Performance Evaluation Report

Contra Costa Health Plan

July 1, 2011–June 30, 2012

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 program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

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

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

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

This report is specific to DHCS's contracted plan, Contra Costa Health Plan ("CCHP" or "the plan"), which delivers care in Contra Costa County, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

Plan Overview

CCHP is a full-scope managed care plan operating in Contra Costa County. CCHP serves members as a Local Initiative (LI) plan under the Two-Plan Model. In a Two-Plan Model county, DHCS contracts with two managed care plans to provide medical services to Medi-Cal beneficiaries. Most Two-Plan Model counties offer an LI plan and a nongovernmental, commercial plan.

Medi-Cal Managed Care beneficiaries in Contra Costa County may enroll in CCHP, the LI plan, or in the alternative commercial plan. CCHP became operational in Contra Costa County to provide MCMC services in February 1997. As of June 30, 2012, CCHP had 77,329 members.[3]

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

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

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

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

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

Assessing Structure and Operations

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

The most recent medical performance review was completed in February 2010, covering the review period of January 1, 2009, through December 31, 2009. HSAG initially reported the detailed findings from this audit in CCHP's 2009–2010 plan-specific evaluation report[4] and summarized them in the plan's 2010–2011 plan-specific evaluation report.

In the previous reports, HSAG noted deficiencies in the following areas:

- Utilization Management
- Availability and Accessibility
- Member Rights
- Quality Management
- Administrative and Organizational Capacity
- State Supported Services

As previously reported, the DHCS Medical Audit Close-out Report letter dated February 3, 2011, noted that the plan had corrected several deficiencies; however, some issues remained unresolved at the time of the audit close-out report.

Listed below are the unresolved deficiencies followed by actions the plan has taken to resolve the deficiencies.

Utilization Management

Deficiency

- The plan did not provide evidence of a method to review delegation activities at least annually, and it did not create corrective action plans (CAPs) based on the findings.

  HSAG found in its review of CCHP's 2012 Program Description and Work Plan that the plan includes an objective to conduct delegation audits; however, HSAG did not have access to the plan's delegation reviews and committee minutes to determine if the plan implements CAPs as appropriate and conducts ongoing monitoring. HSAG did not find any documentation regarding the frequency of the audits or the inclusion of CAPs.

[4] California Department of Health Care Services. *Performance Evaluation Report—Contra Costa Health Plan, July 1, 2009 – June 30, 2010*. March 2012. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

Availability and Accessibility

Deficiency

- The plan did not demonstrate a method to evaluate provider compliance with office wait times, provider telephone waiting time, and call return time.

  HSAG found in its review of CCHP's 2012 Program Description and Work Plan that the plan includes an objective regarding DMHC timely access compliance standards. Actions outlined in the work plan include collecting data through member and provider surveys, reviewing and evaluating the data quarterly, identifying deficiencies, and creating and implementing improvement plans. Specific measures include wait time in offices, wait time for provider offices to answer telephone calls, and wait time for provider offices to return calls. These documented activities appear to address the unresolved deficiency of evaluating provider compliance with wait times and call return times.

Deficiency

- The plan did not demonstrate evidence that claims destined for another health plan were sent within the required time frame of 10 working days.

  The DHCS Medical Audit Close-out Report letter dated February 3, 2011, noted that CCHP made revisions to the plan's Provider Manual and to CCHP's policies, clarifying that prior authorization is not applicable to Medi-Cal members for family planning services. However, CCHP did not provide evidence that claims destined for another health plan were being sent within the required time frame of 10 working days.

Deficiency

- The plan did not implement procedures to monitor contracted emergency departments' access to a sufficient supply of medications.

  The DHCS Medical Audit Close-out Report letter dated February 3, 2011, noted that beginning in January 2011, a new policy will be implemented to address this issue. The plan's Pharmacy Unit will implement procedures to monitor access to and availability of a sufficient supply of emergency medications to last until the member can reasonably be expected to have a prescription filled.

