

Performance Evaluation Report
Contra Costa Health Plan
July 1, 2012–June 30, 2013

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

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Performance Evaluation Report – Contra Costa Health Plan

July 1, 2012 – June 30, 2013

1. INTRODUCTION

Purpose of Report

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

The Code of Federal Regulations (CFR) at 42 CFR §438.364² requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services provided by the states’ Medicaid MCPs. The EQRO’s performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

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

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

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

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

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

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

This report is specific to DHCS’s contracted MCP, Contra Costa Health Plan (“CCHP” or “the MCP”), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

CCHP is a full-scope MCP delivering services to its MCMC members as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). In most TPM counties, there is an LI and a “commercial plan” (CP). DHCS contracts with both plans. The LI is designed—with the input of local government, community groups, and health care providers—to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. MCMC beneficiaries may enroll in CCHP; the LI MCP; or in Anthem Blue Cross Partnership Plan, the alternative CP.

CCHP became operational in Contra Costa County to provide MCMC services effective February 1997. As of June 30, 2013, CCHP had 92,171 MCMC members in Contra Costa County.³

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

Conducting the EQRO Review

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

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

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

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's compliance monitoring reviews to draw conclusions about 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.

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

Readiness Reviews

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

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

Medical Performance Audits and Member Rights Reviews

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

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

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

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

Seniors and Persons with Disabilities Enrollment Survey

From March 4, 2013, through March 6, 2013, DMHC conducted the first survey for CCHP relative to the MCP's SPD program. The survey covered the review period of December 1, 2011, through

⁴ These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

November 30, 2012. DMHC evaluated the following elements specifically related to CCHP's delivery of care to the SPD population:

- ◆ Utilization Management
- ◆ Continuity of Care
- ◆ Access and Availability of Health Care Services
- ◆ Member Rights
- ◆ Quality Management

DMHC provided the results of the SPD enrollment survey outside the review dates for this report. HSAG will report on the results in the MCP's 2013–14 MCP-specific evaluation report.

Audits & Investigation Division Medical Audit

The most recent A&I medical audit for CCHP was conducted March 4, 2013, through March 15, 2013, covering the review period of December 1, 2011, through November 30, 2012. A&I evaluated CCHP's compliance with its contract with DHCS and regulations in the areas of:

- ◆ Utilization Management
- ◆ Continuity of Care
- ◆ Availability and Accessibility
- ◆ Member's Rights
- ◆ Quality Management
- ◆ Administrative and Organizational Capacity

A&I provided the results of the medical audit outside the review dates for this report. HSAG will report on the results in the MCP's 2013–14 MCP-specific evaluation report.

Follow-up from Outstanding Findings and Deficiencies Noted in 2011–12 MCP-Specific Evaluation Report

Although HSAG did not receive follow-up information from DHCS on the outstanding deficiencies and findings from the MCP's February 2010 medical performance review and February 2011 Member Rights/Program Integrity Unit (MR/PIU) on-site review, the MCP's self-reported actions regarding the deficiencies and findings are included in Appendix B of this report. HSAG reviewed CCHP's self-report of actions the MCP has taken to resolve the outstanding issues, along with submitted policies, and it appears that the MCP has addressed the outstanding deficiencies and findings from these reviews.

Strengths

CCHP's self-report provides evidence that the MCP has addressed the outstanding deficiencies and findings from the February 2010 medical performance review and February 2011 MR/PIU review.

Opportunities for Improvement

At this time, it does not appear that the MCP has any outstanding deficiencies or findings from DHCS reviews/audits; therefore, HSAG has no recommendations for the MCP in the area of compliance. It should be noted that since the results from the most recent DMHC SPD enrollment survey and A&I medical audit were provided outside the review dates for this report, it is unknown whether deficiencies were identified that the MCP is required to address.

Conducting the EQRO Review

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

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

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

Validating Performance Measures and Assessing Results

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

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

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

Performance Measure Validation

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

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

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for Contra Costa Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that CCHP followed the appropriate specifications to produce valid rates. Although there were multiple issues of concern, the issues caused minimal impact on the findings. A review of the MCP's HEDIS audit report revealed the following observations:

- ◆ Consistent with the previous two years, CCHP had a backlog in claims data. Although the claims data backlog was mostly resolved, since CCHP has experienced a claims backlog for the last three years, the auditor recommended that the MCP take proactive steps to avoid future backlogs to ensure the MCP's ability to report HEDIS rates.
- ◆ The claims backlog resulted in CCHP not being able to keep up with vendor audits. The auditor recommended that CCHP ensure vendor audits are performed in accordance with the MCP's policies and procedures.

⁶ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

⁷ NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

- ◆ Issues with coding detail and health insurance claim numbers occurred with the MCP’s new transactional system. The auditor recommended that the MCP make changes to the system processes to resolve these issues.
- ◆ At the time of the on-site audit, CCHP had not yet contracted with an NCQA-certified software vendor; therefore, many audit functions had to take place following the site visit. The auditor recommended that CCHP promptly contract with a certified software vendor to avoid placing undue burden on the MCP’s HEDIS staff and the auditor(s).
- ◆ Although CCHP experienced a turnover in several information technology staff assigned to HEDIS, the new staff were well-versed in HEDIS production.

