Performance Evaluation Report

Kern Family Health Care

July 1, 2011–June 30, 2012

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

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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans 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 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 designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more 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.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[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.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, 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.

This report is specific to DHCS's contracted plan, Kern Family Health Care ("KFHC" or "the plan"), which delivers care in Kern County, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

Plan Overview

KFHC is a full-scope managed care plan operating in Kern County. KFHC serves members in Kern County as a Local Initiative (LI) under the Two-Plan Model. In a Two-Plan Model county, DHCS contracts with two managed care plans to provide medical services to Medi-Cal beneficiaries. Most Two-Plan Model counties offer an LI plan and a nongovernmental, commercial health plan.

Medi-Cal Managed Care beneficiaries in Kern County may enroll in KFHC, the LI plan, or in the alternative commercial plan. KFHC became operational in Kern County to provide MCMC services in July 1996. As of June 30, 2012, KFHC had 116,425 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period 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.

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 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from DHCS's compliance monitoring reviews to draw conclusions about KFHC'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. DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of DHCS's Medi-Cal Managed Care Division (MMCD) have historically worked in conjunction with the Department of Managed Health Care to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or the Department of Managed Health Care. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

The most recent medical performance review was completed in April 2007, covering the review period of November 1, 2005, through October 31, 2006. HSAG initially reported findings from this audit in KFHC's 2008–-2009 plan-specific evaluation report.[4] Although deficiencies were noted in the areas of Utilization Management, Availability and Accessibility, and Member Rights, the DHCS *Medical Audit Close-out Report* letter dated August 7, 2007, noted that KFHC had fully corrected all audit deficiencies at the time of the audit close-out report. Although a review by the State Controller's Office was conducted in November 2009 covering the audit period of January 1, 2009, through December 31, 2009, the results from this audit were not approved by DHCS and are therefore not summarized in this report.

Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current medical performance reviews and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

MR/PIU conducted an on-site review of KFHC in June 2012, covering the review period of January 1, 2010, through June 1, 2012. MR/PRU reviewed KFHC's policies and procedures and related documents in the areas of:

- Member Grievances

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

- Prior Authorization Notifications
- Cultural and Linguistic Services
- Marketing
- Program Integrity
- Seniors and Persons with Disabilities (SPD) Sensitivity Training
- Facility Site Review (FSR) Assessments

Additionally, MR/PIU reviewed 50 member grievance files and 50 prior authorization notification files, and conducted on-site visits at five provider offices. No findings were noted in any of the above areas. Please note that while the MR/PIU report was issued outside the July 1, 2011, through June 30, 2012, review period for this plan-specific evaluation report, since the MR/PIU review was conducted within the review period, HSAG included the results.

Strengths

KFHC fully resolved all identified deficiencies from the April 2007 medical performance review. Additionally, the plan demonstrated full compliance in all areas reviewed during the June 2012 MR/PIU review. This demonstrates that the plan's structure supports the delivery of quality, accessible, and timely health care services.

Opportunities for Improvement

KFHC should continue efforts to sustain contract compliance to support the delivery of quality, accessible, and timely health care provided to members.

Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). 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 DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by DHCS for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes 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.

Performance Measure Validation

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of KFHC in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

Performance Measure Validation Findings

The HSAG auditors determined that the plan followed the appropriate specifications to produce valid rates, and no issues were identified.

Performance Measure Results

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

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions (internally developed measure)*
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
AWC	*Adolescent Well-Care Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
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*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*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 KFHC's HEDIS 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

DHCS based the MPLs and HPLs on the National Committee for Quality Assurance's (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.

