Performance Evaluation Report

Contra Costa Health Plan

July 1, 2008–June 30, 2009

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

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1. Executive Summary

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.4 million beneficiaries in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Plan-specific reports are issued in tandem with the technical report. This report is unique to the MCMC Program's contracted plan, Contra Costa Health Plan ("CCHP" or "the plan") for the review period of July 1, 2008, to June 30, 2009. Plan-specific reports include findings for each plan regarding its organizational assessment and structure, performance measures, and QIPs as they relate to the quality, access, and timeliness domains of care. Actions taken by the plan subsequent to June 30, 2009, regarding findings identified within this report will be included in the next annual plan-specific evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPL indicate low performance, rates at or above the HPL indicate high performance, and rates at the MPL or between the MPL and HPL demonstrate average performance.

HSAG found that CCHP demonstrated average performance for the quality domain of care. This was based on the plan's 2009 performance measure rates (which reflected 2008 measurement data), QIP outcomes, and compliance review standards related to measurement and improvement.

Most of CCHP's performance measure rates fell between the established MPLs and HPLs. The plan's rates for *Use of Appropriate Medications for People With Asthma (ASM)* and *Breast Cancer Screening (BCS)* were below the MPL while the plan's rate for *Childhood Immunization Status—Combination 3 (CIS–3)* exceeded the HPL. The plan had three statistically significant increases between its 2008 and 2009 rates and one statistically significant decline.

CCHP can improve the quality of care for members by exploring factors that contributed to the statistically significant decline in its breast cancer screening rate and by improving its rate for the *Use of Appropriate Medications for People With Asthma (ASM)* measure.

QIP outcome data showed that CCHP achieved statistically significant and sustained improvement in childhood immunization rates among Hispanic, Black, and White children. The plan's efforts to improve care as part of its QIP translated into an increase in its overall childhood immunization rate, which was above the HPL in 2009. The plan also had sustained improvement in well-child visits for Hispanic and Black children in the first 15 months of life.

HSAG noted that the plan has an opportunity to improve its documentation of both QIPs to meet compliance with federal requirements for conducting a QIP.

CCHP's strength is in delivering quality care to children, as evidenced by its above-average performance for childhood immunizations; QIP outcomes for improving immunization rates and well-child visits; and statistically significant improvement for three childhood-related performance measures between 2008 and 2009. The plan is just under the HPL for both well-child visits measures and the appropriate treatment for children with an upper respiratory infection.

The plan demonstrated full compliance with DHCS and federal standards that were reviewed in the area of quality management. CCHP's quality program included identification of the accountable area, strategy, goal, objective, target date, and end-of-year status for its activities. The quality program included the areas of diversity, education, health engagement, incentives, performance measurement, quality improvement, and service excellence. Under the joint audit review area of administrative and organizational capacity, the audit showed that CCHP had challenges with hiring a health educator who possessed a master's degree in community or public health education, which was a repeat finding and presents an opportunity for improvement.

Access

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

Many performance measures fall under more than one domain. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

CCHP demonstrated average performance for the access domain of care based on its 2009 performance measure rates that related to access, QIP outcomes that addressed access, and compliance review standards related to the availability of and access to care.

CCHP's 2009 performance measures that related to access all fell between the MPLs and HPLs with the exception of the plan's immunization rate, which exceeded the HPL.

The plan was fully compliant with all requirements reviewed for marketing and enrollment programs, and cultural and linguistic services. Audit findings showed opportunities for CCHP to improve care coordination for members receiving Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and members with developmental disabilities to ensure that members receive all medically necessary services. Additionally, the plan did not have a policy in place for standing referrals for members with HIV/AIDS, which could be an access barrier.

Timeliness

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

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

Based on 2009 performance measure rates for providing timely care and compliance review standards related to timeliness, CCHP demonstrated average performance in the timeliness domain of care.

The plan performed within the MCMC-established thresholds for well-child visits and prenatal and postpartum visits and above the HPL for childhood immunizations in the timeliness domain of care. The plan achieved statistically significant and sustained improvement for its immunization QIP aimed at reducing disparities for Hispanic, Black, and White children. The plan also had sustained improvement for well-child visits among Hispanic and Black children, which suggested that its members were receiving timely care according to recommended practice guidelines.

The plan was fully compliant with all requirements for member grievances. Under the prior-authorization notification, the review conducted by MCMC's Member Rights/Program Integrity Unit noted one finding in which 1 of 50 files reviewed lacked the member rights attachment that includes State fair hearing information. Both member grievances and prior-authorization notifications sent by CCHP were resolved within the required time frames, demonstrating timely utilization decisions.