Performance Measure Results

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

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

Performance Measure Abbreviation	Full Name of 2013 Reporting Year[†] Performance Measure
AAB	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
ACR	<i>All-Cause Readmissions[‡]</i>
AMB–ED	<i>Ambulatory Care—Emergency Department (ED) Visits</i>
AMB–OP	<i>Ambulatory Care—Outpatient Visits</i>
CAP–1224	<i>Children and Adolescents’ Access to Primary Care Practitioners (12–24 Months)</i>
CAP–256	<i>Children and Adolescents’ Access to Primary Care Practitioners (25 Months–6 Years)</i>
CAP–711	<i>Children and Adolescents’ Access to Primary Care Practitioners (7–11 Years)</i>
CAP–1219	<i>Children and Adolescents’ Access to Primary Care Practitioners (12–19 Years)</i>
CBP	<i>Controlling High Blood Pressure</i>
CCS	<i>Cervical Cancer Screening</i>
CDC–BP	<i>Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)</i>
CDC–E	<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>
CDC–H8 (<8.0%)	<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)</i>
CDC–H9 (>9.0%)	<i>Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)</i>
CDC–HT	<i>Comprehensive Diabetes Care—HbA1c Testing</i>
CDC–LC (<100)	<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>
CDC–LS	<i>Comprehensive Diabetes Care—LDL-C Screening</i>
CDC–N	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>
CIS–3	<i>Childhood Immunization Status—Combination 3</i>
IMA–1	<i>Immunizations for Adolescents—Combination 1</i>
LBP	<i>Use of Imaging Studies for Low Back Pain</i>
MMA–50	<i>Medication Management for People with Asthma—Medication Compliance 50% Total</i>
MMA–75	<i>Medication Management for People with Asthma—Medication Compliance 75% Total</i>

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

Performance Measure Abbreviation	Full Name of 2013 Reporting Year[†] Performance Measure
MPM–ACE	<i>Annual Monitoring for Patients on Persistent Medications—ACE</i>
MPM–DIG	<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>
MPM–DIU	<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>
PPC–Pre	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>
PPC–Pst	<i>Prenatal and Postpartum Care—Postpartum Care</i>
W-34	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
WCC–BMI	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>
WCC–N	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>
WCC–PA	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>
[†] The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data. [‡] The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.	

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

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

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

**Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
CCHP—Contra Costa County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	26.52%	43.27%	★★★	↑	18.98%	33.33%
ACR	Q, A	--	16.99%	--	Not Comparable	--	--
AMB-ED	‡	59.47	60.94	‡	Not Comparable	‡	‡
AMB-OP	‡	274.88	217.23	‡	Not Comparable	‡	‡
CAP-1224	A	93.97%	86.74%	★	↓	95.56%	98.39%
CAP-256	A	84.54%	76.18%	★	↓	86.62%	92.63%
CAP-711	A	84.07%	77.96%	★	↓	87.56%	94.51%
CAP-1219	A	83.25%	74.86%	★	↓	86.04%	93.01%
CBP	Q	--	51.34%	--	Not Comparable	--	--
CCS	Q,A	66.67%	66.04%	★★	↔	61.81%	78.51%
CDC-BP	Q	54.99%	59.37%	★★	↔	54.48%	75.44%
CDC-E	Q,A	52.80%	51.09%	★★	↔	45.03%	69.72%
CDC-H8 (<8.0%)	Q	53.04%	49.88%	★★	↔	42.09%	59.37%
CDC-H9 (>9.0%)	Q	36.98%	40.39%	★★	↔	50.31%	28.95%
CDC-HT	Q,A	84.91%	85.40%	★★	↔	78.54%	91.13%
CDC-LC (<100)	Q	36.25%	41.61%	★★	↔	28.47%	46.44%
CDC-LS	Q,A	75.43%	82.00%	★★	↑	70.34%	83.45%
CDC-N	Q,A	87.35%	82.00%	★★	↓	73.48%	86.93%
CIS-3	Q,A,T	85.40%	84.47%	★★★	↔	64.72%	82.48%
IMA-1	Q,A,T	59.85%	71.61%	★★	↑	50.36%	80.91%
LBP	Q	88.58%	92.06%	★★★	↑	72.04%	82.04%
MMA-50	Q	--	56.90%	--	Not Comparable	--	--
MMA-75	Q	--	33.95%	--	Not Comparable	--	--
MPM-ACE	Q	85.62%	83.77%	★★	↔	83.72%	91.33%
MPM-DIG	Q	NA	85.71%	★	Not Comparable	87.93%	95.56%
MPM-DIU	Q	80.95%	83.68%	★★	↔	83.19%	91.30%
PPC-Pre	Q,A,T	83.21%	86.86%	★★	↔	80.54%	93.33%
PPC-Pst	Q,A,T	64.96%	62.53%	★★	↔	58.70%	74.73%
W-34	Q,A,T	77.86%	73.31%	★★	↔	65.51%	83.04%

**Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
CCHP—Contra Costa County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
WCC–BMI	Q	59.37%	56.20%	★★	↔	29.20%	77.13%
WCC–N	Q	55.72%	55.96%	★★	↔	42.82%	77.61%
WCC–PA	Q	46.47%	46.23%	★★	↔	31.63%	64.87%

¹ DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
³ 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
⁴ 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
⁵ Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
⁶ DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
⁷ DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A Not Applicable audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

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

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in

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

measures such as *All-Cause Readmissions*, *Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

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

- ◆ *All-Cause Readmissions—Statewide Collaborative QIP*
- ◆ *Ambulatory Care—Outpatient Visits*
- ◆ *Ambulatory Care—Emergency Department (ED) Visits*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- ◆ *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- ◆ *Comprehensive Diabetes Care—LDL-C Screening*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

⁹ HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD Compared to Non-SPD” column in Table 3.3.

