAB | *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* |
| ACR | *All-Cause Readmissions (internally developed measure)* |
| AMB–ED | *Ambulatory Care—Emergency Department (ED) Visits* |
| AMB–OP | *Ambulatory Care—Outpatient Visits* |
| AWC | *Adolescent Well-Care Visits* |
| CAP–1224 | *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* |
| CAP–256 | *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* |
| CAP–711 | *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* |
| CAP–1219 | *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* |
| 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* |
| IMA–1 | *Immunizations for Adolescents—Combination 1* |

**Table 3.1—Performance Measures Name Key**

| Abbreviation | Full Name of 2012 Performance Measure |
|---|---|
| LBP | *Use of Imaging Studies for Low Back Pain* |
| MPM–ACE | *Annual Monitoring for Patients on Persistent Medications—ACE* |
| MPM–DIG | *Annual Monitoring for Patients on Persistent Medications—Digoxin* |
| MPM–DIU | *Annual Monitoring for Patients on Persistent Medications—Diuretics* |
| PPC–Pre | *Prenatal and Postpartum Care—Timeliness of Prenatal Care* |
| PPC–Pst | *Prenatal and Postpartum Care—Postpartum Care* |
| W-34 | *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 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

DHCS based the MPLs and HPLs on the National Committee for Quality Assurance's (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.

**Table 3.2—Comparison of 2011 and 2012 Performance Measure Results for Partnership HealthPlan of California—Napa/Solano/Yolo Counties**

| Performance Measure[1] | Domain of Care[2] | 2011 HEDIS Rates[3] | 2012 HEDIS Rates[4] | Performance Level for 2012 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| AAB | Q | 26.1% | 42.8% | ★★★ | ↑ | 18.8% | 31.6% |
| AMB–ED | ‡ | -- | 47.8 | -- | Not Comparable | -- | -- |
| AMB–OP | ‡ | -- | 256.9 | -- | Not Comparable | -- | -- |
| AWC | Q,A,T | 39.6% | 50.0% | ★★ | ↑ | 39.6% | 64.1% |
| CAP–1224 | A | -- | 94.9% | -- | Not Comparable | -- | -- |
| CAP–256 | A | -- | 82.9% | -- | Not Comparable | -- | -- |
| CAP–711 | A | -- | 80.3% | -- | Not Comparable | -- | -- |
| CAP–1219 | A | -- | 77.2% | -- | Not Comparable | -- | -- |
| CCS | Q,A | 68.0% | 65.7% | ★★ | ↔ | 64.0% | 78.7% |
| CDC–BP | Q | 60.3% | 69.3% | ★★ | ↑ | 54.3% | 76.0% |
| CDC–E | Q,A | 54.8% | 56.8% | ★★ | ↔ | 43.8% | 70.6% |
| CDC–H8 (<8.0%) | Q | 54.8% | 60.6% | ★★★ | ↔ | 39.9% | 59.1% |
| CDC–H9 (>9.0%) | Q | 34.6% | 28.7% | ★★★ | ↔ | 52.1% | 29.1% |
| CDC–HT | Q,A | 84.0% | 86.6% | ★★ | ↔ | 77.6% | 90.9% |
| CDC–LC (<100) | Q | 49.9% | 49.2% | ★★★ | ↔ | 27.3% | 45.9% |
| CDC–LS | Q,A | 79.4% | 78.2% | ★★ | ↔ | 70.4% | 84.2% |
| CDC–N | Q,A | 78.5% | 83.7% | ★★ | ↑ | 73.9% | 86.9% |
| CIS–3 | Q,A,T | 70.1% | 71.9% | ★★ | ↔ | 64.4% | 82.6% |
| IMA–1 | Q,A,T | -- | 56.8% | -- | Not Comparable | -- | -- |
| LBP | Q | 88.4% | 88.5% | ★★★ | ↔ | 72.3% | 82.3% |
| MPM–ACE | Q | -- | 82.1% | -- | Not Comparable | -- | -- |
| MPM–DIG | Q | -- | 80.9% | -- | Not Comparable | -- | -- |
| MPM–DIU | Q | -- | 82.4% | -- | Not Comparable | -- | -- |
| PPC–Pre | Q,A,T | 89.0% | 87.3% | ★★ | ↔ | 80.3% | 93.2% |
| PPC–Pst | Q,A,T | 69.5% | 70.3% | ★★ | ↔ | 59.6% | 75.2% |
| W-34 | Q,A,T | 67.5% | 74.3% | ★★ | ↑ | 66.1% | 82.9% |
| WCC–BMI | Q | 57.4% | 74.8% | ★★★ | ↑ | 19.7% | 69.8% |
| WCC–N | Q | 49.8% | 65.0% | ★★ | ↑ | 39.0% | 72.0% |
| WCC–PA | Q | 42.1% | 53.7% | ★★ | ↑ | 28.5% | 60.6% |

