Performance Evaluation Report

Kern Family Health Care

July 1, 2008–June 30, 2009

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

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1. Executive Summary

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.4 million beneficiaries in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Plan-specific reports are issued in tandem with the technical report. This report is specific to the MCMC Program's contracted plan, Kern Family Health Care ("KFHC" or "the plan") for the review period of July 1, 2008, to June 30, 2009. Plan-specific reports include findings for each plan regarding its organizational assessment and structure, performance measures, and QIPs as they relate to the quality, access, and timeliness domains of care. Actions taken by the plan subsequent to June 30, 2009, regarding findings identified below will be included in the next annual plan-specific evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPL indicate low performance, rates above the HPL indicate high performance, and rates between the MPL and HPL demonstrate average performance.

HSAG found that KFHC demonstrated average performance for the quality domain of care. This was based on the plan's 2009 performance measure rates (which reflected 2008 measurement data), QIP outcomes, and compliance review standards related to measurement and improvement.

Most of KFHC's performance measure rates fell between the established MPLs and HPLs. No measures were above the HPL and two measures fell below the MPL: *Use of Appropriate Medications for People With Asthma (ASM)* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre).* Two comprehensive diabetes care measures had statistically significant improvement over the previous year.

During the review period, KFHC's *Use of Immunization Registry for Children* QIP showed sustained improvement for all four of the project's indicators. KFHC increased the use of its high-volume providers using the regional immunization registry, increased the percentage of children seen by providers who accessed and used the registry, and increased the percentage rate of children receiving recommended immunizations.

KFHC was fully compliant with review standards for the areas of quality management and administrative and organizational capacity. This demonstrated KFHC had a structure in place to support the delivery of quality care to members.

KFHC can improve quality of care by improving performance measure rates that fell below the MPL, had statistically significant declines, or were at risk for falling below the MPL. KFHC had a statistically significant decrease between 2008 and 2009 for its *Use of Appropriate Medications for People With Asthma (ASM)* measure, which now falls under the MPL. KFHC's 2009 rate is the lowest rate of all MCMC plans and presents a significant opportunity for improvement.[1] KFHC's performance in this area may point to issues with health care quality and with providers who are not practicing care consistent with clinical guidelines. Additional opportunities include the rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* measure, which fell below the MPL, and the rate for the *Cervical Cancer Screening (CCS)* measure, which had a statistically significant decline between 2008 and 2009.

Measures with rates at or only slightly above the MPL include *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)*, *Adolescent Well-Care Visits (AWC),* and *Breast Cancer Screening (BCS).*

The plan was unable to report eye exam rates for diabetic members due to material bias of the rate. In order to trend performance in this area, the plan needs to ensure appropriate data collection for data reporting for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC–E)* measure.

HSAG noted that the plan has an opportunity to improve its documentation of both QIPs to meet compliance with federal requirements for conducting a QIP. Following the Centers for Medicare & Medicaid Services (CMS) protocol for conducting a QIP increases the likelihood that the plan will achieve real and sustained improvement of health outcomes.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members.

The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The Department uses monitoring processes, including audits, to assess plans' compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services. Many performance measures fall under more than one domain. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

[1] Department of Health Care Services. *2009 HEDIS Aggregate Report for Medi-Cal Managed Care Plans*. July 2010.

KFHC demonstrated average performance for the access domain of care based on its 2009 performance measure rates that related to access, QIP outcomes that addressed access, and compliance review standards related to the availability of and access to care.

KFHC's success with its QIP focused on childhood immunizations likely impacted the plan's rate for the *Childhood Immunization Status—Combination 3 (CIS–3)* performance measure, which is only 1.1 percentage points below the HPL.

Opportunities exist to improve performance measures related to access to care, including *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre), Cervical Cancer Screening (CCS), Adolescent Well-Care Visits (AWC),* and *Breast Cancer Screening (BCS).*

For access-related compliance standards, the plan demonstrated monitoring for availability and accessibility of services. The plan monitored access to care through its *Mystery Caller Program*, referral tracking, member services data, access reports, member satisfaction surveys, grievance data, and facility site reviews. KFHC was fully compliant with cultural and linguistic requirements, which helps to ensure member access to appropriate care.

