Performance Evaluation Report

Kaiser Permanente (KP Cal, LLC)

San Diego County

July 1, 2008–June 30, 2009

Medi-Cal Managed Care Division
California Department of
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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 3.6 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 San Diego County ("Kaiser–San Diego 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 MPLs indicate low performance, rates at or above the HPLs indicate high performance, and rates at the MPLs or between the MPLs and HPLs demonstrate average performance.

HSAG found that Kaiser–San Diego County demonstrated above-average performance for the quality of care domain. 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–San Diego County had above-average performance for 8 of 17 measures reported in 2009. Two measures had statistically significant increases from 2008 to 2009, and the plan had no statistically significant decreases. The plan had the highest rate of all MCMC plans in 2009 for the *Breast Cancer Screening (BCS)*, *Cervical Cancer Screening (CCS), Comprehensive Diabetes Care—HbA1c Testing (CDC–HT), Comprehensive Diabetes Care—LDL-C Screening (CDC–LS),* and *Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N)* measures.[1] Two measures had performance below the MPLs: *Adolescent Well-Care Visits (AWC)* and *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst).*

During the review period, Kaiser–San Diego County's *Improving Blood Sugar Levels in Diabetic Members* QIP demonstrated statistically significant and sustained improvement for increasing

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

HbA1c testing for members with diabetes. The plan's effort to increase HbA1c screening is consistent with its performance measure rate, which is now above the HPL.

Medical performance audit results related to the quality domain of care reviewed during the review period showed that Kaiser–San Diego County was fully compliant. The plan demonstrated sufficient resources and capacity to support the delivery of the quality management program. The audit noted one finding due to Kaiser–San Diego County using qualified health professionals to review prior-authorization denials instead of using physicians—as is required by the Medi-Cal managed care contract.

While Kaiser–San Diego County demonstrated above-average performance in delivering quality care, the plan has opportunities to further improve the quality of care for its Medi-Cal managed care members. The plan had two measures that fell below the Medi-Cal managed care MPLs. Kaiser–San Diego County had the second lowest rate of all Medi-Cal managed care plans for its *Adolescent Well-Care Visits (AWC)* measure and the fourth lowest rate of all plans for its *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)* measure.[2]

Although Kaiser–San Diego County increased the rate of HbA1c testing as reported in its diabetes QIP, the plan did not improve the control of HbA1c levels—a more important determinant of member health than the testing measure. The plan lacked identification of barriers specific to this measure and had few interventions that focused on improving control documented within the QIP. The interventions did not completely align with specific barriers which may have contributed to the lack of improvement.

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 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.

[2] Ibid.

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–San Diego County demonstrated average to above-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 above the MPLs for all measures, with the exception of adolescent well-care visits and postpartum care which fell below the MPLs. The plan exceeded the HPLs for cancer screening measures and all diabetes measures except for retinal eye exams.

QIP results showed that the plan significantly improved HbA1c testing among diabetic members from a baseline rate of 82.1 percent to 90.4 percent. This demonstrated good access to care related to laboratory services for members with diabetes.

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 Medi-Cal managed care plans. Additionally, medical performance audit findings showed that the plan was fully compliant in the areas of continuity of care and availability and accessibility of services.

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–San Diego County demonstrated average to above-average performance in the timeliness domain of care.

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

The medical performance audit and the MRPIU's review of prior-authorization requests showed that the plan handled all requests within the appropriate time frames. A review of appeals also showed resolution within the required time frames. The MRPIU review identified two deficiencies related to the grievance system. Of the 90 files reviewed, the plan had one acknowledgment letter that exceeded the time frame. In addition, 2 of 90 files reviewed did not contain information about the member's right to request a fair hearing.

