

Performance Evaluation Report  
Kaiser–San Diego County (KP Cal, LLC)  
July 1, 2011–June 30, 2012

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

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# Performance Evaluation Report – Kaiser–San Diego County

July 1, 2011 – June 30, 2012

## 1. INTRODUCTION

### 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)<sup>1</sup> 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<sup>2</sup> 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.

<sup>1</sup> *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.

<sup>2</sup> 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, KP Cal, LLC, in San Diego County (commonly known as "Kaiser Permanente South" and referred to in this report as "Kaiser–San Diego County" or "the plan"), which delivers care in San Diego 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

KP Cal, LLC, (Kaiser Permanente's California Medicaid line of business) is a full-scope managed care plan that contracts with DHCS separately in Sacramento and San Diego counties. KP Cal, LLC, previously operated a pre-paid health plan, Kaiser PHP, in Marin and Sonoma counties. The DHCS KP Cal, LLC, contracts for Marin and Sonoma counties ended when Partnership HealthPlan of California (PHP), a County Organized Health System (COHS), became operational in Sonoma County in October 2009 and in Marin County in July 2011. Although KP Cal, LLC, serves Medi-Cal beneficiaries in these two counties as a subcontractor to PHP, HSAG's assessment for this report is limited to the contracting plan, not the subcontractors. Therefore, reports for KP Cal, LLC, will no longer include Kaiser PHP in Marin and Sonoma counties.

This report pertains to the San Diego County plan for KP Cal, LLC (Kaiser–San Diego County). Kaiser–San Diego County serves members in San Diego County as a commercial plan under a Geographic Managed Care (GMC) Model. In the GMC Model, DHCS contracts with several commercial health plans within a specified geographic area. This provides MCMC enrollees with more choices.

Kaiser–San Diego County became operational in San Diego County to provide MCMC services in August 1998. As of June 30, 2012, Kaiser–San Diego County had 13,779 MCMC members.<sup>3</sup>

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<sup>3</sup> *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 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. 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 routine medical performance review of Kaiser–San Diego County was completed in February 2007, covering the review period of July 1, 2005, through June 30, 2006. HSAG initially reported findings from this review in Kaiser–San Diego County’s 2008–2009 plan-specific evaluation report.<sup>4</sup>

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 the exception of one unresolved issue in the area of Utilization Management concerning review by a qualified physician for chiropractic denials.

Since the medical performance audit was conducted more than three years prior to the review period for this report, HSAG includes a summary of findings in this report for historical purposes of the most current audit; however, HSAG does not include these outdated results when assessing overall plan performance during the review period.

Additionally, the Department of Managed Health Care conducted a routine medical survey of Kaiser Foundation Health Plan in November 2008 and a follow-up review for a non-routine medical survey in 2009 for the Southern Region; however, these audit results are not specific to Medi-Cal managed care and therefore are not included within 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.

<sup>4</sup> California Department of Health Care Services. *Performance Evaluation Report—Kaiser Permanente (KP Cal, LLC), San Diego County, July 1, 2008 – June 30, 2009*. December 2010. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>.



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.

The most recent MR/PIU review with Kaiser–San Diego County was conducted in August 2011, covering the review period of June 1, 2009, through May 31, 2011. The scope of the review included Grievances, Prior Authorization Notification, Cultural and Linguistic Services, and the False Claims Act. HSAG initially reported on the findings from this review in Kaiser–San Diego County's 2010–2011 plan-specific evaluation report.

Kaiser–San Diego County was not required to respond to the findings. MR/PIU will follow up with the plan on the findings during its next review. Listed below are the findings:

- ◆ In the area of Grievances, of the 100 grievance files reviewed, two were missing the required acknowledgement letters.
- ◆ In the area of Prior Authorization Notification, of the 72 prior authorization files reviewed, one contained a notice of action (NOA) letter that was mailed out to the member outside the three-day required time frame. Additionally, two of the 72 files reviewed contained a prior authorization notification that was sent to the member outside the 14-day required time frame.