The plan can improve access compliance by ensuring appropriate documentation to substantiate paid emergency service claims at reduced levels and by notifying providers of the dispute resolution process. The audit noted that the plan lacked monitoring for the provision of medication in emergency circumstances, a repeat audit finding.

As part of KFHC's group needs assessment and telephonic survey on emergency room (ER) use for the statewide collaborative QIP on decreasing avoidable ER use, the plan learned that the majority of members who accessed the ER did so after hours or on weekends, did not contact the Advice Line before going to the ER, and had not been told by their primary care physician what to do after office hours. The statewide collaborative's member health education campaign attempted to educate members on contacting their providers before going to the ER for many common, non-urgent conditions. KFHC will need to gain provider support and participation to meet the collaborative campaign goal of treating patients in an outpatient setting rather than referring them to the ER.

Timeliness

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

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

enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

Based on 2009 performance measure rates for providing timely care and compliance review standards related to timeliness, KFHC demonstrated average performance in the timeliness domain of care.

The plan performed within the MCMC-established thresholds for well-child visits, postpartum visits, and childhood immunizations in the timeliness domain of care. The plan did not meet the MPL for timeliness of prenatal care.

The plan demonstrated strength in its process for providing continuity and coordination of care for members, including persons with disabilities. This supports members receiving timely care. Additionally, the plan had a process to monitor the completion of initial health assessments for new members. This process has resulted in a 90 percent compliance rate among its providers.

Joint audit review findings noted some deficiencies with prior authorization notifications that did not contain clear and concise language. A file review showed that the plan did not notify providers within 24 hours of denied treatment authorizations. A subsequent review by the Member Rights/Program Integrity Unit (MRPIU) showed the plan fully compliant for prior authorization notifications, suggesting that the plan resolved these issues.

Conclusions and Recommendations

Overall, KFHC demonstrated average performance in providing quality, accessible, and timely health care services to its MCMC members. KFHC's performance measure rates were primarily between the established MPL and HPL. No performance measures exceeded the HPL while two fell below the MPL. KFHC had the lowest rate of all MCMC plans for its *Use of Appropriate Medications for People With Asthma (ASM)* measure. [2]

The plan demonstrated sustained improvement for all four of its study indicators for its QIP project focused on childhood immunization rates. This success has brought the plan very close to achieving the HPL for the *Childhood Immunization Status—Combination 3 (CIS–3)* performance measure rate.

[2] Department of Health Care Services. *2009 HEDIS Aggregate Report for Medi-Cal Managed Care Plans*. July 2010.

KFHC demonstrated above-average performance with most compliance standards across quality, access, and timeliness domains of care. The plan was fully compliant with joint audit review standards for continuity of care, quality management, and administrative and organizational capacity. Additionally, the plan was fully compliant with all areas covered under the MRPIU review.

KFHC has opportunities for improvement related to improved performance measure rates, QIP documentation, and availability and accessibility standards.

Based on the overall assessment of KFHC in the areas of quality and timeliness of and access to care, HSAG recommends the following:

- Focus efforts to improve performance for the *Use of Appropriate Medications for People With Asthma (ASM)* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* measures until they are above the MPL.
- Identify factors that may have contributed to the statistically significant decline in the *Cervical Cancer Screening (CCS)* measure.
- Monitor measures that are slightly above the MPL to ensure there is no decline in performance.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.
- Retire the immunization QIP to allow the plan to focus on another area of low performance. The plan should consider performance measures below the MPL.
- Work with providers to educate their members on what to do after hours to increase the likelihood of the plan achieving improvement during its participation in the statewide collaborative QIP to decrease avoidable ER visits.
- Address issues that contributed to the material biased rate for diabetic eye exams to allow future reporting on this measure.
- Monitor the payment of ER claims to ensure appropriate payment and documentation of reduced-level payments.

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

Plan Overview

Kern Family Health Care (KFHC) is a full-scope managed care plan in Kern County. KFHC became operational with the MCMC Program in July 1996, and as of June 30, 2009, KFHC had 100,934 MCMC members.[3]

KFHC delivers care to members as a Two-Plan model local initiative (LI) plan. In a Two-Plan model county, the DHCS contracts with two managed care plans to provide health care services to members. In most Two-Plan model counties, Medi-Cal beneficiaries in both mandatory and voluntary aid codes can choose between a local initiative plan and a nongovernmental commercial health plan.

