Performance Evaluation Report

Kern Family Health Care

July 1, 2013–June 30, 2014

Managed Care Quality and Monitoring Division
California Department of Health Care Services

April 2015

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July 1, 2013 – June 30, 2014

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)[1] in the State of California through a combination of contracted full-scope and specialty managed care health plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] 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 provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and state-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and operations,

[1] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2013–June 30, 2014). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Kern Family Health Care ("KFHC" or "the MCP"), for the review period July 1, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Health Plan Overview

KFHC is a full-scope MCP delivering services to its MCMC members as a "Local Initiative" (LI) MCP under the Two-Plan Model (TPM). In TPM counties, MCMC beneficiaries may choose between two MCPs; typically, one MCP is an LI and the other a commercial plan (CP). DHCS contracts with both plans. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. MCMC beneficiaries may enroll in KFHC, the LI MCP; or in Health Net Community Solutions, Inc., the alternative CP.

KFHC became operational in Kern County to provide MCMC services effective July 1996. As of June 30, 2014, KFHC had 163,048 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP'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. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to evaluate key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

Medical Audits and SPD Medical Surveys

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were

conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

DHCS received authorization "1115 Waiver" from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-County Organized Health System (COHS) counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

Audits & Investigation Division Medical Audit Findings

The most recent on-site medical audit for KFHC was conducted September 10, 2013, through September 13, 2013, covering the review period of July 1, 2012, through June 30, 2013. A&I reviewed the following areas:

- Utilization Management
- Case Management and Coordination of Care
- Availability and Accessibility of Care
- Member's Rights
- Quality Management
- Administrative and Organizational Capacity

A&I identified deficiencies in all review areas and issued a CAP to KFHC on April 18, 2014. In a letter dated June 1, 2014, DHCS indicated that on May 16, 2014, KFHC provided DHCS with a response to the CAP and that the MCP was found to be in compliance, resulting in DHCS closing the CAP.

Department of Managed Health Care Seniors and Persons with Disabilities Medical Survey Findings

During the September 10, 2013, through September 13, 2013, on-site visit with KFHC, DMHC also conducted an on-site 1115 Medicaid Waiver SPD medical survey of KFHC, covering the review period of July 1, 2012, through June 30, 2013. DMHC reviewed the following areas:

- Utilization Management
- Continuity of Care
- Availability and Accessibility of Services
- Member Rights
- Quality Management

DMHC identified potential deficiencies in all review areas and issued a CAP to KFHC on March 19, 2014. In a letter dated July 8, 2014, DHCS indicated that on July 2, 2014, KFHC provided DHCS with a response to the CAP and that the MCP was found to be in compliance, resulting in DHCS closing the CAP. Note that while the information regarding resolution of the deficiencies was received outside the review period for this MCP-specific evaluation report, HSAG included the information since the time frame was only eight days past the review period and the letter indicated full resolution of all potential deficiencies.

Strengths

KFHC resolved all deficiencies from the most recent audit and survey conducted by DHCS.

Opportunities for Improvement

Since KFHC has no outstanding deficiencies from DHCS's most recent audit and survey, HSAG has no recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal Managed Care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

HSAG conducts validation of the External Accountability Set performance measures as required by DHCS to evaluate the accuracy of the MCPs' reported results. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[4] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[4] The CMS EQR Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Performance Measure Validation

DHCS's 2014 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 32. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[6] of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for Kern Family Health Care* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that KFHC followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the findings is included below.

- KFHC had no enrollment data backlogs during the reporting year.
- KFHC conducted a root cause analysis to determine the source of its abstraction errors. The MCP plans to emphasize training and increase oversight of abstraction accuracy for future audits.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of KFHC's performance measure results for 2011–14. Note that data may not be available for all four years.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 shows the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

DHCS based the MPLs and HPLs on the NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *CDC–H9 (>9.0 percent)* measure. 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.

