Performance Evaluation Report

Kern Family Health Care

July 1, 2009–June 30, 2010

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

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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] 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 the 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. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report–June 2010.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Kern Family Health Care ("KFHC" or "the plan"), which delivers care in Kern County, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

KFHC is a full-scope Medi-Cal managed care plan operating in Kern County. KFHC delivers care to members as a local initiative (LI) under the Two-Plan Model. KFHC has been Knox-Keene licensed since 1996. Knox-Keene licensure is granted by the Department of Managed Health Care (DMHC) to plans that meet minimum required standards according to the Knox-Keene Health Care Service Plan Act of 1975. The act includes a set of laws that regulates managed care organizations (MCOs).

In a Two-Plan Model county, the DHCS contracts with two managed care plans to provide medical services to members. Most counties offer an LI plan and a nongovernmental, commercial health plan.

Members of the MCMC Program in Kern County may enroll in either the LI plan operated by Kern County or in the alternative commercial plan. KFHC became operational with the MCMC Program in July 1996, and as of June 30, 2010, KFHC had 103,834 MCMC members.[2]

[2] *Medi-Cal Managed Care Enrollment Report–June 2010.* 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 that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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 fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division often work in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits are conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

HSAG reviewed the most current medical performance review reports available as of June 30, 2010, to assess plans' compliance with State-specified standards. A medical performance review of KFHC was conducted in November 2006 covering the review period of November 1, 2005, through October 31, 2006.[3] HSAG reported the results of the review in the 2008-2009 plan evaluation report. The results of the subsequent medical performance review were not available and will be reported in the 2010-2011 plan evaluation report for KFHC.

Review findings indicated that KFHC was fully compliant with review standards related to continuity of care, quality management, and administrative and organizational capacity. KFHC also was able to resolve all identified deficiencies in the areas of utilization management, availability and accessibility, and members' rights through corrective action plans.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's 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 member rights reviews are conducted 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 member rights 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, 2010.

MRPIU conducted an on-site review of KFHC in January 2010, covering the review period of November 1, 2007, through December 20, 2009. HSAG reported the review findings in the 2008-2009 plan evaluation report. The MRPIU review found KFHC fully compliant with all areas under the scope of the review. The results for the next MRPIU review were not yet available. HSAG will report the results of the next MRPIU review in the 2010-2011 plan evaluation report.

[3] *California Department of Health Care Services Medical Review – Northern Section, Audits and Investigations, KFHC*, April 13, 2007.

Strengths

KFHC demonstrated full compliance with most of the medical performance review and MRPIU contract standards, and was able to resolve noted deficiencies through corrective action plans.

Opportunities for Improvement

KFHC should implement an internal review process to routinely monitor its performance with contract requirements, particularly focusing on ensuring that corrective action plans are fully implemented and effective.

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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed a HEDIS Compliance Audit™ of KFHC in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[4] Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

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

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Table 3.2.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
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*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of KFHC's HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan's HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

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

Table 3.2—2009–2010 Performance Measure Results for Kern Family Health Care—Kern County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	20.6%	23.3%	★★	↔	20.2%	33.4%
AWC	Q,A,T	38.0%	38.2%	★★	↔	37.9%	59.4%
BCS	Q,A	48.0%	52.1%	★★	↑	45.0%	63.0%
CCS	Q,A	62.6%	62.4%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	65.3%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	NR	35.2%	★	Not Comparable	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	40.0%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	38.4%	51.3%	★	↓	50.6%	29.2%
CDC–HT	Q,A	79.8%	79.9%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	37.2%	29.7%	★★	↓	27.2%	44.7%
CDC–LS	Q,A	76.4%	77.2%	★★	↔	71.5%	82.5%
CDC–N	Q,A	79.6%	81.2%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	77.1%	66.7%	★★	↓	62.4%	80.6%
LBP	Q	‡	75.3%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	75.9%	79.1%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	60.6%	61.8%	★★	↔	57.9%	72.7%
URI	Q	86.0%	85.8%	★★	↔	81.1%	94.5%
W34	Q,A,T	71.3%	71.0%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	58.9%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	57.7%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	46.2%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[5] Performance comparisons are based on the Chi-Square 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 DHCS did not require plans to report this measure in 2009.
NA = The DHCS does not establish an MPL/HPL for first year measures.
★ = 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 to either significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, KFHC demonstrated average to below-average performance, with most measures between the MPL and HPL. The plan had two measures that fell below the MPL, both of which were indicators for *Comprehensive Diabetes Care* (*HbA1c Poor Control —> 9.0 Percent* and *LDL-C Control —<100 mg/dL).*

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline steps to improve care.

