Performance Evaluation Report

Partnership HealthPlan of California

July 1, 2012–June 30, 2013

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

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July 1, 2012 – June 30, 2013

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and

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

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

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

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Partnership HealthPlan of California ("Partnership" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

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

Partnership became operational to provide MCMC services in Solano County in May 1994, in Napa County in March 1998, in Yolo County in March 2001, in Sonoma County in October 2009, and in Marin and Mendocino counties in July 2011. As of June 30, 2013, Partnership had 18,965 MCMC members in Marin County, 20,977 in Mendocino County, 15,560 members in Napa County, 66,708 members in Solano County, 61,890 in Sonoma County, and 28,312 members in Yolo County—for a total of 212,412 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

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

This report section covers 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, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's 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.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits and Member Rights Reviews

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

The most recent routine monitoring review for Partnership was conducted April 18, 2011, through April 20, 2011, covering the review period of November 1, 2008, through January 31, 2011. HSAG reported on the detailed findings from this review in Partnership's previous MCP-specific evaluation reports. MR/PIU conducted a follow-up review for Partnership in August 2012. In addition to following up on the findings identified during the April 2011 review, MR/PIU

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP 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 the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

evaluated Partnership's level of progress in performing cultural awareness and sensitivity training required to meet the needs of the SPD population and physical accessibility review surveys.

In a letter dated May 21, 2013, MR/PIU summarized the results of the August 2012 review. MR/PIU indicated that Partnership had taken appropriate actions to correct the findings from the April 2011 review in the areas of Member Grievances, Prior Authorization Notification, and Cultural and Linguistic Services. Additionally, the letter indicated that MR/PIU found the MCP's progress on providing SPD sensitivity, facility site review tool, and physical accessibility trainings satisfactory.

Strengths

Partnership took actions to fully address the findings from the April 2011 MR/PIU Routine Monitoring Review and has made satisfactory progress on providing SPD sensitivity, facility site review tool, and physical accessibility trainings.

Opportunities for Improvement

Since Partnership resolved all areas of concern identified through the April 2011 MR/PIU survey, HSAG does not have any recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for Partnership HealthPlan of California* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that Partnership followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A review of the MCP's HEDIS audit report revealed the following observations:

- Partnership's documentation for its receipt, loading, and verification of electronically processed files was commendable. The MCP performed sufficient edit checks and validation steps throughout the process, and the MCP experienced no backlogs during the 2012 measurement year in spite of its growth to two new counties.
- The HSAG auditor recommended that Partnership document any changes to the MCP's claims and encounter processes as the MCP upgrades the system. The auditor also recommended that the MCP document in the 2014 Roadmap any backlogs or issues that arise due to the transition.

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

- In response to the previous year's recommendations, Partnership added new staff members to accommodate the MCP's growth and need for cross-training. The new team was well trained in the HEDIS process.

Performance Measure Results

DHCS requires contracted MCPs 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 MCPs operating in certain counties. Partnership was one of the COHS MCPs approved for combined county reporting for Napa, Solano, and Yolo counties. Table 3.4 reflects combined reporting for those three counties. DHCS requires that all existing MCPs 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. Sonoma County's rates are in Table 3.5.

Since Partnership began providing services to MCMC beneficiaries in Marin and Mendocino counties July 2011, HEDIS 2013 was the first year the MCP reported rates for these counties. While the 2013 rates for the measures are presented in Table 3.2 for Marin County and Table 3.3 for Mendocino County, the tables do not include comparisons to 2012 rates since there were no rates in 2012.

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

Table 3.1—Name Key for Performance Measures in External Accountability Set

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions* ‡
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient 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)*
CBP	*Controlling High Blood Pressure*
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*

Table 3.1—Name Key for Performance Measures in External Accountability Set

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
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*
LBP	*Use of Imaging Studies for Low Back Pain*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MMA–75	*Medication Management for People with Asthma—Medication Compliance 75% Total*
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*

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.
‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Table 3.2 below presents a summary of Partnership's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.2 shows the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

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 2012 and 2013 Performance Measure Results
Partnership—Marin County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	NA	NA	Not Comparable	18.98%	33.33%
ACR	Q, A	--	16.04%	--	Not Comparable	--	--
AMB–ED	‡	--	48.34	‡	Not Comparable	‡	‡
AMB–OP	‡	--	304.46	‡	Not Comparable	‡	‡
CAP–1224	A	--	98.76%	★★★	Not Comparable	95.56%	98.39%
CAP–256	A	--	87.69%	★★	Not Comparable	86.62%	92.63%
CAP–711	A	--	NA	NA	Not Comparable	87.56%	94.51%
CAP–1219	A	--	NA	NA	Not Comparable	86.04%	93.01%
CBP	Q	--	50.65%	--	Not Comparable	--	--
CCS	Q,A	--	64.73%	★★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	60.71%	★★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	42.46%	★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	50.40%	★★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	40.08%	★★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	87.70%	★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	34.13%	★★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	71.03%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	79.37%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	78.35%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	67.47%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	85.71%	★★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	NA	--	Not Comparable	--	--
MMA–75	Q	--	NA	--	Not Comparable	--	--
MPM–ACE	Q	--	76.74%	★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	76.71%	★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	78.17%	★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	57.75%	★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	67.59%	★★	Not Comparable	65.51%	83.04%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
Partnership—Marin County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
WCC–BMI	Q	--	83.33%	★★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	63.89%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	44.44%	★★	Not Comparable	31.63%	64.87%

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—Comparison of 2012 and 2013 Performance Measure Results
Partnership—Mendocino County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	28.57%	★★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	9.81%	--	Not Comparable	--	--
AMB–ED	‡	--	57.94	‡	Not Comparable	‡	‡
AMB–OP	‡	--	331.59	‡	Not Comparable	‡	‡
CAP–1224	A	--	95.45%	★	Not Comparable	95.56%	98.39%
CAP–256	A	--	89.15%	★★	Not Comparable	86.62%	92.63%
CAP–711	A	--	NA	NA	Not Comparable	87.56%	94.51%
CAP–1219	A	--	NA	NA	Not Comparable	86.04%	93.01%
CBP	Q	--	57.43%	--	Not Comparable	--	--
CCS	Q,A	--	58.82%	★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	57.18%	★★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	38.86%	★	Not Comparable	45.03%	69.72%