The reader should note the following regarding Table 3.1:

- The *All-Cause Readmissions* measure is a non-HEDIS measure used for the ACR collaborative QIP; therefore, no MPL or HPL is established for this measure.
- For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- The *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures. No MPL or HPL is established for a utilization measure. Additionally, HSAG did not compare performance for these measures.
- Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for 2014:
  - All four *Children and Adolescents' Access to Primary Care* measures.
  - *Cervical Cancer Screening*. Note: MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008; however, due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014. Consequently, HSAG did not include or make comparisons to previous years' rates in this report.
  - *Comprehensive Diabetes Care—LDL-C Control.* (This measure is being eliminated for HEDIS 2015.)
  - *Comprehensive Diabetes Care—LDL-C Screening.* (This measure is being eliminated for HEDIS 2015.)

Table 3.1—Performance Measure Results
KFHC—Kern County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	8.77%	14.94%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	46.64	51.02	50.26	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	282.07	255.50	263.68	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	83.81%	87.71%	88.95%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	90.74%	93.48%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	84.24%	87.62%	89.62%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	**18.27%**	**15.69%**	23.02%	26.35%	↔
Cervical Cancer Screening	Q,A	—	—	—	59.37%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	74.21%	68.61%	65.45%	66.67%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**94.23%**	**92.37%**	**93.24%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**84.12%**	**82.18%**	**84.37%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**79.80%**	**79.43%**	**81.39%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**81.78%**	**82.20%**	**80.60%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	64.96%	72.81%	75.36%	75.67%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	**32.36%**	52.55%	45.80%	45.01%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	79.81%	82.12%	80.29%	80.05%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	**36.50%**	45.26%	47.45%	44.53%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	29.20%	34.31%	33.58%	37.71%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	76.40%	79.38%	76.28%	77.86%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	74.45%	80.11%	77.55%	82.48%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	**54.26%**	45.99%	44.53%	46.96%	↔
Controlling High Blood Pressure	Q	—	—	64.96%	68.37%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	62.53%	75.67%	78.83%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**45.85%**	49.72%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**21.75%**	24.01%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	61.07%	60.34%	62.04%	61.07%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**78.35%**	81.27%	83.70%	81.02%	↔
Use of Imaging Studies for Low Back Pain	Q	**71.89%**	76.45%	74.07%	75.41%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	62.29%	61.80%	64.23%	67.15%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	46.96%	51.58%	66.42%	66.91%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	29.44%	38.44%	48.91%	56.20%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	70.32%	69.10%	67.64%	**66.18%**	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[7] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

[7] Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. Managed care health plan performance measures may include measures from HEDIS; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Table 3.2 and Table 3.3, which present a summary of KFHC's 2014 SPD measure results. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[8] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[8] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.2.

Table 3.2—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for KFHC—Kern County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	11.62%	18.74%	▼	14.94%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.05%	90.14%	↔	88.95%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	93.33%	Not Comparable	93.48%
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.03%	91.41%	↑	89.62%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	93.25%	92.59%	↔	93.24%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	84.37%	84.46%	↔	84.37%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	81.42%	79.50%	↔	81.39%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	80.64%	78.43%	↔	80.60%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	76.89%	72.75%	↔	75.67%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.20%	44.77%	↔	45.01%
Comprehensive Diabetes Care—HbA1c Testing	80.29%	80.78%	↔	80.05%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.72%	49.39%	↔	44.53%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.79%	40.15%	↔	37.71%
Comprehensive Diabetes Care—LDL-C Screening	77.37%	80.78%	↔	77.86%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.81%	83.21%	↔	82.48%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	47.69%	38.20%	▲	46.96%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

▲▼ are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
KFHC—Kern County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
248.15	46.93	492.89	99.42

*Member months are a member's "contribution" to the total yearly membership.

Performance Measure Result Findings

The rate for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure was above the HPL, and the rates were below the MPLs for the following measures:

- All four *Children and Adolescents' Access to Primary Care Practitioners* measures for the third consecutive year
  - Note that the rates improved significantly from 2013 to 2014 for the *25 Months to 6 Years* and *7 to 11 Years* measures and the rate for the *12 to 19 Years* measure declined significantly from 2013 to 2014.
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

In addition to the two measures noted above with rates that improved significantly from 2013 to 2014, the rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* measure improved significantly from 2013 to 2014. The rates for both *Medication Management for People with Asthma* measures improved from 2013 to 2014. Although not statistically significant, the improvement resulted in the rates moving from below the MPLs in 2013 to above the MPLs in 2014. (Note that DHCS did not hold the MCPs accountable to meet the MPLs for these measures in 2013 since 2013 was the first year the measures were reported.)