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a $p$ value of <0.05.
[6] DHCS'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] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

**Table 3.3—Comparison of 2011 and 2012 Performance Measure Results for Partnership HealthPlan of California—Sonoma County**

| Performance Measure[1] | Domain of Care[2] | 2011 HEDIS Rates[3] | 2012 HEDIS Rates[4] | Performance Level for 2012 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| AAB | Q | 21.0% | 47.5% | ★★★ | ↑ | 18.8% | 31.6% |
| AMB–ED | ‡ | -- | 43.2 | -- | Not Comparable | -- | -- |
| AMB–OP | ‡ | -- | 283.0 | -- | Not Comparable | -- | -- |
| AWC | Q,A,T | 36.3% | 58.3% | ★★ | ↑ | 39.6% | 64.1% |
| CAP–1224 | A | -- | 95.2% | -- | Not Comparable | -- | -- |
| CAP–256 | A | -- | 86.5% | -- | Not Comparable | -- | -- |
| CAP–711 | A | -- | 83.3% | -- | Not Comparable | -- | -- |
| CAP–1219 | A | -- | 84.4% | -- | Not Comparable | -- | -- |
| CCS | Q,A | 60.3% | 71.6% | ★★ | ↑ | 64.0% | 78.7% |
| CDC–BP | Q | 62.2% | 76.1% | ★★★ | ↑ | 54.3% | 76.0% |
| CDC–E | Q,A | 49.6% | 54.2% | ★★ | ↔ | 43.8% | 70.6% |
| CDC–H8 (<8.0%) | Q | 51.8% | 59.4% | ★★★ | ↑ | 39.9% | 59.1% |
| CDC–H9 (>9.0%) | Q | 37.1% | 27.0% | ★★★ | ↑ | 52.1% | 29.1% |
| CDC–HT | Q,A | 87.3% | 90.2% | ★★ | ↔ | 77.6% | 90.9% |
| CDC–LC (<100) | Q | 38.4% | 43.8% | ★★ | ↔ | 27.3% | 45.9% |
| CDC–LS | Q,A | 68.9% | 74.3% | ★★ | ↔ | 70.4% | 84.2% |
| CDC–N | Q,A | 77.3% | 80.1% | ★★ | ↔ | 73.9% | 86.9% |
| CIS–3 | Q,A,T | 71.0% | 76.6% | ★★ | ↔ | 64.4% | 82.6% |
| IMA–1 | Q,A,T | -- | 53.0% | -- | Not Comparable | -- | -- |
| LBP | Q | 90.1% | 90.4% | ★★★ | ↔ | 72.3% | 82.3% |
| MPM–ACE | Q | -- | 71.4% | -- | Not Comparable | -- | -- |
| MPM–DIG | Q | -- | 88.6% | -- | Not Comparable | -- | -- |
| MPM–DIU | Q | -- | 73.9% | -- | Not Comparable | -- | -- |
| PPC–Pre | Q,A,T | 88.2% | 83.0% | ★★ | ↓ | 80.3% | 93.2% |
| PPC–Pst | Q,A,T | 67.1% | 75.7% | ★★★ | ↑ | 59.6% | 75.2% |
| W-34 | Q,A,T | 71.7% | 72.2% | ★★ | ↔ | 66.1% | 82.9% |
| WCC–BMI | Q | 77.3% | 86.3% | ★★★ | ↑ | 19.7% | 69.8% |
| WCC–N | Q | 54.4% | 69.4% | ★★ | ↑ | 39.0% | 72.0% |
| WCC–PA | Q | 47.7% | 55.0% | ★★ | ↑ | 28.5% | 60.6% |