Table 3.2—Comparison of 2011 and 2012 Performance Measure Results for Kern Family Health Care—Kern County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	18.3%	15.7%	★	↔	18.8%	31.6%
AMB–ED	‡	--	46.6	--	Not Comparable	--	--
AMB–OP	‡	--	282.1	--	Not Comparable	--	--
AWC	Q,A,T	35.0%	51.3%	★★	↑	39.6%	64.1%
CAP–1224	A	--	94.2%	--	Not Comparable	--	--
CAP–256	A	--	84.1%	--	Not Comparable	--	--
CAP–711	A	--	79.8%	--	Not Comparable	--	--
CAP–1219	A	--	81.8%	--	Not Comparable	--	--
CCS	Q,A	63.2%	65.7%	★★	↔	64.0%	78.7%
CDC–BP	Q	65.0%	72.8%	★★	↑	54.3%	76.0%
CDC–E	Q,A	32.4%	52.6%	★★	↑	43.8%	70.6%
CDC–H8 (<8.0%)	Q	36.5%	45.3%	★★	↑	39.9%	59.1%
CDC–H9 (>9.0%)	Q	54.3%	46.0%	★★	↑	52.1%	29.1%
CDC–HT	Q,A	79.8%	82.1%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	29.2%	34.3%	★★	↔	27.3%	45.9%
CDC–LS	Q,A	76.4%	79.4%	★★	↔	70.4%	84.2%
CDC–N	Q,A	74.5%	80.1%	★★	↑	73.9%	86.9%
CIS–3	Q,A,T	74.2%	68.6%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	62.5%	--	Not Comparable	--	--
LBP	Q	71.9%	76.4%	★★	↑	72.3%	82.3%
MPM–ACE	Q	--	83.8%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	84.2%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	78.3%	81.3%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	61.1%	60.3%	★★	↔	59.6%	75.2%
W-34	Q,A,T	70.3%	69.1%	★★	↔	66.1%	82.9%
WCC–BMI	Q	62.3%	61.8%	★★	↔	19.7%	69.8%
WCC–N	Q	47.0%	51.6%	★★	↔	39.0%	72.0%
WCC–PA	Q	29.4%	38.4%	★★	↑	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS'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] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, KFHC's performance measures had average performance in 2012. Eight measures had a statistically significant increase in performance from 2011 to 2012, and no measures had a statistically significant decline in performance. The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure scored below the MPL for the second year in a row, and no measures scored above the HPLs.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above DHCS-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 (IP) to DHCS. For each area of deficiency, the plan must submit its steps to improve care to DHCS for approval.

HSAG compared the plan's 2011 IP (if one was required) with the plan's 2012 HEDIS rate for that measure 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.

KFHC had seven IPs in place during the review period. Below is a summary of each IP and HSAG's assessment of the progress the plan made toward achieving the MPLs on the measures.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

KFHC identified three main barriers that kept the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure from performing above the MPL in 2011:

- The plan had limited ability to identify providers with a low compliance rate on this measure, which made it difficult to know which providers needed to be educated on the specifications for this measure.
- Members have a tendency to demand that an antibiotic be prescribed as treatment for an acute bronchitis diagnosis.
- The plan had little ability to impact urgent care clinics and emergency rooms prescribing an antibiotic for an acute bronchitis diagnosis.

To address the identified barriers and improve the rate on this measure, KFHC focused on provider and member education. Provider education was targeted to providers who write a high number of prescriptions for antibiotics. Member education included targeted mailings and/or

telephone calls to members who received an antibiotic for acute bronchitis to educate them about bronchitis being a viral infection, which does not warrant a prescription for an antibiotic.

Despite the plan's efforts, performance on this measure declined slightly and remained below the MPL in 2012. KFHC will be required to continue this IP in 2013.

Adolescent Well-Care Visits

KFHC identified three barriers that kept the *Adolescent Well-Care Visits* measure from performing above the MPL in 2011:

- The plan had limited ability to identify providers with low compliance rates on this measure, which made it difficult to know which providers needed to be educated on the specifications for this measure.
- KFHC believed that to avoid discussing sensitive issues in front of their parents, some adolescents were seeking care through specialized services (e.g., family planning), and the plan was not notified of the visit because the adolescent did not provide insurance information.
- The targeted population had transportation challenges.