Finally, the rate for the *All-Cause Readmissions* measure was significantly higher in 2014 when compared to 2013, meaning that significantly more Medi-Cal members aged 21 years and older were readmitted within 30 days of an inpatient discharge in 2014 than in 2013.

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates for the following measures:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Comprehensive Diabetes Care—HbA1c Poor Control (<9.0 Percent)*

The SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure.

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however rates should be interpreted with caution as high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures and HSAG does not provide comparative analysis.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act cycle. DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates (measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid cycle approach (including the Plan-Do-Study-Act cycle) to strengthen

these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

Assessment of MCP's Improvement Plans

KFHC was required to submit no IPs in 2013. Based on 2014 rates, the MCP will work with DHCS to strategize the best approach to improving the rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure.

Strengths

HSAG auditors determined that KFHC followed the appropriate specifications to produce valid rates, and no issues of concern were identified. KFHC conducted a root cause analysis to determine the source of the MCP's abstraction errors, and the MCP plans to emphasize training and increase oversight of abstraction accuracy for future audits.

KFHC had one measure with a rate above the HPL and three measures with rates that improved significantly from 2013 to 2014. The rates for both *Medication Management for People with Asthma* measures improved from below the MPLs in 2013 to above the MPLs in 2014.

DHCS gave KFHC the Most Improved Award during the 2014 Medi-Cal Quality Conference, recognizing the MCP's improved performance on measures from 2013 to 2014.

Opportunities for Improvement

Despite KFHC's efforts to address the MCP's poor performance on all four *Children and Adolescents' Access to Primary Care Practitioners* measures (see Appendix D), the rates for all four measures were below the MPLs for the third consecutive year. Although the MCP achieved significant improvement for two of the measures, the rate for the *12 to 19 Years* measure declined significantly from 2013 to 2014. The MCP has the opportunity to assess if current improvement strategies need to be modified or eliminated and if new strategies should be implemented, especially for the *12 to 19 Years* measure, which had a significant decline in its rate, and the *12 to 24 Months* measure, which had no significant change in its rate.

KFHC also has the opportunity to assess the factors leading to the rate being below the MPL for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure and identify strategies to improve the rate.

Finally, while KFHC provided a summary of actions taken to address the significantly higher readmissions rate for the SPD population (see Appendix D), SPD readmissions continued to be significantly higher in 2014; therefore, HSAG recommends that KFHC continue to assess whether or not the MCP has sufficient processes in place to meet the SPD population's health care needs.

Conducting the EQRO 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 CMS validation protocol[9] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

HSAG organized, aggregated, and analyzed KFHC's validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[9] The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Quality Improvement Project Objectives

KFHC participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2013–June 30, 2014.

Table 4.1 below lists KFHC's QIPs and indicates whether the QIP is clinical or nonclinical, and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

Table 4.1—Quality Improvement Projects for KFHC
July 1, 2013, through June 30, 2014

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Comprehensive Diabetic Quality Improvement Plan	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members leading to improved health outcomes.

KFHC's *Comprehensive Diabetic Quality Improvement Plan* QIP focuses on increasing HbA1c testing, LDL-C screening, and retinal eye exams. Blood glucose monitoring, dyslipidemia/lipid management, and retinopathy screening assist in the development of appropriate treatment plans to decrease the risk of diabetes complications. Lack of appropriate testing in members with diabetes may indicate suboptimal care and case management.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Validation Activity
KFHC—Kern County
July 1, 2013, through June 30, 2014

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				
All-Cause Readmissions	Annual Submission	81%	86%	*Partially Met*
	Annual Resubmission 1	94%	100%	*Met*
Internal QIPs				
Comprehensive Diabetic Quality Improvement Plan	Annual Submission	71%	80%	*Partially Met*
	Annual Resubmission 1	88%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP 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 noncritical) 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*.