**Table 3.3—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
CCHP—Contra Costa County**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	12.72%	19.48%	▼	16.99%
CAP-1224	86.81%	NA	Not Comparable	86.74%
CAP-256	76.24%	74.13%	↔	76.18%
CAP-711	77.74%	82.34%	↑	77.96%
CAP-1219	74.46%	79.63%	↑	74.86%
CDC-BP	59.85%	56.20%	↔	59.37%
CDC-E	49.88%	54.50%	↔	51.09%
CDC-H8 (<8.0%)	40.88%	55.96%	↑	49.88%
CDC-H9 (>9.0%)	51.34%	33.82%	▲	40.39%
CDC-HT	81.27%	88.56%	↑	85.40%
CDC-LC (<100)	33.58%	43.55%	↑	41.61%
CDC-LS	76.16%	84.43%	↑	82.00%
CDC-N	75.91%	86.13%	↑	82.00%
MPM-ACE	78.37%	85.68%	↑	83.77%
MPM-DIG	NA	86.54%	Not Comparable	85.71%
MPM-DIU	77.84%	85.83%	↑	83.68%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.
 ↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.
 ↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.
 ↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.
 (▲ ▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.
 ▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.
 ▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.
 Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.4—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
CCHP—Contra Costa County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
199.28	55.98	299.06	83.56

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

Performance Measure Result Findings

Overall, CCHP performed average on its performance measures in 2013. The following measures had rates above the HPLs:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Use of Imaging Studies for Low Back Pain*

The rates for the *Childhood Immunization Status—Combination 3* and *Use of Imaging Studies for Low Back Pain* measures have been above the HPLs for three consecutive years.

The rates for the following measures had statistically significant improvement from 2012 to 2013:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Comprehensive Diabetes Care—LDL-C Screening*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Use of Imaging Studies for Low Back Pain*

In 2010, 2011, and 2012, CCHP had no measures with rates below the MPLs. In 2013, the MCP had five measures with rates below the MPLs:

- ◆ All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin*

Additionally, in 2011 and 2012, the MCP had no measures with rates that declined significantly from the prior measurement period. In 2013, the rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures and the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure declined significantly from 2012.

Seniors and Persons with Disabilities Findings

The SPD rates for 10 of the 16 measures stratified for the SPD population were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The SPD rate for the *All-Cause Readmissions* measure was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

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

Improvement Plans

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

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

Since CCHP did not have any rates below the MPLs during 2012, no IPs were required. Since the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure was below the MPL in 2013, the MCP will be required to submit an IP for this measure.

Although CCHP's rate on all four *Children and Adolescents' Access to Primary Care Practitioners* measures were below the MPLs in 2013, the MCP will not be required to submit IPs for these measures. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact.

Strengths

Although CCHP experienced a turnover in several information technology staff assigned to HEDIS, the new staff were well-versed in HEDIS production.

CCHP had three measures with rates above the HPLs in 2013, and the rates for four measures had statistically significant improvement from 2012 to 2013. CCHP's performance has remained consistent for the past several years, with few measures having rates below the MPLs.

Opportunities for Improvement

CCHP has the opportunity to make improvements related to the HEDIS audit process, including:

- ◆ Taking proactive steps to avoid claims backlogs since CCHP has experienced a claims backlog for the last three years.
- ◆ Ensuring vendor audits are performed in accordance with the MCP's policies and procedures.
- ◆ Making changes to the MCP's transactional system to resolve issues with coding detail and health insurance claim numbers.
- ◆ Promptly contracting with a certified software vendor to avoid placing undue burden on the MCP's HEDIS staff and the auditor(s).

CCHP has the opportunity to assess the factors leading to all four *Children and Adolescents' Access to Primary Care Practitioners* measures having statistically significant decline from 2012 to 2013 and the rates to be below the MPLs. The MCP also has the opportunity to assess the factors leading to the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure being below the MPL in 2013. Additionally, the MCP has the opportunity to assess the factors leading to the rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure declining significantly from 2012 to 2013 to ensure the rate for this measure remains above the MPL. Finally, CCHP has the opportunity to assess the factors leading to the SPD rate for the *All-Cause Readmissions* measure being significantly worse than the non-SPD population and identify strategies to ensure the MCP is meeting the SPD population's needs.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol¹⁰ to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

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

Validating Quality Improvement Projects and Assessing Results

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

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

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

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

Quality Improvement Project Objectives

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

Table 4.1 below lists CCHP’s QIPs and indicates whether the QIP is clinical or nonclinical and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

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

QIP	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Clinical	Q, A
<i>Reducing Childhood Obesity</i>	Clinical	Q, A
<i>Improving Perinatal Access and Care</i>	Clinical	Q, A, T

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

Prior to initiation of the statewide collaborative QIP, CCHP had a 30-day readmission rate of 12.12 percent among Medi-Cal beneficiaries. CCHP also found that the readmission rate for the SPD population was 17.03 percent, which was higher than the 8.46 percent rate for the non-SPD population.

CCHP’s *Reducing Childhood Obesity* QIP 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 body mass index (BMI) percentile and counseling for nutrition and physical activity, the MCP would have a better foundation to address obesity issues for the targeted age group.

CCHP’s *Improving Perinatal Access and Care* QIP focused on improving the care women receive during and post pregnancy. Being able to maintain regular prenatal care visits throughout a pregnancy can help identify and treat any problems that may arise. Providing postpartum care is also an essential factor that can lead to a successful health outcome.

