Performance Evaluation Report

Kaiser Permanente (KP Cal, LLC)

Sacramento County

July 1, 2010–June 30, 2011

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

June 2012

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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 4.3 million beneficiaries (as of June 2011)[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, 2010–June 30, 2011*, 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 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, KP Cal, LLC, operating in Sacramento County ("Kaiser–Sacramento County" or "the plan"), for the review period July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

KP Cal, LLC, (Kaiser Permanente's California Medicaid line of business) is a full-scope managed care plan that contracts with the Medi-Cal Managed Care Program separately in Sacramento and San Diego counties. Additionally, KP Cal, LLC, operated a pre-paid health plan, Kaiser PHP, in Marin and Sonoma counties. However, Partnership Health Plan, a County Organized Health System (COHS), began operating in Sonoma County in October 2009 and will begin operating in Marin County as of July 1, 2011. Enrollment in the new COHS plan will be mandatory for all eligible Medi-Cal members. Kaiser PHP–Marin and Sonoma counties will no longer contract with the DHCS as a Medi-Cal managed care plan in Marin County, but will continue serving Medi-Cal members as a subcontractor to Partnership Health Plan.

This report pertains to the Sacramento County plan for KP Cal, LLC (Kaiser–Sacramento County). Kaiser–Sacramento County became operational with the MCMC Program in Sacramento County in April 1994, and as of June 30, 2011, it had 28,043 MCMC members.[1]

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

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, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about Kaiser–Sacramento County's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division have historically worked in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits have been 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 audit reports available as of June 30, 2011, to assess plans' compliance with State-specified standards. The most recent medical performance review was completed in February 2007, covering the review period of July 1, 2005, through June 30, 2006. HSAG reported findings from this audit in the 2008–2009 plan evaluation report.[2]

The review showed that Kaiser–Sacramento County had audit findings in the areas of utilization management, continuity of care and administrative and organizational capacity. Deficiencies needing continued attention were in the following areas:

- Implementation of a process to improve prior authorization and concurrent review procedures
- Providing notification of prior authorization denial, deferral, or modification
- Payment of emergency service providers
- Ensuring fraud and abuse reporting
- Process for reviewing delegated utilization management activities

Additionally, Kaiser–Sacramento County requested that the DHCS allow the plan to use American Specialty Health Plan (ASHP) providers to make chiropractic denial decisions because chiropractors provide unique specialty care and ASHP chiropractors are the qualified, licensed health care professional trained to make reviews and decisions pursuant to Knox-Keene standards. The DHCS noted that while this practice meets State requirements, Kaiser–Sacramento County may pursue a contractual amendment with the Medi-Cal Managed Care Division.

The DHCS *Medical Audit Close-Out Report* letter dated July 18, 2007, noted that the plan had fully corrected all audit deficiencies at the time of the audit close-out report. A&I was scheduled to conduct an audit in July 2009; however, this audit was not conducted and the next schedule audit date is undetermined.

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

[2] *Performance Evaluation Report – Kaiser–Sacramento County, July 1, 2008 – June 30, 2009.* California Department of Health Care Services. October 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

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, 2011.

MRPIU conducted an on-site review of Kaiser–Sacramento County in August, 2011 covering the review period of June 1, 2009, through May 31, 2011. The scope of the review included grievances, prior authorization notifications, cultural and linguistic services, and the False Claims Act. There were no MRPIU-related findings for the plan during the review period.

Strengths

Kaiser–Sacramento County was able to resolve noted deficiencies through corrective action plans, demonstrating full compliance with the medical performance review and MRPIU contract standards.

Opportunities for Improvement

There were no opportunities for improvement for Kaiser–Sacramento County, as the plan was fully compliant in medical performance and MRPIU reviews.

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, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about Kaiser–Sacramento County's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of Kaiser–Sacramento County in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. The audit found all rates to be valid for reporting; however, after the audit, the plan notified the DHCS and HSAG that it identified an error with its source code when producing the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, resulting in the rate being over-reported. The plan corrected the rate, HSAG validated the revised rate and source code, and the correct rate is reflected in this report.

