Performance Evaluation Report

Kaiser Permanente (KP Cal, LLC)

Sacramento County

July 1, 2008–June 30, 2009

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

December 2010

TABLE OF CONTENTS

1. Executive Summary

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.6 million beneficiaries (as of June 2009) 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 unique to the MCMC Program's contracted plan, KP Cal, LLC, operating in Sacramento County ("Kaiser–Sacramento County" or "the plan"), for the review period 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 within this report 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 at or above the HPL indicate high performance, and rates at the MPL or between the MPL and HPL demonstrate average performance.

HSAG found that Kaiser–Sacramento County demonstrated above-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.

Kaiser–Sacramento County had above-average performance for 11 of 17 measures reported in 2009. Three measures had statistically significant increases from 2008 to 2009. The plan had the highest rate for performance in four measures in 2009.[1] Only one measure had performance below the MPL—*Adolescent Well-Care Visits (AWC)*—for which the plan showed statistically significant improvement from the previous year's rate. The performance measures span the domains of quality, access, and/or timeliness and demonstrate Kaiser–Sacramento County's efforts to provide quality care.

Kaiser–Sacramento County has an opportunity to improve the quality of care on the *Adolescent Well-Care Visits (AWC)* measure, for which the plan performed below the MPL, and on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* measure, for which the plan

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

performed only 4.8 percentage points above the MPL and was substantially below the 2009 MCMC Program average of 76.9 percent.[2]

During the review period, both of Kaiser–Sacramento County's QIPs were in the baseline phase; therefore, HSAG could not assess for improvement of those health outcomes. HSAG noted that the plan had 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.

The plan demonstrated full compliance with the DHCS's medical audit standards in the quality management area. The plan's extensive use of an electronic medical record supported the use of data to improve quality care. The DHCS's medical audit report noted that the plan had an opportunity to finalize policies and procedures to comply with anti-fraud requirements, although the DHCS noted in its medical audit close-out report that the plan corrected this deficiency. An outstanding audit finding showed that the plan needed to ensure that a physician reviewed all denials, including denials by its delegated entities.

Access

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

The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess 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.

Kaiser–Sacramento County 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.

The plan's performance measure rates were all above the MPL, with the exception of *Adolescent Well-Care Visits (AWC)*. Many access-related performance measures rates exceeded the HPL.

[2] Ibid.

The DHCS's Member Rights and Program Integrity Unit (MRPIU) commended the plan for achieving full compliance with all cultural and linguistic requirements, an area of deficiency for many MCMC plans.

The DHCS's Audits and Investigations Division (A&I) medical performance audit found that the plan was compliant with all areas reviewed for availability and accessibility, except for one emergency room (ER) claim denial, which the plan adequately addressed as part of its corrective action plan.

Timeliness

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

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

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

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

The DHCS's medical performance audit found Kaiser–Sacramento County fully compliant with member grievances. A review of prior-authorization denials and appeals showed that the plan resolved all requests within the appropriate time frames. The audit noted an opportunity for the plan to ensure the notification of members for prior-authorization referral denials, deferrals, and modifications; however, the DHCS's audit close-out letter noted that the plan had corrected this area of deficiency.

Conclusions and Recommendations

Overall, Kaiser–Sacramento County demonstrated above-average performance in providing quality, accessible, health care services to its MCMC members and showed average performance in providing timely services. Kaiser–Sacramento County shared the spot of top performer with another plan for its 2009 performance measures, with 11 of 17 measures exceeding the HPL.[3] The plan had one measure below the MPL: *Adolescent Well-Care Visits (AWC)*.

MRPIU found Kaiser–Sacramento County to be fully compliant with the DHCS's standards for continuity of care, prior-authorization notifications, grievance systems, and program integrity.

The A&I medical performance audit findings indicated that the plan was fully compliant in the areas of continuity of care, member rights, and quality management. Opportunities for improvement exist for the plan related to utilization management.