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that KFHC's annual submission of its *All-Cause Readmissions* QIP received an overall validation status of *Partially Met*. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, KFHC resubmitted the QIP and achieved an overall *Met* validation status, with 94 percent of the evaluation elements and 100 percent of the critical elements receiving a met score. The *Comprehensive Diabetes Quality Improvement Plan* QIP annual submission received an overall validation status of *Partially Met*. KFHC resubmitted the QIP and achieved an overall *Met* validation status, with 88 percent of the evaluation elements and 100 percent of the critical elements receiving a met score.

Table 4.3 summarizes the aggregated validation results for KFHC's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
KFHC—Kern County
(Number = 4 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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)**	88%	13%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		**98%**	**2%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	81%	8%	12%
	VIII: Appropriate Improvement Strategies	40%	60%	0%
Implementation Total**		**69%**	**22%**	**8%**
Outcomes	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**25%**	**0%**	**75%**

*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 stage and/or activity totals may not equal 100 percent due to rounding.

HSAG validated Activities I through VIII for KFHC's *All-Cause Readmissions* annual submission and Activities I through IX for the MCP's *Comprehensive Diabetes Quality Improvement Plan* annual submission.

KFHC demonstrated a strong application of the Design stage, meeting 98 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP met 100 percent of the requirements for all applicable evaluation elements within the Design stage for the *All-Cause Readmissions* QIP. For the *Comprehensive Diabetes Quality Improvement Plan* QIP, KFHC did not consistently document its goals throughout the QIP, resulting in a lower score for Activity III.

Both QIPs progressed to the Implementation stage during the reporting period. KFHC struggled with its application of the Implementation stage for both QIPs, meeting 69 percent of the requirements for all applicable evaluation elements within the study stage. The *All-Cause Readmissions* and *Comprehensive Diabetes Quality Improvement Plan* QIPs had multiple implementation issues, resulting in lower scores for Activities VII and VIII. KFHC corrected the deficiencies in the resubmissions, resulting in both QIPs achieving an overall *Met* validation status.

Only the *Comprehensive Diabetic Quality Improvement Plan* QIP progressed to the Outcomes stage during the reporting period. No QIP indicators achieved statistically significant improvement over baseline, resulting in only 25 percent of the requirements for all applicable elements being met for Activity IX. This QIP was not assessed for sustained improvement (Activity X) since it had not yet progressed to that stage.

Quality Improvement Project Outcomes and Interventions

The *All-Cause Readmissions* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP's interventions for the *All-Cause Readmissions* QIP:

- Implemented a comprehensive transitions of care pilot program which includes the following activities:
  - Medication therapy management
    - Medication reconciliation
    - Potential interactions and patient education
  - Discharge advocate
    - Standardized comprehensive discharge planning (assist with arranging appointments, transportation, and durable medical equipment)
  - Post-discharge clinic and home visit program
    - Two to three day follow-up clinical reevaluation and additional care coordination
  - Health coach
    - Member self-management
    - Symptom recognition
    - Post-discharge care plan
    - Follow-up compliance

Outcome information for the *All-Cause Readmissions* QIP will be included in KFHC's 2014–15 MCP-specific evaluation report.

Table 4.4 summarizes the *Comprehensive Diabetic Quality Improvement Plan* QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

Table 4.4—Quality Improvement Project Outcomes for KFHC—Kern County
July 1, 2013, through June 30, 2014

QIP #1—Comprehensive Diabetic Quality Improvement Plan			
Study Indicator 1: The percentage of diabetic members 18–75 years of age who had HbA1c testing during the measurement year.			
Baseline Period 1/1/11–12/31/11	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**	**Sustained Improvement¥**
82.1%	80.3%	‡	‡
Study Indicator 2: The percentage of diabetic members 18–75 years of age who had LDL-C screening during the measurement year.			
Baseline Period 1/1/11–12/31/11	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**	**Sustained Improvement¥**
79.4%	76.3%	‡	‡
Study Indicator 3: The percentage of diabetic members 18–75 years of age who had diabetic retinal eye exam screening during the measurement year or a negative diabetic retinal eye exam result the year prior to the measurement year.			
Baseline Period 1/1/11–12/31/11	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**	**Sustained Improvement¥**
52.6%	45.8%*	‡	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference over baseline (p value < 0.05).