Conclusions and Recommendations

Overall, Kaiser–San Diego County demonstrated above-average performance in providing quality health care services to its Medi-Cal managed care members and average to above-average performance in providing accessible and timely services. Kaiser–San Diego County was among four plans noted as top performers based on its 2009 performance measures rates, with 8 of 17 measures exceeding the HPLs.[3] The plan had two measures below the MPLs. The plan had statistically significant and sustained improvement for one of its QIP measures focused on improving HbA1c screening rates among members with diabetes, while the indicator for HbA1c control did not improve.

Kaiser–San Diego County was fully compliant with medical performance audit standards for continuity of care, availability and accessibility, members' rights, and quality management. Additionally, the MRPIU review found that the plan was fully compliant in the areas of prior authorization, program integrity, cultural and linguistic services requirements, and marketing and enrollment.

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

- Continued and enhanced focus on improving the *Adolescent Well-Care Visits (AWC)* and *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)* measures until the rates achieve the MPL.
- Retire the *Improving Blood Sugar Levels in Diabetic Members* as a formal QIP since there have been four remeasurement periods, and consider one of the low-performing measures for the next QIP proposal topic area.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.

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

- Conduct annual barrier analyses to ensure that QIP interventions target specific barriers to increase the likelihood of success.
- Monitor the grievance system to ensure timely notification to members and the inclusion of fair hearing information.
- Reeducate staff to ensure that denial notifications for written prior-authorization requests are issued, including circumstances in which the provider agrees to the request being redirected internally.
- Ensure that the open deficiency related to the use of nonphysician reviewers for chiropractic denials is resolved.

HSAG will evaluate Kaiser–San Diego County's progress with these recommendations along with its continued successes in the next annual review.

Plan Overview

KP Cal, LLC (Kaiser Permanente's California Medicaid line of business), is a full-scope managed care plan that contracts with the Medi-Cal Managed Care Program separately in Sacramento and San Diego counties. This report pertains to the San Diego County plan for KP Cal, LLC (Kaiser–San Diego County). Kaiser–San Diego County became operational with the Medi-Cal Managed Care Program in August 1998. As of June 30, 2009, Kaiser–San Diego County had 13,189 MCMC members[4]

Kaiser–San Diego County serves members as 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–San Diego 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–San Diego County is one of the Medi-Cal managed care plans designated to receive non-joint audits. For the purposes of this report, HSAG reviewed the most current medical performance audit reports available as of June 30, 2009, to assess the plan's compliance with State-specified standards.

The most recent medical performance audit conducted by the DHCS's A&I Division occurred in July 2006 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–San Diego County. Results from the audit showed strengths as well as opportunities for improvement.

In the utilization management area, audit results showed that the plan developed and maintained a utilization management program and monitored for over- and underutilization as well as clinical indicators. The audit found that the plan's process did not include a review of prior-authorization denials by a qualified physician. Rather, the plan applied State and federal laws and extended the review to qualified health care professionals. While Kaiser–San Diego County's practice was consistent with State and federal laws, this approach was not compliant with Medi-Cal managed care contract requirements. Fifteen prior-authorization denials were reviewed, and the plan was compliant with meeting the required time frames. The audit noted inconsistency between the plan's policy and staff interview comments related to sending denial notification letters for out-of-plan referral requests when the requested referral could be provided within the plan. The plan must issue a denial notification for written requests for prior authorization, even if the provider agrees to the requested services being redirected internally. Eight prior-authorization appeals were reviewed and found to be resolved appropriately and within the required time frames.

In the area of continuity of care, Kaiser–San Diego County was fully compliant with all review standards. Policies and procedures were in place to ensure coordination and continuity of care for members, including the identification and referral of members for California Children's Services, those eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, and members with developmental disabilities. The audit found that the plan demonstrated monitoring for the completion of initial health assessments (IHAs) and initial health education behavioral assessments (IHEBAs) through quarterly chart audits and through the Kaiser electronic health records database.