Based on the overall assessment of Kaiser–Sacramento County in the areas of quality and timeliness of and access to care, HSAG recommends the following:

- Continue focusing on improving the *Adolescent Well-Care Visits (AWC)* rate until it reaches the MPL and on *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*, which is substantially below the MCMC Program average.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.
- Modify plan policies and procedures to include physician review for all denials.

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

[3] California Department of Health Care Services. *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program*. July 2010.

Plan Overview

KP Cal, LLC, (Kaiser Permanente's California Medicaid line of business) is a full-scope managed care plan, which contracts with the Medi-Cal Managed Care Program separately in Sacramento and San Diego counties. Additionally, KP Cal, LLC, operated a pre-paid health plan, Kaiser PHP, in Marin and Sonoma counties during the review period. This report pertains to the Sacramento County plan for KP Cal, LLC (Kaiser–Sacramento County). Kaiser–Sacramento County became operational with the Medi-Cal Managed Care Program in Sacramento County in April 1994. As of June 30, 2009, Kaiser–Sacramento County had 24,461 MCMC members.[4]

Kaiser–Sacramento County serves members in a commercial plan under a Geographic Managed Care (GMC) model. In the GMC model, Medi-Cal beneficiaries in both mandatory and voluntary aid codes choose between several commercial plans within a specified county.

[4] *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 activity 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 Kaiser–Sacramento County'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.

Medical Performance Audit Review

For most MCMC plans, the DHCS's Audits and Investigations Division (A&I) works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys and medical audits (joint medical audits) of MCMC plans. These joint medical audits assess plans' compliance with contract requirements and State and federal regulations. For five of the MCMC plans, the DMHC and A&I conduct non-joint medical audits approximately once every three years. Kaiser–Sacramento County is one of the Medi-Cal managed care plans designated to receive a non-joint audit. For the purposes of this report, HSAG reviewed the most current medical audit reports available as of June 30, 2009, to assess the plan's compliance with State-specified standards.

The most recent audit occurred in July 2006 as a non-joint audit conducted by the DHCS's A&I Division for the audit period of July 2005 through June 30, 2006.[5] The scope of the audit covered the areas of utilization management, continuity of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity. The audit was specific to Kaiser–Sacramento County. Results from the audit showed strengths as well as opportunities for improvement.

In the utilization management (UM) area, results showed that the plan developed and maintained a UM program and monitored for many utilization indicators electronically, including over- and underutilization data. Fifteen prior-authorization denials were reviewed, and the plan was compliant with meeting the required time frames and making appropriate medical decisions. However, the plan was not compliant with ensuring that a qualified physician reviewed all denials, which impacted both the plan and its delegated entities. In addition, the audit found that the plan did not send denial notification letters for withdrawn, out-of-plan referral requests when the requested referral could be provided within the plan.

Kaiser–Sacramento County was fully compliant with all review standards covered in the area of continuity of care. Policies and procedures were in place to ensure coordination and continuity of care for members, which included the identification of members who were receiving Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and members with developmental disabilities. The audit found that Kaiser–Sacramento County had an online database for monitoring the completion of initial health assessments (IHAs) and initial health education behavioral assessments (IHEBAs) with an average rate for the review period of 89 percent and 99 percent, respectively.

For availability and accessibility, the audit showed that the plan had adequate procedures for obtaining various appointment types, maintaining an adequate number of primary care providers and specialists, and providing access to the plan's HIV clinic. The plan demonstrated monitoring of appointment wait times for routine, urgent, specialist, and after-hours care, as well as monitoring of telephonic access. The audit, which included the review of 20 denied ER claims, showed one finding related to emergency service providers. While 19 of the claims were appropriately adjudicated, one claim did not result in the payment of a screening fee to an out-of-plan provider consistent with the plan's policy and procedure.

In the member grievances area, the audit showed that Kaiser–Sacramento County was fully compliant. The plan had a process in place to track and resolve grievances. All grievances reviewed were acknowledged by the plan in a timely manner, and the files showed that the issues were resolved appropriately.

[5] California Department of Health Services, Audits and Investigations. *Medical Review – KP Cal LLC, Kaiser Permanente GMC – Sacramento.* February 15, 2007.