To address the barriers and improve the rate on this measure, KFHC implemented the following interventions:

- Providers were informed of their performance on this measure.
- A pay-for-performance program was implemented to provide an incentive to all primary care providers (PCPs) and/or OB/GYNs for each adolescent well-care visit completed.
- Transportation vouchers were offered to members to help them get to and from medical appointments.
- Targeted mailings were sent and/or telephone calls were made to members who had not been seen for their adolescent well-care visit to schedule the appointment.

The plan's efforts resulted in statistically significant improvement on this measure from 2011 to 2012, which led to the measure performing above the MPL. KFHC will not be required to submit an IP for this measure in 2013.

Comprehensive Diabetes Care

KFHC was required to submit IPs for three comprehensive diabetes care measures:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

KFHC identified several barriers to the three measures performing above the MPLs in 2011, including:

- Members were not educated on the importance of maintaining their annual diabetic retinal eye exam and diabetes screenings.
- The plan had limited ability to identify providers with low compliance rates on this measure, which made it difficult to know which providers needed to be educated on the specifications for this measure.
- The targeted population had transportation challenges.
- KFHC did not receive timely notification of members being diagnosed with diabetes.
- The plan had difficulty contacting members by mail and telephone to remind them to schedule their appointments because of the transient nature of the population.

To address the barriers and improve the rates on these measures, KFHC implemented several interventions, including:

- Educating members on the importance of getting their diabetic exams and screenings. This included:
  - Making telephone calls to newly enrolled members identified as being diabetic to confirm their PCP, assist with scheduling appointments, and educate them on the recommended diabetic screenings.
  - Sending a report card to members who were in the HEDIS 2011 comprehensive diabetes care population, indicating if they were compliant or not compliant with their diabetic screenings in 2011.
  - Providing daily health education messages through the plan's text message program.
- Providing free lenses and frames for all diabetic members who were seen for their diabetic eye exam.
- Offering transportation vouchers to members to help them get to and from their medical appointments.
- Giving feedback to providers on their performance on these measures.
- Providing an incentive to PCPs for each completed diabetic retinopathy exam and HbA1c test completed within the specified time frame.

KFHC's efforts resulted in statistically significant improvement on all three measures from 2011 to 2012 and performance above the MPLs. The plan will not be required to continue the IPs on these measures.

Use of Imaging Studies for Low Back Pain

KFHC was required to submit an IP in 2012 for the *Use of Imaging Studies for Low Back Pain* measure. The plan indicated that the barrier to this measure performing above the MPL in 2011 was the plan's limited ability to identify providers that had low compliance with this measure.

To address the barrier, KFHC's medical director met with selected providers to notify them of their performance on this measure, and all providers received written reports showing their performance on the use of imaging studies for low back pain. Additionally, the plan implemented a pay-for-performance program where all PCPs were paid an incentive for patients with a principal diagnosis of low back pain who did not have an imaging study within 28 days of diagnosis.

KFHC's efforts resulted in statistically significant improvement on this measure from 2011 to 2012 and performance above the MPL in 2012. The plan will not be required to continue this IP.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

KFHC was required to submit an IP in 2012 for the *Timeliness of Prenatal Care* measure. The plan identified several barriers to this measure performing above the MPL in 2011, including:

- Members were not educated on the importance of prenatal care.
- Providers lacked the knowledge of what constitutes a complete prenatal visit as defined in the HEDIS specifications.
- The plan had limited ability to identify providers with low compliance rates on this measure, which made it difficult to know which providers needed to be educated on the specifications for this measure.
- The targeted population had transportation challenges.
- KFHC did not receive timely notification of all newly pregnant members.

To address the barriers and improve the rates on these measures, KFHC implemented several interventions, including:

Member-Focused Interventions

- Educating members through a 30-second television commercial on the importance of seeking prenatal care within the first 12 weeks of gestation. The commercial was aired in English and Spanish.
- Implementing an obstetrician (OB) case management project to ensure pregnant members were established with an OB, enrolled in the Women, Infants, and Children (WIC) Program, aware of KFHC's contract delivery hospitals, and informed of the benefits of breastfeeding.

- Offering transportation vouchers to members to help them get to and from their medical appointments.
- Using laboratory data to identify all positive pregnancy tests and contacting all newly pregnant members to educate them on the importance of being seen for prenatal care.