Administrative and Organizational Capacity

Deficiency

- CCHP did not demonstrate evidence of policies and procedures regarding compliance with fraud and abuse reporting requirements. The plan also did not provide evidence that incidents of

suspected fraud or abuse are reported to DHCS within 10 working days of the date when the plan first became aware of or was notified of such activity.

CCHP's self-report of actions the plan has taken to address this deficiency stated that the plan has a Compliance Fraud Subcommittee which meets twice each month; however, the plan did not provide evidence to DHCS that incidents of suspected fraud or abuse are reported to DHCS within the required time frame.

Member Rights and Program Integrity Review

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

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

MR/PIU conducted an on-site review of CCHP in February 2011, covering the review period of January 1, 2009, through December 31, 2010. A summary of this review was included in the plan's 2010–2011 plan-specific evaluation report. Findings were identified in the categories of Grievances, Prior Authorization Notifications, and Cultural Linguistic Services. MR/PIU indicated that the finding in the Grievances category was an isolated incident, and no further action from CCHP was required.

Listed below are the findings followed by information HSAG found regarding actions the plan has taken that appear to address the findings:

Prior Authorization Notifications

Findings

- One of 50 prior authorization files contained a Notice of Action (NOA) letter that exceeded the 14-calendar-day maximum time frame.
- One of 50 prior authorization files contained an NOA letter with a date that was prior to the date the decision was made.
- 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.

  HSAG's review of the plan's quality documents did not identify evidence that the plan has taken action to resolve these findings. MR/PIU is in the process of following up with the plan to resolve this finding.

Cultural and Linguistic Services

Finding

- Two of five provider offices visited did not discourage the use of family, friends, or minors as interpreters.

  In its review of CCHP's 2011 Annual Quality Management Program Overview and Evaluation of Effectiveness, HSAG found the document indicates that the plan distributes cultural and linguistic policies and procedures to providers; however, HSAG was not provided documentation that indicates the plan specifically informs providers that they should discourage the use of family, friends, or minors as interpreters.

Strengths

Based on the review findings, CCHP demonstrated efforts to resolve many of the noted deficiencies and findings; and these activities were noted in the plan's quality improvement documents.

Opportunities for Improvement

The plan has an opportunity to improve in the areas of Utilization Management, Availability and Accessibility, Administrative and Organizational Capacity, Prior Authorization Notifications, and Cultural and Linguistic Services. These areas can have an impact on quality, access, and timeliness of care provided to plan members. CCHP should document how the plan will address each of the deficiencies identified during the medical performance review and findings identified during the MR/PIU review and how the plan will monitor progress on resolving the deficiencies and findings.

In addition, the plan's quality improvement evaluation could be improved to provide more robust analysis and detail of the prior year's activities. The existing document lacks a summary of results, barriers, strengths, and recommendations or next steps for future improvement, as appropriate.

Conducting the Review

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

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

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

Validating Performance Measures and Assessing Results

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

Performance Measure Validation

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

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

Performance Measure Validation Findings

HSAG found that CCHP submitted measures that were prepared according to the HEDIS Technical Specifications and were valid. Nevertheless, HSAG had three recommendations for improvement:

- Focus efforts on ensuring sufficient staff are hired and trained to meet the volume of claims and encounters to be processed. The plan experienced a backlog of claims in 2010 and again in 2011. The plan addressed the backlog by adding additional staff. At the time of the final refresh of HEDIS data, the actual amount of backlogged claims amounted to a fraction of 1 percent and therefore did not significantly bias any rates. However, the problem has persisted over the last two years.
- Crosswalk child health and disability prevention (CHDP) codes with all vendors to assure they can be used as administrative data. During the site visit, HSAG auditors discovered that one vendor's data from confidential screening/billing report (PM 160) forms were not appropriately crosswalked and thus could not be used as administrative data for HEDIS reporting.
- Implement a formal process for auditing the manual entry of provider data and reconciliation of provider data across multiple systems.