Table 3.3—Comparison of 2012 and 2013 Performance Measure Results
Partnership—Mendocino County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
CDC–H8 (<8.0%)	Q	--	49.75%	★★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	37.38%	★★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	92.82%	★★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	37.38%	★★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	76.73%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	78.71%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	61.86%	★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	51.46%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	88.05%	★★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	NA	--	Not Comparable	--	--
MMA–75	Q	--	NA	--	Not Comparable	--	--
MPM–ACE	Q	--	84.48%	★★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	85.61%	★★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	88.01%	★★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	69.68%	★★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	62.04%	★	Not Comparable	65.51%	83.04%
WCC–BMI	Q	--	69.91%	★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	55.79%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	31.71%	★★	Not Comparable	31.63%	64.87%

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
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[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.4—Comparison of 2012 and 2013 Performance Measure Results
Partnership—Napa/Solano/Yolo Counties

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	42.76%	33.18%	★★	↓	18.98%	33.33%
ACR	Q, A	--	13.25%	--	Not Comparable	--	--
AMB–ED	‡	47.82	52.33	‡	Not Comparable	‡	‡
AMB–OP	‡	256.88	312.13	‡	Not Comparable	‡	‡
CAP–1224	A	94.91%	96.49%	★★	↑	95.56%	98.39%
CAP–256	A	82.91%	86.42%	★	↑	86.62%	92.63%
CAP–711	A	80.35%	83.67%	★	↑	87.56%	94.51%
CAP–1219	A	77.25%	84.94%	★	↑	86.04%	93.01%
CBP	Q	--	53.86%	--	Not Comparable	--	--
CCS	Q,A	65.71%	65.41%	★★	↔	61.81%	78.51%
CDC–BP	Q	69.27%	66.67%	★★	↔	54.48%	75.44%
CDC–E	Q,A	56.79%	53.42%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	60.58%	53.64%	★★	↓	42.09%	59.37%
CDC–H9 (>9.0%)	Q	28.73%	35.76%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	86.64%	85.65%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	49.22%	42.16%	★★	↓	28.47%	46.44%
CDC–LS	Q,A	78.17%	77.70%	★★	↔	70.34%	83.45%
CDC–N	Q,A	83.74%	84.33%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	71.93%	68.87%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	56.81%	65.33%	★★	↑	50.36%	80.91%
LBP	Q	88.52%	88.95%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	59.90%	--	Not Comparable	--	--
MMA–75	Q	--	39.41%	--	Not Comparable	--	--
MPM–ACE	Q	82.13%	84.46%	★★	↑	83.72%	91.33%
MPM–DIG	Q	80.88%	90.48%	★★	↔	87.93%	95.56%
MPM–DIU	Q	82.38%	82.35%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	87.27%	81.41%	★★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	70.29%	75.92%	★★★	↔	58.70%	74.73%
W-34	Q,A,T	74.34%	74.26%	★★	↔	65.51%	83.04%
WCC–BMI	Q	74.77%	77.44%	★★★	↔	29.20%	77.13%

Table 3.4—Comparison of 2012 and 2013 Performance Measure Results
Partnership—Napa/Solano/Yolo Counties

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
WCC–N	Q	65.05%	67.91%	★★	↔	42.82%	77.61%
WCC–PA	Q	53.70%	52.79%	★★	↔	31.63%	64.87%

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.5—Comparison of 2012 and 2013 Performance Measure Results
Partnership—Sonoma County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	47.47%	27.33%	★★	↓	18.98%	33.33%
ACR	Q, A	--	13.05%	--	Not Comparable	--	--
AMB–ED	‡	43.17	44.10	‡	Not Comparable	‡	‡
AMB–OP	‡	283.01	345.59	‡	Not Comparable	‡	‡
CAP–1224	A	95.24%	96.25%	★★	↔	95.56%	98.39%
CAP–256	A	86.47%	88.58%	★★	↑	86.62%	92.63%
CAP–711	A	83.26%	85.70%	★	↑	87.56%	94.51%
CAP–1219	A	84.36%	88.23%	★★	↑	86.04%	93.01%
CBP	Q	--	54.53%	--	Not Comparable	--	--
CCS	Q,A	71.60%	70.65%	★★	↔	61.81%	78.51%
CDC–BP	Q	76.12%	69.98%	★★	↓	54.48%	75.44%
CDC–E	Q,A	54.24%	57.62%	★★	↔	45.03%	69.72%

Table 3.5—Comparison of 2012 and 2013 Performance Measure Results
Partnership—Sonoma County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
CDC–H8 (<8.0%)	Q	59.38%	51.66%	★★	↓	42.09%	59.37%
CDC–H9 (>9.0%)	Q	27.01%	34.88%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	90.18%	92.27%	★★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	43.75%	39.74%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	74.33%	76.60%	★★	↔	70.34%	83.45%
CDC–N	Q,A	80.13%	80.13%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	76.62%	74.01%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	53.01%	65.66%	★★	↑	50.36%	80.91%
LBP	Q	90.42%	90.32%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	63.71%	--	Not Comparable	--	--
MMA–75	Q	--	41.62%	--	Not Comparable	--	--
MPM–ACE	Q	71.41%	69.27%	★	↔	83.72%	91.33%
MPM–DIG	Q	88.57%	85.29%	★	↔	87.93%	95.56%
MPM–DIU	Q	73.94%	72.08%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	82.96%	85.97%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	75.69%	73.73%	★★	↔	58.70%	74.73%
W-34	Q,A,T	72.16%	74.43%	★★	↔	65.51%	83.04%
WCC–BMI	Q	86.31%	87.15%	★★★	↔	29.20%	77.13%
WCC–N	Q	69.37%	68.46%	★★	↔	42.82%	77.61%
WCC–PA	Q	54.99%	51.64%	★★	↔	31.63%	64.87%

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[8] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

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

The final selected SPD measures are listed below. Following the list of measures are Tables 3.3 and 3.4, which present a summary of Partnership's 2013 SPD measure results. Table 3.6 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.7 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*

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

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Tables 3.6, 3.8, 3.10, and 3.12.

- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Table 3.6—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population Partnership—Marin County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	3.70%	18.83%	▼	16.04%
CAP–1224	98.75%	NA	Not Comparable	98.76%
CAP–256	87.92%	77.97%	↓	87.69%
CAP–711	NA	NA	Not Comparable	NA
CAP–1219	NA	NA	Not Comparable	NA
CDC–BP	62.82%	59.77%	↔	60.71%
CDC–E	41.03%	43.10%	↔	42.46%
CDC–H8 (<8.0%)	39.74%	55.17%	↑	50.40%
CDC–H9 (>9.0%)	50.00%	35.63%	▲	40.08%
CDC–HT	84.62%	89.08%	↔	87.70%
CDC–LC (<100)	30.77%	35.63%	↔	34.13%
CDC–LS	65.38%	73.56%	↔	71.03%
CDC–N	70.51%	83.33%	↑	79.37%
MPM–ACE	67.24%	79.13%	↔	76.74%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	65.91%	79.43%	↔	76.71%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

Table 3.7—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Partnership—Marin County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
275.93	45.40	441.02	62.43

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

Table 3.8—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Partnership—Mendocino County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	8.03%	10.68%	↔	9.81%
CAP–1224	95.44%	NA	Not Comparable	95.45%
CAP–256	89.08%	NA	Not Comparable	89.15%
CAP–711	NA	NA	Not Comparable	NA
CAP–1219	NA	NA	Not Comparable	NA
CDC–BP	61.25%	54.51%	↔	57.18%
CDC–E	31.88%	43.44%	↑	38.86%
CDC–H8 (<8.0%)	45.00%	52.87%	↔	49.75%
CDC–H9 (>9.0%)	40.00%	35.66%	↔	37.38%
CDC–HT	95.63%	90.98%	↔	92.82%
CDC–LC (<100)	32.50%	40.57%	↔	37.38%
CDC–LS	75.00%	77.87%	↔	76.73%
CDC–N	71.25%	83.61%	↑	78.71%
MPM–ACE	79.55%	86.52%	↔	84.48%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	78.57%	88.14%	↔	85.61%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

Table 3.9—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Partnership—Mendocino County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
289.83	51.97	589.67	94.82

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

Table 3.10—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Partnership—Napa/Solano/Yolo Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	6.84%	15.67%	▼	13.25%
CAP–1224	96.69%	86.79%	↓	96.49%
CAP–256	86.57%	82.56%	↓	86.42%
CAP–711	83.59%	84.64%	↔	83.67%
CAP–1219	85.36%	81.91%	↓	84.94%
CDC–BP	69.54%	61.95%	↓	66.67%
CDC–E	52.54%	53.54%	↔	53.42%
CDC–H8 (<8.0%)	49.67%	54.65%	↔	53.64%
CDC–H9 (>9.0%)	37.75%	33.19%	↔	35.76%
CDC–HT	87.64%	85.62%	↔	85.65%
CDC–LC (<100)	37.75%	43.81%	↔	42.16%
CDC–LS	78.15%	77.88%	↔	77.70%
CDC–N	82.12%	88.72%	↑	84.33%
MPM–ACE	78.93%	86.70%	↑	84.46%
MPM–DIG	NA	91.07%	Not Comparable	90.48%
MPM–DIU	74.90%	85.26%	↑	82.35%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

Table 3.11—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Partnership—Napa/Solano/Yolo Counties County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
274.50	47.01	503.87	79.44

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

Table 3.12—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Partnership—Sonoma County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.01%	15.38%	▼	13.05%
CAP–1224	96.29%	NA	Not Comparable	96.25%
CAP–256	88.48%	94.74%	↑	88.58%
CAP–711	85.78%	84.06%	↔	85.70%
CAP–1219	88.24%	88.04%	↔	88.23%
CDC–BP	73.95%	67.77%	↔	69.98%
CDC–E	52.99%	59.60%	↔	57.62%
CDC–H8 (<8.0%)	48.50%	56.07%	↑	51.66%
CDC–H9 (>9.0%)	37.72%	30.91%	▲	34.88%
CDC–HT	90.12%	93.38%	↔	92.27%
CDC–LC (<100)	37.43%	46.58%	↑	39.74%
CDC–LS	78.14%	77.04%	↔	76.60%
CDC–N	79.04%	84.33%	↔	80.13%
MPM–ACE	68.61%	69.54%	↔	69.27%
MPM–DIG	NA	84.38%	Not Comparable	85.29%
MPM–DIU	62.90%	75.51%	↑	72.08%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

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

Table 3.13—2013 Non-SPD and SPD Rates for Ambulatory Care Measures Partnership—Sonoma County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
306.38	38.92	577.11	74.66

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

Performance Measure Result Findings

Across all counties, 11 measures had rates above the HPLs. Even with the addition of two new counties, this is two less measures with rates above the HPLs than in 2012. In 2012, no measures in Napa/Solano/Yolo or Sonoma counties had rates below the MPLs; however, in 2013 Napa/Solano/Yolo and Sonoma counties each had four measures with rates below the MPLs. Marin and Mendocino counties each had five measures with rates below the MPLs.

Napa/Solano/Yolo counties had six measures with rates that improved significantly from 2012 to 2013, and Sonoma County had four measures with rates that improved significantly from 2012 to 2013. Although in 2012 Napa/Solano/Yolo counties had no measures with rates that declined significantly from the previous year, in 2013 these counties had five measures with rates that declined significantly from 2012. Sonoma County had one measure in 2012 with a rate that declined significantly from 2011; in 2013, this county had four measures with rates that declined significantly from 2012. Overall, Partnership's performance on measures declined from 2012 to 2013.

Seniors and Persons with Disabilities Findings

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

- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* in Sonoma County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Mendocino County
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)* in Marin and Sonoma counties
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Marin and Sonoma counties
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* in Sonoma County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Marin, Mendocino, and Napa/Solano/Yolo counties

- *Annual Monitoring for Patients on Persistent Medications—ACE* in Napa/Solano/Yolo counties
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Sonoma and Napa/Solano/Yolo counties

The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

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

- *All-Cause Readmissions* in Marin, Napa/Solano/Yolo, and Sonoma counties
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* in Napa/Solano/Yolo counties
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* in Marin and Napa/Solano/Yolo counties
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* in Napa/Solano/Yolo counties
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* in Napa/Solano/Yolo counties

Mendocino County is the only county that had no measures with SPD rates that were worse than the non-SPD rates.

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

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential

efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

Partnership had no measures with rates below the MPLs in 2012, and the MCP was therefore not required to submit any IPs.

Since 2013 was the first year Partnership was required to report performance measure rates for Marin and Mendocino counties, the MCP will not be required to submit IPs for measures with rates below the MPLs in these counties. While no IPs are required, HSAG recommends that the MCP conduct barrier analyses and identify strategies to improve performance measure rates that were below the MPLs in 2013.

Partnership will be required to submit IPs for the following measures that had rates below the MPLs in 2013:

- *Annual Monitoring for Patients on Persistent Medications—ACE* in Sonoma County
- *Annual Monitoring for Patients on Persistent Medications—Digoxin* in Sonoma County
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Napa/Solano/Yolo and Sonoma counties

Although Partnership's rates on the *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* measure in Napa/Solano/Yolo counties, *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* measure in Napa/Solano/Yolo and Sonoma counties, and *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* measure in Napa/Solano/Yolo counties were below the MPLs in 2013, the MCP will not be required to submit IPs for these measures. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact.