[3] *Medi-Cal Managed Care Enrollment Report-June 2009*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about KFHC's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards primarily fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Joint Audit Review

The DHCS's Audits and Investigations (A&I) Division works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A joint audit is conducted for each MCMC plan approximately once every three years. In addition, the A&I Division periodically conducts non-joint medical audits of five MCMC plans; however, KFHC was not among those plans designated for a non-joint medical audit.

HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. A joint audit for KFHC was conducted in November 2006 covering the review period of November 1, 2005, through October 31, 2006. The audit

covered the areas of utilization management, continuity of care, availability and accessibility, members' rights, quality management, and administrative and organizational capacity.

KFHC was fully compliant with review standards under continuity of care, quality management, and administrative and organizational capacity.

The plan demonstrated compliance with requirements for a utilization management (UM) program. Mechanisms were in place to monitor under- and over-utilization. Additionally, KFHC tracked referrals requiring prior authorization. Findings from the audit noted deficiencies related to the UM prior authorization notifications. Denied, modified, or deferred notification letters did not contain the reason for the decision in clear and concise language. Four of 15 files reviewed showed that the plan did not notify providers within 24 hours of denied treatment authorizations.

KFHC had policies and procedures for primary care physicians to provide coordination and continuity of care for members. Policies and procedures were in place to identify members at-risk for developmental delay and to provide services for persons with disabilities. The plan had a memorandum of understanding with the local regional center to facilitate this care. KFHC monitored the completion of initial health assessments and initial health education behavioral assessments for new members through facility site review. Corrective action plans were issued by the plan for those providers who did not meet compliance, and subsequent review showed 90 to 100 percent compliance.

Under availability and accessibility, the plan maintained procedures for member access to care for routine care, urgent care, routine specialty care, prenatal care, preventive services, office wait times, and telephone accessibility. KFHC monitored access to care through its Mystery Caller Program, referral tracking, member services data, access reports, member satisfaction surveys, grievance data, and facility site reviews. The plan lacked documentation substantiating emergency service claims that were paid at reduced levels. KFHC did not notify emergency service providers of DMHC's dispute resolution process and procedures for obtaining forms and instructions. Additionally, the plan lacked monitoring of the provision of medication prescribed in emergency circumstances, a repeat audit finding.

The plan demonstrated compliance with the grievance system. The audit showed that KFHC's Health Insurance Portability and Accountability Act (HIPAA) policies did not include reporting suspected fraud and abuse to the DHCS, consulting with the DHCS prior to conducting investigations, and reporting investigation results to the DHCS.

KFHC was fully compliant with quality management standards that included the monitoring of the quality of care delivered to members, using qualified providers, and having a quality management program that supports the oversight of plan activities. The plan also demonstrated compliance with organizational capacity to support its quality management program.

Member Rights and Program Integrity Monitoring Review

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

As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2009.

MRPIU conducted an on-site review of KFHC in January 2010, covering the review period of November 1, 2007, through December 20, 3009. The plan was fully compliant with all areas covered under the scope of the review. A prior authorization file review found KFHC compliant with all contract, State, and federal requirements. The plan was compliant with all requirements related to marketing policies and procedures. Five KFHC provider offices were visited and all were found in compliance with the plan's cultural and linguistic services requirements.

MRPIU evaluated KFHC's anti-fraud and abuse program and found that the plan appropriately reported suspected fraud and/or abuse cases to MRPIU. Additionally, policy and procedures were compliant with the False Claims Act.

Strengths

KFHC was fully compliant with joint audit review standards related to continuity of care, quality management, and administrative and organizational capacity. Additionally, the plan was fully compliant with all areas covered under the MRPIU review.

The plan demonstrated a strong process for providing continuity and coordination of care for members, including persons with disabilities. KFHC monitors the completion of initial health assessments and initial behavioral health education assessments for new members. All providers achieved over 90 percent compliance.

