



Medi-Cal Managed Care Division

state of california



Medi-Cal Managed Care External Quality Review Organization

2007-2008 Annual Report of Performance for Kaiser Prepaid Health Plan (KP Cal, LLC)

Submitted by
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Introduction

As of 2009, the Medi-Cal Managed Care Division (MMCD) of the California Department of Health Care Services (the DHCS or “the Department”) contracts with health care plans to provide care to 3.6 million Medi-Cal beneficiaries enrolled in managed care plans in 25 counties throughout California. Healthcare providers within each plan’s contracted network provide comprehensive healthcare services—primary and preventive care, as well as the full range of specialty care mandated by federal and state law.

Federal law pertaining to Medicaid managed care programs (42 CFR § 438.240) requires the DHCS to contract with an External Quality Review Organization (EQRO) to independently evaluate the quality of care provided to Medi-Cal beneficiaries enrolled in any of California’s managed care plans. During the period covered by this report, the DHCS retained the services of the Delmarva Foundation for Medical Care (Delmarva) as its EQRO. Among the services provided by the EQRO is an annual independent assessment of each contracted plan’s “... quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract...” as stated in Title 42 of the U.S. Code.

Plan Background

In addition to contracting with traditional full-scope Managed Care Organizations (MCOs), most of which are licensed Health Maintenance Organizations (HMOs), the DHCS also contracts with KP Cal, LLC (more commonly known as Kaiser) as a Prepaid Health Plan (PHP) in Marin and Sonoma counties. When the Medi-Cal managed care program first expanded into Marin and Sonoma counties in 1992, not enough plans were interested in serving that area to support a Two-Plan or Geographic Managed Care model, and there was no legislative authority for a County-Organized Health System.¹ Since Kaiser was already operating in the region as a private HMO, it contracted with the DHCS to offer a limited number of Medi-Cal enrollees

¹ Medi-Cal beneficiaries receive their health care through three models of health care delivery: County Organized Health Systems (COHS), Geographic Managed Care (GMC), and Two-Plan. COHS plans are county-operated managed care organizations. In the GMC model, enrollees choose from several commercially-operated plans within a certain geographic area. The Two-Plan model consists of Commercial Plans (CPs)—which are commercially-operated managed care plans—and Local Initiatives (LIs)—which are community-developed managed care plans that operate as quasi-governmental agencies.

access to a managed care plan. The plan currently contracts with the DHCS as KP Cal, LLC (referred in this report as “Kaiser PHP” or the “the plan”).

Kaiser PHP has been licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act since 1992. It is a fully capitated, prepaid health plan and provides all basic Medi-Cal covered services, but does exclude some services, such as major organ transplants, chronic renal dialysis, and long-term care. Unlike other Medi-Cal managed care counties, Marin and Sonoma have no mandatory enrollment categories; enrollment in Kaiser PHP is voluntary for all eligible Medi-Cal members in the service area. The contract limits the plan’s enrollment totals. As of December 2007, Kaiser PHP’s total Medi-Cal enrollment was 2,229 members (Marin-660 and Sonoma-1,569).

Federal Reporting Requirements

In 2006, the Centers for Medicare and Medicaid Services (CMS) directed the DHCS to make PHP and specialty plans subject to the same external quality review requirements as other Medi-Cal managed care plans, as well as other appropriate contract requirements, in order for the Department to continue to receive Federal Financial Participation (FFP) for those plans.

Federal regulations require that the quality of care, including access, and timeliness, be evaluated annually by an EQRO. Due to the small size of the PHP and specialty plan populations, the DHCS modified the external quality review requirements applied to these plans as follows:

- Instead of the twelve Healthcare Effectiveness Data and Information Set (HEDIS®)² performance measures required of regular plans, PHP and specialty plans report on only two performance measures (HEDIS or other), selected to be appropriate to the plan’s population.
- PHP and specialty plans are not required to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)³ surveys and instead are required to conduct some kind of member satisfaction survey and periodically report results to the DHCS and the EQRO.

² HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA, 2008). HEDIS measures are used by health care purchasers to assess the quality, access, and timeliness of care and service provided to members of managed care plans. For a more detailed explanation of HEDIS, see Appendix: HEDIS.

³ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ, 2008). The CAHPS program is funded and administered by the U.S. Agency of Healthcare Research and Quality (AHRQ), which works closely with a consortium of public and private organizations to develop and support a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their health care experiences. AHRQ developed the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 2007 4.0H Adult

- While PHP and specialty plans must be engaged in two Quality Improvement Projects (QIPs) at all times just as regular plans, they are not required to participate in statewide collaborative QIPs.