Strengths

During the 2013 HEDIS audit, the auditor noted that Partnership's documentation for its receipt, loading, and verification of electronically processed files was commendable. The MCP performed sufficient edit checks and validation steps throughout the process, and the MCP experienced no

backlogs during the 2012 measurement year in spite of its growth to two new counties. Additionally, in response to the previous year's recommendations, Partnership added new staff members to accommodate the MCP's growth and need for cross-training. The new team was well trained in the HEDIS process.

Across all counties, 11 measures had rates above the HPLs. Napa/Solano/Yolo counties had 6 measures with rates that improved significantly from 2012 to 2013, and Sonoma County had 4 measures with rates that improved significantly from 2012 to 2013.

Opportunities for Improvement

Partnership has the opportunity to ensure that all changes to the MCP's claims and encounter processes that occur as a result of the system upgrade are documented in the MCP's 2014 Roadmap, including any backlogs or issues that arise due to the transition.

Partnership has the opportunity to assess the factors leading to several measures having rates below the MPLs and several measures having rates that declined significantly from 2012 to 2013. Partnership experienced a decline in overall performance on measures from 2012 to 2013, and the MCP has the opportunity to assess the factors that contributed to the decline. Additionally, the MCP has the opportunity to assess the factors leading to the SPD rates for five measures being worse than the non-SPD rates to ensure the SPD population is receiving needed health care services.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[10] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

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

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

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

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

Quality Improvement Project Objectives

Partnership participated in the statewide collaborative QIP and had two internal QIPs in progress during the review period of July 1, 2012–June 30, 2013.

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

Table 4.1—Quality Improvement Projects for Partnership
July 1, 2012, through June 30, 2013

QIP	Counties	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Marin, Mendocino, Napa/Solano/Yolo, and Sonoma	Clinical	Q, A
Improving Care and Reducing Acute Readmissions for People with COPD	Napa/Solano/Yolo	Clinical	A
Improving Access to Primary Care for Children and Adolescents	Marin, Mendocino, Napa/Solano/Yolo, and Sonoma	Clinical	A

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

Prior to initiation of the statewide collaborative QIP, Partnership had a 30-day readmission rate of 12.62 percent among Medi-Cal beneficiaries. Partnership also found that the readmission rate for the SPD population was 14.23 percent, which was higher than the 8.62 percent rate for the non-SPD population.

Partnership's *Improving Care and Reducing Acute Readmissions for People with COPD* QIP attempts to improve the quality of care delivered to members with chronic obstructive pulmonary disease (COPD). The MCP focuses on increasing the percentage of members diagnosed with COPD using spirometry testing, improving the medication management of members with COPD exacerbations, and 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.

Having a primary care provider (PCP) can improve a child's health by receiving immunizations and preventive care. Partnership's *Improving Access to Primary Care for Children and Adolescents* QIP aims to increase the rate at which children and adolescents access their PCP since increasing access to PCPs can positively impact their health. Partnership is focusing on four different age groups for this QIP: 12–24 months, 25 months–6 years, 7–11 years, and 12–18 years.

Quality Improvement Project Validation Findings

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

Table 4.2—Quality Improvement Project Validation Activity
Partnership—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties
July 1, 2012, through June 30, 2013

Name of Project/Study	County	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	Counties received the same score—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma	Study Design Submission	90%	100%	*Met*
Internal QIPs					
Improving Care and Reducing Acute Readmissions for People with COPD	Napa/Solano/Yolo	Annual Submission	85%	100%	*Met*
Improving Access to Primary Care for Children and Adolescents	Counties received the same score—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma	Study Design Submission	90%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by Partnership of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 90 percent of evaluation elements met. Partnership also received an overall validation status of *Met* for its *Improving Care and Reducing Acute Readmissions for People with COPD* QIP annual submission and its *Improving Access to Primary Care for Children and Adolescents* QIP study design submission. Both of the internal QIPs received *Met* scores for 100 percent of the critical elements. The *Improving Care and Reducing Acute Readmissions for People with COPD* QIP submission had 85 percent of the evaluation elements met and the *Improving Access to Primary Care for Children and Adolescents* QIP submission had 90 percent of the evaluation elements met.

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

Table 4.3—Quality Improvement Project Average Rates*
Partnership—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties
(Number = 3 QIP Submissions, 3 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection**	79%	11%	11%
Design Total**		**91%**	**4%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	88%	13%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**92%**	**8%**	**0%**
Outcomes	IX: Real Improvement Achieved	25%	50%	25%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**40%**	**40%**	**20%**

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

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

HSAG validated Activities I through VI for Partnership's *All-Cause Readmissions* QIP and *Improving Access to Primary Care for Children and Adolescents* QIP study design submissions and Activities I

through X for the MCP's *Improving Care and Reducing Acute Readmissions for People with COPD* QIP annual submission.

Partnership demonstrated a strong application of the Design stage, meeting 91 percent of the requirements for all applicable evaluation elements within the study stage for all three QIPs. Partnership did not describe the MCP's data analysis plan for the *All-Cause Readmissions* and *Improving Access to Primary Care for Children and Adolescents* QIPs, resulting in a lower score for Activity VI.

Additionally, HSAG could not replicate any of the *p* values reported by Partnership in the *Improving Care and Reducing Acute Readmissions for People with COPD* QIP, which resulted in a lower score for Activity VII.

Only the *Improving Care and Reducing Acute Readmissions for People with COPD* QIP progressed to the Implementation and Outcomes stages during the reporting period. Partnership demonstrated a strong application of the Implementation stage, meeting 92 percent of the requirements for all applicable evaluation elements within the study stage for this QIP. The score for Activity IX was lowered because Study Indicator 1 has not yet achieved statistically significant improvement over baseline. Study Indicators 2a and 2b demonstrated sustained improvement over baseline, resulting in the QIP achieving a *Met* score for Activity X.

Quality Improvement Project Outcomes and Interventions

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

The *All-Cause Readmissions* and *Improving Access to Primary Care for Children and Adolescents* QIPs did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information for these QIPs is included in the table or report.