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

KFHC had two measures that were below the MPL in 2009.

Timeliness of Prenatal Care

KFHC focused improvement efforts on providing newly pregnant members with education on the importance of prenatal care, nutrition, and other important prenatal information. The plan continued its Transition to Care phone calls to members who were newly diagnosed as pregnant to offer case management services through the postpartum care visit. KFHC obtained agreement from a contracted hospital to notify the plan of all pregnant health plan members seen in the emergency room. The plan also negotiated with contracted laboratories to identify methods that would identify newly pregnant members. KFHC implemented these interventions to address key barriers toward improving performance—lack of timely notification of members who are pregnant and lack of member awareness about the importance of early prenatal care.

Based on the plan's 2010 HEDIS results, the interventions appear to be successful. The *Timeliness of Prenatal Care* measure exceeded the MPL, increasing by more than 3 percentage points. Although the gain was not statistically significant, KFHC met its internal goal within the improvement plan.

KFHC also submitted an improvement plan for the *Use of Appropriate Medications for People with Asthma* measure; however, the measure was removed from the 2010 External Accountability Set (EAS) and, therefore, HSAG did not evaluate its effectiveness.

Strengths

KFHC exceeded the MPL for the majority of its HEDIS measures. The plan achieved a statistically significant improvement in the *Breast Cancer Screening* measure and resolved the reporting issues that resulted in a *Not Report* audit designation for one measure in 2009.

Opportunities for Improvement

KFHC has several opportunities for improvement. The plan should focus efforts on the *Comprehensive Diabetes Care* measures, particularly *HbA1c Poor Control (> 9.0 Percent)* since the measure had a statistically significant decline and performance did not achieve the MPL. The *Eye Exams* indicator was also below the MPL and *LDL-C Control —<100 mg/dL)* experienced a statistically significant decline. KFHC may be able to maximize efficiencies by conducting a barrier analysis focusing on all diabetes care indicators, as well as interventions that may benefit multiple aspects of diabetes care.

The plan's performance in childhood immunizations experienced a statistically significant decline, representing another opportunity for improvement.

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 clinical and nonclinical areas.

HSAG reviews each QIP using the Centers for Medicare & Medicaid Services' (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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

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.

Quality Improvement Projects Conducted

KFHC had one clinical QIP and one internal clinical QIP proposal in progress during the review period of July 1, 2009, through June 30, 2010. 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 goal for KFHC's second project was to improve the health care services provided to diabetic members 18 to 75 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 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.

Blood glucose monitoring, dyslipemia/lipid management, and retinopathy screening assist in the development of appropriate treatment plans to decrease the risk of diabetes complications. Lack of appropriate testing in diabetics may indicate suboptimal care and case management. The plan's

project attempted to increase HbA1c testing, LDL-C screening, and retinal eye exams to minimize the development of diabetes complications.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for Kern Family Health Care—Kern County July 1, 2009, through June 30, 2010

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	57%	50%	*Not Met*
	Resubmission	86%	100%	*Met*
Internal QIPs				
Comprehensive Diabetes Care	Proposal	71%	38%	*Partially Met*
	Resubmission	100%	100%	*Met*

[1] **Type of Review**—Designates the QIP review as a new proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met, Partially Met,* or *Not Met*. In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that KFHC's annual submission of its QIPs received an overall validation status of *Not Met* for the *Reducing Avoidable Emergency Room Visits* and *Partially Met* for the *Comprehensive Diabetes Care* QIP. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted these QIPs and upon subsequent validation, achieved an overall *Met* validation status.

Table 4.2 summarizes the validation results for both of KFHC's QIPs across the CMS protocol activities during the review period. The validation scores presented in Table 4.2 reflect the last submission validated before June 30, 2010.

**Table 4.2—Quality Improvement Project Average Rates*
for Kern Family Health Care—Kern County
(Number = 2 QIPs, 2 QIP Topics)
July 1, 2009, through June 30, 2010**

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	75%	25%	0%
	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		**58%**	**17%**	**25%**

*The activity average rate represents the average percentage of applicable elements with a Met, Partially Met, or Not Met finding across all the evaluation elements for a particular activity.

‡ The QIP did not progress to this activity during the review period and could not be assessed.