This is MMCD's first annual review for Kaiser PHP and covers reporting years (RYs) 2007 and 2008, focusing on performance measurement results and quality improvement activities conducted during calendar years 2006 and 2007.

Definitions

Federal and State regulations require that contracted Medi-Cal plans be assessed for the standards quality, access, and timeliness. The terms quality, access, and timeliness provide the framework for this plan-specific review of Kaiser PHP. Consistency in meaning and use of these key terms are important for a thorough understanding of this report, so definitions are provided below:

- **Quality**, as it pertains to external quality review, is defined by the Centers for Medicare & Medicaid Service (CMS) as "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) 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." (CMS, 2008)
- **Access** (or accessibility) to health care, according to the Agency for Healthcare Research and Quality (AHRQ), means having "the timely use of personal health services to achieve the best health outcomes. Attaining good access to care requires three discrete steps: gaining entry into the health care system; getting access to sites of care where patients can receive needed services; and, finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust." (AHRQ, 2007)
- **Timeliness**, according to AHRQ, is defined as "...the health care system's capacity to provide health care quickly after a need is recognized....Measures of timeliness include waiting time spent in doctors' offices and emergency departments (EDs) and the interval between identifying a need for specific tests and treatments and actually receiving those services." (AHRQ, 2007)

Medicaid and the 3.0H Child Medicaid surveys. Delmarva conducted these CAPHS surveys in 2007 for MMCD's regular contracted health care plans.

Data Sources

Delmarva used five types of standards or information sources to assess Kaiser PHP's performance relative to the plan's ability to provide its members with care that meets federal and state quality, access, and timeliness requirements:

- **Performance Measures.** DHCS and Kaiser PHP chose two HEDIS measures to fulfill the performance measure requirement, and the plan is required to annually report scores for those measures. Although Kaiser PHP submitted 2007 HEDIS results, the plan did not report 2008 HEDIS results due to a contract issue. Therefore, this report addressed only the 2007 HEDIS results.
- **Member Satisfaction Surveys.** Although Kaiser Permanente regularly conducts member satisfaction survey and includes Marin and Sonoma counties in those surveys, Kaiser is unable to isolate results for Kaiser PHP members. Therefore, Delmarva was unable to use survey results in its evaluation of Kaiser PHP.
- **Quality Improvement Projects (QIPs).** This report contains summaries of the QIPs conducted by Kaiser PHP during the period January 1, 2006, and December 31, 2007.
- **Medi-Cal Medical Audits.** The DHCS's Audits and Investigations Division and the California Department of Managed Health Care (DMHC) conduct routine medical surveys (audits) to assess plan compliance with contract requirements and state regulations. In some cases, the DMHC will conduct health plan systems reviews (audits) without the assistance of the DHCS. This report discusses findings from audits conducted by DMHC during the period January 1, 2006, through December 31, 2007.
- **Grievance and Appeal Data.** All plans are required to submit quarterly grievance and appeal data to the DHCS. Additionally, Medi-Cal Managed Care Division's Office of the Ombudsman prepares reports summarizing member calls received by the Office of the Ombudsman. Kaiser PHP data in this area covers calendar years 2006 and 2007.

Because information was not available in all five areas, Delmarva was limited in its ability to provide a complete assessment. The next annual performance review, covering 2008, may present a more complete assessment.

Assessment of Performance

HEDIS Performance Measures

Because children make up a large percentage of Kaiser PHP's population, to fulfill the performance measurement requirement, the plan selected two HEDIS measures relating to the quality of care received by children: *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis*. For a more detailed explanation of HEDIS and the specific HEDIS measures used in this report, see Appendix: HEDIS.

2007 and 2008 HEDIS Performance Measures

Table 1 provides Kaiser PHP's 2007 HEDIS results for the measures, *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis*. Delmarva designates both of these performance measures in the quality domain.

The plan's rates for these two HEDIS measures are compared to the following benchmarks: 2007 Medi-Cal managed care weighted average, 2006 HEDIS national Medicaid average, 2006 HEDIS national commercial average, and the 2007 California Healthy Families average. The Healthy Families Program, administered by the California Managed Risk Medical Insurance Board, is a low-cost health, dental, and vision coverage plan for uninsured children (up to age 19) of working families.

Table 1. Comparison of Kaiser Prepaid Health Plan's 2007 HEDIS Rates with State and National Benchmark Rates.

