Performance Evaluation Report

Kaiser Permanente (KP Cal, LLC)

San Diego 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. Accessed on February 7, 2012.

This report is specific to the MCMC Program's contracted plan, KP Cal, LLC, operating in San Diego County ("Kaiser–San Diego County" or "the plan"), for the review period 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. This report pertains to the San Diego County plan for KP Cal, LLC (Kaiser–San Diego County). Kaiser–San Diego County became operational with the Medi-Cal Managed Care Program in August 1998. As of June 30, 2010, Kaiser–San Diego County had 13,431 MCMC members.[2]

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

[2] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on February 7, 2012.

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–San Diego 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 plans' compliance with State-specified standards.

The most recent medical performance audit conducted by the DHCS's A&I Division occurred in July 2006 for the audit period of July 2005 through June 30, 2006.[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 audit was specific to Kaiser–San Diego County and HSAG included details of the audit in the prior year's evaluation report.[4]

A DHCS *Medical Audit Close-Out Report* dated July 2007 showed that the plan adequately addressed deficiencies related to notification of denials and fraud and abuse reporting. The audit report identified a finding regarding delegation of utilization management activities under the category of Utilization Management. The plan asserted that it intended to formally request a contract amendment that would allow the plan to use its delegated entity, American Specialty Health Plan (ASHP), and ASHP chiropractors to review denied requests for chiropractic services; however, this issue was not corrected at the time of the audit close-out report.

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 Kaiser in August 2009 covering the review period of January 1, 2008, through May 31, 2009. The audit covered Kaiser–Sacramento County, Kaiser–

[3] California Department of Health Services, Audits and Investigations. *Medical Review–KP Cal LLC, Kaiser Permanente GMC–San Diego*. February 15, 2007.
[4] California Department of Health Services. *Plan-Specific Evaluation Report–Kaiser Permanente (KP Cal, LLC)–San Diego County, July 1, 2008, through June 30, 2009.*

San Diego County, and Kaiser's prepaid health plan, Kaiser PHP, in Sonoma and Marin counties. HSAG included review findings pertaining to Kaiser–San Diego County in the prior year's evaluation report.

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

Strengths

Kaiser–San Diego County was compliant with most aspects of the medical performance reviews. The plan's actions taken to address the outstanding areas of deficiency reported in Appendix A showed that the plan is taking appropriate steps to resolve the remaining deficiencies.

Opportunities for Improvement

Kaiser–San Diego County has the opportunity to monitor its grievance acknowledgement time frames and ensure that members receive information on how to access a State Fair Hearing.

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

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 Kaiser–San Diego County in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[5] Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

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[5] 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. 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–San Diego 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–San Diego 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	25.6%	28.0%	★★	↔	20.2%	33.4%
AWC	Q,A,T	28.3%	28.1%	★	↔	37.9%	59.4%
BCS	Q,A	71.6%	73.7%	★★★	↔	45.0%	63.0%
CCS	Q,A	84.3%	83.3%	★★★	↔	60.9%	79.5%
CDC–BP	Q	‡	83.3%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	63.3%	66.7%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	63.7%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	25.9%	23.4%	★★★	↔	50.6%	29.2%
CDC–HT	Q,A	90.2%	94.0%	★★★	↑	76.5%	89.3%
CDC–LC (<100)	Q	54.4%	56.2%	★★★	↔	27.2%	44.7%
CDC–LS	Q,A	88.7%	90.1%	★★★	↔	71.5%	82.5%
CDC–N	Q,A	89.6%	91.7%	★★★	↔	73.4%	85.4%
CIS–3	Q,A,T	73.9%	80.0%	★★	↔	62.4%	80.6%
LBP	Q	‡	85.0%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	86.6%	90.1%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	50.5%	67.9%	★★	↑	57.9%	72.7%
URI	Q	96.7%	97.3%	★★★	↔	81.1%	94.5%
W34	Q,A,T	70.8%	61.6%	★	↓	64.0%	80.3%
WCC–BMI	Q	‡	95.5%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	14.6%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	14.2%	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.
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, 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 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, Kaiser–San Diego County had above-average performance results across the spectrum of HEDIS measures. Two measures had statistically significant increases from 2009 to 2010; and one measure had a statistically significant decrease. Eight measures scored above the national Medicaid 90th percentile, while only two measures fell below the 25th percentile.