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a $p$ value of <0.05.
[6] DHCS'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] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

### Performance Measure Result Findings

Across all counties, 13 measures scored above the HPLs compared to 5 in 2011. No measures fell below the MPLs in 2012. For Napa/Solano/Yolo counties, eight measures had statistically significant improvement from 2011 to 2012; and no measures had a statistically significant decline in performance. In Sonoma County, 10 measures had statistically significant improvement from 2011 to 2012; and one measure, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, had a statistically significant decline in performance. Overall, the plan had average performance on the measures; however, measures falling into the quality domain of care performed above average.

### HEDIS Improvement Plans

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

HSAG compared the plan's 2011 IP (if one was required) with the plan's 2012 HEDIS rate for that measure to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

Partnership did not perform below the MPLs for any measures in 2011 and was therefore not required to submit any IPs.

## Strengths

Across all counties, Partnership exceeded the HPLs on thirteen measures; and no measures performed below the MPLs. These five measures exceeded the HPLs across all counties:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis.*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent).*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent).*
- *Use of Imaging Studies for Low Back Pain.*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total.*

Six measures had statistically significant improvement across all counties:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*.
- *Adolescent Well-Care Visits*.
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*.
- All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures.

## Opportunities for Improvement

Partnership has the opportunity to identify factors in Sonoma County that led to a statistically significant decline in performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and implement strategies to prevent further decline in performance.

## 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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* 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 plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about Partnership's performance in providing quality, accessible, and timely care and services to its MCMC members.

### *Quality Improvement Project Objectives*

Partnership had two clinical QIPs and one clinical QIP proposal in progress during the review period of July 1, 2011–June 30, 2012. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the current DHCS 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. 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.

DHCS requires plans to initiate QIP projects for counties after the plan has been operational in that county for one year; therefore, Partnership included Marin, Mendocino, and Sonoma counties in the new statewide *All-Cause Readmissions* collaborative QIP, which focused on reducing readmissions for members aged 21 years and older. The two statewide collaborative QIPs fell

under the quality and access domains of care, and the COPD project fell under the access domain of care.

The current statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider in an office or clinic setting. At the initiation of the QIP, Partnership had identified 7,517 ER room visits that were avoidable, which was 17.7 percent of the plan's ER visits. The plan's objective was to reduce this rate by using member, provider, and system improvement strategies. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize development of chronic disease.

The new statewide collaborative QIP proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. 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.

Partnership's COPD project attempted to improve the quality of care delivered to members with COPD. The plan focused on increasing the percentage of members diagnosed with COPD using spirometry testing; improving the medication management of members with COPD exacerbations; and finally, reducing the hospital readmissions for members with COPD. Proper diagnostic testing and medication are critical for COPD management. The emergency room readmissions for COPD are an indicator of poorly controlled COPD and suboptimal care.

## Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status across CMS protocol activities during the review period.

**Table 4.1—Quality Improvement Project Validation Activity for Partnership HealthPlan of California— Marin, Mendocino, Napa, Solano, Sonoma, and Yolo Counties July 1, 2011, through June 30, 2012**

| 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 ER Visits* (Napa/Solano/Yolo counties) | Annual Submission | 87% | 100% | *Met* |
| *All-Cause Readmissions** (Marin, Mendocino, Napa/Solano/Yolo, and Sonoma counties) | Proposal | Not Applicable | Not Applicable | *Pass* |
| **Internal QIPs** | | | | |
| *Improving Care and Reducing Acute Readmissions for People with COPD* (Napa/Solano/Yolo counties) | Annual Submission | 88% | 90% | *Partially Met* |
| | Resubmission | 93% | 100% | *Met* |

[1]**Type of Review**—Designates the QIP review as a 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 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*.

