Performance Evaluation Report

Kaiser Permanente (KP Cal, LLC)

Sacramento County

July 1, 2009–June 30, 2010

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

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1. Introduction

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, KP Cal, LLC, operating in Sacramento County ("Kaiser–Sacramento County" or "the plan"), 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

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. Additionally, KP Cal, LLC, operated a pre-paid health plan, Kaiser PHP, in Marin County during the review period and in Sonoma from July 1, 2009, through September 30, 2009. This report pertains to the Sacramento County plan for KP Cal, LLC (Kaiser–Sacramento County). Kaiser–Sacramento County became operational with the MCMC Program in Sacramento County in April 1994, and as of June 30, 2010, it had 26,591 MCMC members.[2]

KP Cal, LLC, has been Knox-Keene licensed since February 2006. 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 regulate managed care organizations (MCOs).

Kaiser–Sacramento County serves members in a commercial plan under a Geographic Managed Care (GMC) model. The GMC model allows enrollees to choose from several commercial plans within a specified geographic area.

[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 Kaiser–Sacramento County'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 the plans' compliance with State-specified standards. The most recent audit occurred in July 2006 as a non-joint audit conducted by the DHCS's A&I Division for the audit period of July 2005 through June 30, 2006.[3] 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 results from this audit were included in the prior evaluation report, *Plan-Specific Evaluation Report—Kaiser Permanente (KP Cal, LLC)—Sacramento County, July 1, 2008, through June 30, 2009*. A more recent A&I Division audit was conducted in July 2009; however, those results were not available at the time of this report and will be included in the next evaluation report.

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

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, cultural and linguistic services, False Claims Act requirements) 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.

The most current MRPIU review for Kaiser–Sacramento County was conducted in August 2009, covering the period of January 1, 2008, through May 31, 2009. The results from this audit were included in the prior evaluation report. The plan was fully compliant with all areas of the review.

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

Strengths

The plan was fully compliant with the MRPIU review and resolved nearly all outstanding deficiencies from the medical performance review.

Opportunities for Improvement

In response to the unresolved issue of ensuring a physician review of all denials, Kaiser–Sacramento County noted, in its response to prior year recommendations in Appendix A, that it revised its policy and procedures to provide a physician review for all denials for Medi-Cal managed care members. HSAG did not identify any further opportunities for improvement during the review period.

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 Kaiser–Sacramento County's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed an NCQA HEDIS Compliance Audit™ of Kaiser–Sacramento County 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 for Kaiser–Sacramento County and did not identify any areas of concern.

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

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. Table 3.1 displays a HEDIS performance measure name key.

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 Kaiser–Sacramento County'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 Kaiser–Sacramento 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	44.3%	61.4%	★★★	↑	20.2%	33.4%
AWC	Q,A,T	32.1%	32.1%	★	↔	37.9%	59.4%
BCS	Q,A	69.3%	73.9%	★★★	↑	45.0%	63.0%
CCS	Q,A	78.1%	81.9%	★★★	↑	60.9%	79.5%
CDC–BP	Q	‡	79.0%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	67.7%	70.1%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	64.6%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	23.8%	23.6%	★★★	↔	50.6%	29.2%
CDC–HT	Q,A	90.1%	92.8%	★★★	↑	76.5%	89.3%
CDC–LC (<100)	Q	56.8%	63.3%	★★★	↑	27.2%	44.7%
CDC–LS	Q,A	85.6%	89.9%	★★★	↑	71.5%	82.5%
CDC–N	Q,A	83.8%	82.1%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	73.0%	75.5%	★★	↔	62.4%	80.6%
LBP	Q	‡	88.4%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	89.1%	88.4%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	70.3%	75.9%	★★★	↑	57.9%	72.7%
URI	Q	98.0%	97.0%	★★★	↔	81.1%	94.5%
W34	Q,A,T	64.6%	66.3%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	38.1%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	46.7%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	24.5%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by 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 *z* test of statistical significance with a *p* value of <0.05.

[6] The 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 because a higher rate indicates poorer performance.

[7] The 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.