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 towards the MPL. In addition, HSAG assessed the plan's need for continuing existing improvement plans and/or developing new improvement plans.

Based on Kaiser–San Diego County's 2009 performance measure rates, the DHCS required the plan to submit 2009 HEDIS improvement plans for two measures: *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Postpartum Care.*

HSAG reviewed Kaiser–San Diego County's 2009 HEDIS improvement plans against the plan's 2010 HEDIS rates, and assessed whether the plan improved its performance in 2010. HSAG provides the following analysis of the plan's 2009 HEDIS improvement plans.

Adolescent Well-Care Visits

Kaiser–San Diego County has struggled to improve its performance on the *Adolescent Well-Care Visits* measure. The plan has scored below the MPL on this measure over four consecutive years. After implementing the HEDIS Improvement Plan in 2009, the plan's 2010's rate for this measure came in lower than 2009. In the initial 2009 improvement plan, Kaiser–San Diego County cited the following challenges:

- Difficulty in keeping this population engaged.
- Health care issues not perceived as important, individuals not wanting to be perceived as "sick."
- School issues for this population.
- Developmental stage of adolescent population, striving for autonomy and control.

The plan implemented one intervention to improve their *Adolescent Well-Care Visits* scores in 2010.

- The outreach staff creates a list of teens who have not been seen for annual well-visits and proactively contacts members to schedule visits.

Postpartum Care

Kaiser–San Diego County was able to improve its score from 2009 to 2010 by approximately 17 percentage points, which brought the plan above the MPL for this measure in 2010. In the initial 2009 improvement plan, Kaiser–San Diego County cited the following challenges:

- Coding errors by physicians and staff.
- Patient contact information: change of address and phone number.
- Patients lacking knowledge of the need for postpartum care.
- Ongoing belief that medical appointments are only when "you feel sick."
- Change in coverage.
- Child care issues.
- Transportation issues.

The plan successfully implemented the following interventions between 2009 and 2010.

- OB/GYNs proactively schedule postpartum visit during the third trimester of pregnancy.
- If a member does not keep her postpartum appointment, the senior service representative is notified to call the member to reschedule her appointment.
- OB/GYNs are notified in their Health Connect in-basket when their patients deliver. The provider will make a follow-up phone call or other contact to the member and will verify that a postpartum appointment has been scheduled.
- A list of members who delivered is also sent to the senior service representative at each location. The postpartum appointments are noted on this list. If a postpartum appointment has not been scheduled, the senior service representative will call the member to schedule the appointment.
- Patients are reminded of their appointments by an automated phone system.

Strengths

Kaiser–San Diego County demonstrated overall high performance scores across a majority of the 2010 HEDIS measures. In fact, eight measures scored above the HPL. One of the plan's biggest strengths is its consistency with HEDIS performance.

Opportunities for Improvement

Kaiser–San Diego County had two HEDIS metrics, *Adolescent Well-Care Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, below the MPL in 2010. Kaiser–San Diego County should focus efforts to improve performance in these areas.

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

Quality Improvement Projects Conducted

Kaiser–San Diego County had two clinical QIPs and one 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 plan's second project, an internal QIP, sought to improve blood sugar levels in members with diabetes. The plan's goal for the third project was to improve postpartum care. All three QIPs fell under the quality and access domains of care. Additionally, the *Improving Postpartum Care* QIP fell under the timeliness domain 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.

Poorly controlled HbA1c levels in diabetics indicate suboptimal care and case management. The purpose of the plan's project is to increase HbA1c testing and glycemic control to minimize the development of diabetes complications.

