Performance Evaluation Report

Contra Costa Health Plan

July 1, 2009–June 30, 2010

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

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.

This report is specific to the MCMC Program's contracted plan, Contra Costa Health Plan ("CCHP" or "the plan"), which delivers care in Contra Costa County, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

CCHP is a county-operated Health Maintenance Organization (HMO) and was the first federally qualified HMO in the country administered by a local government. The plan was licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act on April 6, 1978. The Contra Costa County Board of Supervisors exercises oversight of the Contra Costa Health Plan through a joint conference committee that consists of the Board of Supervisors and the Contra Costa Health Plan. Contra Costa is a full-scope managed care plan in Contra Costa County that 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 in each county to provide medical services to members. Most counties offer an LI plan and a nongovernmental, commercial health plan.

Members of the MCMC Program may enroll in either the LI plan operated by Contra Costa or in the alternative commercial plan. Contra Costa became operational with the MCMC Program in February 1997, and as of June 30, 2010, it had 58,559 MCMC members.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.

Conducting the Review

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

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Medical Performance Review

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

HSAG reviewed the most current audit reports available as of October 30, 2011, to assess plan compliance with State-specified standards. A&I conducted an audit in February 2010 to ascertain that the medical services provided to Medi-Cal members comply with federal and State laws, Medi-Cal regulations and guidelines, and the State contracts.

Simultaneously with the February 2010 audit, A&I prepared a report that presented the findings of CCHP's compliance and implementation of the State Supported Services contract with the State of California (referred to as "the Hyde contract"). The Hyde contract is a separate contract between the DHCS and CCHP that covers abortion services funded only with State funds, as these services do not qualify for federal funding.

A&I's audit report of CCHP covered the review period of January 1, 2009, through December 21, 2009. The scope of the audit included utilization management, availability and accessibility, member rights, quality management, and administrative and organizational capacity.

Utilization management findings showed that the plan did not conduct adequate annual review and monitoring oversight of its delegated entities. The review noted this as a finding under the quality management area as well. Additionally, the review found that the plan did not send delay notification letters for three of thirteen prior authorization requests requiring notification.

Audit results for availability and accessibility showed continued noncompliance regarding monitoring of provider compliance with the plan's standards for wait times in providers' offices, on hold time when calling providers' offices, and call return time. CCHP quality committee minutes lacked documentation of review and analysis of member satisfaction surveys related to access. Additionally, the plan did not monitor its contracted emergency departments to ensure members had access to medications in emergency circumstances until a sufficient amount could be obtained by a member.

The plan's procedures for classifying grievances did not have a mechanism for monitoring by clinical staff to ensure potential quality of care issues are reviewed by the medical director. The review showed that two grievances were classified as nonclinical issues and, therefore, were not reviewed for clinical appropriateness.

The review showed that the plan neglected to report to the DHCS all suspected or actual cases of fraud and/or abuse within the requirement time frames. Furthermore, the findings indicated that the plan lacked policies and procedures to conduct more proactive fraud and abuse detection.

A&I's Hyde Audit

A&I audited CCHP for its compliance with requirements of the Hyde contract. The review showed that the plan's provider manual and policies had some inconsistencies. The provider manual implied that abortion services are subject to prior authorization requirements, while the plan's policies showed that this service is exempt from prior authorization. Additionally, the plan's policies implied a prior authorization requirement for therapeutic abortions for non-plan providers.

The DHCS's Medi-Cal Managed Care Division produced a medical audit close-out report dated February 3, 2011, for both of A&I's audits (the main audit and the Hyde audit). The close-out report showed that CCHP had corrected deficiencies related to emergency services providers, quality improvement system, delegation of quality improvement activities, and the abortion subcategory of State-supported services. Unresolved areas included aspects of delegation oversight, monitoring of provider office wait times, policy language regarding prior authorization, ensuring access to medications in emergency circumstances, grievance procedures, and fraud and abuse.