Provider-Focused Interventions

- Educating OBs and OB office managers through provider bulletins on the importance of seeing pregnant members within the first trimester.
- Providing an incentive to PCPs and OB/GYNs for each prenatal visit completed within the first trimester.

KFHC's efforts resulted in slight improvement on this measure from 2011 to 2012 and performance above the MPL in 2012. The plan will not be required to continue this IP.

Strengths

KFHC had eight measures with statistically significant improvement from 2011 to 2012. The plan had seven IPs, and six were successful at bringing the performance measure rates above the MPLs in 2012.

Opportunities for Improvement

The plan has the opportunity to identify factors that led to continued poor performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, since 2012 was the second consecutive year in which this measure performed below 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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* 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 plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about KFHC's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Project Objectives

KFHC had two clinical QIPs and two clinical QIP proposals in progress during the review period of July 1, 2011–June 30, 2012. All four QIPs fell under the quality and access domains of care.

The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the current DHCS statewide collaborative QIP. 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. At the initiation of the QIP, KFHC had identified 6,183 ER visits that were avoidable, which was 15.9 percent of the plan's ER visits. KFHC's objective was to reduce this rate by implementing both member and provider improvement strategies. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative which focused on reducing readmissions for members aged 21 years and older. The new statewide collaborative proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. 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.

The goal for KFHC's current diabetes project was to improve the health care services provided to diabetic members 18 to 75 years of age. The plan attempted to increase HbA1c testing, LDL-C screening, and retinal eye exams to minimize the development of diabetes complications. Due to delayed implementation of its interventions, the diabetes QIP was closed after the current submission; however, the plan worked with DHCS and HSAG to continue the QIP topic under a new QIP. The new diabetes QIP proposal maintained the same focus on increasing HbA1c testing, LDL-C screening, and retinal eye exams while establishing a new measurement timeline that will allow for the timely implementation of the plan's improvement strategies. 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 diabetics may indicate suboptimal care and case management.

Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Kern Family Health Care—Kern County July 1, 2011, through June 30, 2012

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 ER Visits	Annual Submission	95%	100%	*Met*
*All-Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIPs				
Comprehensive Diabetes Care	Annual Submission	80%	69%	*Partially Met*
	Resubmission 1	92%	100%	*Met*
Comprehensive Diabetic Quality Improvement Plan	Proposal	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a 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 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*.

*During the review period, the *All-Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that the initial submission of KFHC's *Reducing Avoidable Emergency Room Visits* QIP and its *Comprehensive Diabetic Quality Improvement Plan* QIP proposal both received an overall validation status of *Met*. For its ongoing *Comprehensive Diabetes Care* QIP, KFHC's annual submission received a *Partially Met* validation status. As of July 1, 2009, DHCS began requiring plans to resubmit their QIPs until they achieved an overall *Met* validation status. The plan incorporated the validation feedback and upon resubmission, received a *Met* validation status. For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score

Due to unique, one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

Table 4.2 summarizes the aggregate validation results for KFHC's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Kern Family Health Care—Kern County (Number = 4 QIP Submissions, 2 QIP Topics) July 1, 2011, through June 30, 2012

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)**	88%	13%	0%
	III: Clearly Defined Study Indicator(s)	96%	4%	0%
	IV: Correctly Identified Study Population	82%	18%	0%
Design Total		**94%**	**6%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	96%	0%	4%
	VII: Appropriate Improvement Strategies	90%	10%	0%
Implementation Total		**96%**	**2%**	**2%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	92%	8%	0%
	IX: Real Improvement Achieved	50%	0%	50%
	X: Sustained Improvement Achieved	33%	0%	67%
Outcomes Total**		**76%**	**5%**	**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 stage and/or activity totals may not equal 100 percent due to rounding.