Prior authorization notification deficiencies noted in the joint audit findings were corrected by the plan, as evidenced by full compliance with the MRPIU review. In addition, the plan revised its fraud and abuse policies and procedures and MRPIU noted full compliance.

Opportunities for Improvement

KFHC has an opportunity to monitor payment of ER claims to ensure appropriate payment and documentation of reduced-level payments, if applicable.

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about KFHC's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Performance Measure Validation

HSAG performed a HEDIS® Compliance Audit™[4] of KFHC in 2009. HSAG found all measures to be reportable with the exception of two measures. The *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)* measure had significant methodology revisions that resulted in the plan using an incorrect denominator. The plan opted not to resample. KFHC was unable to report the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC–E)* rate due to material bias. Both of these measures received a "Not Report" audit result, which is applied when the rate should not be publically reported because the measure deviated from the HEDIS specification enough to significantly bias the reported rate or the plan chose not to report the measure.

[4] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS Compliance Audit™ is a trademark of the NCQA.

HSAG found KFHC's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

Recommendations from the audit noted that KFHC should explore solutions for obtaining lab results from its providers to reduce the burden of medical record review.

Performance Measure Results

The table below presents a summary of KFHC's county-level HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measures results (based on calendar year 2007 data). In addition, the table shows the plan's HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the NCQA's national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—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 Medicaid 10th percentile. For the two measures with unreported rates, HSAG could not compare KFHC's performance levels to benchmarks or the previous year.

Appendix A includes a performance measure name key with abbreviations contained in the following table.

Table 4.1—2008–2009 Performance Measure Results for Kern Family Health Care—Kern County

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	23.3%	20.6%	★★	↔	20.6%	35.4%
ASM	Q	85.9%	81.5%	★	↓	86.1%	91.9%
AWC	Q,A,T	37.2%	38.0%	★★	↔	35.9%	56.7%
BCS	Q,A	49.9%	48.0%	★★	↔	44.4%	61.2%
CCS	Q,A	64.1%	62.6%	★★	↓	56.5%	77.5%
CDC–E	Q,A	42.1%	NR	Not Comparable	Not Comparable	39.7%	67.6%
CDC–H7 (<7.0%)	Q	34.4%	NR	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	48.1%	38.4%	★★	↑	52.5%	32.4%
CDC–HT	Q,A	74.8%	79.8%	★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	34.7%	37.2%	★★	↔	25.1%	42.6%
CDC–LS	Q,A	67.6%	76.4%	★★	↑	66.7%	81.8%
CDC–N	Q,A	73.8%	79.6%	★★	↔	67.9%	85.4%
CIS–3	Q,A,T	73.5%	77.1%	★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	78.4%	75.9%	★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	58.6%	60.6%	★★	↔	54.0%	70.6%
URI	Q	85.0%	86.0%	★★	↔	79.6%	94.1%
W15	Q,A,T	60.1%	54.3%	★★	↔	44.5%	73.7%
W34	Q,A,T	70.0%	71.3%	★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the full name of each HEDIS measure.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.
[4] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[5] Performance comparisons are based on the *z* test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
†The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.
Not Comparable = Performance could not be compared due either to significant methodology changes between years or because the rate was not reported.
NR = Not Report. The rate was not reported due to significant material bias or the plan chose not to report the measure.

Performance Measure Result Findings

Overall, KFHC demonstrated average performance, falling between the MPL and HPL for most of its reported performance measures in 2009. The plan did not exceed the MCMC goal for any measure. The plan had below-average performance in two areas: *Use of Appropriate Medications for People With Asthma (ASM)* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre).*

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPL. Plans that have rates below this minimum level must submit an improvement plan to the DHCS for each area of deficiency, outlining the steps they will take to improve care.

In 2008, the DHCS did not require KFHC to submit an improvement plan for any measure. However, based on KFHC's 2009 performance, the DHCS required the plan to submit improvement plans for two measures that fell below the MPL: *Use of Appropriate Medications for People With Asthma (ASM)* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre).*

Strengths

KFHC showed a statistically significant improvement over the prior year for *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)* and *Comprehensive Diabetes Care—LDL-C Screening (CDC–LS)*, which demonstrated efforts to provide quality care. Additionally, while the plan's performance for the *Childhood Immunization Status—Combination 3* (CIS-3) measure was stable, the rate is only 1.1 percentage points below the HPL.