Table 4.4—Quality Improvement Project Outcomes for Partnership—Napa/Solano/Yolo Counties July 1, 2012, through June 30, 2013

QIP #1—Improving Care and Reducing Acute Readmissions for People with COPD				
Study Indicator 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				
Baseline Period 1/1/08–12/31/08	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Remeasurement 3 1/1/11–12/31/11**	**Sustained Improvement¥**
21.4%	23.6%	29.4%	27.5%	‡
Study Indicator 2a: Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter who were dispensed systemic corticosteroid within 14 days of the event				
Baseline Period 1/1/08–12/31/08	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Remeasurement 3 1/1/11–12/31/11**	**Sustained Improvement¥**
37.6%	66.7%*	73.5%	56.8%	Yes
Study Indicator 2b: Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter who were dispensed bronchodilator within 30 days of the event				
Baseline Period 1/1/08–12/31/08	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Remeasurement 3 1/1/11–12/31/11**	**Sustained Improvement¥**
46.6%	88.9%*	85.3%	76.5%	Yes
Study Indicator 3: Percentage of all-cause inpatient hospital discharges with an inpatient hospital readmission within 30 days of discharge date for COPD members^				
Baseline Period 1/1/08–12/31/08	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Remeasurement 3 1/1/11–12/31/11**	**Sustained Improvement¥**
28.0%	36.3%**	23.0%*	26.2%	‡

^A lower percentage indicates better performance.

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

* A statistically significant improvement between the measurement period and the baseline (p value < 0.05).

**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.

Improving Care and Reducing Acute Readmissions for People with COPD QIP

Partnership did not meet its project goal of exceeding the national Medicaid 90th percentile for the *Improving Care and Reducing Acute Readmissions for People with COPD* QIP. The MCP was able to increase spirometry testing over the course of the project; however, the improvement was not statistically significant. The indicators for dispensing of corticosteroids and bronchodilators achieved statistically significant and sustained improvement over the life of the project. Partnership reported mixed results for reducing readmissions for COPD members. From baseline to the first remeasurement period, Partnership 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, Partnership improved its performance, reporting a statistically significant decline in readmissions over the baseline rate. However, the significant improvement over baseline was not maintained in the third remeasurement period. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- HSAG noted some documentation errors in the QIP Validation Tool and recommended that the MCP correct the errors in the next QIP submission.
- Partnership completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through the data analysis and a quality improvement process. The documentation included system interventions likely to have a long-term effect and described problem-solving techniques using data analysis to identify possible causes and solutions.
- Partnership evaluated the Home Visiting and Complex Case Management Program to determine if there was a reduction in the readmissions rate and if there was a return on investment. The evaluation results showed a slight reduction in readmissions and a small return on investment.

Although only study indicators 2a and 2b achieved statistically significant and sustained improvement over baseline, since study indicators 1 and 3 saw some improvement, DHCS and HSAG determined that the QIP, overall, was successful, and the QIP was closed.

Strengths

Partnership demonstrated an excellent application of the QIP process for the Design and Implementation stages. Additionally, the MCP achieved an overall *Met* validation status on the first submission of each QIP, showing proficiency with the QIP validation process.

Partnership improved the quality of care delivered to Medi-Cal 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, Partnership improved the medication management of these members by appropriately dispensing systemic corticosteroids and bronchodilators. Additionally, the MCP documented a reduction in the readmissions of members with COPD for the first time since the initiation of the project.

Opportunities for Improvement

Partnership has the opportunity to improve the documentation on the MCP's QIP Summary Forms, including inclusion of a detailed data analysis plan for each QIP. The MCP should reference the QIP Completion Instructions to ensure all required documentation is included on the QIP Summary Form. Additionally, Partnership has the opportunity to improve the accuracy of the documentation on the QIP Summary Form.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Partnership's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about Partnership's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

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

CAHPS Global Rating Measures:

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

CAHPS Composite Measures:

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

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

Table 5.1—CAHPS Measures Domains of Care

Measure	Domains of Care
Rating of Health Plan	Q
Rating of All Health Care	Q
Rating of Personal Doctor	Q
Rating of Specialist Seen Most Often	Q
Getting Needed Care	Q, A
Getting Care Quickly	Q, T
How Well Doctors Communicate	Q
Customer Service	Q
Shared Decision Making	Q

National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

Star Rating	Adult and Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or above the 75th and below the 90th percentiles
★★★ Good	At or above the 50th and below the 75th percentiles
★★ Fair	At or above the 25th and below the 50th percentiles
★ Poor	Below the 25th percentile

Table 5.3 through Table 5.6 present the star ratings for the global ratings and composite measures for Partnership's adult and child Medicaid populations.[15]

Table 5.3—Medi-Cal Managed Care Adult County-Level Global Ratings
Partnership—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Marin	★★★+	★★★★+	★★★★+	★★★★★+
Mendocino	★+	★★★+	★★★★★+	★★★★★+
Napa/Solano/Yolo	★★	★★	★★★★★	★★★★★+
Sonoma	★★	★★★+	★★★★★+	★★★★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.
[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.
[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

Table 5.4—Medi-Cal Managed Care Child County-Level Global Ratings
Partnership—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Marin	★★+	★+	★★+	★★+
Mendocino	★+	★+	★★+	★+
Napa/Solano/Yolo	★★	★★★	★★★★★	★★★★+
Sonoma	★	★	★★★★★	★★★★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Table 5.5—Medi-Cal Managed Care Adult County-Level Composite Measures
Partnership—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Marin	★★★+	★★+	★★+	★★+
Mendocino	★★+	★★★★+	★★★★+	★★★★+
Napa/Solano/Yolo	★★★	★	★★★★	★★★★+
Sonoma	★★★★★+	★★★★★+	★★★+	★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Table 5.6—Medi-Cal Managed Care Child County-Level Composite Measures
Partnership—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Marin	★+	★★+	★+	★★★+
Mendocino	★★★+	★★+	★+	★★★★★+
Napa/Solano/Yolo	★★★	★	★	★★★★★+
Sonoma	★+	★★★+	★+	★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Strengths

Overall, the adult measures had higher ratings than the child measures. All four counties received either an *Excellent* or *Very Good* rating for the adult *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often* measures. The child *Rating of Personal Doctor* measure received an *Excellent* rating in Napa/Solano/Yolo and Sonoma counties and Mendocino and Napa/Solano/Yolo counties received an *Excellent* rating for the child *Customer Service* measure. Sonoma County received an *Excellent* rating for the adult *Getting Needed Care* and *Getting Care Quickly* measures. Please note that across all counties, Partnership had fewer than 100 respondents for most measures so caution should be exercised when evaluating these results.

The ratings for the following measures in Napa/Solano/Yolo counties improved from 2010 to 2013:

- *Rating of Health Plan*—adult populations
- *Rating of Personal Doctor*—adult populations
- *Rating of Specialist Seen Most Often*—adult and child populations
- *Getting Needed Care*—adult and child populations
- *How Well Doctors Communicate*—adult populations
- *Customer Service*—adult and child populations

Partnership in Marin, Mendocino, and Sonoma counties were not surveyed in 2010.