The *Improving Postpartum Care* QIP aims to improve the rate of postpartum visits for women between 21 and 56 days after delivery. Ensuring that women have the appropriate follow-up care after delivery is important to the physical and mental health of the mother.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for Kaiser–San Diego 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	89%	100%	*Met*
Internal QIPs				
Improving Blood Sugar Levels in Diabetic Members	Annual Submission	45%	20%	*Not Met*
	Resubmission	89%	100%	*Met*
Postpartum Care	Proposal	47%	50%	*Not 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, 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 annual submission by Kaiser–San Diego County of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. The annual submission for both the *Improving Postpartum Care* QIP and the *Improving Blood Sugar Levels in Diabetic Members* QIP received a *Not Met* validation status. 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 final validation results for all three of Kaiser–San Diego County's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Kaiser–San Diego County (N = 3 QIPs, 3 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	83%	0%	17%
Implementation Total		**94%**	**0%**	**6%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	88%	6%	6%
	IX: Real Improvement Achieved†	50%	13%	38%
	X: Sustained Improvement Achieved	0%	100%	0%
Outcomes Total		**72%**	**12%**	**16%**

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

Kaiser–San Diego County accurately documented the Design and Implementation stages, scoring 100 percent *Met* on all evaluation elements for five of the six activities. In Activity VII of the *Reducing Avoidable Emergency Room Visits* QIP, the plan did not discuss how they were going to modify their interventions based on lack of improvement in the outcome. In the *Improving Blood Sugar Levels in Diabetic Members* QIP, the Outcomes stage was scored lower in Activity VIII for not providing accurate p values and not addressing validity factors or providing correct result interpretations. Additionally, the score was lower in Activity IX for both QIPs, due to the lack of statistically significant improvement for two of three study indicators.

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. Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Table 4.3—Quality Improvement Project Outcomes for Kaiser–San Diego 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	11.5%	13.1%*	‡	‡

QIP #2—Improving Blood Sugar Levels in Members with Diabetes

QIP Study Indicator	Baseline Period 3/1/03–2/28/04	Remeasurement					Sustained Improvement
		1 3/1/04–2/28/05	2 5/1/05–4/30/06	3 5/1/06–4/30/07	4 5/1/07–4/30/08	5 6/1/08–5/31/09	
Percentage of diabetic members who had at least one HbA1c test in the previous 12 months	82.1%	85.2%	81.5%	86.0%	90.4%*	92.9%*	Yes
Percentage of diabetic members in the denominator who had an HbA1c > 9.5% in the previous 12 months	9.7%	8.5%	15.3%*	18.0%	13.7%	13.6%	No

QIP #3—Improving Postpartum Care

QIP Study Indicator	Baseline Period 11/6/07–11/5/08	Remeasurement 1 11/6/08–11/5/09	Remeasurement 2 11/6/09–11/5/10	Sustained Improvement
Percentage of women who had postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery	50.5%	‡	‡	‡

*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 documented a statistically significant increase in avoidable ER visits between baseline and the first remeasurement period, reflecting a decline in performance. Since collaborative interventions were not initiated until 2009, HSAG could not evaluate the effectiveness of those interventions. Kaiser–San Diego County is working to develop patient instructions in the electronic medical records that inform members regarding what to do if they are not sure their symptoms require emergency attention. These instructions would be printed out and provided to the members at the time of an office visit.

Between Remeasurement 4 and Remeasurement 5 of the *Improving Blood Sugar Levels in Diabetic Members* QIP, the plan reported a statistically significant increase in the percentage of members receiving an HbA1c test. For the second study indicator, the plan showed a slight decrease in the percentage of members whose HbA1c was not controlled; however, this decrease was not statistically significant and could potentially be due to chance.

The *Improving Postpartum Care* QIP proposal had not progressed to the point of reporting outcomes.

Strengths

The plan accurately documented the four activities in the Design stage and the data collection elements in Activity VI of the Implementation stage for both QIPs. Kaiser–San Diego County was also able to demonstrate statistically significant and sustained improvement for increasing HbA1c testing for members with diabetes.

Opportunities for Improvement

The plan should conduct annual barrier analyses to ensure that its QIP interventions target specific barriers. Additionally, Kaiser–San Diego County should include a plan to evaluate the efficacy of the interventions, specifically, using subgroup analysis to determine if initiatives are affecting the entire study population in the same way. The plan should evaluate the outcomes by gender, age, provider, etc., to understand any disparities that may exist in the study population in relationship to the study outcomes.