Opportunities for Improvement

KFHC had the lowest rate of all MCMC plans for its *Use of Appropriate Medications for People With Asthma (ASM)* measure, which presents a significant opportunity for improvement.[5] KFHC's performance in this area may point to issues with health care quality, such as providers not practicing care consistent with clinical guidelines.

Use of Appropriate Medications for People With Asthma (ASM) was also one of the two measures that showed a statistically significant decrease from the plan's 2008 HEDIS rate to its 2009 rate. The other measure was *Cervical Cancer Screening (CCS).* The plan should determine factors that contributed to these declines.

[5] Department of Health Care Services. *2009 HEDIS Aggregate Report for Medi-Cal Managed Care Plans.* July 2010.

Additional opportunities include increasing the rates for *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)*, *Adolescent Well-Care Visits (AWC),* and *Breast Cancer Screening (BCS).* The rates for these measures are at or only slightly above the MPL.

The plan was unable to report eye exam rates for diabetic members due to material bias of the rate.

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about KFHC's performance in providing quality, accessible, and timely care and services to its MCMC members. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Quality Improvement Projects Conducted

KFHC had two clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. KFHC's second project, an internal QIP, sought to increase the use of the immunization registry to increase the plan's documentation of immunization rates in children. Both QIPs fell under the quality and access domains of care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a PCP in an office or clinic setting. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

Incomplete immunizations in children are an indicator of suboptimal preventive care. The use of immunization registries has been shown to be an effective strategy to increase immunization rates.

KFHC's project attempted to improve the quality, access, and timeliness of care delivered to children.

Quality Improvement Project Validation Findings

The DHCS contracted with HSAG as its new EQRO in the second half of 2008. HSAG began validation for QIPs submitted by the plans after July 1, 2008.

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

Table 5.1—QIP Validation Results for Kern Family Health Care—Kern County (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	92%	0%	8%
II.	Clearly Defined, Answerable Study Question(s)	50%	0%	50%
III.	Clearly Defined Study Indicator(s)	79%	14%	7%
IV.	Correctly Identified Study Population	50%	17%	33%
V.	Valid Sampling Techniques (if sampling was used)	100%	0%	0%
VI.	Accurate/Complete Data Collection	75%	6%	19%
VII.	Appropriate Improvement Strategies	80%	20%	0%
VIII.	Sufficient Data Analysis and Interpretation	77%	0%	23%
IX.	Real Improvement Achieved	100%	0%	0%
X.	Sustained Improvement Achieved	100%	0%	0%
Percentage Score of Applicable Evaluation Elements *Met*		**79%**		
Validation Status		***Not Applicable****		
* QIPs were not given an overall validation status during the review period.				

During the period covered by this report, HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the MCMC plans. As a result, many plans had difficulty complying fully with these requirements during the first cycle of QIP validations by HSAG. This was the case with the plan's QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided KFHC, as well as other plans, with an overall validation status of "Not Applicable" for both QIPs. This allowed time for plans to receive technical assistance and training with HSAG's validation requirements without holding up the ongoing progress of QIPs that were already underway.

Quality Improvement Project Outcomes

Tables 5.2 and 5.3 show KFHC's data for its QIPs. For the ER collaborative QIP, KFHC's goal was to reduce the overall rate of members who used the emergency room, with a 1 percent to 5 percent annual reduction in its avoidable ER visit rate. The plan submitted its first remeasurement data in late 2009, after the time period covered by this report. The results of HSAG's assessment for statistically significant improvement will be included in KFHC's next performance evaluation report.

For the immunization QIP, KFHC reported that Combination 3 was used to replace Combination 1 as Study Indicator 1 beginning in calendar year (CY) 2006. Therefore, data for Combination 1 were not included in this report.

Table 5.2—QIP Outcomes for Kern Family Health Care—Kern County

QIP #1—Reducing Avoidable Emergency Room Visits				
		Remeasurement Period		
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	1 1/1/08–12/31/08	2 1/1/09–12/31/09	Sustained Improvement
Percentage of ER visits that were avoidable	15.9%	‡	‡	‡
‡The QIP did not progress to this phase during the review period and could not be assessed.				