Performance Measure Results

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

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions (internally developed measure)*
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
AWC	*Adolescent Well-Care Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of CCHP's HEDIS 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

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

Table 3.2—Comparison of 2011 and 2012 Performance Measure Results for Contra Costa Health Plan—Contra Costa County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	29.6%	26.5%	★★	↔	18.8%	31.6%
AMB–ED	‡	--	59.5	--	Not Comparable	--	--
AMB–OP	‡	--	274.9	--	Not Comparable	--	--
AWC	Q,A,T	40.6%	41.6%	★★	↔	39.6%	64.1%
CAP–1224	A	--	94.0%	--	Not Comparable	--	--
CAP–256	A	--	84.5%	--	Not Comparable	--	--
CAP–711	A	--	84.1%	--	Not Comparable	--	--
CAP–1219	A	--	83.3%	--	Not Comparable	--	--
CCS	Q,A	70.6%	66.7%	★★	↔	64.0%	78.7%
CDC–BP	Q	55.1%	55.0%	★★	↔	54.3%	76.0%
CDC–E	Q,A	49.1%	52.8%	★★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	56.6%	53.0%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	33.9%	37.0%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	86.9%	84.9%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	40.7%	36.3%	★★	↔	27.3%	45.9%
CDC–LS	Q,A	77.7%	75.4%	★★	↔	70.4%	84.2%
CDC–N	Q,A	89.2%	87.3%	★★★	↔	73.9%	86.9%
CIS–3	Q,A,T	87.2%	85.4%	★★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	59.9%	--	Not Comparable	--	--
LBP	Q	88.6%	88.6%	★★★	↔	72.3%	82.3%
MPM–ACE	Q	--	85.6%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	80.9%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	81.8%	83.2%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	67.4%	65.0%	★★	↔	59.6%	75.2%
W-34	Q,A,T	78.8%	77.9%	★★	↔	66.1%	82.9%
WCC–BMI	Q	61.1%	59.4%	★★	↔	19.7%	69.8%
WCC–N	Q	58.9%	55.7%	★★	↔	39.0%	72.0%
WCC–PA	Q	46.5%	46.5%	★★	↔	28.5%	60.6%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, CCHP demonstrated above-average performance in 2012, with most of the performance measure results (16 of 19) falling between the MPLs and the HPLs. The following three measures performed above the HPLs:

- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Childhood Immunization Status—Combination 3*
- *Use of Imaging Studies for Low Back Pain*

No measures had statistically significant changes from 2011 to 2012.

HEDIS Improvement Plans

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

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

CCHP did not have any measures that performed below the MPLs in 2011; therefore, there were no improvement plans required in 2012. CCHP will not be required to implement any improvement plans in 2013 since the plan, once again, had no measures that performed below the MPLs in 2012.

Strengths

CCHP had above-average performance across all measures, with three measures performing above the HPLs. Additionally, no rates fell below the MPLs for the third consecutive year.

Opportunities for Improvement

CCHP shows steady performance across all measures. The plan should monitor measure rates to ensure continued performance above the MPLs on all measures. In addition, the plan should identify areas where performance could be improved even though rates are above the established MPLs, and target efforts for meaningful improvement.

Conducting the Review

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

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

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about CCHP's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Project Objectives

CCHP had two clinical QIPs and one clinical QIP proposal in progress during the review period of July 1, 2011–June 30, 2012. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the current DHCS statewide collaborative QIP. CCHP's second project, an internal QIP, focused on reducing childhood obesity in members aged 3 to 11 years. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative which targeted reducing readmissions for members aged 21 years and older. All three QIPs fell under the quality and access domains of care.

The current statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. At the initiation of the QIP, CCHP had identified 4,421 ER visits that were categorized as avoidable, which was 17.7 percent of the plan's CY 2006 ER visits. CCHP's objective was to

reduce this rate by implementing both member and system improvement strategies. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

The new statewide collaborative proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members leading to improved health outcomes.