HSAG found the following information regarding actions the plan has taken that appear to address the finding in the area of Grievances:

- ◆ Kaiser–San Diego County's self-report indicates that acknowledgement letters are sent out within five days of notice and tracked for compliance. The notification includes information about member rights, including State fair hearings. Additionally, Kaiser–San Diego County's 2012 Quality Program Description report indicates that health plan representatives have a goal to resolve member grievances by the end of the next business day or within five calendar days as noted above. If complaints and grievances cannot be resolved within five days, the case will be transferred to the Member Case Resolution Center (MCRC).

## Strengths

Kaiser–San Diego County has worked to address the MR/PIU finding identified in the area of Grievances.

## Opportunities for Improvement

Kaiser–San Diego County has an opportunity to address the finding within the area of Prior Authorization Notification. Kaiser–San Diego County should provide clarification on how NOA letters are managed within the plan’s system, along with prior authorization letters in general.



## 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®)<sup>5</sup> 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 Kaiser–San Diego County in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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<sup>5</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

**Performance Measure Validation Findings**

HSAG auditors determined that Kaiser–San Diego County followed the appropriate specifications to produce valid rates, and no issues were identified that affected the validity of reported measures. HSAG auditors provided the following observations and recommendations to the plan:

- ◆ Kaiser–San Diego County implemented a questionnaire during member visits to boost the rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents— Nutrition Counseling: Total* and *Physical Activity Counseling: Total* measures. The process for conducting and using the questionnaire and code mapping was reviewed and approved; however, the HSAG auditor recommended that the plan formally document this process in subsequent years.
- ◆ Despite the low volume of claims received by Kaiser–San Diego County, the plan should ensure that denied claims are used consistent with the technical specifications for measures.

**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	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
ACR	<i>All-Cause Readmissions (internally developed measure)</i>
AMB–ED	<i>Ambulatory Care—Emergency Department (ED) Visits</i>
AMB–OP	<i>Ambulatory Care—Outpatient Visits</i>
AWC	<i>Adolescent Well-Care Visits</i>
CAP–1224	<i>Children and Adolescents’ Access to Primary Care Practitioners (12–24 Months)</i>
CAP–256	<i>Children and Adolescents’ Access to Primary Care Practitioners (25 Months–6 Years)</i>
CAP–711	<i>Children and Adolescents’ Access to Primary Care Practitioners (7–11 Years)</i>
CAP–1219	<i>Children and Adolescents’ Access to Primary Care Practitioners (12–19 Years)</i>
CCS	<i>Cervical Cancer Screening</i>
CDC–BP	<i>Comprehensive Diabetes Care (CDC)—Blood Pressure Control (&lt;140/90 mm Hg)</i>
CDC–E	<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>
CDC–H8 (<8.0%)	<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (&lt; 8.0 Percent)</i>
CDC–H9 (>9.0%)	<i>Comprehensive Diabetes Care—HbA1c Poor Control (&gt; 9.0 Percent)</i>
CDC–HT	<i>Comprehensive Diabetes Care—HbA1c Testing</i>
CDC–LC (<100)	<i>Comprehensive Diabetes Care—LDL-C Control (&lt;100 mg/dL)</i>
CDC–LS	<i>Comprehensive Diabetes Care—LDL-C Screening</i>
CDC–N	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>
CIS–3	<i>Childhood Immunization Status—Combination 3</i>
IMA–1	<i>Immunizations for Adolescents—Combination 1</i>

**Table 3.1—Performance Measures Name Key**

Abbreviation	Full Name of 2012 Performance Measure
LBP	<i>Use of Imaging Studies for Low Back Pain</i>
MPM–ACE	<i>Annual Monitoring for Patients on Persistent Medications—ACE</i>
MPM–DIG	<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>
MPM–DIU	<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>
PPC–Pre	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>
PPC–Pst	<i>Prenatal and Postpartum Care—Postpartum Care</i>
W-34	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
WCC–BMI	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>
WCC–N	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>
WCC–PA	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>