*During the review period, the *All-Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that Partnership's annual submission of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. 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, 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 and upon subsequent validation, achieved an overall *Met* validation status. For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

Due to unique, one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

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

**Table 4.2—Quality Improvement Project Average Rates* for Partnership HealthPlan of California—Napa, Solano, and Yolo Counties (Number = 3 QIP Submissions, 2 QIP Topics) July 1, 2011, through June 30, 2012**

| QIP Study Stages | Activity | *Met* Elements | *Partially Met* Elements | *Not Met* Elements |
|---|---|---|---|---|
| Design | I: Appropriate Study Topic | 94% | 6% | 0% |
| | II: Clearly Defined, Answerable Study Question(s) | 100% | 0% | 0% |
| | III: Clearly Defined Study Indicator(s) | 95% | 5% | 0% |
| | IV: Correctly Identified Study Population | 100% | 0% | 0% |
| **Design Total** | | **96%** | **4%** | **0%** |
| Implementation | V: Valid Sampling Techniques (if sampling is used) | Not Applicable | Not Applicable | Not Applicable |
| | VI: Accurate/Complete Data Collection | 93% | 0% | 7% |
| | VII: Appropriate Improvement Strategies | 92% | 8% | 0% |
| **Implementation Total**** | | **93%** | **4%** | **4%** |
| Outcomes | VIII: Sufficient Data Analysis and Interpretation | 92% | 0% | 8% |
| | IX: Real Improvement Achieved | 50% | 50% | 0% |
| | X: Sustained Improvement Achieved | 67% | 0% | 33% |
| **Outcomes Total** | | **77%** | **15%** | **8%** |

*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.

Both the *Reducing Avoidable Emergency Room Visits* QIP and the *Improving Care and Reducing Acute Readmissions for People with COPD* QIP included at least a second remeasurement period and were assessed for Activities I through X.

Partnership successfully applied the QIP process for the design and implementation stages, scoring 96 percent of all applicable evaluation elements *Met* for the design stage and 93 percent of all applicable evaluation elements *Met* for the implementation stage.

For the outcomes stage, the plan was scored down in Activity IX for not demonstrating statistically significant improvement for all of the study outcomes in the *Improving Care and Reducing Acute Readmissions for People with COPD* QIP. 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 and Interventions

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 HealthPlan of California—Napa, Solano, and Yolo Counties July 1, 2011, through June 30, 2012**

| 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** | **Remeasurement 3 1/1/10–12/31/10** | **Sustained Improvement¥** |
| Percentage of ER visits that were avoidable^ | 17.7% | 18.9%* | 21.5%* | 19.1%* | No |

^A lower percentage indicates better performance.
¥ 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.
* A statistically significant difference between the measurement period and prior measurement period ($p$ value < 0.05).

**Table 4.3—Quality Improvement Project Outcomes for Partnership HealthPlan of California—Napa, Solano, and Yolo Counties July 1, 2011, through June 30, 2012**

| QIP #2—Improving Care and Reducing Acute Readmissions for People with COPD | | | | |
|---|---|---|---|---|
| QIP Study Indicator | Baseline Period 1/1/08–12/31/08 | Remeasurement 1 1/1/09–12/31/09 | Remeasurement 2 1/1/10–12/31/10 | Sustained Improvement¥ |
| 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% | 29.4% | Yes |
| 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%* | 73.5% | Yes |
| b) Bronchodilator within 30 days of the event | 46.6% | 88.9%* | 85.3% | Yes |
| 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%* | 23.0* | ‡ |

^A lower percentage indicates better performance.

¥ 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.

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

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

### *Reducing Avoidable Emergency Room Visits* QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, Partnership set a goal to reduce the rate of avoidable ER visits by 10 percent over the life of the project. For this project outcome, a lower rate demonstrates improved performance. The plan did not meet its overall objective; however, it demonstrated a statistically significant improvement of its outcome from the second to the third remeasurement period. Partnership reported two separate statistically significant decreases in performance (1) from the baseline to the first remeasurement period (1.2 percentage points) and (2) from the first to the second remeasurement period (2.6 percentage points). Consequently, the plan's percentage of avoidable ER visits at the final remeasurement period demonstrated a statistically significant decline in performance when compared to the percentage of avoidable ER visits at baseline. Without improvement in the percentage of avoidable ER visits from baseline to

the final remeasurement period, Partnership could not demonstrate sustained improvement. A critical analysis of the plan's improvement strategy resulted in the following observations:

- Partnership documented that a team identified barriers and developed interventions at least annually. The plan provided data-driven results of the barrier analyses from one meeting. The plan did not describe how the identified barriers were prioritized or how interventions were selected for implementation.
- The plan offered a provider incentive to PCPs to increase after-hour access and reduce avoidable ER visits beginning in May 2008. The incentive details were not rolled out to the providers until August and September 2008. In July 2009, the plan expanded the incentive program to include paying PCPs to see other PCPs' members during after-hours, and customizing and distributing the ER collaborative posters. The information regarding the expansion of the incentive program was provided to the PCPs from August to October 2009. The plan documented efforts to provide the PCPs with member-level avoidable ER visit data online in August 2009; however, the plan did not report the PCPs' access to the data until August 2010. During the same time period, Partnership provided reports of the avoidable ER visits to the PCPs first quarterly, then monthly. The plan did not provide details related to the amount of the incentive, how the incentive was applied, evaluations of its effectiveness, or the rationale for the modifications made to the incentive.
- Partnership documented numerous plan-specific interventions. Examples of the interventions include psychiatric evaluations and drug contracts for members with chronic pain; ER diversion clinic; and letters to members aged 40–65 years comparing the cost of an ER visit to a PCP visit. The plan only documented the evaluation results for the ER diversion clinic, which was determined to be unsuccessful in reducing avoidable ER visits.
- Collaborative interventions were initiated in late 2008 and continued through 2010; however, they did not correspond to any improvement in performance. Specifically, the Partnership did not achieve success with the plan-hospital data collection collaboration. Evaluation of this intervention showed that the avoidable ER visit rates were significantly higher at the participating hospital compared to the non-participating hospitals (26.6 percent versus 17.1 percent).
- The plan attributed the decline in performance from baseline to the first remeasurement period to the late implementation of the interventions in 2008. Additionally, the plan related the decline in performance from the first to the second remeasurement period to the H1N1 outbreak.

### *Improving Care and Reducing Acute Readmissions for People with COPD* QIP

For the *Improving Care and Reducing Acute Readmissions for People with COPD* QIP, the plan did not meet its project goal of exceeding the national Medicaid 90th percentile for the project outcomes. The plan was able to demonstrate sustained improvement for increasing spirometry testing and the dispensing of corticosteroids and bronchodilators over the course of the project. The plan reported mixed results for reducing readmissions for COPD members. From baseline to the first remeasurement period, the plan documented a statistically significant increase in the readmissions for COPD members, which represented a decline in performance. From the first to the second remeasurement period, the plan improved its performance, reporting a statistically significant decline in readmissions. A critical analysis of the plan's improvement strategy resulted in the following observations:

- Partnership documented that a team identified barriers and developed interventions during monthly workgroups. Additionally, the plan reported conducting data analyses and monitoring the effectiveness of the interventions. The plan did not include data-driven results of the barrier analyses except for the results of a provider survey. The plan did not describe how the identified barriers were prioritized or how interventions were selected for implementation. Additionally, the plan did not provide the evaluation plans or results for any of the interventions.
- The plan's list of interventions included activities that were actually part of the barrier analyses process. Activities such as conducting a COPD Process Improvement Team meeting, contacting another plan regarding a care transition model, consideration of providing pulmonary rehabilitation and purchasing a portable spirometer, conducting a provider survey, and forming a subcommittee to review the survey results should be included in the barrier analyses process and in the development of interventions.
- The plan documented the planning and progress of interventions without documenting their effects on the project outcomes. For example, the plan coordinated with a pulmonologist to draft a training Webinar in January 2010. By October 2010, the training was still in development. In December 2010, the training was completed and available on the Web; however, the plan failed to clearly document the training content, which project outcomes were targeted, how it would monitor use of the training by the providers, and how it would determine the effectiveness of the intervention.
- Partnership implemented several strong interventions such as the creation of a COPD registry, implementation of a care transition coach, and addition of a pulmonary rehabilitation plan benefit; however, without a method to evaluate the interventions, the plan could not explain periods of little or no improvement of the project outcomes.

## Strengths

Partnership accurately documented the design and implementation stages for QIPs, scoring 96 percent of all applicable evaluation elements *Met* in the design stage and 93 percent *Met* in the implementation stage.