The plan's childhood obesity project attempted to improve the quality of care delivered to children aged 3 to 11 years by implementing provider, member, and system improvement strategies. By increasing the documentation of BMI percentile and counseling for nutrition and physical activity, the plan would have a better foundation to address obesity issues for the targeted age group.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for Contra Costa Health Plan—Contra Costa County July 1, 2011, through June 30, 2012

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	92%	100%	*Met*
*All-Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIPs				
Reducing Childhood Obesity	Annual Submission	96%	100%	*Met*

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

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

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

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

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

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

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

Table 4.2 summarizes the aggregate validation results for 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 QIP Submissions, 2 QIP Topics) July 1, 2011, through June 30, 2012

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	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	94%	0%	6%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**96%**	**0%**	**4%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	82%	18%	0%
	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total**		**85%**	**12%**	**4%**

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

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

For the *Reducing Childhood Obesity* QIP, only Remeasurement 1 data were submitted; therefore, Activity I through Activity IX were completed and validated. The *Reducing Avoidable ER Visits* QIP included Remeasurement 3 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 six of the seven activities.

For the outcomes stage, CCHP was scored lower in Activity VIII for both QIPs since the results were not compared to goals for each measurement period. This same activity for the *Reducing Avoidable Emergency Room Visits* QIP was also scored down for the plan's incorrect interpretation of the results. Activity X was scored down since the *Reducing Avoidable Emergency Room Visits* QIP outcome did not achieve sustained improvement. Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes and Interventions

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

Table 4.3—Quality Improvement Project Outcomes for Contra Costa Health Plan—Contra Costa County July 1, 2011, through June 30, 2012

QIP #1—Reducing Avoidable Emergency Room Visits					
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Remeasurement 3 1/1/10–12/31/10**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable^	16.6%	20.9%*	20.0%*	19.3%*	No

QIP #2—Reducing 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¥**
Percentage of members 3 to 11 years of age who had a BMI percentile documented in their medical record	17.7%	66.6%*	‡	‡
Percentage of members 3 to 11 years of age who had documentation for nutrition counseling in their medical record	51.6%	65.3%*	‡	‡
Percentage of members 3 to 11 years of age who had documentation for physical fitness counseling in their medical record	36.3%	50.5%*	‡	‡

^A lower percentage indicates better performance.
¥ Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.
* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).
‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, CCHP set a goal to reduce the rate of avoidable ER visits by 10 percent over the life of the project. For this project outcome, a lower rate demonstrates improved performance. While the plan did not meet its overall objective, it reported two separate statistically significant increases in performance (1) from the first to the second remeasurement period (0.9 percentage points), and (2) from the second to the third remeasurement period (0.7 percentage points). Ultimately, the plan did not demonstrate sustained improvement since the remeasurement outcomes were not improved over the baseline outcome. Additionally, there was a decline in performance from baseline to the first remeasurement period; the rate of avoidable ER visits increased by a statistically significant amount. A critical analysis of the plan's improvement strategy resulted in the following observations:

- The plan initially used member and provider survey data, claims data, and the Quality Management Department to identify barriers and develop interventions; however, the plan did not document the process or conduct/document other barrier analyses as the project progressed.

- Collaborative interventions were initiated in early 2009, continued through 2010, and may have corresponded to the improvement in performance. Specifically, the plan reported success with the plan-hospital data collection collaboration. CCHP reported that the participating hospital reported 100 percent of the data to the plan within five days. Similarly, CCHP reported that it contacted 100 percent of the members within 14 days of receiving notice of their first ER visit. Evaluation of this intervention showed that the avoidable ER visit rates were lower at the participating hospital compared to the non-participating hospitals (16.1 percent versus 19.5 percent).
- CCHP had member interventions that were implemented beginning in 2007 and continued throughout the project. The plan was not able to address why the decline occurred from the baseline to the first remeasurement period since there was no evaluation of the interventions.

The plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine whether to modify or discontinue existing interventions, or implement new ones, thereby reducing the likelihood of achieving project objectives and improving performance.

Reducing Childhood Obesity QIP

For the *Reducing Childhood Obesity* QIP, CCHP demonstrated statistically significant improvement for all three study indicators from baseline to the first remeasurement period. The plan was able to exceed the initial goal of 50 percent for each outcome. It should be noted that for the baseline measurement period, CCHP indicated that it discovered that the plan's medical record abstraction vendor did not abstract all applicable documentation for the BMI measure, which likely resulted in an underreported rate. The plan modified its medical record review process so all applicable documentation was used in the medical record review for Remeasurement 1, which is likely why the rate increased so significantly at the first remeasurement period. A critical analysis of the plan's improvement strategy resulted in the following observations:

- The plan initially identified that the Quality Management Department was working with content experts to identify barriers to reducing childhood obesity. Eventually, the plan decided to use the documentation of BMI, counseling for nutrition and physical activity, as an improvement strategy. The plan did not provide any specific results of the barrier analyses or any data-driven rationale for the selection of the interventions.
- The plan focused its initial improvement strategies on Hispanic children due to high obesity rates; however, this ethnic/racial group did not have lower documentation rates for BMI and counseling for nutrition and physical activity than the White or Black children. The plan had not used plan-specific data to identify the barriers applicable to its population.
- The plan directed its improvement strategies to provider and member communications such as distribution of the California Association of Health Plans Child & Adolescent Obesity Provider

Toolkit and direct BMI training for medical staff. Additionally, the plan implemented a system change that modified the well-child form to facilitate the documentation of counseling for nutrition and physical activity.

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

Strengths

CCHP demonstrated an excellent application of the design and implementation stages and received *Met* scores for the applicable evaluation elements in six of the seven activities. The plan achieved these scores without the benefit of resubmission, indicating proficiency with the QIP validation process.

For the *Reducing Childhood Obesity* QIP, the plan demonstrated statistically significant improvement in providing documentation of counseling for nutrition and physical activity during the course of the project. With increased counseling for nutrition and physical activity related to obesity, CCHP has an opportunity to begin to address the obesity issues for members aged 3 to 11 years.

Opportunities for Improvement

CCHP should conduct an annual barrier analysis, at minimum. The plan should improve the documentation of the barrier analysis, providing the data, the identified barriers, and the rationale for how the barriers are prioritized. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone.

The interventions implemented should address the high-priority barriers. A method to evaluate the effectiveness of each intervention should be documented, as well as the results of the intervention's evaluation for each measurement period.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

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

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

CCHP showed above-average performance in the quality domain of care. The plan had valid rates for all 2012 performance measures, and overall performance on measures in the quality domain was above average. Three measures in the quality domain of care had rates above the HPLs.

CCHP's two QIPs both fell within the quality domain of care. CCHP demonstrated an excellent application of the QIP design and implementation stages and received *Met* scores for the applicable evaluation elements in six of the seven activities. The plan achieved these scores without the benefit of resubmission, indicating proficiency with the QIP validation process.

Although some quality-related deficiencies from CCHP's most recent medical performance and MR/PIU reviews remained unresolved, CCHP demonstrated efforts to resolve many of the quality-related deficiencies.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

CCHP showed above-average performance in the access domain of care. Measures falling in the access domain of care performed above average overall, with two measures performing above the HPLs.

CCHP's two QIPs also fall within the access domain of care. The plan's *Reducing Avoidable Emergency Room Visits* QIP showed improvement in performance along the three remeasurement periods. However, the plan did not achieve sustained improvement on this QIP since the remeasurement outcomes were not improved over the baseline outcome.