Quality Improvement Project Validation Findings

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

**Table 4.2—Quality Improvement Project Validation Activity
CCHP—Contra Costa County
July 1, 2012, through June 30, 2013**

Name of Project/Study	Type of Review ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Overall Validation Status ⁴
Statewide Collaborative QIP				
<i>All-Cause Readmissions</i>	Study Design Submission	70%	100%	<i>Partially Met</i>
	Study Design Resubmission 1	90%	100%	<i>Met</i>
Internal QIPs				
<i>Reducing Childhood Obesity</i>	Annual Submission	89%	100%	<i>Met</i>
<i>Improving Perinatal Access and Care</i>	Study Design Submission	44%	43%	<i>Not Met</i>
	Study Design Resubmission 1	100%	100%	<i>Met</i>
¹ Type of Review —Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG’s validation criteria to receive an overall <i>Met</i> validation status. ² Percentage Score of Evaluation Elements <i>Met</i> —The percentage score is calculated by dividing the total elements <i>Met</i> (critical and noncritical) by the sum of the total elements of all categories (<i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i>). ³ Percentage Score of Critical Elements <i>Met</i> —The percentage score of critical elements <i>Met</i> is calculated by dividing the total critical elements <i>Met</i> by the sum of the critical elements <i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i> . ⁴ Overall Validation Status —Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> .				

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by CCHP of its *All-Cause Readmissions* QIP received an overall validation status of *Partially Met*. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on the validation feedback, CCHP resubmitted the proposal and upon subsequent validation, achieved an overall *Met* validation status with 100 percent of critical elements and 90 percent of evaluation elements met. CCHP received an overall validation status of *Met* for its *Reducing Childhood Obesity* QIP annual submission with 100 percent of critical elements and 89 percent of evaluation elements being met. CCHP received an overall validation status of *Not Met* for its *Improving Perinatal Access and Care* QIP study design submission. Upon resubmission, CCHP received an overall validation status of *Met* with 100 percent of both critical and evaluation elements being met.

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

Table 4.3—Quality Improvement Project Average Rates*
CCHP—Contra Costa County
(Number = 5 QIP Submissions, 3 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	80%	20%	0%
	III: Clearly Defined Study Indicator(s)	90%	10%	0%
	IV: Correctly Identified Study Population	80%	20%	0%
	V: Valid Sampling Techniques (if sampling is used)	94%	0%	6%
	VI: Accurate/Complete Data Collection**	62%	12%	27%
Design Total		81%	8%	11%
Implementation	VII: Sufficient Data Analysis and Interpretation	89%	11%	0%
	VIII: Appropriate Improvement Strategies	67%	33%	0%
Implementation Total		83%	17%	0%
Outcomes	IX: Real Improvement Achieved	75%	0%	25%
	X: Sustained Improvement Achieved	0%	100%	0%
Outcomes Total		60%	20%	20%
*The activity average rate represents the average percentage of applicable elements with a <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> finding across all the evaluation elements for a particular activity.				
**The stage and/or activity totals may not equal 100 percent due to rounding.				

HSAG validated Activities I through VI for both CCHP’s *All-Cause Readmission* and *Improving Perinatal Access and Care* study design submissions and Activities I through X for the MCP’s *Reducing Childhood Obesity* QIP annual submission.

CCHP demonstrated an adequate application of the Design stage, meeting 81 percent of the requirements for all applicable evaluation elements within the study stage for all three QIPs (five QIP submissions). In the initial submission of the *All-Cause Readmissions* QIP, CCHP did not provide all required information in Activity VI, resulting in a lower score for this activity. In the resubmission, the MCP provided additional documentation, resulting in the scores for three elements improving and the QIP receiving an overall *Met* validation status. In the initial submission of the *Improving Perinatal Access and Care* QIP, the MCP did not clearly define the study question, resulting in a lower score in Activity II and Activity III. Additionally, the MCP did not provide all required documentation in Activities IV through VI, resulting in lower scores for these activities. The MCP corrected the deficiencies, resulting in the QIP meeting 100 percent of the

requirements for all applicable evaluation elements for the Design stage for the resubmission. The MCP met 100 percent of the requirements for all applicable evaluation elements within the study stage for the *Reducing Childhood Obesity* QIP annual submission.

Only the *Reducing Childhood Obesity* QIP progressed to the Implementation and Outcomes stages. The MCP demonstrated an adequate application of the Implementation stage, meeting 83 percent of the requirements for all applicable evaluation elements within the study stage for this QIP. CCHP provided an incomplete interpretation of the MCP's findings, resulting in a lower score for Activity VII. In Activity VIII, CCHP introduced a new intervention; however, the MCP did not indicate when the intervention would be implemented and did not add it to the improvement strategies table in Activity VII. The incomplete documentation led to a lowered score for Activity VIII.

The *Reducing Childhood Obesity* QIP received a lower score for Activity IX since the rates for all three study indicators declined at Remeasurement 2. Although the rates for Study Indicators 1 and 3 declined, the rates for these indicators still demonstrated sustained improvement over the baseline rates. The score for Activity X was lowered since the rate for Study Indicator 2 did not maintain the statistically significant improvement over baseline that it had achieved in Remeasurement 1.

Quality Improvement Project Outcomes and Interventions

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

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

**Table 4.4—Quality Improvement Project Outcomes for CCHP—Contra Costa County
July 1, 2012, through June 30, 2013**

QIP #1—Reducing Childhood Obesity			
Study Indicator 1: Percentage of members 3 to 11 years of age who had a BMI percentile documented in their medical record			
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[‡]
17.7%	66.6%*	61.4%**	Yes
Study Indicator 2: Percentage of members 3 to 11 years of age who had documentation for nutrition counseling in their medical record			
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[‡]
51.6%	65.3%*	57.4%	No
Study Indicator 3: Percentage of members 3 to 11 years of age who had documentation for physical fitness counseling in their medical record			
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[‡]
36.3%	50.5%*	47.1%	Yes
[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. * Statistically significant improvement over the baseline rate (p value < 0.05). ** A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).			