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

Performance Measure Results

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

Table 3.1—HEDIS® 2011 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2011 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of Kaiser–Sacramento County's HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. The table shows the plan's HEDIS 2011 performance compared to the MCMC-established MPLs and 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—2010–2011 Performance Measure Results for Kaiser—Sacramento County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	61.4%	54.8%	★★★	↔	19.7%	35.9%
AWC	Q,A,T	32.1%	39.0%	★★	↑	38.8%	63.2%
BCS	Q,A	73.9%	74.1%	★★★	↔	46.2%	63.8%
CCS	Q,A	81.9%	84.1%	★★★	↑	61.0%	78.9%
CDC–BP	Q	79.0%	77.8%	★★★	↔	53.5%	73.4%
CDC–E	Q,A	70.1%	67.5%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	64.6%	63.1%	★★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	23.6%	21.5%	★★★	↔	53.4%	27.7%
CDC–HT	Q,A	92.8%	94.0%	★★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	63.3%	62.7%	★★★	↔	27.2%	45.5%
CDC–LS	Q,A	89.9%	92.1%	★★★	↔	69.3%	84.0%
CDC–N	Q,A	82.1%	83.1%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	75.5%	80.2%	★★	↑	63.5%	82.0%
LBP	Q	88.4%	87.5%	★★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	88.4%	91.6%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	75.9%	71.7%	★★	↔	58.7%	74.4%
URI	Q	97.0%	97.3%	★★★	↔	82.1%	94.9%
W34	Q,A,T	66.3%	69.0%	★★	↑	65.9%	82.5%
WCC–BMI	Q	38.1%	52.8%	★★	↑	13.0%	63.0%
WCC–N	Q	46.7%	60.3%	★★	↑	34.3%	67.9%
WCC–PA	Q	24.5%	59.8%	★★★	↑	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).

[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.

[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.

[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.

[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, Kaiser–Sacramento County demonstrated above-average performance across the 2011 HEDIS performance measures. The plan scored above the HPLs on twelve measures compared to nine in 2010. The plan did not score below the MPLs on any measures. Kaiser–Sacramento County also achieved statistically significant increases on seven measures and did not have any measures that had a statistically significant decrease.

HEDIS Improvement Plans

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

For plan measure rates that required a 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with the plan's 2011 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

Kaiser–Sacramento County had no performance measures below the MPLs; therefore, no improvement plan was required in 2011.

Adolescent Well-Care Visits

Kaiser–Sacramento County was able improve its performance on the *Adolescent Well-Care Visits* (*AWC*) measure from 2010 to 2011 and scored above the MPL. In the 2010 improvement plan, the plan cited the following barriers and challenges among a few others:

- Policy—Kaiser–Sacramento County does not support the use of incentives (e.g., member gift cards, supplementary provider payments) as a tactic to increase HEDIS rates.
- Member Involvement—Despite repeated appointment reminders and communication to members (e.g., automated and live phone calls, postcards) the fail-to-keep rate for this population is approximately 30%.

Kaiser–Sacramento County implemented several interventions that helped increase its 2011 *Adolescent Well-Care Visits* measure. The plan continued its birthday card reminder system in which patients were sent birthday cards with reminders to schedule a well-care visit with their physicians. The final intervention Kaiser–Sacramento County implemented was a Care Coordination Project in which members who are due for *AWC* are contacted to schedule their appointments.

Kaiser–Sacramento County also imparted on their physicians the importance of reallocating appointment visit types from urgent care to preventive well visit appointments which increased appointment availability after 3:30 p.m. This facilitated adolescents being seen after school and minimized missed work for parents. Finally, the plan identified dependent adolescents of adult members enrolled in the Medi-Cal Care Coordination program who were due for a well visit and contacted them to facilitate their being seen by a provider.

Strengths

In 2011, Kaiser–Sacramento County scored very well overall on HEDIS measures, with twelve measures scoring above the HPLs. The plan also had a statistically significant change on seven measures, indicating successful ongoing improvement in 2011. Another strength for Kaiser–Sacramento County was that it was able to increase the score for *AWC* above the MPL, which means that the 2010 improvement plan was successful.

Opportunities for Improvement

Kaiser–Sacramento County should continue to focus on continuing to execute its improvement plan for *AWC;* its 2011 HEDIS score was only 0.02 percentage points above the MPL.

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, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about Kaiser–Sacramento County's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Projects Conducted

Kaiser–Sacramento County had two clinical QIPs in progress during the review period of July 1, 2010, through June 30, 2011. The first QIP targeted the reduction of avoidable ER visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. The plan's second project, an internal QIP, was aimed at increasing awareness of and counseling for childhood obesity in children 3 to 11 years of age. Both QIPs fell under the quality and access domains of care.