Medi-Cal Managed Care Member Rights and Program Integrity Review

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

As part of the monitoring process, 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, 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, and cultural and linguistic services. Notably, the plan demonstrated timely acknowledgment and resolution of member grievances that all prior-authorization notifications were sent within required time frames and all denials were reviewed by a physician.

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

Opportunities for Improvement

The plan has opportunities to correct unresolved audit deficiencies by demonstrating implementation of the actions outlined in the corrective action plan and monitor its efforts to ensure compliance. The plan should demonstrate adequate monitoring of provider wait times since this is a continued area of improvement. These areas should be outlined within CCHP's quality improvement work plan to ensure ongoing attention and monitoring.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about 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.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed a HEDIS Compliance Audit™ of CCHP in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[3] Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

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

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. Table 3.1 displays a HEDIS performance measure name key.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 below presents a summary of CCHP's HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan's HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

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

Table 3.2—2009–2010 Performance Measure Results for Contra Costa Health Plan–Contra Costa County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	32.5%	31.9%	★★	↔	20.2%	33.4%
AWC	Q,A,T	47.4%	38.7%	★★	↓	37.9%	59.4%
BCS	Q,A	43.7%	56.2%	★★	↑	45.0%	63.0%
CCS	Q,A	67.9%	69.3%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	53.1%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	53.5%	48.5%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	52.6%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	42.2%	31.8%	★★	↑	50.6%	29.2%
CDC–HT	Q,A	83.0%	85.4%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	42.2%	40.7%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	79.4%	78.6%	★★	↔	71.5%	82.5%
CDC–N	Q,A	82.3%	86.5%	★★★	↔	73.4%	85.4%
CIS–3	Q,A,T	82.5%	77.1%	★★	↔	62.4%	80.6%
LBP	Q	‡	87.1%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	83.5%	84.7%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	68.1%	68.1%	★★	↔	57.9%	72.7%
URI	Q	93.6%	92.8%	★★	↔	81.1%	94.5%
W34	Q,A,T	77.4%	74.7%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	18.5%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	49.1%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	38.4%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ The DHCS did not require plans to report this measure in 2009.
NA= The DHCS does not establish an MPL/HPL for first year measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.
Not Comparable = Performance could not be compared due to either significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, CCHP had average performance results across the spectrum of HEDIS measures. Two measures had statistically significant increases from 2009 to 2010, while one measure had a statistically significant decrease. One measure, *Comprehensive Diabetes Care—Medical Attention for Nephropathy,* scored above the national Medicaid 90th percentile, while the remaining measures fell between the 25th and 90th percentiles.

HEDIS Improvement Plans

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

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing towards the MPL. In addition, HSAG assessed the plan's need for continuing existing improvement plans and/or developing new improvement plans.

Based on CCHP's 2009 performance measure rates, the DHCS required the plan to submit 2009 HEDIS improvement plans for two measures:

- *Use of Appropriate Medications for People With Asthma*
- *Breast Cancer Screening*

HSAG reviewed CCHP's 2009 HEDIS improvement plans using HEDIS 2010 rates and assessed whether the plan improved its performance in 2010. HSAG provides the following analysis of the plan's 2009 HEDIS improvement plans.

Use of Appropriate Medications for People With Asthma

CCHP was required to develop a HEDIS improvement plan to improve the rate of prescribing appropriate medication for people with asthma. The plan's improvement plan failed to outline any possible barriers that were negatively affecting this measure.

To address this low-performing measure, the plan implemented three interventions to improve performance including stratifying data by provider, counseling top noncompliant providers, and sending a list of asthma patients not on a controller inhaler.

This measure was retired from the required reporting set in 2010; therefore, HSAG was unable to assess whether the plan was effective in increasing performance.

Breast Cancer Screening

CCHP implemented a successful improvement plan targeting breast cancer screening and achieved statistically significant improvement in 2010. CCHP increased its score to 56.2 percent, a 12.5 percent point increase over its 2009 score.

The plan implemented three interventions to identify patients in need of screening: contacting providers to assist in scheduling members, improving its data production process, and sending reminder letters to members. These efforts helped raise the measure above the MPL in 2010.