Reducing Childhood Obesity QIP

The rates for Study Indicators 1 and 3 for the *Reducing Childhood Obesity* QIP demonstrated sustained improvement at Remeasurement 2; however, Study Indicator 2 did not demonstrate sustained improvement. A critical analysis of the MCP’s QIP Summary Form and QIP Validation Tool resulted in the following observations:

- ◆ CCHP provided an incomplete interpretation of the MCP’s findings during the reporting period.
- ◆ CCHP continued implementing provider education interventions. Additionally, the MCP indicated that it designed an electronic version of a new well-child form which prompts the provider for appropriate counseling and documentation of BMI percentile to be used in the new electronic health record. CCHP did not indicate when the intervention would be implemented or how the intervention would be evaluated, and it did not include this intervention in the improvement strategies table located in Activity VII on the QIP Summary Form.

- ◆ Although the rates for Study Indicators 1 and 3 declined from Remeasurement 1 to Remeasurement 2, these two indicators achieved sustained improvement over baseline at Remeasurement 2. The sustained improvement demonstrates that the implemented interventions were successful at improving and sustaining the rates of documentation of BMI and physical fitness counseling.
- ◆ The rate for Study Indicator 2 (documentation for nutritional counseling) declined and did not maintain the statistically significant improvement over baseline that had been achieved in Remeasurement 1.

Strengths

Overall, CCHP demonstrates adequate application of the QIP Design and Implementation stages. The *Reducing Childhood Obesity* QIP was successful at achieving statistically significant and sustained improvement for two of three study indicators.

Opportunities for Improvement

CCHP has the opportunity to ensure all required documentation is included in the QIP Summary Form since the MCP had several instances of incomplete documentation.

Since the study indicator related to documentation of nutrition counseling for the *Reducing Childhood Obesity* QIP did not achieve sustained improvement at Remeasurement 2, CCHP has the opportunity to conduct a new barrier analysis and assess if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers. Additionally, although not statistically significant, since the rates for the BMI and physical fitness counseling indicators for this QIP declined at Remeasurement 2, the MCP has the opportunity to assess the factors leading to a decline in the rates for these indicators to determine if modifications need to be made to existing strategies to avoid further decline in the rates.

For all QIPs, CCHP has the opportunity to ensure that the MCP has an evaluation plan for each intervention so that it can determine whether to modify or discontinue existing interventions, or implement new ones, to increase the likelihood of achieving positive project outcomes.

Conducting the EQRO Review

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

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

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

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

Findings

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

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

CAHPS Global Rating Measures:

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

CAHPS Composite Measures:

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

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

Table 5.1—CAHPS Measures Domains of Care

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

National Comparisons

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

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

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

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

Table 5.3 through Table 5.4 present the star ratings for the global ratings and composite measures for CCHP's adult and child Medicaid populations.¹⁵

**Table 5.3—Medi-Cal Managed Care County-Level Global Ratings
CCHP—Contra Costa County**

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

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

¹² National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.

¹³ NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.

¹⁴ Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.

¹⁵ Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

**Table 5.4—Medi-Cal Managed Care County-Level Composite Measures
CCHP—Contra Costa County**

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★★	★★★★
Child	★	★	★	★★
+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.				

Strengths

The MCP received a *Very Good* rating for the adult *Customer Service* measure and a *Good* rating for both the adult and child *Rating of Personal Doctor* measures.

CCHP improved its ratings on the following adult measures from 2010 to 2013:

- ◆ *Rating of Personal Doctor*
- ◆ *Rating of Specialist Seen Most Often*
- ◆ *Customer Service*

Opportunities for Improvement

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

Conducting the EQRO Review

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

Methodology

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

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

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

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

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

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

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

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

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

Encounter Data Validation Findings

Review of Encounter Systems and Processes

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

CCHP's process for submitting claims and encounter data files aligns with industry standards. CCHP stated that its log table contains all previous and current records to ensure complete and accurate monthly encounter files. DHCS's records indicated that CCHP had less than 0.3 percent of claims/encounters rejected by DHCS for all encounter types.

Record Completeness

Overall, CCHP had fairly high record surplus rates for all claim types, indicating relatively incomplete data when comparing DHCS's data and the encounter data extracted from CCHP's data system for this study. The record surplus rates ranged from 22.7 percent for the Pharmacy claim type to 56.5 percent for the Medical/Outpatient claim type which were all worse than the respective statewide record surplus rates by at least 7 percentage points. The high record surplus rates for all claim types were mainly because the data CCHP submitted to HSAG did not contain the records with certain *Billing/Reporting Provider Number* or *Referring/Prescribing/Admitting Provider Number* data elements. While two out of the three claim types had record omission rates that were

better than the statewide rates, the record omission rate for the Pharmacy claim type was worse than the statewide rate by more than 23 percentage points. The high record omission for the Pharmacy claim type was mainly due to the duplicated records (based on client identification number, date of service, and payment) in the data CCHP submitted to HSAG.

Data Element Completeness

While CCHP had element omission rates of 0.2 percent or less for the majority of the key data elements, CCHP had poor element omission rates for the data elements *Rendering Provider Number* and *Provider Specialty* in the Medical/Outpatient claim type, which had rates worse than the respective statewide rates by at least 30 percentage points. The *Rendering Provider Number* had an element omission rate of 74.8 percent, although approximately 86 percent of the records with the element omission had a *Rendering Provider Number* that was identical to the *Billing/Reporting Provider Number*. The data element *Provider Specialty* had an element omission rate of 38.6 percent and 80.9 percent of the values omitted from the DHCS data were populated with the value of “HO.” For the *Provider Specialty* and the *Rendering Provider Number* data elements, more than 40 percent of the records with element omissions had a provider type of “16” (Community Hospital Inpatient) which does not require values for the *Rendering Provider Number* or *Provider Specialty* based on the Encounter Data Element Dictionary. Therefore, it is possible that a system edit from the MCP or DHCS may have contributed to the element omission.