Opportunities for Improvement

Partnership's CAHPS results showed below average-performance for the majority of the child global ratings and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as Partnership's highest priorities: *Rating of Health Plan, Rating of All Health Care*, and *Getting Needed Care*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 Partnership CAHPS MCP-Specific Report*. Areas for improvement spanned the quality and access domains of care.

Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[16] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[16] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Partnership's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

Encounter Data Validation Findings

Review of Encounter Systems and Processes

The information provided in Partnership's Roadmap and supplemental questionnaire demonstrate that the MCP has procedures in place for the creation, validation, correction, and ongoing monitoring of encounter data.

Partnership's processes for submitting claims and encounter data files adhere to industry best practices. Partnership stated that monthly reports are generated to measure the timeliness and completeness of encounter data submissions. The MCP also receives monthly error and warning reports from DHCS on the files submitted. These reports are reviewed by an IT staff member to determine the necessary programming modifications needed to correct the reported issues in order to prevent reoccurrence in future file submissions to DHCS.

Record Completeness

Overall, Partnership had relatively low record omission and record surplus rates (less than 10 percent) for the Medical/Outpatient and Hospital/Inpatient claim types, indicating relatively complete Medical/Outpatient and Hospital/Inpatient data when comparing DHCS's data and the encounter data extracted from Partnership's data system for this study. However, the Pharmacy data were relatively incomplete when comparing the two data sources because of Partnership's poor Pharmacy record omission rate (46.3 percent), which was worse than the statewide rate by

33.0 percentage points. The Pharmacy records omitted from DHCS's data were mainly due to members not populated in DHCS's data, members' dates of service not in DHCS's data, or the duplicated records (based on county, member, date of service, and drug/medical supply identifiers) in the MCP's data. The remaining five record omission or record surplus rates were all better than the statewide rates. The record omission and record surplus rates for the four counties were consistent for the Medical/Outpatient and Hospital/Inpatient claim types. The Pharmacy claim type had the most county-level variations, with record omission rates ranging from 42.2 percent for Napa County to 54.6 percent for Yolo County.

Data Element Completeness

Partnership had fair performance for data element completeness, with element omission and element surplus rates less than 1.5 percent for the majority of the key data elements across the three claim types. The majority of the data elements also had element omission rates that were similar to or better than the statewide rates. Only the *Revenue Code* for the Hospital/Inpatient claim type and the *CPT/HCPCS Codes* for the Medical/Outpatient claim type had element omission rates that were considerably worse than the statewide rates (by 48.4 percentage points and 8.4 percentage points, respectively) due to the *Revenue Code* values beginning with "LT" and *CPT/HCPCS Codes* values beginning with "CH" in the MCP's data. For the element surplus rates, Partnership's performance was similar to or better than the statewide rates with the exception of four rates. The element surplus rate for the *Referring/Prescribing/Admitting Provider Number* in the Hospital/Inpatient claim type was worse than the statewide rate by 2.7 percentage points. The *Billing/Reporting Provider Number, Referring/Prescribing/Admitting Provider Number,* and *Provider Type* data elements for the Pharmacy claim type had element surplus rates worse than the statewide rates by 12.5, 7.8, and 92.2 percentage points, respectively. The poorest element surplus rate was for the *Provider Type* data element in the Pharmacy claim type, which had an element surplus rate of 100.0 percent, indicating that there were no values listed in the MCP's data for this element. However, in DHCS's data, all matched records had a value of "24" (Pharmacies/Pharmacist). The Hospital/Inpatient claim type had notable county-level variation for the *Revenue Code*, which had element omission rates ranging from 41.7 percent for Solano County to 61.3 percent for Sonoma County. The Pharmacy claim type had county-level variation for two data elements, *Billing/Reporting Provider Number* and *Referring/Prescribing/Admitting Provider Number*, which had element surplus rates ranging from 0.0 percent (Yolo County) to 22.1 percent (Solano County). For the remaining rates, there were minimal county-level variations.

Data Element Accuracy

Partnership had element accuracy rates that were greater than 90 percent for all key data elements across the three claim types except the three elements listed below.

- The *Referring/Prescribing/Admitting Provider Number* had element accuracy rates less than 17 percent and fell below the respective statewide element accuracy rates by more than 74 percentage points for all three claim types. The low accuracy rates were observed because Partnership's data file had provider numbers beginning with a number, and DHCS's data file had provider numbers beginning with a letter.
- The *Provider Type* had element accuracy rates of 79.4 percent for the Medical/Outpatient claim type and 75.8 percent for the Hospital/Inpatient claim type. Both rates were below the statewide rates by more than 11 percentage points.
- The *Provider Specialty* had an element accuracy rate of 38.4 percent for the Medical/Outpatient claim type, which was 56.3 percentage points below the statewide rate.

Partnership had notable county-level variation for some of the element accuracy rates. For example, the difference between the highest and lowest element accuracy rates was more than 26 percentage points for the *Referring/Prescribing/Admitting Provider Number* in the Pharmacy claim type, *Provider Type* in the Medical/Outpatient and Hospital/Inpatient claim types, and *Provider Specialty* in the Medical/Outpatient claim type.

Due to the poor element accuracy and element completeness for a number of data elements in each of the three claim types, the Medical/Outpatient, Hospital/Inpatient, and Pharmacy claim types had all-element accuracy rates of 24.5 percent, 7.2 percent, and 0.0 percent, respectively. All of these all-element accuracy rates fell below the statewide rates by more than 39 percentage points. All counties had an all-element accuracy rate of 0.0 percent for the Pharmacy claim type, while the Medical/Outpatient and Hospital/Inpatient claim types had all-element accuracy rates ranging more than 12 percentage points across counties.

Recommendations

Based on its review, HSAG recommends the following:

- Partnership should work with DHCS to investigate why the CCNs in the MCP's data and the CCNs in DHCS's data were not comparable for the Medical/Outpatient data, Hospital/Inpatient data, and Pharmacy data from Kaiser.
- Partnership should investigate the high record omission rate for the Pharmacy claim type and create strategies for improvement.
- Partnership should investigate the reason(s) for the relatively poor element omission rates for the *Revenue Code* in the Hospital/Inpatient claim type and the *CPT/HCPCS Codes* in the Medical/Outpatient claim type and take necessary actions for future improvement.