Conclusions and Recommendations

Overall, CCHP demonstrated average performance in providing quality, accessible, and timely health care services to its MCMC members. CCHP's performance measure rates were primarily between the established MPLs and HPLs. The plan exceeded the HPL for its *Childhood Immunization Status—Combination 3 (CIS–3)* measure. It performed best on childhood-related measures and continued to demonstrate improvement toward the HPL in these areas. Opportunities exist for the plan to address its breast cancer screening rate. CCHP demonstrated compliance with the DHCS standards for member grievances, marketing and enrollment programs, and cultural and linguistic services.

Based on the overall assessment of CCHP in the areas of quality and timeliness of and access to care, HSAG recommends the following:

- Develop targeted, evidence-based interventions to address the statistically significant decline in breast cancer screening rates.
- Recruit a qualified health educator to meet contractual requirements.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.
- Modify care coordination processes to ensure that medically necessary services are coordinated for members receiving EPSDT services and members with disabilities.
- Develop a standing referral policy and procedure for members with HIV/AIDS that includes access to and monitoring for qualified providers.
- Conduct ongoing monitoring of prior authorization notifications to ensure that State fair hearing information is included.

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

Plan Overview

Contra Costa Health Plan is a full-scope managed care plan in Contra Costa County. CCHP became operational with the MCMC Program in February 1997, and as of June 30, 2009, the plan had 53,274 MCMC members.[1]

CCHP serves members as a local initiative (LI) under a Two-Plan model. In a Two-Plan model county, the DHCS contracts with two managed care plans to provide health care services to members. In most Two-Plan model counties, Medi-Cal beneficiaries in both mandatory and voluntary aid codes can choose between a local initiative plan and a nongovernmental commercial health plan.

[1] *Medi-Cal Managed Care Enrollment Report - June 2009*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. The DHCS conducts this review activity through an extensive monitoring process to assess plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about CCHP's performance in providing quality, accessible, and timely health care services to its MCMC members. Compliance monitoring standards primarily fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Joint Audit Review

The DHCS's Audits and Investigations Division (A&I) works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A joint audit is conducted for each MCMC plan approximately once every three years. In addition, the DHCS's A&I Division periodically conducts non-joint medical audits of five MCMC plans; however, CCHP was not among those plans designated for a non-joint medical audit.

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plan compliance with State-specified standards. A joint audit of CCHP was conducted in January 2007, covering the review period of January 1, 2006, through December 31, 2006. The scope of the audit covered the areas of utilization management (UM), continuity of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity. Results from the audit showed strengths as well as opportunities for improvement.

In the UM area, CCHP showed that it developed and maintained a UM program, monitored for over- and underutilization of health care services, and complied with prior-authorization review requirements and procedures. The plan was compliant with all requirements reviewed in this category.

For continuity of care, the plan had policies and procedures in place for the coordination and continuity of care for its members. The audit found that CCHP was unable to identify all members receiving EPSDT services and all members who had developmental disabilities. As a result, the plan could not ensure that members referred for these services were receiving all medically necessary services. This was a repeat finding.

For availability and accessibility, the audit showed that the plan's policy documented the time to obtain various appointments, including primary care, urgent care, emergency care, and prenatal care. However, the audit noted that the plan's policy did not include access standards for specialty services, telephone wait time, and call-return time for provider offices. CCHP also did not have a mechanism for monitoring telephone wait time or call-return time for provider offices. Additionally, although the plan referred members to Contra Costa County's HIV and AIDS program, the audit found that the plan did not have a specific policy for standing referrals to HIV/AIDS specialists, a process for verifying HIV/AIDS provider qualifications, or oversight of delegated provider groups regarding provider qualifications for serving this population.

In the member grievances area, the audit showed that CCHP had a process in place to track and resolve grievances. All grievance files reviewed for the audit were acknowledged in a timely manner, and the files showed that the issues were resolved appropriately. The audit found that the plan's Health Insurance Portability and Accountability Act of 1996 (HIPAA) policies did not address all the reporting requirements, including the requirement to provide the DHCS with oral and written notification of a suspected or actual breach of security regarding the unauthorized use or disclosure of protected health information.

For the quality management area, the plan demonstrated implementation and maintenance of a quality management program to monitor, evaluate, and take action to address needed improvements. CCHP was compliant with all the requirements reviewed in this category.

Under the administrative and organizational capacity area, the review showed one finding, that administrative oversight of health education was provided by a health educator who did not possess a master's degree in community or public health education. This was a repeat finding. CCHP's corrective action plan for the 2003 audit stated that a clinical management coordinator with a master's degree in community health had been hired to oversee the health education program; however, this position did not exist during the 2007 audit.