2007 HEDIS Measure	2007 Kaiser PHP Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*	2006 HEDIS National Commercial Average*	2007 California Healthy Families Average†
Appropriate Treatment for Children With Upper Respiratory Infection	94.9%	78.9%	82.5%	82.9%	83.1%
Appropriate Testing for Children With Pharyngitis	91.4%	1) ‡	52.0%	69.7%	31.0%
* Rates obtained from the <i>Report of the 2007 Performance Measures for Medi-Cal Managed Care Plans</i> . † 2007 rates obtained from the Healthy Families Program at http://www.mrmib.ca.gov/MRMIB/quality_reports.html . ‡ This measure was not a 2007 reporting requirement by Medi-Cal Managed Care so no plan average could be determined.					

Kaiser PHP reported a 2007 HEDIS rate of 94.9 percent for the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, higher than all other benchmarks. Most notably, Kaiser PHP's rate was 16 percentage points higher than the 2007 Medi-Cal managed care weighted average.

For 2007, for the *Appropriate Testing for Children With Pharyngitis* measure, Kaiser PHP scored 91.4 percent, exceeding all other benchmarks. The plan's rate far exceeded the 2007 California Healthy Families average by over 60 percentage points.

Kaiser PHP reported no 2008 HEDIS rates due to a contract issue. The plan will be reporting 2009 HEDIS rates.

Quality Improvement Projects

PHP and specialty plans are required to participate in two Quality Improvement Projects (QIPs) at all times, but are not required to participate in the statewide collaborative QIPs. These plans may conduct either two internal QIPs or conduct one internal QIP and participate in a small group collaborative QIP if approved by the DHCS.

Prior to 2007, Kaiser PHP did not comply with the contract requirement to have two QIPs underway. In 2007, Kaiser PHP submitted documentation for two internal QIPs: *Cervical Cancer Screening* and *Smoking Cessation*. Kaiser PHP chose these QIPs, as they were being conducted by its parent organization, Kaiser Permanente North. However, the plan did not design either QIP to report data specific to Kaiser PHP's Medi-Cal managed care population in Marin and Sonoma counties and so did not fully meet the Department's QIP requirements. During 2009, DHCS and Kaiser PHP discussed the need for future QIP topics that fully comply with contract requirements.

Delmarva categorized the *Cervical Cancer Screening* QIP in the timeliness of care domain and the *Smoking Cessation* QIP in the quality domain. The discussion below presents details of each QIP and an analysis of the results.

Cervical Cancer Screening

The plan has been conducting an internal QIP on cervical cancer with a goal to reduce the incidence, morbidity and mortality related to cervical cancer screening.

➤ **Relevance:**

- Kaiser PHP reported that 83 percent of its members are women and children and that there are 80 to 100 invasive cervical cancer cases every year in Northern California.
- Kaiser's score on the *Cervical Cancer Screening* HEDIS measure was below the 25th percentile in 2005.

Note: Kaiser PHP was not required to report HEDIS scores for the *Cervical Cancer Screening* measure, so the scores noted in the QIP were assumed to be scores for the larger Kaiser Permanente

organization. However, these scores do not match the 2005 and 2006 HEDIS audited scores reported by the EQRO for that measure for Kaiser North.

- Pap screening for women ages 18 to 64 years helps reduce the cervical cancer morbidity and mortality rates, and is the most cost-effective cancer-screening tool available today.

➤ **Goal:**

Achieve a *Cervical Cancer Screening* rate of 85 percent (NCQA HEDIS 2006 National 75th Percentile) for the larger Kaiser organization among the eligible population of women ages 24 to 64 years by Remeasurement 1.

➤ **Best Interventions (Planned):**

- Targeted outreach by the health plan to age-appropriate women in Marin and Sonoma counties including telephone calls, mailings, and in-person reminders when they are due for a cervical cancer screening.
- A reminder system was to be implemented to inform providers when member-screening tests are due.

➤ **Outcomes:**

HEDIS *Cervical Cancer Screening* measure:

- 2005 (Baseline): 80.2%
- 2006 (Remeasurement 1): 82.3%

Note: Kaiser PHP did not submit its 2006 status report for this QIP until late in 2007. Delmarva returned the status report to the plan, indicating it did not meet QIP requirements and asking that the plan resubmit after addressing issues noted by the EQRO. The plan did not resubmit this status report in time for Delmarva to reflect final validated results in this report.

