Performance Evaluation Report

Contra Costa Health Plan

July 1, 2010–June 30, 2011

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

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1. Introduction

Purpose of Report

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

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

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

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

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

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

Plan Overview

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 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, 2011, it had 66,244 MCMC members.[2]

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

Conducting the Review

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

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

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

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

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about 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) have historically worked in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits have been conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

For this report, HSAG reviewed the most current audit reports available as of June 30, 2011, to assess plans' compliance with State-specified standards. The most recent medical performance review was completed in February 2010, covering the review period of January 1, 2009, through December 31, 2009. Detailed findings from this review were included in the plan's prior evaluation report.[3]

The review showed that CCHP had audit findings in the areas of utilization management, continuity of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity. The DHCS *Medical Audit Close-Out Report* letter dated February 3, 2011, noted that the plan had fully corrected several audit deficiencies; however, some issues remained unresolved at the time of the audit close-out report.

In the audit area of delegation of utilization management activities, the plan was found to not be conducting internal annual delegation reviews and creating formal corrective action plans based on review findings on a consistent basis. In the area of availability and accessibility, the plan was not regularly evaluating wait times for members as well as not paying family planning claims without prior authorization. In the member rights section of the review, it was found that not all of the grievances that were filed were sent to the medical director for review. Finally, in the area of administrative and organizational capacity, the plan was identified as not having implemented a comprehensive fraud and abuse detection program.

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, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These member rights reviews are conducted before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

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

[3] California Department of Health Services. *Contra Costa Health Plan Performance Evaluation Report – July 1, 2009 – June 30, 2010*. August 2011.

MRPIU conducted an on-site review of CCHP in February 2011, covering the review period of January 1, 2009, through December 31, 2010. The scope of the review included grievances, prior authorization notifications, marketing, cultural and linguistic services, and the False Claims Act. MRPIU noted findings in the categories of grievances, prior authorization, and cultural and linguistic services.

In the category of member grievance, it was noted that one of 50 grievances contained a "Your Rights" attachment that was missing a clear and concise explanation outlining the circumstances under which the medical service shall be continued while a fair hearing decision is pending. MRPIU determined this was an isolated incident and no further action was required.

In the category of prior authorization, three items were noted. First, one of 50 prior authorization files contained a Notice of Action (NOA) letter that exceeded the 14-calendar-day maximum time frame. Next, one of 50 prior authorization files contained an NOA letter with a date that was prior to the date the decision was made. Finally, one of 50 prior authorization files reviewed contained a resolution letter in the member's preferred language but not in English; therefore, it was not possible to determine if the letter contained the required explanation of the plan's decision. In the category of cultural and linguistic services, MRPIU noted that two of five provider offices visited did not discourage the use of family, friends, or minors as interpreters.

Strengths

For the MRPIU review, CCHP was fully compliant in the area of marketing and with the False Claims Act, and the plan was able to resolve many of the deficiencies identified during the medical performance review through corrective action plans. CCHP's 2011 Quality Management Program Description and Work Plan indicated that the plan is taking steps to correct the deficiency in its member grievance system and oversight.

Opportunities for Improvement

CCHP should implement an internal review process to ensure that corrective action plans are fully implemented and effective. The plan should continue to routinely monitor ongoing performance to ensure compliance with contract requirements.

Conducting the Review

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

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

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

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about 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 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[4] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of CCHP in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. While the audit did not determine issues significant to bias a rate, the audit team provided some observations and recommendations. The audit team noted that the plan had a significant backlog of claims during the measurement year and while the plan was able to address the backlog for the purposes of HEDIS reporting, the audit team recommended that CCHP continue its efforts to staff and train claims processors to ensure adequate cross-training and coverage. In rare instances the plan's processors changed invalid codes to valid codes to bypass claims adjudication edits. HSAG recommended that this practice be discontinued even though its use was infrequent. Finally, the plan can consider investigating ways to obtain the PM 160 data for members because these data were not available to the plan since providers load PM 160 data directly to the State. This does not impact HEDIS reporting since it is mitigated by hybrid review. However, the plan could realize cost savings by gaining this valuable administrative information for future HEDIS reporting.

[4] 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. The following table displays a HEDIS performance measure name key with abbreviations contained in Table 3.2.