KFHC submitted Remeasurement 2 data for the *Comprehensive Diabetes Care* QIP and Remeasurement 3 data for the *Reducing Avoidable Emergency Room Visits* QIP; therefore, HSAG validated Activity I through Activity X. The *Comprehensive Diabetic Quality Improvement Plan* QIP proposal progressed through Activity V. KFHC demonstrated an accurate application of the design stage and received *Met* scores for 94 percent of all applicable evaluation elements. Similarly for the implementation stage, the plan received *Met* scores for 96 percent of the applicable evaluation elements.

For the outcomes stage, KFHC was scored lower in Activity IX for its *Comprehensive Diabetes Care* QIP since the project outcomes did not demonstrate statistically significant improvement. Additionally in Activity X for the same QIP, since the plan never demonstrated improvement of its outcomes, it could not achieve sustained improvement. 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 and Interventions

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 Kern Family Health Care—Kern County July 1, 2011, through June 30, 2012

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**	**Remeasurement 3 1/1/10–12/31/10**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable^	15.9%	16.9%*	14.7%*	13.3%*	Yes
QIP #2—Comprehensive Diabetes Care					
QIP Study Indicator		**Baseline Period 1/1/08–12/31/08**	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Sustained Improvement¥**
The percentage of diabetic members 18–75 years of age who received an HbA1c test during the measurement year		79.8%	79.9%	79.8%	No
The percentage of diabetic members 18–75 years of age who received an LDL-C screening during the measurement year		76.4%	77.2%	76.4%	No
The percentage of diabetic members 18–75 years of age who received a retinal eye exam during the measurement year or a negative retinal exam in the year prior to the measurement year		34.1%	35.2%	32.4%	No

Table 4.3—Quality Improvement Project Outcomes for Kern Family Health Care—Kern County July 1, 2011, through June 30, 2012

QIP #3—Comprehensive Diabetic Quality Improvement Plan				
QIP Study Indicator	**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¥**
The percentage of diabetic members 18–75 years of age who received an HbA1c test during the measurement year	‡	‡	‡	‡
The percentage of diabetic members 18–75 years of age who received an LDL-C screening during the measurement year	‡	‡	‡	‡
The percentage of diabetic members 18–75 years of age who received a retinal eye exam during the measurement year or a negative retinal exam in the year prior to the measurement year	‡	‡	‡	‡

^A lower rate indicates better performance.

¥ 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.

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

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

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, KFHC set an overall objective to decrease the rate of avoidable ER visits by at least 3 percent. For this project outcome, a lower rate demonstrates improved performance. The plan met its overall objective; it reduced the percentage of avoidable ER visits by a statistically significant amount from the first to the second remeasurement period (2.2 percentage points) and then again from the second to the third remeasurement period (1.4 percentage points). The third remeasurement period rate remained below the baseline rate, demonstrating sustained improvement for the project.

While the plan achieved statistically significant improvement for two remeasurement periods, there was a statistically significant decline in performance from baseline to the first remeasurement period. A critical analysis of the plan's improvement strategy allowed for the following observations:

- The plan did not document a complete barrier analyses process and analyses results for each measurement period, although the plan did include the results of the member and provider surveys.

- Collaborative interventions were initiated in early 2009 and potentially correspond to the improvement in performance. In 2010, the plan documented success with the plan-hospital data collection collaborative intervention. KFHC received 100 percent of the ER visit data from the participating hospital within 5 days of the ER visit. The plan reported contacting approximately 92 percent of the members within 14 days of their ER visit. The rate of avoidable ER visits at the participating hospital was significantly lower than the plan's overall rate (11.7 percent versus 13.3 percent).
- Plan-specific interventions were limited in number and scope. The plan listed provider and member newsletters as a primary method to provide education related to avoidable ER visits. Additionally, the plan referred to the Member Handbook as an additional source of information related to the use of the ER. The plan did not evaluate the effectiveness of any of its plan-specific interventions.
- The plan reported the lack of urgent care centers as an initial barrier to reducing avoidable ER visits; however, the plan only documented trying to negotiate contracts with more urgent care centers and never reported success in obtaining any new contracts. Although the plan identified its requirement of preauthorization for urgent care as a barrier in 2010, removing the prior authorization process did not begin until October 2011.