★ = Below average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, below average 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, average 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, above average performance is relative to the national Medicaid 10th percentile.

↑= Statistically significant increase.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

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, Kaiser–Sacramento County had above-average performance for its reported 2010 performance measures. Performance measure rates were either stable or showed an improvement in 2010 when compared to 2009 performance measure rates. The plan had seven statistically significant improvements and no significant declines in performance.

Nine performance measures rates were above the MCMC HPL. Kaiser–Sacramento County had only one measure in 2010 that was below the MPL for its *Adolescent Well Care Visits* measure.

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 the steps it will take 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 for continuing its existing improvement plans and/or developing new improvement plans.

Based on Kaiser–Sacramento County's 2009 performance measure rates, the DHCS required the plan to submit its HEDIS improvement plan for its one measure that fell below the MPL in 2009—the *Adolescent Well Care Visits* measure. Kaiser–Sacramento County follows its pediatric clinical practice guidelines, which do not recommend an adolescent well-visit annually; therefore, the practice of its plan is in direct conflict with the MCMC program requirements, which likely contributes to the low rate.

The plan initiated improvement efforts related to this measure beginning in 2007 and has shown a slow, upward trend with a rate of 25.5 percent reported for HEDIS 2007 to 32.1 percent for HEDIS 2009. The plan's rate remained stable at 32.1 percent in 2010, with no improvement and no decrease from its 2009 rate.

As part of its improvement efforts, plan physicians and staff were trained on consistent coding of exams within the electronic medical record as well as educated about performance at well-visit exams when an adolescent presented for a routine or urgent care office visit. The health plan also sends birthday cards to adolescents to encourage scheduling of annual well visits. Kaiser–Sacramento County also started to screen files of enrolled adult MCMC members in an existing

Care Coordination pilot program to determine if they had dependent adolescents covered under the MCMC program and contacted them to schedule an appointment.

Strengths

Overall, Kaiser–Sacramento County had above-average performance measures rates in 2010. The plan successfully exceeded the HPL for nine measures, and had only one measure below the MPL. Performance measure rates in 2010 remained stable or showed statistically significant improvement over 2009 rates.

Kaiser–Sacramento County showed above-average performance in managing chronic disease such as diabetes; providing cancer screening services to women; and appropriately treating adults with acute bronchitis and children with upper respiratory infections.

Opportunities for Improvement

Kaiser–Sacramento County has an opportunity to improve its well visits for both children and adolescents. The plan's *Adolescent Well-Care Visits (AWC)* measure remained below the MPL despite improvement efforts over the last several years. Additionally, the plan's rate of 66.3 percent for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* is relatively low when compared to other plans and is just above the MPL of 64.0 percent.

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 Kaiser–Sacramento County's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Projects Conducted

Kaiser–Sacramento County submitted one ongoing clinical QIP and one internal QIP proposal during the review period of July 1, 2009, through June 30, 2010. The first QIP targeted the reduction of avoidable ER visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. The plan's second project, an internal QIP, was aimed at increasing awareness of and counseling for childhood obesity in children 3 to 11 years of age. Both QIPs fell under the quality and access domains of care.

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

Childhood obesity is a condition not often addressed that can be an indicator of suboptimal preventive care. Kaiser–Sacramento County's project attempted to increase screening and counseling related to obesity, thereby improving the quality of care delivered to children.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for Kaiser–Sacramento 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	95%	100%	*Met*
Internal QIPs				
Childhood Obesity	Proposal	86%	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, 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.

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that the initial submission by Kaiser–Sacramento County for its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. The plan also received a *Met* validation status for its *Childhood Obesity* QIP proposal submission. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status; therefore, the plan was not required to resubmit either QIP.

Table 4.2 summarizes the validation results for both of Kaiser–Sacramento County's QIPs across CMS protocol activities during the review period.

Table 4.2––Quality Improvement Project Average Rates* for Kaiser–Sacramento 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	83%	0%	17%
	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		**94%**	**0%**	**6%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	90%	10%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**92%**	**8%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation†	88%	13%	0%
	IX: Real Improvement Achieved	75%	0%	25%
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		**83%**	**8%**	**8%**

***** 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.

†The sum of an activity or stage may not equal 100 percent due to rounding.