➤ **Attributes/Barriers to Outcomes:**

- Barrier: Lack of member awareness of the appropriate time and intervals for screenings.
- Barrier: Lack of member education regarding the importance of screenings.
- Barrier: Member awkwardness regarding making appointments for screenings.

Smoking Cessation

The plan is conducting an internal QIP on smoking prevention with a goal to increase the percentage of members receiving advice to quit smoking.

➤ **Relevance:**

- Smoking is the leading preventable cause of death in the United States and is responsible for over 400,000 deaths per year. Studies indicate that 70 percent of smokers are interested in quitting, and smokers report they would be more likely to stop if a healthcare provider advised them to quit.

- Kaiser Permanente is utilizing Kaiser PHP's membership in a pilot project developed around the HEDIS *Medical Assistance with Smoking Cessation* measure. (Again, note that Kaiser PHP did not report 2006 HEDIS scores for this measure for its members in Marin and Sonoma counties, so this discussion relates to the larger Kaiser Permanente population.)

➤ **Goal:**

Achieve the NCQA 2005 national commercial average rate of 71.5 percent on the HEDIS *Medical Assistance with Smoking Cessation* measure.

➤ **Best Interventions:**

- Kaiser considers smoking status a member "vital sign," and members are asked if they smoke by a health care practitioner in all departments at every visit.
- Members who smoke are advised to quit and are counseled by their provider, with a variety of tools and resources provided by the health plan, including member brochures in English and Spanish, smoking cessation classes, and Kaiser Healthy Lifestyles internet program.

➤ **Outcomes:**

HEDIS measure *Medical Assistance with Smoking Cessation*:

- 2005 (Baseline): 67.7%
- 2006 (Remeasurement 1): 67%

Note: Kaiser PHP did not submit its 2006 status report for this QIP until late in 2007. Delmarva returned the status report to the plan, indicating the report did not meet QIP requirements and asking that the plan resubmit the report after addressing issues noted by the EQRO. Kaiser PHP did not resubmit this QIP status report in time for Delmarva to reflect final validation results in this report.

➤ **Attributes and Barriers to Outcomes:**

Barrier: Providers do not identify smokers during interactions with members.

In the *Cervical Cancer Screening* QIP, Kaiser's rates showed a 2.1 percentage point increase for the *Cervical Cancer Screening* measure from baseline to first remeasurement. The plan fell short of its goal to achieve 85 percent by Remeasurement 1. The plan was out of compliance with its QIP reporting requirements in 2008, failing to resubmit a status report with 2007 remeasurement data in time for inclusion in this report.

In the *Smoking Cessation* QIP, Kaiser was unable to demonstrate an increase in the rate from baseline to first remeasurement. Again, the plan was out of compliance with its QIP reporting requirements in 2008 and did not submit an updated status report with 2007 remeasurement data in time for inclusion in this report.

After such a long lapse in reporting and without baseline and remeasurement results specific to Kaiser PHP's service area, MMCD is concerned whether these QIPs are meaningful. MMCD has recommended that Kaiser PHP close out these QIPs and submit proposals for two new projects, taking care to choose topics

and design the projects so that they will be appropriate for Kaiser's Marin/Sonoma membership. The plan can base these QIPs on QIPs already underway within the larger Kaiser Permanente system, but the plan must be able to present baseline measurements and remeasurements specifically for its members in Marin and Sonoma counties.

Member Satisfaction Survey

MMCD's Plan Management Branch waived Kaiser PHP's requirement to administer a member satisfaction survey because Kaiser PHP members are included in the sampled population for the CAHPS survey administered by the EQRO, as well as Kaiser's own member surveys. Kaiser PHP indicated that it is not possible at this time to report survey results just for the members in Marin and Sonoma counties.

Grievance and Ombudsman Reports

MMCD requires contracted health plans to maintain grievance systems in accordance with the California Code of Regulations, Title 28, Section 1300.68. Plans must track all grievances received—in writing or verbally—in a grievance log. Plans submit quarterly reports to MMCD, as well as to the Department of Managed Health Care (DMHC), with detailed information about pending grievances and those that were not resolved within 30 days (MMCD All Plan Letter No. 03-008).

MMCD's Office of the Ombudsman also provides assistance to members who have questions or problems related to provider and plan services, as well as other areas, such as Medi-Cal eligibility. The Office of the Ombudsman functions, in part, to help solve problems from a neutral standpoint to ensure that members receive all medically necessary covered services for which plans are contractually responsible. Complaints or issues that are not resolved immediately by the Office of the Ombudsman are entered into the Ombudsman Case Management System (OCMS) for tracking and follow-up. The Office of the Ombudsman also assists members who wish to request a formal hearing with the State Fair Hearings Board.