Comprehensive Diabetes Care QIP

For the *Comprehensive Diabetes Care* QIP, the plan's objective was to increase HbA1c testing and retinal eye exams by 20 to 25 percent and to increase LDL-C screening by at least 10 percent. The plan did not achieve its objectives. From baseline to the final remeasurement period, the plan did not report statistically significant improvement for any of the study outcomes. Without first achieving statistically significant improvement, the plan was unable to demonstrate sustained improvement for the project. A critical analysis of the plan's improvement strategy allowed for the following observations:

- The plan did not document a complete barrier analyses process and analyses results for each measurement period.
- The majority of the interventions consisted of newsletters and bulletins to members and providers, which were repeated in subsequent years without any way to measure the impact of the interventions.
- Disease Management staff members were used to contact the members regarding required testing, although the plan reported that successful contact with members was minimal. Disease Management staff members also interacted with and educated providers regarding American Diabetes Association (ADA) recommendations; however, HEDIS rates were not shared with the providers.

- The plan's targeted opening of a diabetic clinic during the project was delayed, and its initial offering of services was limited. The plan reported that it would require more time before the diabetic clinics would be fully operational and able to provide education, monitoring, and timely treatment to diabetic members.

Comprehensive Diabetic Quality Improvement Plan QIP

With approval for this new *Comprehensive Diabetic Quality Improvement Plan* QIP proposal that addresses the same three HEDIS measure outcomes as the prior diabetes QIP, KFHC was able to confirm that it will have a strong improvement strategy in place with the implementation of interventions beginning in CY 2012.

Strengths

KFHC accurately documented the activities for the design and implementation stages.

Additionally, over the course of the *Reducing Avoidable Emergency Room Visits* QIP, KFHC significantly reduced the percentage of avoidable ER visits for its members in Kern County by 2.6 percentage points.

Opportunities for Improvement.

KFHC has an opportunity to improve its intervention strategies to achieve sustained improvement in QIP outcomes. At a minimum, barrier analysis should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone. Barrier analyses should be data-driven.

As part of the barrier analyses, the plan should conduct subgroup analyses to determine if the outcomes differ by gender, age, provider, and/or other selected groupings, which will enable the plan to develop targeted interventions to groups with lower performance related to the outcomes. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

KFHC should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine whether to modify, discontinue, or implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care. A more detailed description of HSAG's scoring process is included in Appendix A.

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for its MCMC members through the provision of health care services and the plan's structural and operational characteristics.

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries 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, 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.

Overall, KFHC demonstrated average performance in the quality domain of care. HSAG reviewed the plan's Quality Improvement Program Description, which describes a structure that supports the delivery of quality health care services to MCMC members. In addition, the plan was fully compliant with all medical performance reviews with no deficiencies.

KFHC showed substantial improvement in the area of performance measures. Eight measures falling into the quality domain of care had statistically significant improvement from 2011 to 2012, and no quality measures had a statistically significant decline in performance. Between 2011 and

2012, KFHC improved six of seven performance measure rates that scored below the 2011 MPLs, resulting in rates above the 2012 MPLs for these measures.

The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, which falls under the quality domain of care, performed below the MPL for the second straight year and continues to present an opportunity for improvement.

KFHC's QIPs all fell under the quality domain of care. The plan demonstrated understanding of the QIP design and implementation stages. Additionally, the plan significantly reduced the percentage of avoidable ER visits for the plan's members in Kern County and demonstrated sustained improvement for the *Reducing Avoidable Emergency Room Visits* QIP.

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 MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and 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. Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Overall, KFHC demonstrated average performance in the access domain of care. Three measures falling into the access domain of care had statistically significant improvement from 2011 to 2012, and no access measures had statistically significant decline in performance. The plan was required to submit IPs for three access measures with rates below the MPLs in 2011, and the rates on all three measures improved to above the MPLs in 2012.

In addition to falling under the quality domain of care, KFHC's QIPs fell under the access domain of care. As indicated above, the *Reducing Avoidable Emergency Room Visits* QIP demonstrated sustained improvement, suggesting that for conditions more appropriately managed by a PCP, members are accessing their PCP for care rather than the ER.

