Performance Evaluation Report

Kaiser Permanente (KP Cal, LLC)

San Diego County

July 1, 2010–June 30, 2011

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

June 2012

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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 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, Kaiser Permanente (KP Cal, LLC), operating in San Diego County ("Kaiser–San Diego 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. This report pertains to the San Diego County plan for KP Cal, LLC (Kaiser–San Diego County). Kaiser–San Diego County became operational with the Medi-Cal Managed Care Program in August 1998, and as of June 30, 2011, Kaiser–San Diego County had 13,997 MCMC members.[2]

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

[2] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 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–San Diego County's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division 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.

For this report, HSAG reviewed the most current audit reports available as of June 30, 2010, to assess the 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.[3]

The review showed that Kaiser–San Diego County had audit findings in the areas of utilization management, and administrative and organizational capacity. The DHCS *Medical Audit Close-Out Report* letter dated July 18, 2007, noted that the plan had fully corrected several audit deficiencies with only one deficiency remaining: delegated UM activities.

DMHC conducted a routine audit in August 2009 and a non-routine audit in July 2010. The results from these audits were not available at the time HSAG produced this report; therefore, the findings will be included in the plan's next evaluation report.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These member rights reviews are conducted before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2011.

MRPIU conducted an on-site review of Kaiser in August of 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.

In the category of grievances, MRPIU noted that of the 50 grievance files reviewed, five were missing the member's right to request a fair hearing, and two were missing the required acknowledgement letters. In the prior authorization category, one of the 36 files reviewed contained a notice of action (NOA) letter that was mailed out to the member after the maximum three-day time frame.

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

Strengths

Kaiser–San Diego County had relatively few deficiencies identified in the medical performance review and MRPIU reports. This indicates the plan is following its policies and procedures with a few exceptions. Most of the issues that were identified in the medical performance audit were addressed by the plan in its corrective action plan.

Opportunities for Improvement

The plan has the opportunity to strengthen its procedures relating to acknowledgement letters and timeliness in the prior authorization category to ensure 100 percent compliance.

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 the plan'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®)[4] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of Kaiser–San Diego County in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. There were no concerns identified by the audit team.

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

Performance Measure Results

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

Table 3.1—HEDIS® 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–San Diego 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—San Diego 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	28.0%	20.5%	★★	↔	19.7%	35.9%
AWC	Q,A,T	28.1%	44.0%	★★	↑	38.8%	63.2%
BCS	Q,A	73.7%	73.8%	★★★	↔	46.2%	63.8%
CCS	Q,A	83.3%	84.3%	★★★	↔	61.0%	78.9%
CDC–BP	Q	83.3%	85.8%	★★★	↔	53.5%	73.4%
CDC–E	Q,A	66.7%	77.1%	★★★	↑	41.4%	70.1%
CDC–H8 (<8.0%)	Q	63.7%	65.5%	★★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	23.4%	21.2%	★★★	↔	53.4%	27.7%
CDC–HT	Q,A	94.0%	94.0%	★★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	56.2%	66.5%	★★★	↑	27.2%	45.5%
CDC–LS	Q,A	90.1%	93.6%	★★★	↑	69.3%	84.0%
CDC–N	Q,A	91.7%	94.6%	★★★	↑	72.5%	86.2%
CIS–3	Q,A,T	80.0%	84.1%	★★★	↔	63.5%	82.0%
LBP	Q	85.0%	84.2%	★★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	90.1%	89.2%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	67.9%	68.5%	★★	↔	58.7%	74.4%
URI	Q	97.3%	98.9%	★★★	↑	82.1%	94.9%
W34	Q,A,T	61.6%	64.6%	★	↔	65.9%	82.5%
WCC–BMI	Q	95.5%	98.1%	★★★	↑	13.0%	63.0%
WCC–N	Q	14.6%	51.2%	★★	↑	34.3%	67.9%
WCC–PA	Q	14.2%	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–San Diego County had above-average performance results across the spectrum of HEDIS measures. Fifteen out of twenty-one measures scored above the HPLs and one measure fell below the MPL. Nine measures had a statistically significant increase and no measure had a statistically significant decrease in 2011.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at, or above, the established MPLs. DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan. 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 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.