Member Rights and Program Integrity Monitoring Review

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

As part of the monitoring process, the MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2009.

MRPIU conducted a routine monitoring review of CCHP in February 2009, covering the review period of January 1, 2008, through December 31, 2008. The plan was fully compliant with all requirements reviewed for member grievances, marketing and enrollment programs, and cultural and linguistic services. Under the prior authorization notification, MRPIU noted one finding in which 1 of 50 files reviewed lacked the member rights attachment that includes State fair hearing information.

Strengths

CCHP demonstrated multiple strengths for compliance with federal and State standards under the areas of quality management, utilization management, member grievances, marketing and enrollment programs, and cultural and linguistic services. Notably, the plan demonstrated timely acknowledgment and resolution of member grievances, sent all prior-authorization notifications within required time frames, and included all the required language and State fair hearing information in virtually all prior-authorization notifications.

CCHP's quality program included identification of the accountable area, strategy, goal, objective, target date, and end-of-year status. The program covered the areas of diversity, education, health engagement, incentives, performance measurement, quality improvement, and service excellence.

Opportunities for Improvement

The plan has opportunities to improve in the areas of care coordination, accessibility and availability of services, and administrative and organizational capacity. CCHP needs to modify its policies and procedures to ensure coordination between the plan, the regional center, and the primary care physician for members receiving early start and developmental disability services. Additionally, the plan needs to revise its privacy policies related to notification of security breaches and standing referrals for members with HIV/AIDS.

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about CCHP's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Performance Measure Validation

HSAG performed a HEDIS® Compliance Audit™[2] of CCHP in 2009. HSAG found all measures to be reportable and that CCHP's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

Recommendations from the audit included considering methods to expand CCHP's validation of claims and encounter data; implement steps to reconcile the disposition of rejected claims and encounters; and explore alternatives to replace the manual updating of CPT codes, which has the potential to introduce errors into the system.

[2] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS Compliance Audit™ is a trademark of the NCQA.

Performance Measure Results

The table below presents a summary of CCHP's county-level HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measures results (based on calendar year 2007 data). In addition, the table shows the plan's HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the National Committee for Quality Assurance (NCQA)'s national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—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 Medicaid 10th percentile.

Due to significant methodology changes for the *Comprehensive Diabetes Care—HbA1c Control (< 7.0 Percent)* measure for 2009, the MCMC Program was unable to compare 2008 and 2009 performance results for this measure. Tables 4.1 notes the 2009 rate as a *Not Report* audit result.

Appendix A includes a performance measure name key with abbreviations contained in the following tables.

Table 4.1—2008–2009 Performance Measure Results for Contra Costa Health Plan—Contra Costa County

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	37.5%	32.5%	★★	↔	20.6%	35.4%
ASM	Q	86.2%	85.9%	★	↔	86.1%	91.9%
AWC	Q,A,T	38.9%	47.4%	★★	↑	35.9%	56.7%
BCS	Q,A	47.6%	43.7%	★	↓	44.4%	61.2%
CCS	Q,A	69.7%	67.9%	★★	↔	56.5%	77.5%
CDC–E	Q,A	52.6%	53.5%	★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	32.8%	NR	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	38.0%	42.2%	★★	↔	52.5%	32.4%
CDC–HT	Q,A	82.0%	83.0%	★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	42.1%	42.2%	★★	↔	25.1%	42.6%
CDC–LS	Q,A	77.9%	79.4%	★★	↔	66.7%	81.8%
CDC–N	Q,A	81.3%	82.3%	★★	↔	67.9%	85.4%
CIS–3	Q,A,T	80.0%	82.5%	★★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	80.2%	83.5%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	61.5%	68.1%	★★	↑	54.0%	70.6%
URI	Q	91.9%	93.6%	★★	↑	79.6%	94.1%
W15	Q,A,T	68.3%	71.0%	★★	↔	44.5%	73.7%
W34	Q,A,T	66.5%	77.4%	★★	↑	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the full name of each HEDIS measure.

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

[3] HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.

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

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

[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.

[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

† The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

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

NR = Not Report. The plan chose not to report the rate or the rate could not be reported due to material bias.

Performance Measure Result Findings

Overall, CCHP demonstrated average performance, falling between the MPLs and HPLs for most of its reported performance measures in 2009. It exceeded the MCMC goal for *Childhood Immunization Status—Combination 3 (CIS–3)* but had below-average performance in two areas: *Use of Appropriate Medications for People With Asthma (ASM)* and *Breast Cancer Screening (BCS)*. CCHP had statistically significant changes in performance between 2008 and 2009 for five measures, four of which were improvements.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPL. Plans that have rates below this minimum level must submit an improvement plan to the DHCS for each area of deficiency, outlining the steps they will take to improve care.