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

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.[6]

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–San Diego 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*

[6] 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–San Diego 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	★★★★★	★★★★★	★★★★★	★★★★★

Table 5.3— Kaiser–San Diego County
Medi-Cal Managed Care County-Level Composite Ratings

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

Strengths

At the global ratings level, Kaiser–San Diego County achieved perfect scores in all of the ratings. At the composite rating level Kaiser–San Diego County received perfect scores in: *How Well Doctors Communicate* and *Shared Decision Making* in the Adult category. In the Child category, Kaiser–San Diego County received perfect scores in: *Getting Needed Care, How Well Doctors Communicate,* and *Customer Service.*

Opportunities for Improvement

At the composite ratings level, Kaiser–San Diego County's CAHPS results showed opportunity for greatest improvement in the *Getting Care Quickly* category in the Child segment. Another area to focus on would be *Customer Service* in the Adult segment, as it scored above the 50th percentile.

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 as Kaiser–San Diego County's highest priority: *Customer Service, Getting Care Quickly,* and *Getting Needed Care.* 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 Kaiser–San Diego County.* 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.

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

Kaiser–San Diego County had above-average performance for all measures, with the exception of the *Adolescent Well-Care Visits (AWC)* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* measures. The plan showed a statistically significant increase in its *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)*, between 2009 and 2010 and the rate is now above the MPL. The plan also showed a statistically significant increase in *Comprehensive Diabetes Care—HbA1c Testing (CDC–HT)*.

During the review period, Kaiser–San Diego County's *Improving Blood Sugar Levels in Diabetic Members* QIP demonstrated statistically significant and sustained improvement for increasing HbA1c testing for members with diabetes; however, the plan struggled to improve the rate of members with good control.

Most of the outstanding issues from the prior year's medical performance audit report were resolved. Member satisfaction results for both the child and adult populations exceeded the national

Medicaid 80th and 90th percentiles, respectively, across all global rating measures, including the overall rating of health plan, health care, personal doctor, and specialist seen most often.

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

The plan's performance measure rates were above the MPLs for all measures, with the exception of *Adolescent Well-Care Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.*

QIP results showed that the plan significantly improved HbA1c testing among diabetic members. This demonstrated good access to care related to laboratory services for members with diabetes.

Medical performance audit findings showed that the plan was adequately compliant in the areas of continuity of care, availability and accessibility of services, and cultural and linguistic services. Both adult and child populations rated *How Well Doctors Communicate* and *Getting Needed Care* measures with favorable results.

Timeliness

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

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

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

Based on 2010 performance measure rates for providing timely care and compliance review standards related to timeliness, Kaiser–San Diego County demonstrated above-average performance in the timeliness domain of care.

The plan performed within the MCMC-established thresholds for childhood immunizations and prenatal and postpartum care. However, the plan did not meet the MPLs for *Adolescent Well-Care Visits* and for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

The plan was generally compliant with utilization management standards related to timeliness of care. The few areas related to the grievance system were resolved by the actions taken by the plan to address areas of deficiency.

Parents and/or caretakers of child members rated *Getting Care Quickly* as the lowest area of satisfaction, while adult members were more satisfied in this area.

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–San Diego County's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, Kaiser–San Diego County demonstrated above-average performance in providing quality, access, and timely health care services to its Medi-Cal managed care members. Overall, Kaiser–San Diego County had above-average performance results across the spectrum of HEDIS measures. Two measures had statistically significant increases from 2009 to 2010; while one measure had a statistically significant decrease. Eight measures scored above the national Medicaid 90th percentile, while only two measures fell below the 25th percentile. Kaiser–San Diego County was also able to demonstrate statistically significant and sustained improvement for increasing HbA1c testing for members with diabetes.

Kaiser–San Diego County was adequately compliant with medical performance audit standards for continuity of care, availability and accessibility, members' rights, and quality management. Additionally, the MRPIU review found that the plan was adequately compliant in the areas of

prior authorization, program integrity, cultural and linguistic services requirements, and marketing and enrollment. Kaiser–San Diego County had exceptional performance with member satisfaction results, with nearly all measures demonstrating high performance when compared with national Medicaid percentiles.