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

Comprehensive Diabetic Quality Improvement Plan QIP

KFHC's objective for the *Comprehensive Diabetic Quality Improvement Plan* QIP was to achieve statistically significant improvement for all study indicators over the life of the QIP. From baseline to Remeasurement 1, the QIP did not achieve the project objective for all three study indicators. The rates for all three study indicators decreased during the reporting period, with the decrease for Study Indicator 3 being statistically significant. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- KFHC did not provide complete and/or accurate information throughout the QIP Summary Form.
- Initially, KFHC did not perform a complete and/or accurate data analysis of its results; however, the MCP provided this information in its resubmission.
- Although KFHC performed an initial causal/barrier analysis, the MCP should have performed additional analysis due to the decline in the study indicators' rates to determine if the original barriers identified were still applicable.

- Since this is a member-based QIP topic, KFHC should focus on member-based interventions likely to have long-term effects and induce permanent change rather than provider-based interventions.
- In its initial QIP submission, KFHC did not provide an evaluation plan for the implemented interventions; however, the MCP provided this information in its resubmission.
- Although the interventions were not successful improving the QIP outcomes, following is a brief description of the interventions implemented by KFHC:
  - Established the Delano Regional Medical Center Diabetic Clinic, open to all eligible members with diabetes and who are 18 years of age or older.
  - Continued the Text Message Pilot Program in order to increase HbA1c testing.
  - Continued the Pay-for-Performance program for providers.
  - Continued to receive monthly laboratory data files from various laboratories to use as supplemental data.

Strengths

KFHC demonstrated an excellent application of the QIP Design stage for both the *All-Cause Readmissions* and the *Comprehensive Diabetes Quality Improvement Plan* QIPs. The MCP met all requirements for all applicable evaluation elements within the Design stage for its *All-Cause Readmissions* QIP.

Opportunities for Improvement

In response to HSAG's recommendations in KFHC's 2012–13 MCP-specific evaluation report, KFHC indicated that all documents are reviewed and approved prior to submission (see Appendix D). Since the MCP had to resubmit both QIPs due to incomplete or inaccurate documentation, the MCP demonstrates continued opportunities for improving its QIP documentation. The MCP should continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

Since KFHC's *Comprehensive Diabetes Quality Improvement Plan* QIP has not been successful in improving the QIP indicators' rates, the MCP should conduct a new causal/barrier analysis and assess if it needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.

Conducting the EQRO Review

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each MCP in the three domains of care—quality, access, and timeliness. A numerical score is calculated for each domain of care for performance measure rates, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care and converted to a rating of above average, average, or below average. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the MCPs' medical audit/SPD medical survey reviews and assessment of the accuracy and completeness of encounter data to determine overall performance within each domain of care, as applicable. A more detailed description of HSAG's scoring process is included in Appendix C.

Please note that when a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[10]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP 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, DHCS monitors aspects of an MCP'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. DHCS also uses the results

[10] This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

HSAG reviewed KFHC's quality improvement program description and found detailed documentation of both an organizational structure and processes that support the delivery of quality care to the MCP's members.

Following is a summary of KFHC's performance related to quality performance measures:

- The rate was above the HPL for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure.
- The rate improved significantly from 2013 to 2014 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* measure.
- The rates for both *Medication Management for People with Asthma* measures improved from below the MPLs in 2013 to above the MPLs in 2014.
- The rate was below the MPL for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure.
- The rate for the *All-Cause Readmissions* measure was significantly higher in 2014 when compared to 2013, meaning that significantly more Medi-Cal members aged 21 years and older were readmitted within 30 days of an inpatient discharge in 2014 than in 2013.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and the SPD rates for the following measures were significantly better than the non-SPD rates:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

The SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure, meaning that significantly more members in the SPD population (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than were members in the non-SPD population.

Both of KFHC's QIPs fell into the quality domain of care. Only the *Comprehensive Diabetic Quality Improvement Plan* QIP progressed to the Outcomes stage. Since the QIP did not achieve positive outcomes for any of the study indicators, KFHC has opportunities for improving the quality of care provided to members with diabetes.

Overall, KFHC showed average performance related to the quality domain of care.

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP'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. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HSAG reviewed KFHC's available quality improvement information and found descriptions of monitoring and evaluation activities designed to ensure member access to needed health care services. Additionally, the MCP has goals and objectives related to ensuring member access to care.