CCHP has made progress toward resolving the access-related deficiencies identified during the plan's most recent medical performance and MR/PIU reviews. HSAG made several recommendations to assist the plan in resolving the remaining deficiencies and findings.

Timeliness

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

DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations,

well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

CCHP showed average performance in the timeliness domain of care. Measures within the timeliness domain of care performed average overall, with one measure performing above the HPL.

CCHP has made progress toward resolving the timeliness-related deficiencies identified during the plan's most recent medical performance and MR/PIU reviews. HSAG made several recommendations to assist the plan in resolving the remaining deficiencies.

Follow-Up on Prior Year Recommendations

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

Recommendations

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

- Ensure that all outstanding deficiencies from the medical performance review are fully resolved. Specifically:
  - Provide documentation regarding the frequency of the delegation audits or the inclusion of CAPs.
  - Provide evidence that claims destined for another health plan are being sent within the required time frame of 10 working days.
  - Provide evidence that in January 2011, the plan's Pharmacy Unit implemented procedures to monitor access to and availability of a sufficient supply of emergency medications to last until the member can reasonably be expected to have a prescription filled.
  - Provide evidence that incidents of suspected fraud or abuse are reported to DHCS within 10 working days of the date when the plan first became aware of or was notified of such activity.
- Ensure that all outstanding findings from the MR/PIU review are fully resolved. Specifically:
  - Provide evidence that all NOA letters include the required information and are sent within the required time frames.

   - Provide documentation that providers are informed that they should discourage the use of family, friends, or minors as interpreters.
- Consider revising the format of the annual quality improvement evaluation to include a summary of results, barriers, strengths, and recommendations or next steps for future improvement, as appropriate.
- Focus efforts on ensuring sufficient staff are hired and trained to meet the volume of claims and encounters to be processed throughout the year to reduce claims backlog.
- Crosswalk CHDP codes with all vendors to assure they can be used as administrative data in future years as a strategy to improve performance measure rates.
- Implement a formal process for auditing the manual entry of provider data and reconciliation of provider data across multiple systems.
- Conduct and document a QIP barrier analysis, annually at minimum. Documentation should include the data, the identified barriers, and the rationale for prioritizing the barriers.
- Implement QIP interventions which target the high-priority barriers, documenting the effectiveness of each intervention and the intervention's evaluation for each measurement period.

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

Quality, Access, and Timeliness

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

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

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

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

Access Domain

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

Timeliness Domain

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

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

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

- **Sustained Improvement** *(Table 4.3)*: Activity X—**Achieved Sustained Improvement**
  - **Above Average =** All study indicators achieved sustained improvement.
  - **Average =** Not all study indicators achieved sustained improvement.
  - **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain.

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

for **Contra Costa Health Plan**

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

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

2010–2011 EQR Recommendation	CCHP's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
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.	CCHP currently has a Compliance Fraud Subcommittee. When CCHP is issued a corrective action plan, the CAP is scheduled for this subcommittee which meets twice per month. All issues with meeting the CAP requirements and maintaining the CAP requirements are addressed within this subcommittee.
Continue efforts to staff and train claims processors to ensure adequate cross-training and coverage.	CCHP will continue efforts 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.	The practice of changing codes to bypass adjudication edits should drastically reduce or stop completely now that we are in ccLink (EPIC). Most of the changing of codes was not intended to change actual billed codes or avoid adjudication edits, but to bypass the QicLink system programming so that we could pay the claim correctly. For PM 160 data, we only see the actual PM 160 form submitted to our scanning company Docustream. Any clinical data associated would be at the doctor's office.
Focus on creating statistically significant increases in the measures that did not meet the HPLs in 2011.	We are currently implementing a Disease Management program which is expected to raise scores in WCC and CDC measures. For other measures, medium- and long-term goals have been set, but interventions are still being planned.
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.	This QIP officially ended at the end of 2010, but we have continued the most successful intervention.
Address all deficiencies noted in the current QIP submissions before resubmitting next year.	Deficiencies addressed.