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

- Monitor the grievance process to ensure timeliness of acknowledgement letters and member notifications of their right to a State Fair Hearing.
- Continued and enhanced focus on improving the *Adolescent Well-Care Visits (AWC)* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* measures until the rates achieve the MPL.
- Improve initial QIP submission documentation to meet compliance with the CMS protocol for conducting QIPs.
- Conduct annual barrier analyses to ensure that QIP interventions target specific barriers and evaluate the efficacy of the interventions using subgroup analysis to determine if the initiatives are affecting the entire study population in the same way.
- Evaluate QIP outcomes by gender, age, provider, etc., to understand any disparities that may exist in the study population in relationship to the study outcomes.
- Explore specific barriers associated with HbA1c control and address those barriers.

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

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

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

EQR Recommendation	Plan Actions That Address Recommendation
Continued and enhanced focus on improving the *Adolescent Well-Care Visits* (*AWC*) and *Prenatal and Postpartum Care—Postpartum Care* (*PPC–Pst*) measures until the rates achieve the MPL.	Steps to improve *AWCs* in current QIP includes identification, outreach, provider education, additional clinics (teen and Saturday), and capitalizing on potential opportunities, such as immunizations and sports physicals. Kaiser–San Diego County 2010 HEDIS rate for Postpartum Care is 67.9%—well above MPL. Continue interventions as outlined in most recent QIP
Retire the Improving Blood Sugar Levels in Diabetic Members as a formal QIP since there have been four remeasurement periods, and consider one of the low-performing measures for the next QIP proposal topic area.	Kaiser–San Diego County did not meet the MPL for the 3–6 year old well-child visits and plans to initiate a QIP for this area.
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.	Kaiser–San Diego County will use HSAG's QIP Summary Form for improved documentation.
Conduct annual barrier analyses to ensure that QIP interventions target specific barriers to increase the likelihood of success.	QIPs are evaluated periodically and annually in determining effectiveness of measures taken for improvement regionally and by the appropriate specialty (i.e., Peds – Pediatric Department Administrator). Adjustments are made as needed.
Monitor the grievance system to ensure timely notification to members and the inclusion of fair hearing information.	Timely Notification Adherence to the notification and timeliness requirements of CCR Titles 22 and 28 is monitored on a daily, monthly, and quarterly basis. Notification of State Fair Hearing Rights Beginning June 22, 2008, Member Services automated the production of Member Grievance correspondence. All NOAs include a copy of the YOUR RIGHTS/State Fair Hearing notification pursuant to MMCD All Plan Letters 04006 and 05005.

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

EQR Recommendation	Plan Actions That Address Recommendation
Reeducate staff to ensure that denial notifications for written prior-authorization requests are issued, including circumstances in which the provider agrees to the request being redirected internally.	This process is closely monitored and controlled. Re-direct denials are handled in our Outside Referral Department by a limited number of staff members. The senior outside referral coordinator is the primary responsible staff member for this function. When she is out of the office we re-delegate this task to another staff member who has been trained. There is additional staff for back up as needed. The staff are periodically updated and trained according to policy.
Ensure that the open deficiency related to the use of nonphysician reviewers for chiropractic denials is resolved.	Member Grievance P&P 50-2 (rev. 8/16/2007) Complaint, Grievance, and Appeal Process & Resolution for Non-Medicare Members, specified that Member Services would obtain an investigative report from an American Specialty Health Plan (ASHP) provider. ASHP is the affiliated provider for chiropractic care. However, decisions to approve or deny requests for chiropractic care were reviewed according to the requirements of 50-2 (rev. 2007). P&P 50-2 (2007) §C.4.c.i & iii provided that medical necessity determinations are made based upon physician review and all Medi-Cal member cases are processed using the Medical Necessity determinations process. Member Grievance P&P 50-2 (rev. 12/15/2010) Complaint, Grievance, and Appeal Process & Resolution for Non-Medicare Members, specifies that the grievance process is applicable to affiliated providers. American Specialty Health Plan is the affiliated provider for chiropractic care. P&P 50-2 (2010) §C.4.f.iii provides all denials for Managed Medi-Cal members are reviewed by a physician. This includes requests for chiropractic care related to the treatment of the spine by manual manipulation.