Following is a summary of KFHC's performance related to access performance measures:

- The rates were below the MPLs for all four *Children and Adolescents' Access to Primary Care Practitioners* measures for the third consecutive year.
  - Note that the rates improved significantly from 2013 to 2014 for the *25 Months to 6 Years* and *7 to 11 Years* measures, and the rate for the *12 to 19 Years* measure declined significantly from 2013 to 2014.
- The rate was below the MPL for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.
- The rate for the *All-Cause Readmissions* measure was significantly higher in 2014 when compared to 2013 which, as indicated above, means that significantly more Medi-Cal members aged 21 years and older were readmitted within 30 days of an inpatient discharge in 2014 than in 2013.

Nine of the performance measures stratified for the SPD population fall into the access domain of care. As indicated above, the SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure, meaning that significantly more members in the SPD population (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than were members in the non-SPD population.

Both of KFHC's QIPs fell into the access domain of care. As indicated above, only the *Comprehensive Diabetic Quality Improvement Plan* QIP progressed to the Outcomes stage. Since the

QIP did not achieve positive outcomes for any of the study indicators, KFHC has opportunities for improving access to care for members with diabetes.

Overall, KFHC showed below-average performance related to the access domain of care.

Timeliness

The timeliness domain of care relates to an MCP'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.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' 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. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

KFHC's quality improvement program description includes information about members' rights, the MCP's structure for addressing grievances, and the MCP's processes for oversight and evaluation of continuity and coordination of care and utilization management.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which falls into the timeliness domain of care, was below the MPL.

Overall, KFHC showed average performance related to the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2012–13 MCP-specific evaluation report. KFHC's self-reported responses are included in Appendix D.

Recommendations

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

- Assess if current improvement strategies for the *Children and Adolescents' Access to Primary Care Practitioners* measures need to be modified or eliminated and if new strategies should be implemented, especially for the *12 to 19 Years* measure, which had a significant decline in its rate, and the *12 to 24 Months* measure, which had no significant change in its rate.
- Assess the factors leading to the rate being below the MPL for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, and identify strategies to improve the rate.
- Continue to assess whether or not the MCP has sufficient processes in place to meet the SPD population's health care needs since the SPD rate was significantly worse than the non-SPD rate for the *All-Cause Readmissions* measure.
- Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.
- Conduct a new causal/barrier analysis for the *Comprehensive Diabetes Quality Improvement Plan* QIP, and assess if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.

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

Table A.1 provides two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table A.1—HEDIS 2014 SPD Trend Table
KFHC—Kern County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	17.07%	18.74%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	95.53	99.42	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	487.16	492.89	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	92.05%	90.14%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	93.33%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.17%	91.41%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	87.76%	92.59%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	86.32%	84.46%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.00%	79.50%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	85.37%	78.43%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	73.72%	72.75%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.18%	44.77%	↔
Comprehensive Diabetes Care—HbA1c Testing	83.21%	80.78%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.57%	49.39%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	40.69%	40.15%	↔
Comprehensive Diabetes Care—LDL-C Screening	83.76%	80.78%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	84.85%	83.21%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	36.31%	38.20%	↔

*Member months are a member's "contribution" to the total yearly membership.

Table B.1 provides two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

Table B.1—HEDIS 2014 Non-SPD Trend Table
KFHC—Kern County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	6.27%	11.62%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	48.21	46.93	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	240.89	248.15	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.38%	88.05%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.34%	88.03%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	92.43%	93.25%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	82.13%	84.37%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	79.38%	81.42%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	82.19%	80.64%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	75.73%	76.89%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	43.98%	47.20%	↔
Comprehensive Diabetes Care—HbA1c Testing	77.37%	80.29%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.53%	46.72%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	31.39%	34.79%	↔
Comprehensive Diabetes Care—LDL-C Screening	72.99%	77.37%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.09%	79.81%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	46.35%	47.69%	↔

*Member months are a member's "contribution" to the total yearly membership.

Quality, Access, and Timeliness Scoring Process

Scale
2.5–3.0 = Above Average
1.5–2.4 = Average
1.0–1.4 = Below Average

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[11] This process allows HSAG to evaluate each MCP's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.1)

Quality Domain

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.
   - If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.
3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

[11] The CMS protocols specify that the EQRO must include an assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Access and Timeliness Domains

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.
   - If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

Validation *(Table 4.2)*: For each QIP submission and subsequent resubmission(s), if applicable.