Strengths

CCHP had two measures with statistically significant improvements between 2009 and 2010 for *Breast Cancer Screening* and *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*. The plan exceeded the national Medicaid 90th percentile for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure with a rate of 86.5 percent.

Opportunities for Improvement

The plan's largest opportunity is to improve its HEDIS improvement plan documentation to better support the identified barriers and ensure that interventions are aligned appropriately. Other results remained fixed from 2009. Although CCHP did not record a single measure below the MPL in 2010, it only had one measure that exceeded the HPL in 2010. CCHP has the opportunity to expand the number of metrics that finish above the HPL in 2011.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Quality Improvement Projects Conducted

CCHP had two clinical QIPs in progress during the review period of July 1, 2009, through June 30, 2010. 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. The second QIP focused on reducing health disparities related to obesity among ethnic groups. The two 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 project attempted to improve the quality of care delivered to Hispanic and Black children by increasing the evaluation of obesity.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for both of CCHP's QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Contra Costa Health Plan–Contra Costa County July 1, 2009, through June 30, 2010

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	68%	80%	*Not Met*
	Resubmission	86%	100%	*Met*
Internal QIPs				
Reducing Health Disparities—Childhood Obesity	Proposal	36%	44%	*Not Met*
	Resubmission	100%	100%	*Met*

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

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

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

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

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met, Partially Met,* or *Not Met.* In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that the initial submission by CCHP of both its *Reducing Avoidable Emergency Room Visits* and *Reducing Health Disparities–Childhood Obesity* QIP received an overall validation status of *Not Met.* As of July 1, 2009, the DHCS began requiring plans to resubmit their QIPs until they achieve an overall *Met* validation status. Based on the validation feedback, the plan resubmitted the QIPs and upon subsequent validation, achieved an overall *Met* validation status for both QIPs.

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

Table 4.2—Quality Improvement Project Average Rates* for Contra Costa Health Plan–Contra Costa County (Number = 2 QIPs, 2 QIP Topics) July 1, 2009, through June 30, 2010

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%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	80%	20%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**93%**	**7%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation†	88%	13%	0%
	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		**67%**	**8%**	**25%**

* 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.

‡ No QIPs were assessed for this activity/evaluation element.

† The sum may not equal 100 percent due to rounding.

For the *Reducing Health Disparities–Childhood Obesity* QIP, only Activities I through Activity V were required and therefore completed. CCHP submitted Remeasurement 1 data for its *Reducing Avoidable Emergency Room Visits* QIP; therefore, HSAG validated Activity I through Activity IX. CCHP demonstrated an accurate application of the Design and Implementation stages, scoring 100 percent on all evaluation elements for six of the seven activities. Activity VI was scored down for the plan not providing complete date ranges for the study's timeline in its *Reducing Avoidable Emergency Room Visits* QIP. For the Outcomes stage, CCHP was scored lower in Activity VIII for the plan's lack of interpretation for the study indicator outcomes between baseline and Remeasurement 1 for its *Reducing Avoidable Emergency Room Visits* QIP. Additionally, the *Reducing Avoidable Emergency Room Visits* QIP did not demonstrate statistically significant improvement; therefore, CCHP received a score of 25 percent for Activity IX.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods. Sustained improvement is defined as improvement in performance over baseline which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Table 4.3—Quality Improvement Project Outcomes for Contra Costa Health Plan–Contra Costa County July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement**
Percentage of ER visits that were avoidable	16.6%	20.9%*	‡	‡
QIP #2—Reducing Health Disparities—Childhood Obesity				
QIP Study Indicator	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement**
1) Percentage of members 3 to 11 years of age who had a BMI percentile documented in their medical record	‡	‡	‡	‡
2) Percentage of members 3 to 11 years of age who had documentation for nutrition counseling in their medical record	‡	‡	‡	‡
3) Percentage of members 3 to 11 years of age who had documentation for physical fitness counseling in their medical record	‡	‡	‡	‡

*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05)
‡The QIP did not progress to this phase during the review period and could not be assessed.