KFHC accurately documented the Design and Implementation stages, upon resubmission scoring 100 percent Met for all evaluation elements in all six activities for both QIPs. For the *Reducing Avoidable Emergency Room Visits* QIP, the plan did not correctly interpret statistical significance and reversed the numerator and denominator in Activity VIII of the Outcomes stage. Additionally, for the same QIP, the plan did not demonstrate statistically significant improvement in Activity IX. Neither QIP had progressed to a second remeasurement period; therefore, Activity X was not assessed.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3—Quality Improvement Project Outcomes for Kern Family Health Care—Kern County (Number = 2 QIPs, 2 QIP Topics) July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement**
Percentage of ER visits that were avoidable	15.9%	16.9%*	‡	‡
QIP #2—Comprehensive Diabetic Care				
QIP Study Indicator	**Baseline Period 1/1/08–12/31/08**	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Sustained Improvement**
The percentage of diabetic members 18-75 years of age who received an HbA1c test during the measurement year	‡	‡	‡	‡
The percentage of diabetic members 18-75 years of age who received an LDL-C screening during the measurement year	‡	‡	‡	‡
The percentage of diabetic members 18-75 years of age who received a retinal eye exam during the measurement year or a negative retinal exam in the year prior to the measurement year	‡	‡	‡	‡
*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05) ‡The QIP did not progress to this phase during the review period and could not be assessed.				

KFHC reported a statistically significant decline in performance for the *Reducing Avoidable Emergency Room Visits* QIP. The plan documented only a few plan-specific interventions prior to 2009. In early 2009, the plan initiated the collaborative interventions; however, since the plan had only reported calendar year 2008 results, HSAG could not evaluate the effectiveness of those interventions. The *Comprehensive Diabetes Care* QIP was in the proposal phase during the review period and had not progressed to the point of reporting study indicator outcomes.

Strengths

KFHC accurately documented the Design and Implementation stages for both QIPs, scoring 100 percent *Met* for all applicable evaluation elements in all six applicable activities.

Opportunities for Improvement

KFHC has an opportunity to improve its QIP documentation in order to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that KFHC use HSAG's QIP Completion Instructions, which will help the plan address all required elements within the CMS protocol activities. The plan should apply lessons learned from the QIP process to each annual submission and not rely so heavily on the ability to resubmit QIPs.

The member health education campaign for the statewide collaboration, implemented in 2009, attempted to educate members about contacting their providers before going to the ER for many common, non-urgent conditions. KFHC stated that more time will be necessary to improve outcomes; however, the plan 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. KFHC should include a plan to evaluate the efficacy of the interventions—specifically, using subgroup analysis to determine if the initiatives are affecting the entire study population in the same way. The plan should evaluate the outcomes by gender, age, provider, and/or other selected groupings, which will enable the plan to address, through the development of plan-specific interventions, any disparities that may exist in the study population in relationship to the study outcomes.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan surveys.[5]

The administration of the CAHPS surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS Surveys be administered to both adult members and the parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

The Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about KFHC's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures as follows:

CAHPS Global Rating Measures:

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

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

CAHPS Composite Measures:

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

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance (NCQA)'s HEDIS® benchmarks and thresholds or NCQA's national Medicaid data, when applicable. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 5.1.

Table 5.1—Star Ratings Crosswalk

Stars	Adult Percentiles	Child Percentiles
★★★★★	≥ 90th percentile	≥ 80th percentile
★★★★	75th percentile–89th percentile	60th percentile–79th percentile
★★★	50th percentile–74th percentile	40th percentile–59th percentile
★★	25th percentile–49th percentile	20th percentile–39th percentile
★	< 25th percentile	< 20th percentile

Table 5.2— Kern Family Health Care—Kern County Medi-Cal Managed Care County-Level Global Ratings

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

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Table 5.3— Kern Family Health Care—Kern County
Medi-Cal Managed Care County-Level Composite Measures

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Adult	★	★	★	★	★★
Child	★	★	★	★★★+	★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Strengths

KFHC's adult members expressed higher levels of satisfaction in the *Rating of Personal Doctor*. KFHC also achieved higher child satisfaction results in the *Rating of Specialist Seen Most Often* global rating and the *Customer Service* composite measure, although KFHC should exercise caution due to the low number of respondents for these higher performing child measures.

Opportunities for Improvement

KFHC's CAHPS results showed primarily poor performance for most global rating categories and composite scores for both adults and children. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the plan's CAHPS results. The purpose of the analysis was to help decision-makers identify specific aspects of care that are most likely to benefit from quality improvement activities. Based on the key driver analysis, HSAG identified the following measures as KFHC's highest priority: *Rating of All Health Care, Rating of Health Plan,* and *Getting Care Quickly*. The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 KFHC CAHPS Plan-Specific Report*. Areas for improvement spanned the quality, access, and timeliness domains of care.