Kaiser–Sacramento County successfully applied the QIP process for the Design and Implementation stages, scoring 100 percent *Met* on all evaluation elements for four of the six activities. Scores were lower for Activity I in the *Childhood Obesity* QIP since the plan did not include a discussion of the eligible study population or whether members with special health care needs were included or excluded. Additionally, in Activity VI of the same QIP, the plan did not discuss how the study indicators were produced. For the Outcomes stage, Kaiser–Sacramento County was scored lower in Activity VIII for not using the 95 percent confidence level for statistical testing and in Activity IX, for the lack of real improvement since the study indicator did not demonstrate statistically significant improvement.

Quality Improvement Project Outcomes

Table 4.3 summarizes 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 Kaiser–Sacramento County 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	11.6%	10.8%	‡	‡
QIP #2—Weight Assessment and Counseling for Nutrition and Physical Activity in Children				
QIP Study Indicator	**Baseline Period 1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement**
Percentage of members 3-17 years of age who had an outpatient visit with a primary care provider and who had evidence of BMI percentile documentation in the medical record	‡	‡	‡	‡
Percentage of members 3-17 years of age with documentation in the medical record of counseling for nutrition during the measurement year	‡	‡	‡	‡
Percentage of members 3-17 years of age with documentation in the medical record of counseling for physical activity during 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.

The plan demonstrated a decrease in avoidable ER visits between baseline and the first remeasurement period; however, the decrease was not statistically significant and could potentially be due to chance. Since collaborative interventions were not initiated until 2009, HSAG could not evaluate the effectiveness of those interventions. Kaiser–Sacramento County is working to develop patient instructions in the electronic medical records that inform members about what to do if they are not sure if their symptoms are an emergency. These instructions would be printed out and provided to members at the time of an office visit.

The *Childhood Obesity* QIP proposal had not progressed to the point of reporting outcomes.

Strengths

Kaiser–Sacramento County accurately documented the necessary requirements for the Design and Implementation stages with 94 percent and 92 percent, respectively, of the applicable evaluation elements scored *Met*.

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

Opportunities for Improvement

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

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

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 Kaiser–Sacramento County'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—Kaiser–Sacramento County Medicaid 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—Kaiser–Sacramento County
Medicaid County-Level Composite Ratings

Population	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

Kaiser–Sacramento County demonstrated exceptional overall performance for member satisfaction. The plan performed best on child global ratings and composite ratings when compared with adult global ratings; however, the plan performed above the national Medicaid 50th and 40th percentiles for both adult and child populations respectively for the following measures: *Rating of Health Plan, Rating of All Health Care,* and *Rating of Personal Doctor.*

Opportunities for Improvement

The plan had only one adult measure below the national Medicaid 50th percentile for *Shared Decision Making* and no child measures below the 40th percentile.

While the plan showed little need for improvement in member satisfaction survey results, HSAG conducted a key-drivers-of-satisfaction analysis that focused on the top three highest priorities based on the plan's CAHPS results. The purpose of the key-drivers-of-satisfaction analysis was to help decision makers identify specific aspects of care most likely to benefit from quality improvement (QI) activities. Based on the key-driver analysis, HSAG identified the following measures for Kaiser–Sacramento County as moderate priorities: *Rating of Specialist Seen Most Often* and *Shared Decision Making.* Additionally, HSAG identified one area as a low priority: *Getting Care Quickly*. The plan should review the detailed recommendations for improving member satisfaction in these areas, as outlined by HSAG in the *Medi-Cal Managed Care Program—2010 Kaiser Permanente–North 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. Lastly, some member satisfaction measures relate to quality of care.

HSAG found that Kaiser–Sacramento County demonstrated above-average performance for the quality domain of care. This was based on the plan's 2010 performance measure rates (which reflected 2009 measurement data), QIP outcomes, and compliance review standards related to measurement and improvement.