In the *Reducing Avoidable ER Visits* QIP, CCHP reported an increase in the percentage of avoidable ER visits; furthermore, the increase was statistically significant and was probably not due to chance. An increase for this measure reflects a decline in performance. Since collaborative interventions were not initiated until early 2009, HSAG could not evaluate the effectiveness of those interventions.

The *Reducing Health Disparities–Childhood Obesity* QIP had not progressed to the point of CCHP having study indicator results.

Strengths

CCHP demonstrated a good application of the QIP process for QIP topic selection, the development of study questions, and the definition of the study population. For the applicable QIPs, CCHP demonstrated sound sampling methodology to achieve generalizable overall rates. Additionally, CCHP implemented accurate data collection methods and appropriate improvement strategies.

Opportunities for Improvement

The plan implemented the collaborative interventions in 2009 for the *Reducing Avoidable ER Visits* QIP; however, it should incorporate a method to evaluate the effectiveness of those interventions. The plan should also conduct another barrier analysis and identify new or revised plan-specific interventions to reduce the avoidable ER visits since the study indicator outcomes demonstrated a statistically significant decline in performance.

The *Reducing Health Disparities—Obesity* QIP will be validated again next year; therefore, CCHP may need additional technical assistance related to conducting disparity QIPs, especially related to statistical testing. CCHP should incorporate the feedback provided related to data collection and improvement strategies in its upcoming activities. Once the data are collected, the plan will need to determine if a disparity between ethnic groups exists in order to continue with the QIP as a disparity QIP.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan surveys.[4]

The administration of the CAHPS surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS surveys be administered to both adult members and the parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

The Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about CCHP'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 as follows:

CAHPS Global Rating Measures:

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

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

CAHPS Composite Measures:

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

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance (NCQA)'s HEDIS® benchmarks and thresholds or NCQA's national Medicaid data, when applicable. 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*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 5.1.

Table 5.1—Star Ratings Crosswalk

Stars	Adult Percentiles	Child Percentiles
★★★★★	≥ 90th percentile	≥ 80th percentile
★★★★	75th percentile–89th percentile	60th percentile–79th percentile
★★★	50th percentile–74th percentile	40th percentile–59th percentile
★★	25th percentile–49th percentile	20th percentile–39th percentile
★	< 25th percentile	< 20th percentile

Table 5.2—Contra Costa Health Plan–Contra Costa County Medi-Cal Managed Care County-Level Global Ratings

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★★	★
Child	★★	★	★★★	★★★+

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Table 5.3—Contra Costa Health Plan–Contra Costa County Medi-Cal Managed Care County-Level Composite Ratings

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Adult	★	★	★★★	★+	★★★★
Child	★	★	★★	★★★	★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Strengths

At the global ratings level, Contra Costa Health Plan performed best in the child categories *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*, scoring above the 40th percentile. At the composite rating level in the adult category, *How Well Doctors Communicate* and *Shared Decision Making* scored above the 50th and 75th percentiles respectively. The *Customer Service* rating in the child category scored above the 40th percentile.

Opportunities for Improvement

At the global ratings level, Contra Costa Health Plan's CAHPS results showed the opportunity for the most improvement in the *Rating of All Health Care* category. Overall, the adult segment scored lower satisfaction ratings than the child segment. At the composite rating level, the two categories that need the most improvement are *Getting Needed Care* and *Getting Care Quickly,* each scoring a one star rating. Unlike the global ratings, the composite ratings showed that the child segment demonstrated an overall lower satisfaction rating than the adult rating.

HSAG conducted a key drivers of satisfaction analysis that focused on the top three highest priorities based on the plan's CAHPS results. The purpose of the key drivers of satisfaction analysis was to help decision makers identify specific aspects of care most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as Contra Costa Health Plan's highest priority: *Rating of All Health Care, Getting Care Quickly, and Getting Needed Care*. The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 Contra Costa Health Plan CAHPS Plan-Specific Report*. Areas for improvement spanned the quality, access, and timeliness domains of care.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

The DHCS uses the results of performance measures and quality improvement projects (QIPs) 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.