In 2008, the DHCS did not require CCHP to submit any improvement plans because all measures were above the MPL. Based on 2009 performance, the DHCS required CCHP to submit an improvement plan for measures that fell below the MPL: *Use of Appropriate Medications for People With Asthma (ASM)* and *Breast Cancer Screening (BCS)*.

Strengths

CCHP performed above the MMCD goal for the *Childhood Immunization Status—Combination 3 (CIS–3)* measure. Childhood immunizations span the domains of quality, access, and timeliness.

Four measures showed statistically significant improvement, including three child-related measures: *Adolescent Well-Care Visits (AWC), Appropriate Treatment for Children With Upper Respiratory Infection (URI),* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*, which demonstrated efforts to provide quality care. Additionally, the plan improved its *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)* rate and is only 2.5 percentage points below the HPL.

Opportunities for Improvement

CCHP's performance for *Breast Cancer Screening (BCS)* fell below the MPL and was the only measure with a statistically significant decrease, which provided an opportunity for improvement. CCHP's performance in this area may point to issues with health care access and/or quality.

Conducting the Review

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

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about CCHP's performance in providing quality, accessible, and timely care and services to its MCMC members. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Quality Improvement Projects Conducted

CCHP had three clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. CCHP's second project, an internal QIP, aimed to reduce ethnic disparities for childhood immunizations and well-child visits. The third QIP focused on reducing health disparities related to obesity among ethnic groups. The three QIPs spanned the quality, access, and timeliness domains of care.

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

The plan's disparity projects attempted to improve the quality of care delivered to Hispanic and Black children by increasing immunization rates, increasing well-child visits, and increasing the evaluation of obesity.

Quality Improvement Project Validation Findings

The DHCS contracted with HSAG as its new EQRO in the second half of 2008. HSAG began validation for QIPs submitted by the plans after July 1, 2008.

Table 5.1 summarizes the validation results for all three of CCHP's QIPs across CMS protocol activities during the review period.

Table 5.1—QIP Validation Results for Contra Costa Health Plan—Contra Costa County (N=3 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	94%	0%	6%
II.	Clearly Defined, Answerable Study Question(s)	33%	0%	67%
III.	Clearly Defined Study Indicator(s)	74%┼	16%┼	11%┼
IV.	Correctly Identified Study Population	33%	22%	44%
V.	Valid Sampling Techniques (if sampling was used)	100%	0%	0%
VI.	Accurate/Complete Data Collection	55%	18%	27%
VII.	Appropriate Improvement Strategies	75%┼	13%┼	13%┼
VIII.	Sufficient Data Analysis and Interpretation	48%	24%	29%
IX.	Real Improvement Achieved	63%	25%	13%
X.	Sustained Improvement Achieved	100%	0%	0%
Percentage Score of Applicable Evaluation Elements *Met*		**64%**		
Validation Status		***Not Applicable****		

* QIPs were not given an overall validation status during the review period.
┼Percentage totals for an activity may exceed 100 percent due to rounding.

During the period covered by this report, HSAG's application of the CMS validation requirements was more rigorous than previously experienced by MCMC plans. As a result, many plans had difficulty complying fully with these requirements during the first cycle of QIP validations by HSAG. This was the case with CCHP's QIPs, none of which fully met the new validation criteria. As directed by DHCS, HSAG provided CCHP, as well as other plans, with an overall validation status of "Not Applicable" for all three QIPs. This allowed time for plans to receive technical assistance and training with HSAG's validation requirements without holding up the ongoing progress of QIPs that were already underway.

Quality Improvement Project Outcomes

Table 5.2 shows CCHP's data for its QIPs. For the ER collaborative QIP, CCHP's goal was to reduce the overall rate of members who used the emergency room annually by 1 to 2 percent in its avoidable ER visit rate. The plan submitted its first remeasurement data in late 2009, after the time period covered by this report. The results of HSAG's assessment for statistically significant improvement will be included in CCHP's next performance evaluation report.

For the *Reducing Health Disparities* QIP, no specific goals were reported, although the plan documented that the goal of the QIP was to significantly improve childhood immunization rates and well-visits in the first 15 months of life for both Black and Hispanics. CCHP reported both the administrative and hybrid rates for the study indicators. The sampling methodology used to generate the hybrid rate resulted in a study sample that was generalizable to the overall population but was not adequate to report rates by race/ethnicity; therefore, only the administrative rates are included in Table 5.2.