The plan was fully compliant in the area of availability and accessibility of services. 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/AIDS specialty care clinic. The plan demonstrated monitoring of appointment wait times for routine, urgent, specialist, and after-hours care, as well as monitoring of telephonic access. A review of ER claim denials showed that Kaiser–San Diego County appropriately adjudicated the claims within the required time frames.

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

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

In 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. Kaiser–San Diego County was compliant with all the requirements reviewed in this area.

The administrative and organizational capacity area had mixed results. Kaiser–San Diego County was compliant with demonstrating adequate capacity and staff to support the quality program. However, the plan was not fully compliant with requirements 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. At the time of the review, the plan was in the process of developing a policy to comply with State and federal fraud and abuse reporting requirements.

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 other State requirements, the contract between the DHCS and the plan requires physician review.

A DHCS *Medical Audit Close Out Report* dated July 2007 showed that the plan adequately addressed deficiencies related to notification of denials and fraud and abuse reporting. The audit noted that the plan intended to formally request a contract amendment that would allow the plan to use its delegated entity, American Specialty Health Plan (ASHP), and ASHP chiropractors to review denied requests for chiropractic services. Therefore, this issue was not resolved at the time of the audit close-out report.

In addition to the DHCS's A&I medical performance audit, the Department of Managed Health Care (DMHC) initiated a routine medical survey in June 2006, with follow-up continuing through November 2009. It was unclear from the audit report whether the scope of the audit for Kaiser's southern region, including San Diego 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 the DHCS's Web site.[6]

[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

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, 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 Kaiser in August 2009 covering the review period of January 1, 2008, through May 31, 2009. The audit covered Kaiser–Sacramento County, Kaiser–San Diego County, and Kaiser's prepaid health plan, Kaiser PHP, in Sonoma and Marin counties. In this report, HSAG included review findings pertaining only to Kaiser–San Diego County.

Kaiser–San Diego County was fully compliant with requirements for prior-authorization notifications, cultural and linguistic services, marketing and enrollment, and program integrity. MRPIU noted two findings related to Kaiser–San Diego County's grievance system. One of 90 grievance files reviewed exceeded the acknowledgement letter time frame. Two of 90 files reviewed did not contain information about the member's right to request a fair hearing in the resolution letter.

Strengths

Overall Kaiser–San Diego County was compliant with most areas of review for both the medical performance audit and MRPIU. The plan was fully compliant in the areas of continuity of care, availability and accessibility, members' rights, quality management, and cultural and linguistic services requirements.

Opportunities for Improvement

Kaiser–San Diego County should continue to monitor its grievance system to ensure timely notification to members and the inclusion of State fair hearing information. The plan needs to ensure that staff is trained to provide a denial notification for written prior-authorization requests that are redirected internally. Additionally, Kaiser–San Diego County needs to ensure that it submits a formal request to the DHCS to use nonphysician reviewers for chiropractic denial review and that it resolves the audit deficiency.

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 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–San Diego 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–San Diego County in 2009. HSAG found all measures to be reportable and that Kaiser–San Diego 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–San Diego County's strength for the extensive use of electronic health records and closed/integrated system that lends itself to accurate and complete data when deriving its HEDIS rates. HSAG provided one recommendation to the plan to continue its efforts to improve and enforce the accuracy of provider coding.