For the quality management area, the plan demonstrated implementation and maintenance of a quality management program to monitor, evaluate, and take action to address needed improvements. The plan was compliant with all the requirements reviewed in this area.

For the administrative and organizational capacity area, the plan was in the process of developing a policy to comply with State and federal fraud requirements; therefore, the plan was not fully compliant at the time of the review for reporting suspected fraud and/or abuse complaints to the DHCS, consulting with the DHCS prior to conducting an investigation, and reporting results to the DHCS at the conclusion of an investigation.

A DHCS audit close-out letter to the plan in July 2007 noted that the plan sufficiently addressed all of the areas of audit deficiency with the exception of requiring a qualified physician to review all denials. The plan requested that the DHCS consider allowing the plan to use American Specialty Health Plan providers to make chiropractic denial decisions since these licensed providers comply with Knox-Keene standards. The DHCS noted that while this practice meets State requirements, the contract between the DHCS and the plan requires physician review.

In addition to the DHCS's A&I medical performance audit, the Department of Managed Health Care (DMHC) conducted a non-joint routine medical survey in December 2008. It was unclear from the medical survey whether the scope of the audit for Kaiser's northern region, Sacramento County, included review of Kaiser's Medi-Cal managed care plan. Therefore, the results were excluded from this evaluation report, but they can be accessed on DHCS's Web site.[6]

Member Rights and Program Integrity Monitoring Review

The DHCS's Member Rights and 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, it 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 performed 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.

[6] Department of Managed Health Care, Division of Plan Surveys. *Final Report – Routine Medical Survey of Kaiser Foundation Health Plan, Inc. August 2009.* Available at: http://www.dmhc.ca.gov/library/reports/med_survey/med_default.aspx

MRPIU conducted an on-site review of Kaiser–Sacramento County in August 2009 covering the review period of January 1, 2008, through May 31, 2009. Kaiser–Sacramento County was fully compliant with all areas of review, including grievances, prior-authorization notifications, cultural and linguistic services requirements, and program integrity.

Strengths

The plan demonstrated compliance with many areas covered under the DHCS's A&I medical performance audit and MRPIU review. Kaiser–Sacramento County's structure supports continuity and coordination of care. The plan is primarily a closed system that allows better controls for data completeness. High completion rates for IHAs and IHEBAs demonstrated good processes for monitoring and following up with members to ensure that they are linked to health care services in a timely and appropriate manner. Additionally, the plan uses an electronic health record that supports the use of data to identify opportunities for improvement in a timely manner.

Opportunities for Improvement

The plan needs to update its policies and procedures to ensure physician review of all denials.

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about Kaiser–Sacramento County'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 early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Performance Measure Validation

HSAG performed a HEDIS® Compliance Audit™[7] of Kaiser–Sacramento County in 2009. HSAG found all measures to be reportable and that Kaiser–Sacramento County's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

The audit noted Kaiser–Sacramento County's strength for the extensive use of electronic health records and a closed-integrated system that lends itself to accurate and complete data when deriving its HEDIS rates. No recommendations were provided.

[7] 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.

Performance Measure Results

The table below presents a summary of Kaiser–Sacramento County'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 national Medicaid 10th percentile.

Due to significant methodology changes for the *Comprehensive Diabetes Care—HbA1c Control (<7.0 Percent)* measure for 2009, the MCMC Program was unable to compare 2008 and 2009 performance results for this measure.