Table 3.1—HEDIS® 2011 Performance Measures Name Key

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

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

For all but one measure, 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—2010–2011 Performance Measure Results for Contra Costa Health Plan—Contra Costa County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	31.9%	29.6%	★★	↔	19.7%	35.9%
AWC	Q,A,T	38.7%	40.6%	★★	↔	38.8%	63.2%
BCS	Q,A	56.2%	57.4%	★★	↔	46.2%	63.8%
CCS	Q,A	69.3%	70.6%	★★	↔	61.0%	78.9%
CDC–BP	Q	53.1%	55.1%	★★	↔	53.5%	73.4%
CDC–E	Q,A	48.5%	49.1%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	52.6%	56.6%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	31.8%	33.9%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	85.4%	86.9%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	40.7%	40.7%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	78.6%	77.7%	★★	↔	69.3%	84.0%
CDC–N	Q,A	86.5%	89.2%	★★★	↔	72.5%	86.2%
CIS–3	Q,A,T	77.1%	87.2%	★★★	↑	63.5%	82.0%
LBP	Q	87.1%	88.6%	★★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	84.7%	81.8%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	68.1%	67.4%	★★	↔	58.7%	74.4%
URI	Q	92.8%	93.3%	★★	↔	82.1%	94.9%
W34	Q,A,T	74.7%	78.8%	★★	↔	65.9%	82.5%
WCC–BMI	Q	18.5%	61.1%	★★	↑	13.0%	63.0%
WCC–N	Q	49.1%	58.9%	★★	↑	34.3%	67.9%
WCC–PA	Q	38.4%	46.5%	★★	↑	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).

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

[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.

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

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

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

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, CCHP had above average performance results across the spectrum of HEDIS measures. Four measures had statistically significant increases from 2010 to 2011; and there were no measures with statistically significant decreases. Three measures (*Comprehensive Diabetes Care—Medical Attention for Nephropathy, Childhood Immunization Status—Combination 3, and Use of Imaging Studies for Low Back Pain)* scored above the national Medicaid 90th percentile, while the remaining measures fell between the MPLs and HPLs.

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 steps to improve care.

For plan measure rates that required a 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with the plan's 2011 HEDIS scores to assess whether the plan was successful in achieving or progressing toward achieving the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

The plan did not have any measures fall below the MPLs in 2010; therefore, no improvement plans were required in 2011.

Strengths

CCHP had strong HEDIS performance in 2011. Three measures (*Comprehensive Diabetes Care—Medical Attention for Nephropathy, Childhood Immunization Status—Combination 3,* and *Use of Imaging Studies for Low Back Pain)* performed above the HPLs in 2011. The plan also had statistically significant improvement in four measures while not incurring a statistically significant decrease in any performance measures. The plan also benefited from the success of its 2010 improvement plans, as it will not be required to create any improvement plans based on 2011 performance.

Opportunities for Improvement

The plan should focus efforts on maintaining strong performance in 2012. CCHP's biggest opportunity for improvement is focusing on creating statistically significant increases in the measures that did not meet 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, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about 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, 2010–June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of 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, 2010, through June 30, 2011

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	90%	90%	*Partially Met*
	Resubmission	97%	100%	*Met*
Internal QIPs				
Reducing Health Disparities—Childhood Obesity	Proposal	76%	62%	*Partially 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*.

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that the initial submission by CCHP of both its *Reducing Avoidable Emergency Room Visits* and *Reducing Health Disparities–Childhood Obesity* QIPs received an overall validation status of *Partially Met.* As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted 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, 2010, through June 30, 2011

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	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation†	100%	0%	0%
	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**94%**	**0%**	**6%**

*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.

For the *Reducing Health Disparities–Childhood Obesity QIP*, only Remeasurement 1 data were submitted; therefore, Activities I through Activity IX were completed and validated. The *Reducing Avoidable ER Visits* QIP included Remeasurement 2 data and progressed through Activity X.

CCHP demonstrated an accurate application of the design and implementation stages, scoring 100 percent on all applicable evaluation elements for all seven activities. For the outcomes stage, CCHP was scored lower in Activity X because the *Reducing Avoidable Emergency Room Visits* QIP did not achieve sustained improvement. 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.

Quality Improvement Project Outcomes

Table 4.3 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods. 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, 2010, through June 30, 2011

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable	16.6%	20.9%*	20.0%*	No
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	17.7%	‡	‡	‡
2) Percentage of members 3 to 11 years of age who had documentation for nutrition counseling in their medical record	51.6%	‡	‡	‡
3) Percentage of members 3 to 11 years of age who had documentation for physical fitness counseling in their medical record	36.3%	‡	‡	‡

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

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

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

In the *Reducing Avoidable ER Visits* QIP, CCHP reported a decrease in the percentage of avoidable ER visits; furthermore, the decrease was statistically significant and was probably not due to chance. A decrease for this measure reflects improvement in performance. Collaborative interventions were initiated in early 2009 and potentially correspond to the improvement in performance. Although the plan's performance improved from Remeasurement 1 to Remeasurement 2, the Remeasurement 2 performance remained below the baseline performance.

Overall, the plan did not demonstrate sustained improvement since the remeasurement outcomes were not improved over the baseline outcome.

The *Reducing Health Disparities–Childhood Obesity* QIP had not progressed to the point of remeasurement study indicator results, so improvement could not be evaluated.

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. The plan implemented accurate data collection methods and appropriate improvement strategies. With appropriate improvement strategies, CCHP was able to achieve a statistically significant decline in avoidable ER visits from the prior measurement period.