- Partnership should investigate why all Pharmacy records were missing a value for the data element *Provider Type* in the data submitted to HSAG, while DHCS's data had a value present for this field.
- Partnership should investigate the reason(s) for the relatively poor element surplus rates for the *Billing/Reporting Provider Number* and *Referring/Prescribing/Admitting Provider Number* in the Pharmacy claim type so that it can improve the element surplus rates for these two data elements.
- For the Medical/Outpatient claim type, both data sources were missing values for the data element *Rendering Provider Number*. Partnership should discuss with DHCS if it should modify its processes and procedures in order to collect and submit data to DHCS for this data element in the future.
- For the Hospital/Inpatient claim type, both data sources were missing values for the data elements *Primary Surgical Procedure Code* and *Secondary Surgical Procedure Code*. Partnership should discuss with DHCS if it should collect and submit data to DHCS for these data elements in the future.
- Partnership had six element accuracy rates below 80 percent. The MCP should review the inaccuracies, investigate the cause(s), and improve its processes and procedures to increase these accuracy rates in the future.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[17]

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

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

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

HSAG reviewed Partnership's quality improvement program description, which provides a summary of the MCP's organizational structure and processes used to ensure quality care is provided to Medi-Cal members.

Across all counties, 10 measures that fall into the quality domain of care had rates above the HPLs, and 13 quality measures had rates below the MPLs. Comparisons to 2012 could only be made for Napa/Solano/Yolo and Sonoma counties. The following quality measures had rates with statistically significant improvement from 2012 to 2013:

- *Immunizations for Adolescents—Combination 1* in Napa/Solano/Yolo and Sonoma counties
- *Annual Monitoring for Patients on Persistent Medications—ACE* in Napa/Solano/Yolo counties

The following quality measures had rates that were significantly worse in 2013 when compared to 2012:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Napa/Solano/Yolo and Sonoma counties
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* in Sonoma County
- *Comprehensive Diabetes Care—Hemoglobin A1c(HbA1c) Control (<8.0 Percent)* in Napa/Solano/Yolo and Sonoma counties
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Napa/Solano/Yolo and Sonoma counties
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* in Napa/Solano/Yolo counties
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Napa/Solano/Yolo counties

The following quality measures that were stratified for the SPD population had SPD rates that were significantly better than the non-SPD rates:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Mendocino County
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)* in Marin and Sonoma counties
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Marin and Sonoma counties
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* in Sonoma County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Marin, Mendocino, and Napa/Solano/Yolo counties
- *Annual Monitoring for Patients on Persistent Medications—ACE* in Napa/Solano/Yolo counties

- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Sonoma and Napa/Solano/Yolo counties

The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

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

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

Mendocino County is the only county that had no measures with SPD rates that were significantly worse than the non-SPD rates.

All CAHPS measures fall into the quality domain of care. Across all counties, most of the adult measures received a *Good* or better rating, and most of the child measures received a *Fair* or *Poor* rating.

Partnership's *All-Cause Readmissions* QIP falls into the quality domain of care. Since this QIP did not progress to the Outcomes stage, HSAG could not assess the QIP's success at improving the quality of care delivered to the MCP's Medi-Cal members.

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

Access

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

HSAG reviewed Partnership's quality improvement program documents and found descriptions of several activities focused on ensuring access to services, including monitoring and evaluation of members' access to care.

Two measures that fall into the access domain of care had rates above the HPLs:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* in Marin County
- *Comprehensive Diabetes Care—HbA1c Testing* in Mendocino County

Across all counties, 12 access measures had rates that were below the MPLs.

As indicated above, comparisons to 2012 could only be made for Napa/Solano/Yolo and Sonoma counties. The following access measures had rates with statistically significant improvement from 2012 to 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* in Napa/Solano/Yolo counties
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* in Napa/Solano/Yolo and Sonoma counties
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* in Napa/Solano/Yolo and Sonoma counties
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* in Napa/Solano/Yolo and Sonoma counties
- *Childhood Immunization Status—Combination 1* in in Napa/Solano/Yolo and Sonoma counties

The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure falls into the access domain of care. This measure's rate declined significantly in Napa/Solano/Yolo counties from 2012 to 2013.

The following access measures that were stratified for the SPD population had SPD rates that were significantly better than the non-SPD rates:

- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Marin, Mendocino, and Napa/Solano/Yolo counties
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* in Sonoma County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Mendocino County

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

- *All-Cause Readmissions* in Marin, Napa/Solano/Yolo, and Sonoma counties
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* in Napa/Solano/Yolo counties

- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* in Marin County
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* in Napa/Solano/Yolo counties
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* in Napa/Solano/Yolo counties

As indicated above, Mendocino County is the only county that had no measures with SPD rates that were significantly worse than the non-SPD rates.

The *Getting Needed Care* CAHPS measure falls into the access domain of care. The MCP's counties had mixed results for this measure:

- Marin County received a *Good* rating for the adult population and a *Poor* rating for the child population
- Mendocino County received a *Fair* rating for the adult population and a *Good* rating for the child population
- Napa/Solano/Yolo counties received a *Good* rating for both the adult and child populations
- Sonoma County received an *Excellent* rating for the adult population; however, this county received a *Poor* rating for the child population

Partnership's *Improving Care and Reducing Acute Readmissions for People with COPD* and *Improving Access to Primary Care for Children and Adolescents* QIPs fall into the access domain of care. Only the *Improving Care and Reducing Acute Readmissions for People with COPD* QIP progressed to the Implementation and Outcomes stages. Overall, this QIP achieved positive outcomes; and based on the QIP's success at improving access to care for members with COPD, the QIP was closed.

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

Timeliness

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

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

identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

Partnership's quality documents include some activities that support the MCP in ensuring timely services are provided to members.

The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure, which falls into the timeliness domain of care, was above the HPL in Napa/Solano/Yolo counties in 2013. The following timeliness measures had rates below the MPLs in 2013:

- *Childhood Immunization Status—Combination 3* in Mendocino County
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Marin County
- *Prenatal and Postpartum Care—Postpartum Care* in Marin County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Mendocino County

As indicated above, comparisons to 2012 could only be made for Napa/Solano/Yolo and Sonoma counties. These counties had statistically significant improvement from 2012 to 2013 on rates for the *Immunizations for Adolescents—Combination 1* measure, which falls into the timeliness domain of care. The rate for one timeliness measure, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, declined significantly in Napa/Solano/Yolo counties from 2012 to 2013.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. The results for this measure were somewhat mixed across counties:

- Marin County received a *Fair* rating for both the adult and child populations.
- Mendocino received a *Very Good* rating for the adult population and a *Fair* rating for the child population.
- Napa/Solano/Yolo counties received a *Poor* rating for both the adult and child populations.
- Sonoma received an *Excellent* rating for the adult population and a *Good* rating for the child population.