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 the results of performance measures and quality improvement projects (QIPs) 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. Finally, some member satisfaction measures relate to quality of care.

KFHC showed average to below-average performance based on its 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, member satisfaction survey results, and the results of the medical performance and member rights reviews as they related to quality. KFHC either fully met contract requirements that relate to quality (under the measurement and improvement area standards) or was able to resolve any deficiencies prior to the close-out period. For most performance measures, the plan's rates were between the MPL and the HPL. KFHC had two measures below the MPL, three measures with a statistically significant decline, and one with a statistically significant improvement. All of the performance measures addressed quality.

KFHC performed poorly on most member satisfaction survey results for both adults and children. Performance results were higher for *Rating of Personal Doctor* for adults and *Rating of Specialist Seen Most Often* global rating and *Customer Service* composite measure for children, although the child response size was small. These findings indicate that KFHC members are less satisfied with most health plan services, presenting an opportunity to improve for the plan.

QIP results showed that the plan did well with documenting the QIP study design and implementation phases. The plan experienced a decline in performance in the collaborative QIP, although results for Remeasurement 2 are not yet available. The other QIP, aimed at improving

comprehensive diabetes care, is a good area of focus for KFHC, given the declines in diabetes-related performance measures and two diabetes measures below the MPL.

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 a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

The plan demonstrated average to below-average performance based on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results. While performance measure results showed the plan performed between the MPL and HPL for most measures, the collaborative QIP showed a decline in performance for the first remeasurement period.

Member satisfaction results related to access were low across results for both adults and children.

For access-related compliance standards, the plan met all of the requirements or addressed any deficient areas with corrective action plans.

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.

KFHC exhibited average to below-average performance in the timeliness domain of care based on 2010 performance measure rates for providing timely care, medical performance and member rights reviews related to timeliness, and member satisfaction results related to timeliness.

Performance measure rates showed a statistically significant decline in the *Childhood Immunization Status* measure, which relates to timeliness. Other measures of timeliness, including prenatal care and well-child care visits, had average performance, exceeding the MPL but not achieving the HPL.

Member satisfaction results showed that the plan had poor performance in the *Getting Care Quickly* category for both adult and child populations as well as for other satisfaction measures assessing timeliness. This suggests that members perceive that they do not always receive care in a timely manner.

KFHC demonstrated full compliance with contract standards that relate to timeliness.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. KFHC's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, KFHC showed average to below-average performance in providing quality health care services that are accessible and timely to its MCMC members. The plan has many opportunities for improvement.

The selection of a QIP targeting diabetes care should result in improvements in both performance measures and QIP outcomes for members with diabetes.

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

- As the *Comprehensive Diabetes Care* QIP progresses, evaluate the effectiveness of the interventions. If improvements are not made, conduct sub-group analysis to identify specific barriers to improving care for diabetic members and adjust interventions to address these barriers.

- In addition to focusing improvement efforts on diabetes care, target improvement efforts toward *Childhood Immunization Status,* the other area of performance that fell below the MPL.
- Review the 2010 plan-specific CAHPS results report and develop strategies to address the *Rating of All Health Care, Rating of Health Plan,* and *Getting Care Quickly* priority areas.