The plan successfully improved the quality of care delivered to members with COPD. Partnership increased the use of spirometry testing to diagnose and classify severity stage in newly diagnosed COPD members aged 42 years and older. For members aged 40 years and older with a COPD exacerbation that resulted in an inpatient admission or an ER visit, the plan improved the medication management of these members by appropriately dispensing systemic corticosteroids and bronchodilators. Additionally, the plan documented a reduction in the readmissions of members with COPD for the first time since the initiation of the project.

## Opportunities for Improvement

Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

With the implementation of any intervention and especially for multiple interventions, the plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

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

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care. A more detailed description of HSAG's scoring process is included in Appendix A.

## *Quality*

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

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries 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, 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.

Overall, Partnership performed above average in the quality domain of care.

Across all counties, 13 measures falling into the quality domain of care performed above the HPLs; and 18 quality measures had statistically significant improvement from 2011 to 2012. Only one quality measure, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, had statistically significant decline in performance from 2011 to 2012, and no measures performed below the MPLs in 2012.

Partnership's *Reducing Avoidable Emergency Room Visits* QIP fell into the quality domain of care. The plan received a validation score of *Met* and demonstrated understanding of the design and implementation stages. Although Partnership did not meet its goal to reduce the rate of avoidable ER visits by 10 percent over the life of the project, the plan demonstrated a statistically significant improvement of its outcome from the second to the third remeasurement period.

## 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 MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and 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. Medical performance reviews, MR/PIU reviews, 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Overall, Partnership's performed average in the access domain of care. The plan appears to have made some effort to resolve access-related findings identified during the plan's most recent MR/PIU review.

Across all counties, one measure falling into the access domain of care performed above the HPL; and no measures fell below the MPLs. One access measure, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, had a statistically significant decline in performance, and six access measures had a statistically significant improvement in performance from 2011 to 2012.

Partnership's *Improving Care and Reducing Acute Readmissions for People with COPD* QIP fell into the access domain of care. The plan was required to submit the proposal for this QIP twice before receiving an overall validation status of *Met*; but, overall, the plan demonstrated successful application of the QIP process for the design and implementation stages. While Partnership did not meet its project goal of exceeding the Medicaid 90th percentile for the project outcomes, the plan was able to show continued improvement for two of its three indicators.

## Timeliness

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

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

Overall, Partnership's performed average in the timeliness domain of care. Across all counties, one measure performed above the HPL; and no measures performed below the MPLs. Four timeliness measures had statistically significant improvement from 2011 to 2012, and one timeliness measure, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, had statistically significant decline in performance.

## Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. Partnership's self-reported responses are included in Appendix B.

## Recommendations

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

- Ensure that all open medical performance review member grievance deficiencies are fully resolved.
- Ensure that all open MR/PIU findings are fully resolved. Specifically,
  - Provide documentation of a mechanism to ensure NOA letters are sent within the required time frame.
  - Provide documentation of a mechanism to ensure that providers use the current NOA letter template and "Your Rights" attachment.
  - Provide documentation that provider trainings on translator services have resulted in providers discouraging the use of family, friends, or minors as translators.
- Identify factors in Sonoma County that led to a statistically significant decline in performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and implement strategies to prevent further decline in performance.
- Implement QIP interventions that are data-driven and targeted, which may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

- Ensure that each QIP intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

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

## Quality, Access, and Timeliness

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

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

## Performance Measure Rates

*(Refer to Tables 3.2 and 3.3)*

### *Quality Domain*

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) greater than negative three, if there are two or less measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than three.
3. To be considered ***Below Average***, a plan will have three or more measures below the MPLs than it has above the HPLs.

### Access Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus and the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

### Timeliness Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

## Quality Improvement Projects (QIPs)

*(Refer to Tables 4.1 and 4.3)*

- **Validation** *(Table 4.1)*: For each QIP submission and subsequent resubmission(s), if applicable.
  - **Above Average** is not applicable.
  - **Average** = *Met* validation status.
  - **Below Average** = *Partially Met* or *Not Met* validation status.
- **Outcomes** *(Table 4.3)*: Activity IX, Element 4—**Real Improvement**
  - **Above Average** = All study indicators demonstrated statistically significant improvement.
  - **Average** = Not all study indicators demonstrated statistically significant improvement.
  - **Below Average** = No study indicators demonstrated statistically significant improvement.