For the *Reducing Health Disparities: Obesity* QIP, a separate project from the previous disparities QIP, CCHP's baseline goal was to reduce the variance across ethnic groups to less than 10 percent as related to each of the study indicators.

Table 5.2—QIP Outcomes for Contra Costa Health Plan—Contra Costa County

QIP #1—Reducing Avoidable Emergency Room Visits				
		Remeasurement Period		
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	1 1/1/08–12/31/08	2 1/1/09–12/31/09	Sustained Improvement
Percentage of ER visits that were avoidable	16.6%	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Reducing Health Disparities						
		Remeasurement Period				
QIP Study Indicator†	Baseline Period 1/1/03–12/31/03	1 1/1/04–12/31/04	2 1/1/05–12/31/05	3 1/1/06–12/31/06	4 1/1/07–12/31/07	Sustained Improvement
1) Percentage of children who received the Combo 2 immunization						
a. Hispanic	64.0%	60.0%	62.4%	73.9%*	83.6%*	Yes
b. Black	33.0%	25.9%¥	24.1%	43.9%*	58.9%*	Yes
c. White	45.9%	38.9%	27.9%¥	41.0%*	67.6%*	Yes
2) Percentage of children who received six or more well-child visits in the first 15 months of life						
a. Hispanic	23.9%	22.9%	30.1%*	30.8%	27.5%	Yes
b. Black	15.6%	25.0%	20.2%	28.4%	26.6%	Yes
c. White	32.4%	20.6%	24.4%	34.3%	24.6%	No
†Administrative rates reported. * Designates statistically significant improvement over the prior measurement period. ¥ Designates statistically significant decline in performance over the prior measurement period.						

QIP #3—Reducing Health Disparities: Obesity			
QIP Study Indicator	**Baseline Period 1/1/08–12/31/08**	**Remeasurement 1 1/1/09–12/31/09**	**Sustained Improvement**
1) Percentage of members accessing a PCP:			
a. Black	79.9%	‡	‡
b. White	83.1%	‡	‡
c. Hispanic	87.5%	‡	‡
d. Total members	84.8%	‡	‡
2) Percentage of members included in the WCC measure, based on continuous enrollment:			
a. Black	55.1%	‡	‡
b. White	52.2%	‡	‡
c. Hispanic	66.6%	‡	‡
d. Total members	60.6%	‡	‡
3) Variance between ethnic groups in having a BMI recorded amongst those eligible for inclusion in the WCC measure	NR	‡	‡
4) Prevalence of pediatric obesity amongst those eligible for inclusion in the WCC measure	NR	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed. NR The data was not reported in this submission.			

Strengths

CCHP demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data. In addition, for the applicable QIPs, CCHP demonstrated sound sampling methodology to achieve generalizable overall rates and demonstrated sustained improvement.

The plan demonstrated statistically significant and sustained improvement for increasing immunization rates for Hispanic, Black, and White children. The plan's success with this QIP indicator also had an impact on its childhood immunization performance measure, which was above the Medicaid national 90th percentile.

CCHP increased the percentage of children who received six or more well-child visits in the first 15 months of life among Hispanic and Black members, and it showed sustained improvement for both of these groups.

In addition to the statewide collaborative interventions, CCHP implemented plan-specific interventions to reduce avoidable ER visits. In July 2008, CCHP introduced a stepped intervention with the Institute for Health Care Improvement focusing on high ER users. Frequent ER users with three avoidable visits were sent letters, users with four avoidable visits were referred to a clinical care coordinator for immediate follow-up, and members with five or more avoidable visits were referred to a nine-month case management plan. In addition, the plan focused on promoting the Advice Nurse Unit to both members and providers. These interventions were linked to identified barriers and showed promise for reducing avoidable ER visits.

Opportunities for Improvement

CCHP can improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with the DHCS requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

While the *Reducing Health Disparities* QIP focused on improving immunizations will be retired by the plan, the *Reducing Health Disparities—Obesity* QIP will be validated next year; therefore, CCHP may need additional technical assistance related to conducting disparity QIPs, especially related to statistical testing.

The table below provides abbreviations of HEDIS performance measures used throughout this report.

Table A.1—HEDIS® Performance Measures Name Key

Abbreviation	Full Name of HEDIS® Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ASM	*Use of Appropriate Medications for People With Asthma*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–E	*Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed*
CDC–H7	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)*
CDC–H9	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC	*Comprehensive Diabetes Care—LDL-C Control*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W15	*Well-Child Visits in the First 15 Months of Life (Six or More Visits)*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*