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

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
Focus efforts to improve performance for the Use of Appropriate Medications for People With Asthma (ASM) measure and the Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) measure until they are above the MPL.	1. Appropriate Medications for People with Asthma – New member packets include flyer of free health care, including asthma information. New member entry wherein all newly enrolled members identified as having asthma are referred to the Community Wellness Program, which provides in-depth education to members regarding asthma, treatment, and prevention. Established MOU with American Lung Association (ALA) to provide educational materials to providers and members. Providers were given information on the Breathe Well Live Well program established by the ALA as well as flyers for members on how to obtain services. Pharmacy formulary – established asthma guidelines to be used by providers as to when quick-relief medications vs. long-term preventive medications are to be used. When a TAR is submitted with inappropriate treatment steps being followed, a copy of the Step Treatment criteria is faxed to both the pharmacy and the provider with a notation saying "Patient education is essential at every step." 2. Prenatal and Postpartum OB Case Management – KFHC identifies pregnant members through referrals, hospital face sheets new member entry phone contacts, and member self-referrals. Members are contacted by phone and educated on all aspects of pregnancy, including: timely prenatal care (confirming of OB provider and prenatal care education along with scheduling assistance for timely appointments), education on contracted hospitals for delivery, infant IHA/Well Child Visit, child Immunizations, and postpartum exam. Follow-up by phone contact as necessary. New member packets include a flyer on free health education, including prenatal care. Educational packets emphasizing the importance of seeking timely prenatal care are mailed to all newly pregnant members. Member newsletter articles; i.e., "Preparing for a healthy pregnancy." Negotiations with contracted laboratories on ways KFHC can be notified timely of positive pregnancy tests for members.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
Identify factors that may have contributed to the statistically significant decline in the Cervical Cancer Screening (CCS) measure.	The plan has identified reluctance of teens to seek services in this county if they believe/perceive their parents will be informed. The plan no longer is providing monetary incentive for providers to administer screenings to eligible female members. The plan no longer is providing member incentives.
Monitor measures that are slightly above the MPL to ensure there is no decline in performance.	1. Postpartum Incentive Project – members contacted and offered gift card to encourage the importance of having their postpartum exam. 2. Newborn's first PCP visit incentive – offered incentive to members who bring their infants in for first PCP exam (IHA) and immunizations. 3. Asthmatics - a. Individual asthma education, including medication use, through referral to the Community Wellness Program. b. Pharmacy attaches National Guidelines to its NOA letters regarding asthma medications. 4. Diabetics – a. Individual and group education at KFHC. b. Community Wellness Program education at their selected facility or in the member's home (home visits). c. Bakersfield Memorial Hospital – group education. d. KFHC sponsored diabetic center – diabetic education, diabetic labs, foot exams, and medication education. e. Diabetic eye exam mailing. f. Pharmacy attaches national guidelines to its NOA letters regarding diabetic medications. 5. BMI, nutrition and physical activity – KFHC attended the train-the-trainer training in March and May 2010, followed by training of QI RN staff and Provider Relations staff for provider trainings. 6. Antibiotic use – participation in the Alliance Working for Antibiotic Resistance Education (AWARE). a. Tool kits mailed to all providers identified as a high antibiotic prescribers. b. Pharmacy attaches national guidelines to its NOA letters regarding antibiotic medications.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
	7. Back-to-school postcard mailings reminder for immunizations and well-child visits (physical exams). 8. Provider training regarding any and all HEDIS measures provided throughout year by QI RNs. 9. Health Education Department mailings, as necessary. 10. Developing a Provider Scoreboard for providers to access information/data regarding the status of their members and the current HEDIS measures. 11. Risk pool designed to compensate providers for quality of care, which includes some HEDIS measures where there is a decline in performance. 12. Marketing TV and radio commercials plus printed mailings regarding immunizations and well-child visits (physical exams). 13. Negotiations with contracted laboratories on ways KFHC can be notified in a timely manner of diabetic lab screenings. 14. Negotiations with the American Lung Association (ALA) regarding availability of services and potential grant opportunities.
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.	KFHC is using HSAG's QIP Summary Form.
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.	The immunization QIP was retired on 11/20/09. Subsequently, KFHC considered performance measures below the MPL and submitted the Diabetic Quality Improvement QIP by 2/18/2010. The Diabetic QIP was approved by the DHCS-MMCD via e-mail dated 3/17/10 and approved by HSAG via e-mail dated 4/23/10.
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.	Provider Relations educated and asked providers to collaborate in educating KFHC members on what to do after hours throughout 2009. The providers were also given a poster with a companion brochure for members to aid in educating members.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
Address issues that contributed to the material biased rate for diabetic eye exams to allow future reporting on this measure.	Issues revolved around HEDIS Vendor Managedcare.co in 2010. Managedcare.com was unable to provide accurate data or reporting data for 2009. Vision benefits for Medi-Cal beneficiaries 21 years and older changed 7/1/09.
Monitor the payment of ER claims to ensure appropriate payment and documentation of reduced-level payments.	Claims and Utilization Management – Retrospectively, the KFHC Claims Department in conjunction with the KFHC medical director review claims and disputes data to determine proper coding of level of care for ER visits. It is important to note that the former issue of KFHC's legal obligation to downcode emergency service claims to the level supported by documentation received has been largely moot where, subsequent to the subject DHCS finding, KFHC contracted with the two former non-contracted large emergency service physician groups that generated the largest volume of emergency service claims that were downcoded and the subject of dispute. Under KFHC's contracts with the emergency service physician groups, coding issues and related disputes are obviated where the physicians are paid at a stipulated case rate of $75 per visit for any one of the five levels of emergency service provided, rather than on the former basis where the Medi-Cal Fee-For-Service Program rates were paid to non-contracted emergency service physician groups at the fee schedule rate that varied based on the five levels of coding for emergency services.