The plan showed average performance in the quality domain. This assessment was based on CCHP's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

The plan was able to report valid rates for all 2010 performance measures, and all quality-related rates performed between the MPL and HPL. Two measures had a statistically significant increase and one had a statistically significant decrease in 2010.

QIP results showed that the plan did well with documenting the QIP study design and implementation phases. However, in CCHP's *Reducing Avoidable Emergency Room Visits* QIP, the plan had a statistically significant decrease in performance.

Although CCHP did not have improved performance based on the 2010 HEDIS and QIP study indicator rates, the plan did demonstrate compliance with many of the medical performance reviews conducted during the review period. Opportunities relate to ensuring adequate oversight of the plan's delegated entities and monitoring areas of deficiency until issues are fully resolved.

Access

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

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

The plan demonstrated average performance in the access domain. This assessment was based on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results.

For access-related compliance standards, the plan continued to lack monitoring mechanisms to evaluate provider compliance with wait times in providers' offices, on hold time when calling providers' offices, and call return time. Despite the opportunities for continued improvement, the plan was fully compliant with the access standards reviewed in the MRPIU.

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.

CCHP demonstrated average performance in the timeliness domain of care. This assessment was based on 2010 performance measure rates for providing timely care, medical performance and member rights reviews related to timeliness, and member satisfaction results related to timeliness.

Performance measure rates related to timeliness showed that the plan performed between the MPL and HPL for all of the measures. The plan has an opportunity to improve its performance on all measures related to timeliness to achieve the HPL.

Member satisfaction results showed that the plan demonstrated poor performance in the *Getting Care Quickly* category for both adult and child populations. This suggests that members perceive that they do not always receive care in a timely manner.

Medical performance audits showed that, overall, the plan processed and provided timely notification of prior authorization and utilization management decisions.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. CCHP's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, CCHP had average performance in the quality, access, and timeliness domains of service.

CCHP showed steady performance measures rates in 2010 compared with 2009 rates. The plan was generally compliant with documentation requirements across performance measures, QIPs, and State and federal requirements; however, the plan still had opportunities to improve performance in all areas.

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

- Correct unresolved areas of audit deficiencies by incorporating plan monitoring activities within the quality improvement work plan.
- Focus efforts to ensure that there is a mechanism in place to monitor provider wait times.
- Explore opportunities to move performance measure rates beyond steady performance.
- Review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 Contra Costa Health Plan CAHPS Plan-Specific Report*.

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

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address Recommendation
Develop targeted, evidence-based interventions to address the statistically significant decline in breast cancer screening rates.	Lists of patients needing screening were faxed to providers in October 2009. The decline in our compliance rate was actually largely due to a data problem. We had not been receiving complete screening data from Kaiser, but that has been solved and is reflected in 2010 and 2011 HEDIS measures.
Recruit a qualified health educator to meet contractual requirements.	A qualified, Masters-prepared health educator has been in place since September 2007.
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.	Plan has used HSAG's QIP Summary Form since receiving the recommendation.
Modify care coordination processes to ensure that medically necessary services are coordinated for members receiving EPSDT services and members with disabilities.	The Plan now makes every effort to have new members complete a health risk assessment that will alert us if they are receiving such services. Also, the assessment specifically asks whether there are developmental difficulties.
Develop a standing referral policy and procedure for members with HIV/AIDS that includes access to and monitoring for qualified providers.	UM Policy 15.028 specifies standing referrals for HIV/AIDS and states: *Members diagnosed with HIV or AIDS are referred to the Contra Costa AIDS Program. In turn, the Program refers the member to an HIV/AIDS specialist and assists the member with care coordination between the HIV/AIDS specialist and PCP.* Credentialing Policy 11.019 specifies procedures to ensure HIV/AIDS providers meet the definition of an HIV/AIDS specialist according to California State regulations
Conduct ongoing monitoring of prior authorization notifications to ensure that State fair hearing information is included.	The State Fair Hearing information is on denial and modification notice templates, so the information is on every letter. The wrong letter was inadvertently provided during the audit.