1. **Above Average** is not applicable.
2. **Average** = *Met* validation status.
3. **Below Average** = *Partially Met* or *Not Met* validation status.

Outcomes *(Table 4.4)*: Activity IX, Element 4—Real Improvement

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

Sustained Improvement *(Table 4.4)*: Activity X—Achieved Sustained Improvement

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Some, but not all, study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

APPENDIX D. MCP'S SELF-REPORTED FOLLOW-UP ON EXTERNAL QUALITY REVIEW RECOMMENDATIONS FROM THE JULY 1, 2012–JUNE 30, 2013 PERFORMANCE EVALUATION REPORT

for **Kern Family Health Care**

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with KFHC's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table D.1—KFHC's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

2012–13 External Quality Review Recommendation Directed to KFHC	Actions Taken by KFHC During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Continue close oversight of all supplemental data sources, including two new non-standard supplemental data sources, to ensure validation is conducted and HEDIS measure specifications are followed.	The Information Technology (IT) Department has extract, transform, and load (ETL) procedures that import data from all supplemental sources. These data are validated through ETA and database constraints that restrict unstructured or invalid data from being passed to the HEDIS solution. Additionally, the data are reviewed each year for adherence to the HEDIS import specification to ensure that all data elements are still accurate.
2. Related to improving performance measure rates:	
a. Assess the factors leading to the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure to decline significantly to prevent this measure's rate from moving from above the MPL to below the MPL. The rate for this measure improved significantly from 2011 to 2012, and the MCP may benefit from identifying the strategies that led to the improvement so they can be implemented, as appropriate, moving forward.	Additional medical records are reviewed during the focused site reviews to evaluate diabetes care. Findings are evaluated with input from Disease Management. Evaluation and interventions include: • Referrals are written for a diabetic eye examination, but members are not making appointments or following up with their ophthalmologist. o Education given to office/clinic staff on ways to follow up with members to maximize members' engagement continues with varied success. o Member-specific reminder letters mailed to diabetic members for unclaimed services and tests such as the HbA1c test, kidney function screening, LDL lipid blood test, and the dilated eye exam. o The text messaging/diabetic reminder program was not continued beyond June 2013. Evaluation showed increased member engagement and satisfaction. Current plans include resuming this program. • Referrals are written to non-participating providers. o Education is given to office/clinic staff on ways to ensure in-plan providers are used. o New ophthalmic providers were contracted for remote/rural areas.

2012–13 External Quality Review Recommendation Directed to KFHC	Actions Taken by KFHC During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	○ In the past three months, one new ophthalmologist was credentialed. ○ Review of grievances show only one ophthalmology access issue in the past six months. • Diabetes Education. ○ Diabetes care is followed by the disease management program. Encounter data is reviewed to identify diabetics. During outreach calls, members who have not accessed their eye exam are assisted in accessing care and are given diabetic education if they do not want to attend formal classes. KHS continues to call member to assist in scheduling their eye exams. ○ Delano Diabetic Clinic Pilot was not spread as quickly as expected; however, targeted outreach in the Delano geographic area has resumed.
b. Assess the factors leading to a significantly higher rate of readmissions for the SPD population when compared to the non-SPD population to ensure the MCP is meeting the needs of the SPD population.	Readmissions within 30 days are reviewed by utilization management (UM), quality improvement (QI) and the associate medical director to identify opportunities for improvement. Reasons for readmissions were identified for all membership, with a focus on the SPD population. To address the identified issues, the following interventions were developed: • Pre-discharge medication reconciliation is performed by contracted specialty pharmacist group with face-to-face counseling and medication packaging options to improve understanding and compliance. • High-risk members receive phone triage performed by KHS RN case managers within 24 to 28 hours post discharge to assess if all needs have been met and barriers to receiving care were removed. • Facilitate a primary care physician (PCP) or post discharge clinic follow-up appointment with a provider and, if necessary, transportation, within 72 hours by a KHS RN case manager (if not done by member). • Additional education, discharge instructions, or pending authorized services are provided as identified through individual member case notes. Quarterly reporting to PCPs identifying their patients with three or more emergency department (ED) visits in the previous quarter. This information allows the PCP an opportunity to affect high-risk members.