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

Table 4.1—2008–2009 Performance Measure Results for Kaiser–Sacramento 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	35.4%	44.3%	★★★	↔	20.6%	35.4%
ASM	Q	96.2%	96.7%	★★★	↔	86.1%	91.9%
AWC	Q,A,T	26.0%	32.1%	★	↑	35.9%	56.7%
BCS	Q,A	62.7%	69.3%	★★★	↑	44.4%	61.2%
CCS	Q,A	77.4%	78.1%	★★★	↔	56.5%	77.5%
CDC–E	Q,A	66.0%	67.7%	★★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	42.5%	43.3%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	26.5%	23.8%	★★★	↔	52.5%	32.4%
CDC–HT	Q,A	89.9%	90.1%	★★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	53.1%	56.8%	★★★	↔	25.1%	42.6%
CDC–LS	Q,A	85.5%	85.6%	★★★	↔	66.7%	81.8%
CDC–N	Q,A	87.6%	83.8%	★★	↓	67.9%	85.4%
CIS–3	Q,A,T	73.0%	73.0%	★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	87.5%	89.1%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	71.3%	70.3%	★★	↔	54.0%	70.6%
URI	Q	96.7%	98.0%	★★★	↑	79.6%	94.1%
W15	Q,A,T	66.7%	73.9%	★★★	↔	44.5%	73.7%
W34	Q,A,T	62.1%	64.6%	★★	↔	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.

Performance Measure Result Findings

Overall, Kaiser–Sacramento County demonstrated above-average performance, exceeding the MCMC goal (HPL) for 65 percent of its reported performance measures in 2009. The plan had below-average performance for only one measure, *Adolescent Well-Care Visits (AWC).*

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.

The DHCS required Kaiser–Sacramento County to submit two improvement plans for *Adolescent Well-Care Visits (AWC)* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34).* As part of its improvement efforts, plan physicians and staff conducted outreach to members to schedule well-care visits. To optimize patient visits, the plan implemented staff education that included the criteria for well-child visits since the plan's data showed that approximately 70 percent of pediatric visits were for minor illnesses or routine problems. In the following year, Kaiser–Sacramento County did not have statistically significant improvement of its *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* rate; however, the plan's rate increased above the MPL for HEDIS 2009 and no improvement plan for this measure was required. Kaiser–Sacramento County's *Adolescent Well-Care Visits (AWC)* rate was below the MPL in 2008. The plan implemented an intervention similar to the effort to optimize well-child office visits. While the plan's 2009 HEDIS rate for this measure increased significantly from 2008, it remained below the MPL; therefore, the DHCS required Kaiser–Sacramento County to continue an improvement plan for its *Adolescent Well-Care Visits (AWC)* measure.

Strengths

Kaiser–Sacramento County was identified as the top MCMC Program performer along with San Francisco Health Plan. Both plans scored above the HPL for 11 of 17 measures in 2009. Kaiser–Sacramento County was the highest performer of all MCMC plans for its *Use of Appropriate Medications for People With Asthma (ASM), Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent) (CDC–9), Comprehensive Diabetes Care—LDL-C Control (CDC–LS),* and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* measures. Additionally, the plan showed a statistically significant increase over the prior year for three measures: *Adolescent Well-Care Visits (AWC), Breast Cancer Screening (BCS),* and *Appropriate Treatment for Children With Upper Respiratory Infection (URI).* These measures spanned the domains of quality, access, and/or timeliness and demonstrated efforts to provide quality care.

Opportunities for Improvement

Kaiser–Sacramento County had the fourth lowest rate of all MCMC plans for its *Adolescent Well-Care Visits (AWC)* measure, which continued to present a significant opportunity for improvement. Similarly, although Kaiser–Sacramento County's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* rate increased above the MPL for HEDIS 2009, the measure was only 4.8 percentage points above the MPL.

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 Kaiser–Sacramento County'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

Kaiser–Sacramento County 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 ER visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. Kaiser–Sacramento County's second project, an internal QIP, was aimed at increasing awareness of and counseling for childhood obesity in children 3–11 years of age. 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 primary care provider in an office or clinic setting. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

Childhood obesity is a condition not often addressed and can be an indicator of suboptimal preventive care. Kaiser–Sacramento County's project attempted to increase screening and counseling related to obesity, thereby improving the quality 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 Kaiser–Sacramento County's QIPs across CMS protocol activities during the review period.