Similarly, the element surplus rates were fairly low (0.4 percent or less) for the majority of the key data elements. However, the *Referring/Prescribing/Admitting Provider Number* for the Medical/Outpatient and Hospital/Inpatient claim types and *Billing/Reporting Provider Number* and *Provider Type* for the Pharmacy claim type had very poor element surplus rates (greater than 99 percent), which were worse than the statewide rates by more than 92 percentage points. For the Medical/Outpatient claim type, the *Referring/Prescribing/Admitting Provider Number* had element surplus rates of 99.9 percent due to an invalid *Referring/Prescribing/Admitting Provider Number* value populated in DHCS’s data. Therefore, DHCS’s Medical/Outpatient data did not contain additional valid values for this data element. For the other three element surplus rates, DHCS’s data contained valid values. However, in response to HSAG’s preliminary file review document, CCHP stated that, for Hospital/Inpatient data, the majority of the *Referring/Prescribing/Admitting Provider Number* values were missing from its data warehouse, and the *Billing/Reporting Provider Number* and *Provider Type* were not available for the Pharmacy data in its data warehouse.

Data Element Accuracy

CCHP had element accuracy rates of 95 percent or higher for each of the key data elements except the *Billing/Reporting Provider Number*, *Provider Type*, and *Provider Specialty* in the Medical/Outpatient data, which had element accuracy rates of 94.3 percent, 82.2 percent, and 64.4 percent, respectively. For the *Billing/Reporting Provider Number*, there was one main contributor to the provider number mismatch in DHCS's data and the MCP's data. For the *Provider Type*, nearly 89 percent of the mismatched values were from a value of "26" (Physicians) in the DHCS file and a value of "22" (Physicians Group) in the CCHP file. The inaccuracy for the *Provider Specialty* was mainly due to the nonnumeric provider specialties such as "CH" and "LA," which were present in the MCP's data but not in DHCS's data. For all of the key data elements, the *Provider Type* and *Provider Specialty* in the Medical/Outpatient claim type were the only elements with accuracy rates substantially below the respective statewide rates (i.e., 12 percentage points or more).

All three claim types had an all-element accuracy rate of 0.0 percent due to the poor element surplus rates for several data elements. The all-element accuracy rate for each of the claim types fell below the respective statewide rates by more than 60 percentage points.

Recommendations

Based on its review, HSAG recommends the following:

- ◆ For both data sources, there were no long-term care (LTC) records. However, in CCHP's response to HSAG's preliminary file review results, CCHP indicated that it had LTC records in its data system. CCHP should clarify with DHCS whether the LTC records should be submitted with the value of "L" for the data element *Format Code* so that DHCS can identify the LTC records in the future.
- ◆ CCHP should clarify why the *Claim Control Numbers (CCNs)* in the data CCHP submitted to HSAG and in DHCS's data were not comparable for all claim types.
- ◆ CCHP should investigate the high record omission rate for the Pharmacy claim type and create strategies for improvement.
- ◆ CCHP should investigate the high record surplus rates for all three claim types and apply appropriate quality control procedures to avoid similar issues occurring in future data submissions.
- ◆ CCHP should investigate the high element omission rates for the *Rendering Provider Number* and *Provider Specialty* in the Medical/Outpatient claim type.
- ◆ CCHP's data system did not contain *Referring/Prescribing/Admitting Provider Number* data elements for the majority of the Medical/Outpatient and Hospital/Inpatient records. CCHP should

investigate whether more values for the data element *Referring/Prescribing/Admitting Provider Number* can be submitted to DHCS.

- ◆ For the Pharmacy data, CCHP stated that the values for the *Billing/Reporting Provider Number* and *Provider Type* were not available in its data warehouse. However, DHCS's Pharmacy data contained valid values for these two data elements. CCHP should investigate this discrepancy and modify its processes and procedures as needed.
- ◆ For DHCS's Medical/Outpatient data, the majority of the records had an invalid value populated for the *Referring/Prescribing/Admitting Provider Number*. CCHP should work with DHCS to identify the reason(s) why the invalid value was stored in the DHCS data warehouse.
- ◆ For the Medical/Outpatient claim type, CCHP should investigate the inaccuracy for the data elements *Billing/Reporting Provider Number*, *Provider Type*, and *Provider Specialty* for future improvement on the data element accuracy rates.
- ◆ CCHP should develop policies and procedures for processing and resubmitting corrected/rejected encounters.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

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

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

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

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

CCHP submitted quality documents for HSAG's review as part of the process for producing this MCP-specific evaluation report. HSAG found the 2013 Annual Quality and Performance Improvement Program Description and Work Plan to provide a very basic description of the MCP's quality program, including objectives and actions to be taken related to each quality program area. In CCHP's 2011–12 MCP-specific evaluation report, HSAG recommended that the MCP consider revising the format of its annual quality improvement evaluation to include a summary of results, barriers, strengths, and recommendations or next steps for future improvement, as appropriate. Appendix B includes CCHP's self-reported response to HSAG's recommendation, which indicates that the MCP revised the evaluation report to include sections by topic with discussion of results, barriers, strengths, and next steps, as appropriate. HSAG reviewed the MCP's 2012 evaluation report and although there is a section at the end of the report titled, "Evaluation of Effectiveness" that includes the various topics, the level of detail indicated in Appendix B is not apparent.