[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–San Diego 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—San Diego 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	20.3%	25.6%	★★	↔	20.6%	35.4%
ASM	Q	91.9%	89.4%	★★	↔	86.1%	91.9%
AWC	Q,A,T	28.0%	28.3%	★	↔	35.9%	56.7%
BCS	Q,A	70.7%	71.6%	★★★	↔	44.4%	61.2%
CCS	Q,A	79.4%	84.3%	★★★	↑	56.5%	77.5%
CDC–E	Q,A	64.3%	63.3%	★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	39.7%	38.0%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	25.6%	25.9%	★★★	↔	52.5%	32.4%
CDC–HT	Q,A	90.6%	90.2%	★★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	48.9%	54.4%	★★★	↔	25.1%	42.6%
CDC–LS	Q,A	90.1%	88.7%	★★★	↔	66.7%	81.8%
CDC–N	Q,A	92.3%	89.6%	★★★	↔	67.9%	85.4%
CIS–3	Q,A,T	78.2%	73.9%	★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	83.0%	86.6%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	43.6%	50.5%	★	↔	54.0%	70.6%
URI	Q	95.1%	96.7%	★★★	↔	79.6%	94.1%
W15	Q,A,T	42.2%	57.9%	★★	↔	44.5%	73.7%
W34	Q,A,T	59.4%	70.8%	★★	↑	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–San Diego County demonstrated average to above-average performance, ranging from the MPL to a level above the HPL for most of its reported performance measures in 2009. The plan exceeded the MCMC goal (HPL) for eight measures. The plan had below-average performance for two measures: *Adolescent Well-Care Visits (AWC)* and *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst).*

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. Plans that have rates below these minimum levels 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–San Diego County to submit four improvement plans based on its 2008 performance measure rates for: *Adolescent Well-Care Visits (AWC), Prenatal and Postpartum Care—Postpartum Care (PPC–Pst), Well-Child Visits in the First 15 Months of Life (W15),* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34).*

The following year, the plan reported a statistically significant increase for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* rate. This rate increased above the MPL for HEDIS 2009, and no improvement plan for this measure was required for the plan's 2009 performance. Although Kaiser–San Diego County did not have statistically significant improvement for its *Well-Child Visits in the First 15 Months of Life (W15)* measure, the rate increased above the MPL for HEDIS 2009, and no improvement plan for this measure was required for its 2009 performance. The plan used the same interventions for both well-child measures. Interventions included implementing in early 2007 electronic medical records in medical offices to capture the well visits and a case management model as of November 2008 for ongoing monitoring and outreach to parents of children needing well visits.

For the other two measures—*Adolescent Well-Care Visits (AWC)* and *Prenatal and Postpartum Care–Postpartum Care (PPC–Pst)*—the rates increased in 2009; however, the change was not statistically significant, and the rates remained below the MPLs. Based on the plan's 2009 performance, the DHCS required Kaiser–San Diego County to submit improvement plans for these two measures.

Strengths

Kaiser–San Diego County performed above the HPLs on eight measures: *Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS)*, five *Comprehensive Diabetes Care* measures, and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*. In fact, the plan had the highest rate of all MCMC plans for its *Breast Cancer Screening (BCS)*, *Cervical Cancer Screening (CCS), Comprehensive Diabetes Care—HbA1c Testing (CDC–HT), Comprehensive Diabetes Care—LDL-C Screening (CDC–LS),* and *Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N)* measures. Based on the high number of measures above the HPLs, HSAG identified Kaiser–San Diego County as one of four high-performing plans in the *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program* report.[8]

The *Cervical Cancer Screening (CCS)* measure showed a statistically significant increase over the previous year. These measures spanned the domains of quality and access. In addition, the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (*W34*) measure showed statistically significant improvement, which demonstrated efforts to improve the quality, access, and timeliness of care.

Opportunities for Improvement

Kaiser–San Diego County had the second-lowest rate of all MCMC plans for its *Adolescent Well-Care Visits (AWC)* measure, which continued to present a significant opportunity for improvement. The plan's performance in this area may point to the need for age-specific interventions to address issues with health care quality, access, and/or timeliness.

Kaiser–San Diego County also had the fourth lowest rate of all MCMC plans for its *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)* measure, which also continued to present a significant opportunity for improvement. The plan implemented only member interventions and did not identify or address any system or provider barriers.

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

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–San Diego 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–San Diego 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 emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. The plan's second project, an internal QIP, sought to improve blood sugar levels in members with diabetes. 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.

Poorly controlled HbA1c levels in diabetics indicate suboptimal care and case management. Kaiser–San Diego County's project attempted to increase HbA1c testing and glycemic control to minimize the development of diabetes complications.