Adolescent Well-Care Visits

In the past, Kaiser–San Diego County has struggled to improve its performance on *Adolescent Well-Care Visits*. However, in 2011, the plan was able to achieve the MPL and had a statistically significant improvement from 2010. Kaiser–San Diego County's 2010 improvement plan identified several barriers contributing to low HEDIS performance. These included:

- Parents are often unable to take time off to bring the patient into the office for well-child appointments.
- Member transportation issues.
- Perceived lack of importance of scheduling a visit when there is no apparent critical clinical need per parent/patient.
- Challenges contacting member due to incorrect phone number or address.
- Previous outreach list cumbersome for staff to prioritize outreach efforts.

The plan was able to execute its plan for improvement which included the following actions:

- The Pediatric and Adult Primary Care Department Administrators will receive a monthly report developed by the San Diego Analysis and Data Reporting Department of Medi-Cal patients ages 12 to 21 years old that are due for an adolescent well-visit within 14 to 120 days. The list will be distributed to outreach coordinators at each medical office building.
- Improve coding of adolescent well-child visits.

- Convert school-required sport physicals to well-child visits.
- Work with pediatric chiefs to improve physician awareness of opportunities related to other visit types.

Strengths

Kaiser–San Diego County demonstrated overall high performance scores across all 2011 HEDIS measures. In fact, fifteen measures, scored above the HPLs, compared to eight in 2010. The plan was able to successfully execute its improvement plan for *AWC*. Also, there was only one measure with a statistically significant decrease in 2011. One of the plan's biggest strengths is its consistency when it comes to HEDIS performance.

Opportunities for Improvement

Kaiser–San Diego County only had one HEDIS measure, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, fall below the MPL in 2011; the plan will need to conduct an improvement plan for this measure in 2012.

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

Quality Improvement Projects Conducted

Kaiser–San Diego County had two clinical QIPs in progress during the review period of July 1, 2010–June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. The plan's goal for the second project was to improve postpartum care. Both QIPs fell under the quality and access domains of care. Additionally, the *Improving Postpartum Care* QIP fell under the timeliness domain of care.

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

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

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for Kaiser—San Diego County July 1, 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	82%	100%	*Met*
Internal QIPs				
Postpartum Care	Annual Submission	60%	55%	*Not Met*
	Resubmission	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–San Diego County of its *Reducing Avoidable Emergency Room Visits* received an overall validation status of *Met*. The plan's *Postpartum Care* QIP initially received a *Not Met* score. As of July 1, 2010, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted the QIP and upon subsequent validation, achieved an overall *Met* validation status.

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

Table 4.2—Quality Improvement Project Average Rates* for Kaiser—San Diego 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	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	80%	10%	10%
	VII: Appropriate Improvement Strategies	83%	17%	0%
Implementation Total		**81%**	**13%**	**6%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	75%	19%	6%
	IX: Real Improvement Achieved†	63%	0%	38%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**68%**	**12%**	**20%**

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

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

Kaiser–San Diego County successfully applied the QIP process for the design stage, scoring 100 percent *Met* on all applicable evaluation elements for all four of the applicable activities.

For the implementation stage, Kaiser–San Diego County was scored lower in Activity VI in both QIPs for not providing a timeline and not addressing previous recommendations to do so. In Activity VII for the *Reducing Avoidable Emergency Room Visits* QIP, the plan did not narratively discuss the interventions that were implemented.

In Activity VII of the outcomes stage, the plan was scored down in both QIPs for providing an incomplete interpretation of the results. Additionally, for the *Reducing Avoidable ER Visits* QIP, the plan did not provide a complete data analysis plan and did not identify whether there were factors that affected the internal and external validity of the findings.