- **Sustained Improvement** *(Table 4.3)*: Activity X—**Achieved Sustained Improvement**
  - **Above Average =** All study indicators achieved sustained improvement.
  - **Average =** Not all study indicators achieved sustained improvement.
  - **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 performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity 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.

# Appendix B. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

*for* **Partnership HealthPlan of California**

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with Partnership's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

**Table B.1—Grid of Partnership's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report**

| 2010–2011 EQR Recommendation | Partnership's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation |
|---|---|
| Revise the plan policy for payment of claims submitted beyond the six-month billing limit. Send misdirected claims to subcontractors within 10 working days. | PHC has revised its policy on payment of claims beyond the 6-month billing limit. PHC is sending misdirected claims to subcontractors within 10 working days. |
| Include grievances from Kaiser, at least quarterly, for commission review. | Kaiser grievances are now included in Board member meetings for review. These meetings occur on a bimonthly basis. |
| Include all five pages of State Fair Hearing instructions, providing members with complete guidance on the hearing process. | This has been a standard process since we expanded to Marin and Mendocino. All acknowledgement and resolution letters have hearing information included. Letters are cross checked to have all five pages of the State Fair Hearing instructions with the member grievance resolution letter. |
| Sonoma County should benchmark with Partnership's HEDIS scores in Napa, Solano, and Yolo counties. | On an annual basis, PHC's QI team compares HEDIS rates for Sonoma County to rates in Eastern Counties (Napa, Solano, & Yolo) as well as to NCQA's current Means, Percentiles, and Ratios. A detailed presentation showing results and comparisons by county was provided to PHC's internal and external quality improvement committees. |
| Use HSAG's QIP Completion Instructions to help the plan's compliance with all required elements. | PHC consistently follows HSAG's QIP instructions for all project submissions. To minimize the potential for having to resubmit the documents when errors are identified by HSAG, all QIP submissions are reviewed by both the director of QI/PI as well as the HEDIS project manager. Both team members have experience with completing projects using HSAG's QIP form. The plan's multi-county IQIP submission, which included Sonoma County, received an overall "Met" status with no resubmission necessary. In addition, the QIP for readmissions received an overall "Met" status.<br><br>PHC's QI team participates in all HSAG-facilitated technical assistance calls related to changes or revisions to the QIP process. |
| 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. | PHC started collecting and analyzing data quarterly. Rates for QIP indicators are monitored both quarterly and annually. Assessment of rates more regularly allows PHC to:<br>a) Identify opportunities for improvement—review performance data at the aggregate level as well as at the subgroup level to focus on areas with low performance<br>b) Conduct barrier analysis to identify & prioritize challenges—use fish bone diagrams to identify drivers and barriers.<br>c) Evaluate effectiveness of interventions—develop an evaluation plan with clear measures and a data collection strategy.<br>d) Make modifications to current interventions and/or identify new interventions—based on regularly collecting data at least quarterly.<br><br>Quarterly data are displayed in run charts and statistical control charts to determine improvements and to what extend these are sustained. |

**Table B.1—Grid of Partnership's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report**

| 2010–2011 EQR Recommendation | Partnership's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation |
|---|---|
| | Quarterly updates are shared with our Quality Improvement committees.<br><br>The above changes have been implemented in several projects: readmissions the collaborative QIP, and the Access to Care QIP. |
| 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. | PHC hired an analyst with a background in biostatistics and epidemiology. PHC completed an analysis of all HEDIS clinical data where data were stratified by key demographic variables (age, sex, ethnicity and language spoken). In addition, data for the readmissions collaborative have been stratified by hospital, by provider, by age/sex and by disease/condition. When evaluating our various QIPs, we will stratify our data to identify specific populations that benefited from the interventions. |
| Initiate two QIPs for Sonoma County to meet DHCS requirements since the plan has been operational for one year. | Completed. PHC has two active & approved QIPs:<br>• Statewide Collaborative QIP (Reducing Readmissions) and IQIP (Improving Access to Primary Care for Children & Adolescents) |