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

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-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 MCP:

- Ensure that all changes to the MCP's claims and encounter processes that occur as a result of the system upgrade are documented in the MCP's 2014 Roadmap, including any backlogs or issues that arise due to the transition.
- Since Partnership had 18 measures with rates below the MPLs in 2013 and 9 measures with rates that were significantly worse in 2013 when compared to 2012, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.
- Assess the factors leading to the SPD rates for five measures being significantly worse than the non-SPD rates to ensure the MCP is meeting the needs of the SPD population.
- Since the MCP has shown success at improving rates for some measures and sustaining acceptable rates on others, the MCP should consider duplicating applicable successful strategies when approaching improvement efforts on measures with declining rates or rates below the MPLs.
- Ensure documentation on the QIP Summary Form is complete and accurate. Partnership should reference the QIP Completion Instructions to ensure understanding of all information required to be included on the QIP Summary Form.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Rating of Health Plan, Rating of All Health Care,* and *Getting Needed Care* priority areas.
- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2 through 3.5)

Quality Domain

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

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

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

Access and Timeliness Domains

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

CAHPS Survey Measures

(Refer to Tables 5.3 through 5.6)

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

Quality Domain

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

Access Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

Timeliness Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Not all study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

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 and Medi-Cal Managed Care Division reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures, CAHPS measures, and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the encounter data validation (EDV) study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

Appendix B. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

for Partnership HealthPlan of California

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with Partnership's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table B.1—Partnership's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	Partnership's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. Ensure that all open medical performance review member grievance deficiencies are fully resolved.	Conducted on-site audit of the delegate and reported deficiency with required documentation from the delegate that its staff addressed the timeliness issue.
2. Ensure that all open MR/PIU findings are fully resolved. Specifically,	
a. Provide documentation of a mechanism to ensure notice of action (NOA) letters are sent within the required time frame.	Please refer to Att. 1 Policy MCUP3041 under A. Section 1 – TAR Review Process, 14 for the UM Decision Timeline. **NOTE:** HSAG reviewed the policy that Partnership submitted as documentation for actions the MCP has taken to address the recommendation and found that the policy includes the required documentation.
b. Provide documentation of a mechanism to ensure that providers use the current NOA letter template and "Your Rights" attachment.	Following the October 2012 monitoring review progress report, Partnership has since been continuing to monitor the quality of Prior Authorization Notifications. Woodland Health Care's denial letters have been observed to be up to date.
c. Provide documentation that provider trainings on translator services have resulted in providers discouraging the use of family, friends, or minors as translators.	Proper procedures for using interpreters remain a standing agenda item during provider trainings. These procedures are also posted on Partnership HealthPlan's Web site and can be found here: http://www.partnershiphp.org/Provider/LangAssist.htm Also, in Att. 2 is a delegation grid that shows how results are monitored and evaluated. **NOTE:** HSAG reviewed the information referenced that Partnership submitted as documentation for actions the MCP has taken to address the recommendation and found that the documentation includes the required information.

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3. 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.	In June 2012, PHC convened a Prenatal Postpartum Learning Network (PPLN) to improve early access to prenatal and postpartum care across all counties. The purpose of the PPLN is to bring Partnership HealthPlan providers and community-based organizations together to network, share best practices, and learn and apply quality improvement methodologies to strengthen prenatal and postpartum outcomes of care. The PPLN offered educational Webinars on using QI methods and using data to drive improvements in prenatal and postpartum care; in addition participants exchanged best practices and shared challenges at in-person meetings. In 2012, we hosted a total of two events: one Webinar and one share and learn in-person meeting. Based on the success of interventions conducted for pregnant women seen at Clinic Ole in Napa county, PHC coordinated a best practices Webinar in August 2012 to help Sonoma County providers and providers in other counties implement interventions to increase access to prenatal and postpartum care. In September 2012, the PPLN convened for a Share and Learn meeting, during which participants had an opportunity to create and share storyboards about their program to display the great work that they are actively doing. The event ended with an open forum to have a discussion on the following topics: eligibility, exercise classes, incentives, transportation resources, and outreach for no shows. To ensure that strategies implemented were sustained over time, PHC focused its efforts on facilitating conversations between providers to encourage improved infrastructures that serve pregnant women across all counties. PHC is also in the process of reviewing its Growing Together Program, which primarily serves our eastern regions, to see what interventions should be tailored to the Sonoma region. The goal is to roll out interventions in early 2014 to impact our 2015 HEDIS rates.
4. 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.	Based on HEDIS 2012 data, PHC's *Children and Adolescents' Access to Primary Care Practitioners* (CAP) Medi-Cal rates were much lower than the benchmark and were below the minimum performance level with the exception for 12–24 months threshold in Sonoma county. These measures were identified as areas for improvement. With a growing Medi-Cal population, this was an important measure for which to conduct targeted interventions to ensure that existing pediatric members and new members in a growing Medi-Cal population receive appropriate and timely access to care. In October 2012, PHC worked with a vendor to conduct a robo-call intervention that provided a reminder call to all homes with children between the ages of 1–19 to follow up with their Primary Care Physician for routine visits. PHC's member services team was also trained to speak to the importance of routine primary care visits to encourage PHC members to take their children in for their annual or bi-annual visit, depending on the child's age. In addition, we shared guidelines that emphasize the importance of annual visits since the CAP measure does not

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	align with the Child Health and Disability Prevention (CHDP) requirements. We did a Webinar on this and also provided some resources online to providers. This intervention proved to be successful and was also an intervention that could be conducted on an annual basis across all counties, with finite resources.
5. 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.	All QI interventions include a charter and plan for evaluation. The main intervention we implemented during this time period was conducting robo-calls to members due for annual exams per the CAP measure. This plan is clearly documented in our QIP submission and is summarized below. In addition, we complete an evaluation of our largest set of interventions which comprise our pay-for-performance program (PCP QIP). A logic model was developed and is attached (Att. 3). This framework allows us to evaluate different aspects of the program. An evaluation was completed for the automated calls for Remeasurement period 1 which demonstrated statistically significant results in several CAP measures across counties. Below is the evaluation plan: • PHC will run rates by provider and at the plan level quarterly to identify areas for improvement (e.g., providers to target) and to measure the effectiveness of interventions implemented. The previous one or two year look-back period (depending on the measure) will be used quarterly to monitor changes in performance. Run charts will be used to display data over time to assess any observed variation. • PHC will complete an annual analysis using the selected indicator at the plan level. As part of the annual analysis, data will be stratified by the key demographic variables described above to further analyze whether a decrease in disparities was observed. A Chi-square test will be used to test for statistical significance. All measurement periods will be compared to baseline, in addition to Remeasurement 1 compared to Remeasurement 2. In addition, results for all remeasurement periods will be compared to established goals/benchmarks. We will look for statistical significance at $p < .01$.