Table 5.1—QIP Validation Results for Kaiser–Sacramento County (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	100%	0%	0%
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	85%	0%	15%
IV.	Correctly Identified Study Population	33%†	33%†	33%†
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	64%	27%	9%
VII.	Appropriate Improvement Strategies	67%	33%	0%
VIII.	Sufficient Data Analysis and Interpretation	38%	25%	38%
IX.	Real Improvement Achieved	75%	0%	25%
X.	Sustained Improvement Achieved	‡		
Percentage Score of Applicable Evaluation Elements *Met*		**66%**		
Validation Status		***Not Applicable****		

‡ The QIP did not progress to this activity during the review period and could not be assessed.
* QIPs were not given an overall validation status during the review period.
† The sum may not equal 100 percent due to rounding.

Kaiser–Sacramento County initially identified and submitted the baseline data for the ER collaborative QIP for the period as January 1, 2006, through December 31, 2006, and the remeasurement data as January 1, 2007, through December 31, 2007. HSAG validated the QIP using the remeasurement data; however; the QIP timeline was revised by the collaborative to better reflect the actual progress of the QIP. Therefore, HSAG will assess again for real improvement with next year's submission.

During the period covered by this report, HSAG's application of the CMS validation requirements was more rigorous than previously experienced by 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 Kaiser–Sacramento County's QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided Kaiser–Sacramento County, 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. Kaiser–Sacramento

County completed the technical training offered by HSAG in early 2009, but did not submit another QIP for validation until after the period covered by this report. The plan's validation results for these QIP submissions will be included in the next performance evaluation report.

Quality Improvement Project Outcomes

Table 5.2 shows Kaiser–Sacramento County's baseline data for its ER QIPs. To satisfy the collaborative QIP requirements, remeasurement data were reclassified as baseline data; this was the only year of data included in the project during the review period. The plan's goal was a reduction of 3 percent in its avoidable ER visit rate. The plan's first remeasurement year data will be submitted in time to be included in the next performance evaluation report (July 1, 2009, through June 30, 2010), at which time HSAG will assess for real improvement.

For the obesity QIP, Kaiser–Sacramento County did not establish a baseline goal and had not progressed to the point of reporting indicator results.

Table 5.2—QIP Outcomes for Kaiser–Sacramento 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	11.6%	‡	‡	‡
‡The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Reducing Childhood Obesity		
QIP Study Indicator	Baseline Period 1/1/06–12/31/06	Sustained Improvement
Percentage of Geographic Managed Care Medi-Cal members 3–11 years of age who had an outpatient visit with a primary care provider and who had evidence of BMI percentile documentation in the medical record	NR	‡
Percentage of Geographic Managed Care Medi-Cal members 3–11 years of age with documentation in the medical record of counseling for nutrition during the measurement year.	NR	‡
Percentage of Geographic Managed Care Medi-Cal members 3–11 years of age with documentation in the medical record of counseling for physical activity during the measurement year.	NR	‡
‡The QIP did not progress to this phase during the review period and could not be assessed. NR Data was not reported in the current QIP submission.		

Strengths

Kaiser–Sacramento County demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data. In addition, Kaiser–Sacramento County clearly identified the QIP study indicators.

Kaiser–Sacramento County implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits. The plan, as part of a pilot project, implemented a case management program for MCMC members who are high risk and high users of the ER.

Kaiser–Sacramento County's internal QIP on childhood obesity has the potential to impact the plan's performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* measure, which was a first-year measure for HEDIS 2009. To increase provider awareness, Kaiser–Sacramento County will use the Child and Adolescent Obesity Provider Toolkit developed and issued by the California Medical Association Foundation and the California Association of Health Plans in 2008.

Opportunities for Improvement

Kaiser–Sacramento County 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.

Kaiser–Sacramento County identified that members presenting at the ER are often seeking medication for pain. Although the plan had pain management services, the plan acknowledged the difficulty in modifying behavior for this population. The plan will need to continue developing initiatives to address this issue.

Kaiser–Sacramento County identified provider barriers associated with the lack of body mass index and counseling documentation in the electronic medical records. Kaiser–Sacramento County is still developing interventions to educate the providers about appropriate coding. The plan will need to conduct annual barrier analyses to identify additional/ongoing barriers related to the obesity measures.

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*