For Activity IX, the plan was scored down for the lack of real improvement since the *Reducing Avoidable ER Visits* QIP study indicator did not demonstrate statistically significant improvement between the most recent measurement period and the prior measurement period. The study

indicator was assessed for sustained improvement in Activity X; however, for the *Reducing Avoidable Emergency Room Visits* QIP, sustained improvement was not achieved since none of the remeasurement results were improved over baseline. Sustained improvement is defined as improvement in performance over baseline, that 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—San Diego 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	11.5%	13.1%*	15.9%	No
QIP #2—Improving Postpartum Care				
QIP Study Indicator	**Baseline Period 11/6/07–11/5/08**	**Remeasurement 1 11/6/08–11/5/09**	**Remeasurement 2 11/6/09–11/5/10**	**Sustained Improvement¥**
Percentage of women who had postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery	50.5%	67.9%*	‡	‡

¥ 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 documented an increase in avoidable ER visits between baseline and the first remeasurement period, reflecting a decline in performance. Collaborative interventions were initiated in 2009; however, they did not correlate with any improvement in the QIP outcome. Kaiser–San Diego County developed patient instructions in the electronic medical records that inform members regarding what to do if they are not sure their symptoms require emergency attention. These instructions were printed out and provided to the members at the time of an office visit. The plan will need to evaluate the efficacy of these interventions.

The *Improving Postpartum Care* QIP outcomes improved from baseline to Remeasurement 1. The documented a statistically significant increase in timely postpartum visits. The plan had not progressed to the point of a second remeasurement so sustained improvement could not be assessed.

Strengths

The plan accurately documented the four activities in the design stage for both QIPs. Kaiser–San Diego County was also able to demonstrate statistically significant for increasing timely postpartum visits.

Opportunities for Improvement

Kaiser–San Diego County has an opportunity to improve its QIP documentation—specifically, addressing prior recommendations. Recommendations not addressed from prior submissions will result in scores being lowered for the applicable evaluation elements.

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

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.

HSAG found that Kaiser–San Diego County demonstrated average performance for the quality of care domain. This was based on the plan's 2011 performance rates (which reflected 2010 measurement data), QIP outcomes, and compliance review standards related to measurement and improvement.

Kaiser–San Diego County had strong performance for all measures with the exception of *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. The plan had statistically significant increases in nine measures relating to quality, showing a strong commitment to HEDIS performance. Other measures with potential for improvement are *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, and *Prenatal and Postpartum Care—Postpartum Care*. These measures are below the HPLs and had no statistically significant change during the year.

For *Reducing Avoidable Emergency Room Visits,* the plan documented an increase in avoidable ER visits between baseline and the first remeasurement period, reflecting room for improvement relating to quality. However, the postpartum QIP had a statistically significant increase in the frequency of members receiving care between 21 and 56 days after delivery.

The plan's performance on the MRPIU review revealed a small number of findings related to the quality domain of care. The findings, however, were not process related; instead, the problems were unique to the situation. Overall, Kaiser–San Diego County performed very well on the medical audit and will need to address the unresolved deficiency from its corrective action plan.

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 and 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, availability of services, coordination and continuity of care, and access to covered services under the Medi-Cal Managed Care Program.

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

Kaiser–San Diego County demonstrated average performance for the access domain of care based on its 2011 performance measure rates, QIP outcomes, and compliance review standards.

The plan's performance measure rates were above the HPLs for seven of eleven measures related to access, which shows the plan's focus on member access. There was only one measure below the MPL, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.*

The *Improving Postpartum Care* QIP shows a focus from the plan in improving the access of women seeking care after childbirth in the period of time between baseline and the first remeasurement period.

Medical performance audit findings shows the plan was in compliance with reporting criteria related to access.

Timeliness

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

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

Based on 2011 performance measure rates for providing timely care and compliance review standards related to timeliness, Kaiser–San Diego County demonstrated average performance in the timeliness domain of care.

The plan performed within the MCMC-established thresholds for adolescent well-care visits, prenatal and postpartum care measures. It outperformed the HPL for the childhood immunization measure and underperformed on the well-child visits measure. A few of the timeliness-related measures were above MPLs but below HPLs, which had no statistically significant improvement during the year: *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care.*

The *Improving Postpartum Care* QIP revealed that members were seen by their physicians in a timely manner following childbirth.