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

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

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for Kaiser—Sacramento County July 1, 2010, through June 30, 2011

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				
Childhood Obesity	Proposal	89%	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*.

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that the initial submission by Kaiser–Sacramento County for its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. The plan also received a *Met* validation status for its *Childhood Obesity* QIP proposal submission. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status; therefore, the plan was not required to resubmit either QIP.

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

Table 4.2—Quality Improvement Project Average Rates* for Kaiser—Sacramento County (Number =2 QIP Submissions, 2 QIP Topics) July 1, 2010, through June 30, 2011

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	83%	0%	17%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**94%**	**0%**	**6%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	90%	10%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**93%**	**7%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total†		**76%**	**0%**	**24%**

*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.

Kaiser–Sacramento County submitted baseline data for the *Childhood Obesity* QIP, so HSAG assessed Activities I through VIII. The plan successfully applied the QIP process for the design and implementation stages, scoring 100 percent *Met* on all applicable evaluation elements for four of the six applicable activities. For the outcomes stage, the plan's *Reducing Avoidable Emergency Room Visits* QIP was scored down for not demonstrating statistically significant improvement in Activity IX and for not achieving sustained improvement in Activity X. 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.

Quality Improvement Project Outcomes

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

Table 4.3—Quality Improvement Project Outcomes for Kaiser—Sacramento County (Number = 2 QIP Submissions, 2 QIP Topics) July 1, 2010, through June 30, 2011

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable	11.6%	10.8%	14.3%*	No

QIP #2—Weight Assessment and Counseling for Nutrition and Physical Activity in Children				
QIP Study Indicator	**Baseline Period 1//09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
Percentage of members 3-17 years of age who had an outpatient visit with a primary care provider and who had evidence of BMI percentile documentation in the medical record	56.8%	‡	‡	‡
Percentage of members 3-17 years of age with documentation in the medical record of counseling for nutrition during the measurement year	63.6%	‡	‡	‡
Percentage of members 3-17 years of age with documentation in the medical record of counseling for physical activity during the measurement year	47.9%	‡	‡	‡

¥ 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.

*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05)

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

The plan demonstrated a statistically significant increase in avoidable ER visits between the first and second remeasurement period, which reflected a decline in performance. The collaborative interventions were initiated in early 2009; however, they were not associated with any improvement in the outcome. While Kaiser–Sacramento County demonstrated improvement from baseline to Remeasurement 1, it was unable to maintain the initial improvement, and in fact, the

Remeasurement 2 rate was significantly higher than the baseline rate. Therefore, the plan did not achieve sustained improvement.

Kaiser–Sacramento County had not progressed to the point of reporting remeasurement data for the *Childhood Obesity* QIP, so HSAG could not assess for real and sustained improvement.

Strengths

Kaiser–Sacramento County accurately documented the necessary requirements for the design and implementation stages with 94 percent and 93 percent, respectively, of the applicable evaluation elements scored *Met*. For the outcomes stage, the plan accurately analyzed and interpreted the study indicator outcomes. The plan achieved these scores without the benefit of resubmission, indicating proficiency with the QIP validation process.

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

Opportunities for Improvement

The plan implemented the collaborative interventions in 2009 for the *Reducing Avoidable ER Visits* QIP; however, when multiple interventions are implemented, the plan should incorporate a method to evaluate the effectiveness of each intervention. The plan should also conduct another barrier analysis and identify new or revised plan-specific interventions to sustain the reduction of avoidable ER visits since the study indicator outcome remain above the outcome reported at baseline.

Kaiser–Sacramento County should also include a plan to evaluate the efficacy of the interventions for its *Childhood Obesity* QIP, 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.

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 project (QIP) 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.

Kaiser–Sacramento County demonstrated above-average performance in the quality domain based on the plan's 2011 performance measure rates (which reflected 2010 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement.

Kaiser–Sacramento County was able to resolve noted deficiencies through corrective action plans, demonstrating full compliance with the medical performance review and MRPIU contract standards.

The plan successfully exceeded the HPL for twelve measures, and had a statistically significant change on seven measures. Additionally, Kaiser–Sacramento County's improvement plan for its *Adolescent Well-Care Visits* showed success by scoring 0.02 percentage points above the MPL.

For its QIPs, Kaiser–Sacramento County accurately documented the necessary requirements for the design and implementation stages, and accurately analyzed and interpreted study indicator outcomes for the outcome stages. The plan indicated proficiency with the QIP validation process and did not require resubmission.