Kaiser–Sacramento County had above-average performance measures rates in 2010. The plan successfully exceeded the HPL for nine measures, and had only one measure below the MPL. Performance measure rates in 2010 remained stable or showed statistically significant increase over 2009 rates. Kaiser–Sacramento County continued to show strength in managing chronic disease such as diabetes, providing cancer screening services to women, and in practicing proper antibiotic use for adults with acute bronchitis and children with upper respiratory infections.

For its QIPs, Kaiser–Sacramento County accurately documented the necessary requirements for the Design and Implementation stages. The plan had a slight decrease in its avoidable ER visits rate during the review period, although not statistically significant, and identified challenges with modifying member behavior, particularly with members seeking pain medications. Opportunities exist for the plan to continue to modify interventions and evaluate the effectiveness of those interventions.

Kaiser–Sacramento County noted that, in response to the unresolved issue of ensuring a physician review of all denials, it revised its policy and procedure to provide a physician review for all denials of Medi-Cal managed care members.

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 access to covered services under the Medi-Cal Managed Care Program.

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.

Kaiser–Sacramento County demonstrated average to above-average performance for the access domain of care based on its 2010 performance measure rates that related to access, medical performance review results related to availability and access to care, and member satisfaction results.

Overall, Kaiser–Sacramento County had performance measure rates above the MPL; however, the plan has an opportunity to improve its well visits for both children and adolescents. The plan's *Adolescent Well-Care Visits (AWC)* measure remained below the MPL despite improvement efforts over the last several years.

Medical performance review results showed Kaiser–Sacramento County achieving full compliance with respect to all access-related standards including cultural and linguistic service requirements, an area of deficiency for many MCMC plans. Overall, member satisfaction results revealed scores above national 40th and 50th percentiles for child and adult populations respectively. The plan's rate for *Shared Decision Making* for the adult population was the only measure to fall below the national Medicaid 25th percentile.

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.

Kaiser–Sacramento County demonstrated above-average performance in the timeliness domain of care based on 2010 performance measure rates related to providing timely care, medical performance reviews standards related to timelines, and member satisfaction results.

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

The DHCS's medical performance audit found Kaiser–Sacramento County fully compliant with member grievances and prior authorizations. Member satisfaction results showed good rating of *Getting Needed Care* and *Getting Care Quickly* composite ratings.

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. Kaiser–Sacramento County's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, Kaiser–Sacramento County had above-average performance in providing quality and timely services to its MCMC members and average to above-average performance in providing accessible services.

Kaiser–Sacramento County continues to excel in its performance measure rates, when compared to other MCMC plans and national averages. The plan corrected all outstanding medical performance review deficiencies, suggesting the plan is fully compliant. Member satisfaction scores rank among the highest for MCMC plans.

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

- Work to resolve internal clinical practice guidelines that directly conflict with the *Adolescent Well-Care Visits* measure.
- Focus efforts to improve the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure.
- Implement a process to evaluate QIP interventions to determine the effectiveness of each.
- Review the detailed recommendations for improving member satisfaction in these areas, as outlined by HSAG in the *Medi-Cal Managed Care Program—2010 Kaiser Permanente—North CAHPS Plan-Specific Report.*

In the next annual review, HSAG will evaluate Kaiser–Sacramento County'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
Continue focusing on improving the Adolescent Well-Care Visits (AWC) rate until it reaches the MPL and on Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34), which is substantially below the MCMC Program average.	♦ Provider education on AWC specifications and coding. ♦ Optimizing the member appointment by performing the elements of an AWC, if appropriate. ♦ Implementation of a HEDIS toolbar feature in the electronic medical record that prompts providers with specific health actions linked to the AWC and other HEDIS specifications that are due for the patient.
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.	HSAG's QIP form was used with the last two annual submissions. Points of Clarification noted in the validation report have been and will continue to be incorporated in report submissions.
Modify plan policies and procedures to include physician review for all denials.	Policy and Procedure 50-2 Complaint, Grievance, and Appeal Process & Resolution for Non-Medicare Members (rev. 12-15-2010) §C. 4.f.iii. provides that all denials for Medi-Cal Managed members are reviewed by a physician.