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–San Diego County's QIPs across CMS protocol activities during the review period.

Table 5.1—QIP Validation Results for Kaiser—San Diego County (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	83%┼	8%┼	8%┼
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	69%┼	15%┼	15%┼
IV.	Correctly Identified Study Population	50%	17%	33%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	50%	25%	25%
VII.	Appropriate Improvement Strategies	17%	50%	33%
VIII.	Sufficient Data Analysis and Interpretation	38%	31%	31%
IX.	Real Improvement Achieved	38%┼	38%┼	25%┼
X.	Sustained Improvement Achieved	0%	100%	0%
Percentage Score of Applicable Evaluation Elements *Met*		**49%**		
Validation Status		***Not Applicable****		

* QIPs were not given an overall validation status during the review period.
┼ The sum may not equal 100 percent due to rounding.

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 Kaiser–San Diego County's QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided Kaiser–San Diego 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.

Quality Improvement Project Outcomes

Table 5.2 shows Kaiser–San Diego County's data for its QIPs. For the ER collaborative QIP, Kaiser–San Diego County set a goal to reduce the overall rate of avoidable ER visits by 10 percent from its baseline rate over the duration of the QIP. 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 *Improving Blood Sugar Levels in Diabetic Members* QIP, Kaiser–San Diego County set a goal to increase the percentage of diabetic members with at least one glycemic test (HbA1c Test) within the previous 12 months to 84 percent over the duration of the QIP. The plan set a goal to decrease by 8 percent the percentage of diabetic members with HbA1c levels greater than 9.5 percent.

Table 5.2—QIP Outcomes for Kaiser—San Diego 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	11.5%	‡	‡	‡
‡The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Improving Blood Sugar Levels in Diabetic Members						
		Remeasurement Period^				
QIP Study Indicator	Baseline Period 3/1/03–2/28/04	1 3/1/04–2/28/05	2 6/1/05–5/31/06	3 6/1/06–5/31/07	4 6/1/07–5/31/08	Sustained Improvement
1) Percentage of diabetic members with at least one blood sugar test (HbA1c) within the last 12 months	82.1%	85.2%	81.1%	86.0%	90.4%*	Yes
2) Percentage of diabetic members with HbA1c > 9.5%	9.7%	8.4%	15.3%¥	18.0%	13.7%	No
^ During Remeasurement 2, the measurement period shifted to begin in May. [HSAG, the symbol ^ should move from QIP 2 title to "Remeasurement Period" cell. * Designates statistically significant improvement over the prior measurement period. ¥ Designates statistically significant decline in performance over the prior measurement period.						

Strengths

The plan demonstrated an understanding of documenting support for its QIP topic selections and providing plan-specific data. Kaiser–San Diego County implemented a plan-specific intervention in addition to the statewide collaborative interventions to reduce avoidable ER visits. In the second quarter of 2008, the plan focused on an expanded case management model for members, which would include high-risk and/or frequent users of the ER. Kaiser–San Diego County also was able to demonstrate statistically significant and sustained improvement for increasing HbA1c testing for members with diabetes. The plan's effort to increase HbA1c screening was consistent with its performance measure rate, which was above the HPL.

Opportunities for Improvement

Kaiser–San Diego 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.

The plan should conduct annual barrier analyses to ensure that its QIP interventions target specific barriers. QIP topics should address areas demonstrating the need for improvement.

Although Kaiser–San Diego County increased the rate of HbA1c testing, the plan did not improve the control of HbA1c levels, a more important determinant of member health. Review of the plan's QIP interventions for this measure showed that the plan implemented very few new interventions that specifically focused on improving control. The plan initiated individual case management follow-up with these members beginning in late September 2007, which may not have been in place long enough to determine the success of this initiative. Kaiser–San Diego County needs to further explore the specific barriers associated with this measure and target specific interventions to address those targeted barriers.

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*