<table>
<tr><th>2012–13 External Quality Review Recommendation Directed to KFHC</th><th>Actions Taken by KFHC During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation</th></tr>
<tr><td>c. Assess the factors leading to the rates for the four Children and Adolescents' Access to Primary Care Practitioners measures being below the MPLs, including the factors leading to the rates for the 12–24 Months and 25 Months–6 Years measures declining significantly from 2012 to 2013.</td><td>Data for the CAP measures was reviewed by the chief executive officer (CEO), chief medical officer (CMO), QI staff, and business analyst. Evaluation of factors relating to poor rates of children and adolescents accessing their PCPs include:
Migrant population with limited extended family support.
Multi-parity (first-born children more likely to be seen per recommendations, with later-born children only seen when ill or injured.)
Working parents unable to take time off during the day for a well-child visit.
The following interventions were developed to address the issues identified:
Member outreach mailings include providing the Preventive Care Guidelines.
Preventive Care Guidelines provided in the New Member's Packet.
Preventive Care Guidelines are provided to all members annually.
Health segments on local Spanish TV channels stress the importance of seeing PCP regularly for preventive services.
Member newsletter includes the importance of well-child visits.
Grants to PCPs to extend hours and/or add providers.
This measure is included in the pay-for-performance (P4P) program.
These problem-prone measures have responded to interventions aimed at increasing the rates of children and early adolescents accessing their PCPs. While still below the MPL, the following improvement has been noted over 2013 rates:<table><tr><th>Measure</th><th>2013 Rates</th><th>2014 Rates</th><th>Difference</th></tr><tr><td>CAP-1224</td><td>92.37</td><td>93.24</td><td>+0.87</td></tr><tr><td>CAP-256</td><td>82.18</td><td>84.37</td><td>+2.19</td></tr><tr><td>CAP-711</td><td>79.43</td><td>81.39</td><td>+1.96</td></tr></table></td></tr>
<tr><td>3. Ensure all required documentation is included in the QIP Summary Form and that all the information is accurate.</td><td>To ensure that all required documentation is included in the QIP Summary Form, the quality improvement supervisor uses reports from interdepartmental teams to complete the form with support from two RNs and a business analyst. The QIP Summary Form is reviewed for completeness and approved by the CMO prior to submission.</td></tr>
</table>

2012–13 External Quality Review Recommendation Directed to KFHC	Actions Taken by KFHC During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation

4. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly* priority areas.	*Rating of All Health Care*
	• Focus groups sessions held to elicit feedback and identify specific needs.
	• Health fairs held in outlying communities.
	Getting Needed Care
	• Transitions of care pilot.
	  ○ Development of post-discharge clinic for those members unable to obtain PCP visit within 72 hours post-discharge.
	• Grants to expand clinic hours and/or expand hours.
	• Evaluation of wait time for specialist (SPC) appointment with contracting efforts for those with long turnaround time (TAT).
	  ○ Endocrinology.
	  ○ Pain Management.
	• Pilot diabetes clinic developed—includes health education and preventive care.
	  ○ High patient satisfaction.
	  ○ Planned spread to high volume hospital.
	• Provider portal includes list of preventive services due.
	• Information on health literacy audio library included in member wellness newsletter.
	• 24-hour Nurse Advice Help Line.
	  ○ Includes access to health literacy audio library.
	• Member newsletter includes the importance of well-child visits.
	• Member outreach mailings include Preventive Care Guidelines.
	Getting Care Quickly
	• Electronic, automatic referral process implemented.
	• Grants to expand clinic hours and/or expand hours.
	• Evaluation of wait time for SPC appointment with contracting efforts for those with long TAT.
	  ○ Endocrinology.
	  ○ Pain Management.

5. Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.	The 2012-2013 MCP-Specific Encounter Data Validation Study Report was reviewed by the executive team, and KHS scored fairly well. The chief information officer (CIO) continues to improve and enhance the technical strategies of the organization to continually improve operations so that quality encounter data are processed by KHS.

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