The plan experienced a decline in performance achieving a statistically significant increase in avoidable ER visits during the remeasurement period and had not progressed to the point of reporting remeasurement data for the *Childhood Obesity* QIP, so real and sustained improvement could not be assessed.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of, and access to, all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the Medi-Cal Managed Care Program.

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

Kaiser–Sacramento County demonstrated average performance for the access domain of care based on 2011 performance measure rates and medical performance review.

Overall, Kaiser–Sacramento County performed between the MPL and HPL for all performance measures and showed statistically significant improvement in four measures. The plan's *Reducing Avoidable Emergency Room Visits* QIP was not successful in limiting the access of its members for unnecessary emergency room visits, but this was not uncommon throughout Medi-Cal plans. Kaiser–Sacramento County had not progressed to the point of reporting remeasurement data for the *Childhood Obesity* QIP, so HSAG could not assess the QIP's impact on member access to *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC).*

Timeliness

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

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

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

Kaiser–Sacramento County demonstrated average performance in the timeliness domain of care based on 2011 performance measure rates and medical reviews.

The plan showed statistically significant improvement in the measures of *Adolescent Well-Care Visits, Childhood Immunization Status—Combination 3* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 plan-specific evaluation report. Kaiser–Sacramento County's self-reported responses are included in Appendix A.

Conclusions and Recommendations

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

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

- Ensure that grievance acknowledgement letters and NOA letters are sent out within required time frames.
- Focus efforts to improve the *AWC* measure.
- When implementing multiple interventions, Kaiser–Sacramento County should incorporate a method to evaluate the effectiveness of each intervention.
- Conduct another barrier analysis and identify new or revised plan-specific interventions to sustain the reduction of avoidable ER visits.
- Evaluate the efficacy of the interventions for the *Childhood Obesity* QIP. The plan should use subgroup analysis to determine if initiatives are affecting the entire study population in the same way and evaluate the outcomes by gender, age, provider, etc., to identify any disparities that may exist within the study population in relationship to outcomes.

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

Appendix A. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

for Kaiser Permanente (KP Cal, LLC) – Sacramento County

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with the plan's self-reported actions that address the recommendations. Neither Health Services Advisory Group, Inc. (the external quality review organization for Medi-Cal Managed Care) nor any State agency has confirmed implementation of the actions that the plan self-reported in the grid.

Table A.1—Grid of Kaiser–Sacramento County's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	Kaiser–Sacramento County's Self-Reported Actions That Address the EQR Recommendation
Work to resolve internal clinical practice guidelines that directly conflict with the *Adolescent Well-Care Visits* measure.	Kaiser North–GMC Sacramento Department's *Children's Preventive Services* policy (approved August 11, 2008) clarifies this requirement to Providers. Policy states: "Provider must meet Federal and State requirements for providing preventative services to Medi-Cal enrollees under the age of 21. The Contractor shall make best efforts to ensure timely provisions of periodic health assessments to all enrollees under age 21 in accordance with the most recent recommendations of the American Academy of Pediatrics (AAP)." The policy is included in the provider orientation manual to educate new providers. Since its implementation several years ago, the policy has been reinforced in bi-monthly GMC Quality Committee meetings and during discussions of the CAP for this HEDIS measure. Strategies to give providers education and to use alerts in the electronic medical record were implemented in 2009, 2010 and 2011, resulting in the HEDIS 2011 rate of 39%, a 6.9 percentage point improvement from the prior year, falling above the MPL for the first time in several years.
Focus efforts to improve the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure.	The same activities listed above apply to this recommendation. HEDIS 2011 showed a 2.7 percentage point increase from prior year, falling above the MPL.
Implement a process to evaluate QIP interventions to determine the effectiveness of each.	QIP interventions are evaluated by the GMC Quality Improvement Team. This team, comprised of content experts and relevant others, is assembled for the duration of each QIP project. At the data review cycle periods, the team evaluates the effectiveness of the interventions using the methods listed the report's data analysis plan, and makes recommendations for change, if appropriate.
Review the detailed recommendations for improving member satisfaction in these areas, as outlined by HSAG in the *Medi-Cal Managed Care Program—2010 Kaiser Permanente—North CAHPS Plan-Specific Report.*	Kaiser North has demonstrated above average performance and will continue to share initiatives and best practices in meeting and exceeding members' expectations at the local Community Advisory Committee and GMC Coalition meetings.