The plan implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits. KFHC identified the lack of after-hour and weekend options for non-urgent care for its members and is subsequently in negotiations with additional urgent care centers to increase available options to members.

Table 5.3—QIP Outcomes for Kern Family Health Care—Kern County

QIP #2—Use of Immunization Registry for Children						
QIP Study Indicator	Baseline Period 1/1/04–12/31/04	Remeasurement Period 1 1/1/05–12/31/05	2 1/1/06–12/31/06	3 1/1/07–2/31/07	4 1/1/08–12/31/08	Sustained Improvement
1) Percentage of children who had all of the immunizations identified in Combination #1 plus VZV (Varicella) and Pneumococcal Conjugate (Combo 2)^	70.3%	73.5%	77.1%	‡	‡	Yes
2) Percentage of eligible children who were continuously enrolled for 12 months immediately preceding their second birthday and who had four DtaP/DT, three OPV/IPV, one MMR, three HiB, three hepatitis B, and one Varicella vaccination (VZV) by the time period specified and by the child's second birthday (Combo 3)	65.1%	69.8%	76.9%*	80.3%	80.8%	Yes
3) Percentage of targeted "high volume providers" (primary care providers who administer 50% of the immunizations to target population) that access and use the regional immunization registry for children 0–2 years of age.	75.4%	79.7%	87.0%	89.9%	‡	Yes
4) Percentage of children ages 0–2 years seen by providers that access and use the regional immunization registry	37.5%	40.0%*	43.5%*	45.0%	‡	Yes

^ The first study indicator replaced the Combination #1 study indicator in CY 2006.
‡The QIP did not progress to this phase during the review period and could not be assessed.
* Designates statistically significant improvement over the prior measurement period.

KFHC demonstrated sustained improvement for all four of its study indicators within its immunization QIP. The plan showed a statistically significant increase in the rate of Combination 3 immunizations from 65.1 percent at baseline to 80.8 percent at Remeasurement 4. KFHC increased the use of high-volume providers using the regional immunization registry and increased the percentage of children seen by providers who accessed and used the registry.

The plan used member, provider, and system interventions, which contributed to both real and sustained improvement of the childhood immunization rates. Interventions selected by KFHC to increase member awareness included television commercials and materials distributed to members during prenatal and postpartum provider visits. KFHC also joined the Central Valley Immunization Information System (registry) and implemented targeted interventions to increase provider registry participation, including distribution of risk pool monies.

Strengths

KFHC demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data. KFHC used sound sampling methodology for its immunization QIP. Additionally for the immunization QIP, KFHC demonstrated both real and sustained improvement for all four of its study indicators.

KFHC's success with its QIPs on childhood immunizations likely impacted the plan's rate for the *Childhood Immunization Status—Combination 3 (CIS–3)* performance measure, which was only 1.1 percentage points below the HPL.

Opportunities for Improvement

KFHC has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with the DHCS requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

As part of KFHC's group needs assessment and telephonic survey on ER use for the statewide collaborative QIP, the plan identified that the majority of members who accessed the ER did so after hours or on weekends. Additionally, over 70 percent of the ER users did not contact the Advice Line prior to going to the ER and 46 percent of the members questioned had not been told by their PCP what to do after office hours. The member health education campaign for the statewide collaboration attempted to educate members about contacting their providers before going to the ER for many common, non-urgent conditions. KFHC will need to gain provider support and participation to meet the collaborative campaign goal of treating patients in an outpatient setting rather than referring them to the ER.

The table below provides abbreviations of HEDIS performance measures used throughout this report.

Table A.1—HEDIS® Performance Measures Name Key

Abbreviation	Full Name of HEDIS® Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ASM	*Use of Appropriate Medications for People With Asthma*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–E	*Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed*
CDC–H7	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)*
CDC–H9	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC	*Comprehensive Diabetes Care—LDL-C Control*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W15	*Well-Child Visits in the First 15 Months of Life (Six or More Visits)*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*