The following quality measures had rates above the HPLs in 2013:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Use of Imaging Studies for Low Back Pain*

The rates for two of these measures, *Childhood Immunization Status—Combination 3* and *Use of Imaging Studies for Low Back Pain*, have been above the HPLs for three consecutive years.

Four quality measures had rates with statistically significant improvement from 2012 to 2013:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Comprehensive Diabetes Care—LDL-C Screening*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Use of Imaging Studies for Low Back Pain*

The rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure, which falls into the quality domain of care, declined significantly from 2012 to 2013, and the rate for one quality measure, *Annual Monitoring for Patients on Persistent Medications—Digoxin* was below the MPL in 2013.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and the SPD rates for eight of these measures were significantly better than the non-SPD

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

The SPD rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care, was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had significantly more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

All CAHPS measures fall into the quality domain of care. Overall, the MCP had below-average ratings for both the adult and child populations. The only measure with an above-average rating was the adult *Customer Service* measure, which received a *Very Good* rating. The results of the survey suggest that members are dissatisfied with the quality of care being provided by the MCP.

All three of CCHP's QIPs fall into the quality domain of care. The *All-Cause Readmissions* and *Improving Perinatal Access and Care* QIPs did not progress to the Outcomes stage; therefore, HSAG was not able to assess the QIPs' success at improving the quality of care delivered to the MCP's members. The *Reducing Childhood Obesity* QIP progressed to the Outcomes stage, and the QIP was successful at improving documentation of BMI and physical fitness counseling in the medical chart and sustaining the improvement, potentially leading to improved quality of care for members in the study group who are obese.

Overall, CCHP showed average performance related to the quality domain of care.

Access

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

The rate for the *Childhood Immunization Status—Combination 3* measure, which falls into the access domain of care, was above the HPL in 2013. Additionally, two access measures, *Comprehensive*

Diabetes Care—LDL-C Screening and *Immunizations for Adolescents—Combination 1* had rates with statistically significant improvement from 2012 to 2013.

The rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures, which fall into the access domain of care, declined significantly from 2012 to 2013 and the rates in 2013 were below the MPLs. Additionally, the rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure, which falls into the access domain of care, declined significantly from 2012 to 2013.

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and five of these measures had SPD rates that were significantly better than the non-SPD rates. As indicated above, the better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The *All-Cause Readmissions* measure falls into the access domain of care. As indicated above, the SPD rate for this measure was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had significantly more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

Overall, CCHP performed below average on the access-related CAHPS measure, *Getting Needed Care*, receiving a *Poor* rating for both the adult and child populations. These ratings suggest that members are not satisfied with the level of access to needed services.

All three of CCHP's QIPs fall into the access domain of care. As indicated above, the *All-Cause Readmissions* and *Improving Perinatal Access and Care* QIPs did not progress to the Outcomes stage; therefore, HSAG was not able to assess the QIPs' success at improving members' access to needed health care services. Also as indicated above, the *Reducing Childhood Obesity* QIP progressed to the Outcomes stage, and the QIP was successful at improving documentation of BMI and physical fitness counseling in the medical chart and sustaining the improvement. This improvement suggests that obese members in the study group have access to needed services.

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

Timeliness

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

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas

such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

The rate for one timeless measure, *Childhood Immunization Status—Combination 3*, was above the HPL in 2013. The four other required timeliness measures had average rates, and no timeliness measures had rates with statistically significant change from 2012 to 2013.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. This measure received a *Poor* rating for both the adult and child populations, suggesting that members are not satisfied with the time it takes to receive needed health care services.

The *Improving Perinatal Access and Care* QIP falls into the timeliness domain of care. As indicated above, this QIP did not progress to the Outcomes stage; therefore, HSAG was not able to assess the QIP's success at providing timely perinatal care to members.

Overall, CCHP showed average performance related to the timeliness domain of care.

Follow-Up on Prior Year Recommendations

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

- ◆ Consider revising the MCP's quality documents to include more robust information, using headings to denote the various important content areas (i.e., results, barriers, strengths, and next steps, as appropriate) and ensure that activities cover all domains of care (i.e., quality, access, timeliness).
- ◆ Consider making improvements that will positively affect the MCP's HEDIS audit process, including:
 - Taking proactive steps to avoid claims backlogs to ensure the MCP's ability to report HEDIS rates.

- Ensuring vendor audits are performed in accordance with the MCP’s policies and procedures.
- Making changes to the MCP’s transactional system to resolve issues with coding detail and health insurance claim numbers.
- Promptly contracting with a certified software vendor to avoid placing undue burden on the MCP’s HEDIS staff and the HEDIS auditor(s).
- ◆ Engage in the following efforts to improve performance related to required measures:
 - Assess the factors leading to all four *Children and Adolescents’ Access to Primary Care Practitioners* measures having statistically significant decline from 2012 to 2013 and the rates to be below the MPLs, and identify strategies to implement to prevent further decline in the rates.
 - Assess the factors leading to the rate for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure being below the MPL in 2013, and identify interventions to implement to bring the rate for this measure above the MPL.
 - Assess the factors leading to the rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure declining significantly from 2012 to 2013 to ensure the rate for this measure remains above the MPL.
 - Assess the factors leading to the SPD rate for the *All-Cause Readmissions* measure being significantly higher than the non-SPD rate and identify strategies to ensure the MCP is meeting the SPD population’s needs.
- ◆ Engage in the following efforts to improve performance related to QIPs:
 - Review the QIP Completion Instructions prior to submitting QIPs to ensure all required documentation is included in the QIP Summary Form.
 - Ensure that the MCP has an evaluation plan for each QIP intervention so that it can determine whether to modify or discontinue existing interventions, or implement new ones, to increase the likelihood of achieving positive project outcomes.
 - Since the study indicator related to documentation of nutrition counseling for the *Reducing Childhood Obesity* QIP did not achieve sustained improvement at Remeasurement 2, conduct a new barrier analysis and assess if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.
 - Although not statistically significant, since the rates for the BMI and physical fitness counseling indicators for the *Reducing Childhood Obesity* QIP declined at Remeasurement 2, consider assessing the factors leading to a decline in the rates for these indicators to determine if modifications need to be made to existing strategies to avoid further decline in the rates.