It should be noted that the DHCS monitors plans' quarterly grievance reports and MMCD Office of the Ombudsman monthly statistics in order to understand what aspects of provider and plan performance generate many or few grievances, calls, or requests for State Fair Hearings over time. The Department holds discussions with plans regarding unusual patterns in grievances, calls, or hearing requests when appropriate. The Department does not generally perceive any particular number of grievances, calls, or hearing requests as indicators of poor plan performance. Rather, these statistics are an ongoing indication of the degree to which plan members are using the various avenues available to them to ask questions or raise concerns about healthcare quality and plan service.

Kaiser PHP's Grievance Reports

- 2006: 37 grievances
- 2007: 9 grievances

Delmarva found that Kaiser PHP's method of reporting grievances precludes categorization of grievances into subject areas related to quality, access or timeliness. MMCD's Plan Management Branch is working with Kaiser to improve its grievance reporting.

Office of the Ombudsman's Reports

➤ **Ombudsman Case Management System**

- Marin County – 2006 and 2007 (combined): 5 OCMS cases
- Sonoma County – 2006 and 2007 (combined): 39 OCMS cases

➤ **State Fair Hearings**

- Marin 2006: 0 State Fair Hearings
- Sonoma 2006: 0 State Fair Hearings
- Marin 2007: 0 State Fair Hearings
- Sonoma 2007: 2 State Fair Hearings

Managed Care Audit Findings

The health plan systems review (audit) is a comprehensive review of a health plan's compliance with the Knox-Keene Act and its resulting performance in meeting the needs of enrollees. Generally, Medi-Cal medical audits are conducted jointly by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). In this case, DMHC conducted the 2005 audit of Kaiser (North and South) without the DHCS's involvement.

DMHC conducted its audit for Kaiser North during November 2005. In April 2006, DMHC released its audit report assessing Kaiser North and Kaiser South. The audit report includes Kaiser PHP counties, Marin and Sonoma; however, the report does not break out results by county.

The audit included an on-site meeting, review of documents and staff interviews. Auditors surveyed four major areas for performance: Quality Management; Grievances and Appeals; Access and Availability of Services; and Utilization Management.

Auditors found that Kaiser had opportunities for improvement in the Grievance and Appeals area, which Delmarva categorized in the quality domain. Auditors found that Kaiser did not consistently provide immediate notification to the complainant of his/her right to contact the DMHC regarding an urgent grievance. Kaiser North developed corrective action plans regarding this deficiency. The DMHC reviewed

the plan's revised procedures regarding expedited reviews and member notification of his/her right to contact DMHC about an urgent grievance. Upon review of the revised procedures, the DMHC found that the plan had corrected the deficiency.

Delmarva found no deficiencies within the access to care or timeliness of care domains in the audit findings reported for Kaiser North during this reporting period.

Conclusions

For 2007 HEDIS, Kaiser PHP reported two measures: *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis*. In both instances, the plan exceeded all benchmarks, scoring 94.9 percent and 91.4 percent, respectively.

Kaiser PHP submitted two QIPs during the reporting period. For the *Cervical Cancer Screening* QIP, Kaiser showed an increase in the rate for the *Cervical Cancer Screening* measure from baseline to first remeasurement. For the *Smoking Cessation* QIP, Kaiser was unable to demonstrate an increase in the rate for the HEDIS *Medical Assistance with Smoking Cessation* measure from baseline to first remeasurement. MMCD noted compliance issues related to Kaiser PHP not submitting the required QIP status reports on a timely basis and not being able to report baseline and remeasurement results for the plan's specific service area.

Recommendations

Since Kaiser PHP scored well on the two performance measures, *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis*, Delmarva recommends that the plan now identify other measures that would benefit from focused improvement efforts.

Kaiser PHP's contract with the DHCS requires annual reporting of performance measures and QIPs and administration of a member satisfaction survey. The DHCS recommends that Kaiser PHP work collaboratively with the Department and the EQRO to become fully compliant with contract requirements related to external quality review. Specifically, Delmarva recommends that Kaiser PHP:

- Adhere to timely submission of QIP reports.
- Close out both existing QIPs, since status reporting has not been timely and have not been in compliance with QIP requirements, and initiate two new QIPs. The proposals for the new QIPs will have to be approved by the DHCS and validated by the EQRO.
- Engage in development and implementation of a member satisfaction survey for future reporting.