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.

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.

Overall, KFHC demonstrated average performance in the timeliness domain of care. No deficiencies in areas impacting the timelines domain of care were identified in the most recent June 2012 MR/PIU review, and deficiencies from the 2007 medical performance review in the areas of Utilization Management and Member Rights were fully resolved.

One measure falling into the timeliness domain of care had statistically significant improvement from 2011 to 2012, and no timeliness measures had statistically significant decline in performance. The plan was required to submit IPs for two measures falling into the timeliness domain of care with rates below the MPLs in 2011, and the rates on all three measures improved to above the MPLs in 2012.

Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. KFHC's self-reported responses are included in Appendix B.

Recommendations

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

- Assess the factors that are leading to a continued decline in performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure and identify interventions to be implemented that will result in an improvement on performance.

- Perform QIP barrier analyses to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone. Additionally, barrier analyses should be data-driven.
- As part of the QIP barrier analyses, conduct subgroup analyses to determine if the outcomes differ by gender, age, provider, and/or other selected groupings, which will enable the plan to develop targeted interventions to groups with lower performance related to the outcomes. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.
- Ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine whether to modify, discontinue, or implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

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

Quality, Access, and Timeliness

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

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) greater than negative three, if there are two or less measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than three.
3. To be considered ***Below Average***, a plan will have three or more measures below the MPLs than it has above the HPLs.

Access Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus and the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Timeliness Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

- **Validation** *(Table 4.1)*: For each QIP submission and subsequent resubmission(s), if applicable.
  - **Above Average** is not applicable.
  - **Average** = *Met* validation status.
  - **Below Average** = *Partially Met* or *Not Met* validation status.
- **Outcomes** *(Table 4.3)*: Activity IX, Element 4—**Real Improvement**
  - **Above Average** = All study indicators demonstrated statistically significant improvement.
  - **Average** = Not all study indicators demonstrated statistically significant improvement.
  - **Below Average** = No study indicators demonstrated statistically significant improvement.

- **Sustained Improvement** *(Table 4.3)*: Activity X—**Achieved Sustained Improvement**
  - **Above Average =** All study indicators achieved sustained improvement.
  - **Average =** Not all study indicators achieved sustained improvement.
  - **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 performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity 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.

Appendix B. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

for **Kern Family Health Care**

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with KFHC's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table B.1—Grid of KFHC's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	KFHC's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Focus improvement efforts on the *Comprehensive Diabetes Care* QIP, analyze and evaluate the improvement plans, and measure effectiveness of the strategies and interventions.	KHS rates increased and exceeded the minimum performance level (MPL) for all eight indicators in the *Comprehensive Diabetes Care* measure for HEDIS 2012. Three of these indicators, Eye Exam (Retinal) Performed, Hemoglobin A1c (<8.0%), and HbA1c Poor Control fell below the MPLs for HEDIS 2011. KHS saw a significant rate increase in the Exam (Retinal) Performed and the HbA1c Poor Control indicators for HEDIS 2012. KHS assessed that the targeted mailings (member report card) that detailed member compliance as of the beginning of the fourth quarter 2011 were deemed successful. In addition, the providers were given a report based on the previous year's HEDIS compliance rate in all reported measures. The continuation of the Disease Management program that contacts all diabetic members and educates on the importance of diabetic screenings, assists members in scheduling their PCP visits and/or specialty appointments, and offers diabetic services also impacted the HEDIS 2012 rates.
Reduce the amount of measures that fall below the MPLs by using 2011 data to focus efforts on 2012 HEDIS performance.	KHS reduced the number of measures that fell below the MPLs from seven to one: • *Comprehensive Diabetes Care* measure (three indicators in this measure fell below the MPLs for HEDIS 2011)—the member report card, HEDIS provider compliance rate report, and Disease Management Program increased the rates for the three measures. • *Use of Imaging Studies for Low Back Pain*—the HEDIS provider compliance rate report intervention implemented was deemed successful, for the rate exceeded the MPL for HEDIS 2012. • *Timeliness of Prenatal Care*—the HEDIS provider compliance rate report cards and the OB Case Management program was successful, for these interventions contributed to the rate increase and also helped the measure exceed the MPL for HEDIS 2012. • *Adolescent Well-Care Visits*—the HEDIS provider compliance rate report card intervention implemented was successful, for the rate exceeded the MPL for HEDIS 2012.
Review HSAG's QIP Completion Instructions to ensure all required elements within activities are addressed to improve the plan's QIP documentation and increase compliance with validation requirements.	KHS continues to review the QIP completion instructions during each submission to ensure that all required elements within the activities are addressed. In addition to reviewing the completion instructions, KHS will review all previous validation reports and ensure all elements are met. KHS completed/closed the Diabetes QIPs and received an overall status of *Met* from the EQRO in November 2011. KHS planned on continuing the Diabetes QIP and submitted the proposal for validation and was approved in May 2012 by both MMCD and the EQRO. The proposal received a validation status of *Met* and receiving 100% in both the evaluation elements and critical elements sections.