- ◆ Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Getting Needed Care*, *Getting Care Quickly*, and *Rating of All Health Care* priority areas.
- ◆ Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

Quality, Access, and Timeliness Scoring Process

Scale

2.5–3.0 = Above Average

1.5–2.4 = Average

1.0–1.4 = Below Average

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

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

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

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

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

Access and Timeliness Domains

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

CAHPS Survey Measures

(Refer to Tables 5.3 through 5.4)

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

Quality Domain

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

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

Access Domain

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

Timeliness Domain

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

Quality Improvement Projects (QIPs)

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

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

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

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

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

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

Calculating Final Quality, Access, and Timeliness Scores

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

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

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

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

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

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

for **Contra Costa Health Plan**

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

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

2011–12 External Quality Review Recommendation	CCHP’s Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
Ensure that all outstanding deficiencies from the medical performance review are fully resolved. Specifically:	
1. Provide documentation regarding the frequency of the delegation audits or the inclusion of CAPs.	Delegation audits are performed annually; CAPs are produced as appropriate and followed up on. 2011 was an exception with Contra Costa Regional Medical Center (CCRMC) and health centers. Due to delays getting information from them, 2011 and 2012 were combined. They will be audited before the end of 2013. The next Kaiser audit will be October 15, 2013. The plans who annually audit Kaiser as a team adopted, starting this year, a scoring system to determine when a CAP is needed. Before this, plans used varying methodologies.
2. Provide evidence that claims destined for another health plan are being sent within the required time frame of 10 working days.	Claims are pulled weekly and forwarded to Kaiser. See claim policy CLM 4.536. NOTE: HSAG reviewed the policy referenced above, and it includes that the claims must be sent within 10 working days.
3. 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.	1. Updated printed member formulary to call out availability of 24-hour Walgreens pharmacy. 2. CCHP pharmacy director will poll random members utilizing ERs about medication supplied and medication supply policy when discharging ER patients after regular pharmacy business hours. 3. Added the following to Pharmacy policy and procedure PM6-010: “To monitor if members have access to a sufficient supply of medications in emergency situations to last until the member can reasonably be expected to have a prescription filled, CCHP will review the policy and procedure of the emergency room at the contracted hospital. If warranted CCHP will randomly select and

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	<p>review Emergency Department claims to determine if prescribed medications were dispensed in sufficient quantities. Contra Costa Health Service's electronic medical record, through its Client Relationship Manager function is able to report and track aggregated calls that are specific to not receiving drugs in cases of an emergency."</p> <p>Please see attachment "3.3.7 PM6-010 Pharmacy services (revised 11-12).docx.doc."</p> <p>NOTE: The MCP submitted the policy as part of the process for the production of this report. HSAG reviewed the policy, and it appears to meet the requirements.</p>
<p>4. 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.</p>	<p>See MS 8.045 Referral of Improper Disclosure for Member Services.</p> <p>This policy describes the reporting timelines for suspected fraud and abuse.</p> <p>During the audit period of July 31, 2012-June 30, 2013, there were two cases reported to DHCS Program Integrity Unit and both cases were reported within 10 working days.</p>
<p>Ensure that all outstanding findings from the MR/PIU review are fully resolved. Specifically:</p>	
<p>1. Provide evidence that all NOA letters include the required information and are sent within the required time frames.</p>	<p>The Medi-Cal NOAs are now embedded in the Health Plan's ccLink electronic record. If a NOA is needed for a member, the only NOA available to generate is connected, by product line, to the member.</p>
<p>2. Provide documentation that providers are informed that they should discourage the use of family, friends, or minors as interpreters</p>	<p>The Provider Manual contains the statement below, and this is one of the items highlighted in the orientation each provider receives.</p> <p>Providers are required by regulations to discourage members from using their own interpreters, such as family members, friends or minors.</p>
<p>Additional Recommendations:</p>	
<p>1. 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.</p>	<p>More detail has been added as suggested. The annual evaluation is arranged by topic. Each section includes discussion of results, barriers, strengths, and next steps, as appropriate. Also, the evaluation now meets NCQA Accreditation standards, according to an NCQA reviewer.</p>
<p>2. 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.</p>	<p>Claims unit has added 4 full-time employees that are devoted to claims processing. Additionally the Claims Unit has a part-time shift of 3 Claims Adjusters who work evenings and some Saturdays.</p>

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3. 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.	Currently under consideration.
4. Implement a formal process for auditing the manual entry of provider data and reconciliation of provider data across multiple systems.	It is unclear from the report what this is about or what concern or deficiency it addresses.
5. 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.	This analysis is currently underway for both QIPs.
6. Implement QIP interventions which target the high-priority barriers, documenting the effectiveness of each intervention and the intervention's evaluation for each measurement period.	This will be reflected in QIP submissions.