Appendix: HEDIS®

HEDIS Background

The Healthcare Effectiveness Data and Information Set (HEDIS®)⁴ is a nationally recognized, standardized set of performance indicators developed by the National Committee for Quality Assurance (NCQA). NCQA's Committee on Performance Measurement annually evaluates and makes collective decisions about the content of the measures and the entire HEDIS process. State governments, employer and business groups, payers, and consumers use the results of these measures. More than 90 percent of all national health plans use HEDIS to measure their performance on established dimensions of health care and plan services.

HEDIS data collection and validation is standardized across all plans. HEDIS methodology makes it possible to compare the performance of health plans to each other and to national benchmarks. Results are used to identify performance variances to help plans focus their quality improvement activities.

HEDIS Domains of Care

NCQA assigns each of the technically-defined HEDIS measures (71 measures in 2007 and 70 measures in 2008) to one of eight domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care (Adult and Child CAHPS)
- Use of Services
- Cost of Care
- Health Plan Descriptive Information
- Health Plan Stability
- Informed Health Care Choices

DHCS-Required Measures

2007 DHCS-Required HEDIS Measures

For the 2007 Reporting Year, the DHCS required its regular contracted plans to report on 12 selected HEDIS measures—including multiple indicators for *Comprehensive Diabetes Care* and *Prenatal and Postpartum*

⁴ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Care—for a total of 16 measurement indicators.⁵ Because Kaiser PHP is a Prepaid Health Plan (PHP), MMCD required one of these 16 indicators to be reported by the plan: *Appropriate Treatment for Children With Upper Respiratory Infection* and chose another HEDIS measure *Appropriate Testing for Children With Pharyngitis*, as the second required HEDIS measure. Kaiser PHP's second measure is not required of regular contracted plans.

2008 DHCS-Required HEDIS Measures

For the 2008 Reporting Year, the DHCS required its regular contracted plans to report on 12 selected HEDIS measures—including multiple indicators for *Ambulatory Care*, *Childhood Immunization Status*, *Comprehensive Diabetes Care*, and *Prenatal and Postpartum Care*—for a total of 23 measurement indicators.⁶ Kaiser was again required to report on the same two HEDIS measures as for 2007, but did not report scores in 2008 due to a contract issue.

The DHCS strives to select measures that gauge the quality of care provided to and access to care experienced by the largest segments of the Medi-Cal managed care population. The EQRO compiles and validates the measurement results from all the plans and communicates the results to the DHCS in an annual *Performance Measures for Medi-Cal Managed Care Plans* report.

The *Report of the 2007 Performance Measures for Medi-Cal Managed Care Plans* and the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Plans* (“*Annual Performance Measures reports*”) provide the Medi-Cal managed care weighted average for each measure. The Medi-Cal managed care weighted average accounts for variation in membership across plans. The plans' HEDIS data processes are audited according to the protocols described in the *Annual Performance Measures reports*. Kaiser PHP's rates in this plan report were taken from the *Annual Performance Measures reports*, as were the state and national benchmark rates used for comparison.

Performance Level Criteria

This report utilizes the following established benchmarks in assessing plans' performance on measures:

- Medi-Cal Managed Care Weighted Average (Same Year)
- National Medicaid Average (Prior Year)
- National Commercial Average (Prior Year)

⁵ The measures are set forth annually in All Plan Letters issued by the DHCS and available on its website. See All Plan Letter No. 06-010, entitled “Quality and Performance Improvement Program Requirements for 2007.”

* MPLs/HPLs were not applied to these measures in 2007.

⁶ The measures are set forth annually in All Plan Letters issued by the DHCS and available on its website. See All Plan Letter No. 07-013, entitled “Quality and Performance Improvement Program Requirements for 2008.”

* MPLs/HPLs were not applied to these measures in 2008.

The DHCS compares plan rates to Minimum Performance Levels (MPLs) and High Performance Levels (HPLs) for each measure to assess further program-wide quality of care and to identify specific health plan improvement needs. MPLs and HPLs are equal to the 25th and the 90th percentiles, respectively, of the 2006 and 2007 national Medicaid results. The performance benchmarks (MPLs and HPLs) were taken from NCQA's *Quality Compass* for the previous year.

The HPL rates help identify plans that outperform the national Medicaid 90th percentile from the previous year. The DHCS does not apply the MPL and HPL to the first-year scores reported for any measure since that rate establishes a "baseline". Similarly, the MPL and HPL are not applied in years when there were substantive changes to a measure's technical specifications, since making a comparison to the previous rate would be inappropriate.

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