Table B.1—Grid of KFHC's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	KFHC's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Use a *Point of Clarification* to address all elements scored *Met* to prevent those scores from being lowered to a *Partially Met* or *Not Met* score in subsequent validations.	KHS will review all previous validation reports to identify if any Point of Clarification comments are made and ensure to address these comments. KHS makes all efforts to address the Point of Clarifications comments in order to prevent scores from being lowered to a *Partially Met* or *Not Met* score for the new submission. In addition, KHS will continue to review QIP completion instructions prior to each submission to ensure that all required elements within the activities are addressed.
Perform a barrier analysis to identify and prioritize barriers in each measurement period to improve intervention strategies and QIP outcomes.	The Disease Management staff identified that many members did not know the difference between a routine eye exam and a diabetic (retinal) eye exam. In order to reduce this barrier, the DM staff would assist members in scheduling their appointments for their diabetic eye exam and mail out a reminder notice. In addition, the DM staff would contact the member the day prior to remind them of their appointment. A follow-up would be attempted after the appointment to ensure compliance. If the member did not go to his or her appointment, the process would start all over until the member was compliant. KHS identified that the Risk Pool process was unfavorable among the providers. KHS began planning the Pay for Performance Program, which is a more transparent program that will incentivize providers quarterly on a claims based payment. KHS also conducted a survey with diabetic members regarding alternative methods of receiving daily health messages; therefore, KHS began planning a Text Message Pilot Program.
Evaluate the efficacy of interventions using subgroup analysis to determine if initiatives are affecting the whole study population in the same way, evaluate outcomes by selected subgroups, identify any disparities that exist in the study population as they pertain to study outcomes, and make the necessary revisions in the QIP interventions while clearly documenting the process used.	KHS conducted subgroup analysis of the HEDIS 2012 *Comprehensive Diabetes Care* measure for three of the administrative screening indicators (HbA1c Testing, LDL-C Screening and Diabetic "Retinal" Eye Exam Screening) to determine if the initiatives are affecting the whole study population and the findings are as follows: KHS concluded that there were no disparities in compliance between the male and female population for the three screenings. The rates for the screenings were all within three percentage points. KHS learned that members 18-39 years of age had lower compliance rates in the three screenings compared to members greater than 40 years of age. KHS learned that members that reside in some of the outlying areas such as Wasco, Shafter, McFarland, and Delano have some of the lowest compliance rates in completing these screenings.

Table B.1—Grid of KFHC's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	KFHC's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
	KHS began the planning stages of implementing two new pilot programs: • Text Message Pilot program—to be designed to target members (based on survey results) ages 19-49 years of age that are willing to receive daily health messages via text message. • Delano Regional Medical Center Diabetic Clinic—the plan will establish a clinic in Delano for members to receive comprehensive preventative and pharmacological intervention including nutrition classes, Pharm-D counseling, foot and eye exams, and lab specimen acquisition that reside in outlying areas.