Opportunities for Improvement

The plan should address all deficiencies noted in the current submission before resubmitting next year. Deficiencies that are not addressed result in current scores being lowered in the subsequent validation.

The plan implemented the collaborative interventions in 2009 for the *Reducing Avoidable ER Visits* QIP; however, when multiple interventions are implemented, the plan should incorporate a method to evaluate the effectiveness of each intervention. The plan should also conduct another barrier analysis and identify new or revised plan-specific interventions to sustain the reduction of avoidable ER visits since the study indicator outcomes remain above the outcomes reported at baseline.

The *Reducing Health Disparities—Obesity* QIP will be validated again next year, and remeasurement rates will be included; however, since there is not a statistical difference in the outcomes by ethnicity, this QIP should not be continued as a disparity QIP. The only difference in rates by ethnicity that was close to being statistically significant was that Whites had the lowest documented BMI rate (7 percent) compared to Hispanic or Black members (20 percent and 17 percent, respectively). CCHP reported that, currently, its providers do not have a consistent way to capture and track BMI and nutrition/physical fitness counseling. The plan should focus on improving these documentation issues across the entire eligible population and not implement ethnic-specific interventions.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

The plan showed average performance in the quality domain. This assessment was based on CCHP's 2010 performance measure rates (which reflect 2010 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 2011 performance measures and all quality-related rates performed between the MPLs and HPLs. Three quality measures performed above the HPLs: (*Comprehensive Diabetes Care—Medical Attention for Nephropathy, Childhood Immunization Status—Combination 3, and Use of Imaging Studies for Low Back Pain).* Four measures had statistically significant increases in 2011.

From the medical performance review, numerous deficiencies in the quality domain were identified, including clinical grievances that were not referred to the medical director for review and quality activities that were delegated to the pharmacy vendor that were not being overseen. In the MRPIU review, it was noted that provider offices visited did not discourage the use of family, friends, or minors as interpreters.

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.

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.

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

The plan demonstrated below-average performance in the access domain. This assessment was based on a review of 2011 performance measure rates that related to access, QIP outcomes, and results of the medical performance and member rights reviews related to the availability and accessibility of care.

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.

The plan was able to report valid rates for all 2011 performance measures and all access-related rates performed between the MPL and HPL. One measure *Childhood Immunization Status—Combination 3,* showed statistically significant improvement.

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.

The plan demonstrated average performance in the timeliness domain. Performance measure rates related to timeliness showed that the plan performed between the MPL and HPL for all of the measures. The plan achieved the HPL on one measure and showed a statistically significant improvement for the *Childhood Immunization Status—Combination 3* measure.

Medical performance audit results and member rights reviews showed that the plan has the opportunity to improve timeliness by ensuring that claims destined for another health plan are sent within 10 working days and that prior authorization NOA letters do not exceed the 14-day time frame.

Follow-Up on 2009–2010 Recommendations

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

Conclusions and Recommendations

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

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.

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

- Implement an internal review process to ensure that corrective action plans are fully implemented and effective; findings from reviews are fully corrected, and that the plan continues to routinely monitor ongoing performance to ensure it is compliant with contract requirements.
- Continue efforts to staff and train claims processors to ensure adequate cross-training and coverage.
- Discontinue the practice of allowing claims processors to change invalid codes to valid codes to bypass claims adjudication edits. Consider investigating ways to obtain the PM 160 data for members as a potential for realizing cost savings by gaining this valuable administrative information for future HEDIS reporting.

- Focus on creating statistically significant increases in the measures that did not meet the HPL in 2011.
- Conduct another barrier analysis and identify new or revised plan-specific interventions to sustain the reduction of avoidable ER visits since the study indicator outcomes remain above the outcomes reported at baseline.
- Address all deficiencies noted in the current QIP submissions before resubmitting next year.

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

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

for Contra Costa Health Plan

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

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

2009–2010 EQR Recommendation	CCHP's Self-Reported Actions That Address the EQR Recommendation
Correct unresolved areas of audit deficiencies by incorporating plan monitoring activities within the quality improvement workplan.	All deficiencies have been resolved, and monitoring activities for them have been incorporated into the workplan.
Focus effort to ensure that there is a monitoring mechanism of provider wait times.	Measurement of provider office wait times, phone hold times, and call back times has been added to the Quality workplan.
Explore opportunities to move performance measure rates beyond steady performance.	Rates are studied each year and opportunities for improvement are prioritized. 2011 found an average improvement of four percentage points per measure. There were three measures above the HPL and none below MPL.
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.	Getting Care Quickly: We have an Access Task Force and are continually working to remove barriers to access. Most of our providers do have same day appointments available. We are experimenting with telemedicine in the form of having a physician available through the Advice Nurse line. Our largest provider group is running numerous Kaizen events around access and patient flow. We are currently designing our EHR which will go into use July 1, 2012, and which will provide means of electronic communication between members and providers. Enhanced Provider Directories: Most recommendations for enhanced provider information have been in place for several years. One exception: we have not begun publishing physician-level performance measures.