The plan was generally compliant with utilization management standards related to timeliness of care. However, the MRPIU findings revealed room for improvement regarding the timely notice of action letters and grievance notifications.

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

Conclusions and Recommendations

Overall, Kaiser–San Diego County demonstrated above-average performance in providing quality, access, and timely health care services to its Medi-Cal managed care members. The plan had above-average performance across the spectrum of HEDIS measures. Nine measures had statistically significant increases; while only one measure had a statistically significant decline in performance. Fifteen measures, scored above the national Medicaid 90th percentile, while only one measure fell below the 25th percentile, an improvement over 2010's results.

Kaiser–San Diego County was fully compliant with medical performance audit standards for continuity of care, availability and accessibility, members' rights, and quality management. Utilization management and administrative and organizational capacity were the only categories in which there were findings. The MRPIU review found that the plan was fully compliant with most areas of the report with the exception of prior authorization.

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

- Strengthen procedures relating to acknowledgement letters and timeliness in the prior authorization category.
- Evaluate why the HEDIS measure*, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, fell below the MPL.
- Conduct annual barrier analyses to ensure that QIP interventions target specific barriers and evaluate the efficacy of interventions using subgroup analysis to determine if the initiatives are affecting the entire study population in the same way.
- Evaluate QIP outcomes by gender, age, provider, etc., to understand disparities in the study population in relationship to the study's outcomes.

In the next annual review, HSAG will evaluate Kaiser–San Diego 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) – San Diego 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–San Diego County's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	Kaiser–San Diego County's Self-Reported Actions That Address the EQR Recommendation
Enhance the HEDIS improvement plan for *Adolescent Well-Care Visits*.	Steps to improve AWV include continued identification, outreach enhancement, provider education, and providing opportunities in a teen acceptable environment, i.e., age appropriate setting and age ranges. KP San Diego hosted several sports physical clinics throughout the summer months. Immunization checks are converted into well visits when possible. Service Representatives ensure current contact information at all visit types and during incoming calls.
Conduct annual barrier analyses to ensure that its QIP interventions target specific barriers.	Each QIP has periodic review of progress along with a formal annual review. Interventions that are not effective are eliminated and team query is made for identified barriers reported by members, along with evaluation of results comparing the various clinics throughout San Diego County. For example, the PPV QIP identified members delivering at outside facilities were not uploading their delivery date to the tracking system causing the PPV to fall outside the measurement timeframe. System implemented to correct this. Another area identified from the barrier analysis included members coming in for procedures during their PPV and not coding correctly to count for the measure. As a result, more robust education was provided to the providers. For the ED Collaborative QIP, thru barrier analysis we learned new patients did not know who their PCP was and what clinic the PCP was located at. As a result of this barrier analysis, in addition to the written correspondence sent out to new members, Kaiser Permanente staff called every patient seen in the ED and provided verbal education and instruction regarding care, PCP, clinic locations, and how to make an appointment. In addition, as a service enhancer, Kaiser Permanente implemented a program reaching out to new members to assist them in obtaining the care they need and to ensure they are satisfied with the services they are receiving.
For QIPs, 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.	The PPV QIP intervention tracking includes results for the member, provider, and clinic. Enhanced outcomes are measured for the well visits of all age ranges.

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

2009–2010 EQR Recommendation	Kaiser–San Diego County's Self-Reported Actions That Address the EQR Recommendation
Relating to CAHPS, the plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program – 2010 Kaiser Permanente – South.*	Kaiser South Member Services has a robust grievance process which includes member notification of their right to a State Fair Hearing. Kaiser South is using the approved QIP submission form for QIPs and has recently submitted the All Cause Hospital Readmission Quality Improve Project Proposal and the Children and Adolescents' Access to Primary Care Practitioners on the HSAG Summary Form as required. Kaiser South is committed to continue the work in place to improve adolescent well visits and postpartum visits to further improve timely access and care. In efforts to continually improve diabetes care and management, Kaiser South has incentivized this initiative into Kaiser South' performance sharing program, employees receive incentive based on successful rate of A1C testing of members with diabetes which then translates into appropriate diabetes management.