Table 3.2 presents a summary of Kaiser–San Diego County’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 Kaiser–San Diego County

Performance Measure <sup>1</sup>	Domain of Care <sup>2</sup>	2011 HEDIS Rates <sup>3</sup>	2012 HEDIS Rates <sup>4</sup>	Performance Level for 2012	Performance Comparison <sup>5</sup>	DHCS's Minimum Performance Level <sup>6</sup>	DHCS's High Performance Level (Goal) <sup>7</sup>
AAB	Q	20.5%	38.3%	★★★	↑	18.8%	31.6%
AMB–ED	‡	--	37.2	--	Not Comparable	--	--
AMB–OP	‡	--	478.5	--	Not Comparable	--	--
AWC	Q,A,T	44.0%	51.2%	★★	↑	39.6%	64.1%
CAP–1224	A	--	99.5%	--	Not Comparable	--	--
CAP–256	A	--	94.4%	--	Not Comparable	--	--
CAP–711	A	--	94.5%	--	Not Comparable	--	--
CAP–1219	A	--	96.5%	--	Not Comparable	--	--
CCS	Q,A	84.3%	85.0%	★★★	↔	64.0%	78.7%
CDC–BP	Q	85.8%	88.0%	★★★	↔	54.3%	76.0%
CDC–E	Q,A	77.1%	75.2%	★★★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	65.5%	69.7%	★★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	21.2%	19.0%	★★★	↔	52.1%	29.1%
CDC–HT	Q,A	94.0%	96.2%	★★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	66.5%	69.4%	★★★	↔	27.3%	45.9%
CDC–LS	Q,A	93.6%	95.2%	★★★	↔	70.4%	84.2%
CDC–N	Q,A	94.6%	95.2%	★★★	↔	73.9%	86.9%
CIS–3	Q,A,T	84.1%	87.0%	★★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	88.3%	--	Not Comparable	--	--
LBP	Q	84.2%	76.0%	★★	↔	72.3%	82.3%
MPM–ACE	Q	--	92.2%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	91.7%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	89.2%	94.7%	★★★	↑	80.3%	93.2%
PPC–Pst	Q,A,T	68.5%	73.2%	★★	↔	59.6%	75.2%
W-34	Q,A,T	64.6%	68.6%	★★	↑	66.1%	82.9%
WCC–BMI	Q	98.1%	97.8%	★★★	↔	19.7%	69.8%
WCC–N	Q	51.2%	65.1%	★★	↑	39.0%	72.0%
WCC–PA	Q	59.8%	76.3%	★★★	↑	28.5%	60.6%

<sup>1</sup> DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).  
<sup>2</sup> HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).  
<sup>3</sup> HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.  
<sup>4</sup> HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.  
<sup>5</sup> Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.  
<sup>6</sup> 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.  
<sup>7</sup> 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**

Kaiser–San Diego County continues to demonstrate excellent performance on the required measures, which span all three domains of care. Fourteen measures performed above the HPLs, and no measures performed below the MPLs. The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which performed below the MPL in 2011, had statistically significant improvement from 2011 to 2012, moving performance to above the MPL. Five other measures had statistically significant improvement from 2011 to 2012, and no measures had a statistically significant decline in performance.

### **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.

Kaiser–San Diego County was required to continue the IP for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in 2012. Below is a summary of the IP and HSAG's analysis of the progress the plan made on improving performance on the measure.

### ***Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life***

Kaiser–San Diego County indicated that the interventions to address poor performance on this measure were implemented too late in the year to positively impact the 2012 rate for this measure.

The plan continued the following interventions from 2011:

- ◆ Had an increased clinical focus on annual preventive and well-child care and reporting on progress at reaching goals at monthly provider meetings.
- ◆ Developed monthly outreach lists of members who met measurement criteria.
- ◆ Made up to three outreach telephone calls to members to schedule their well-child visits. Members who did not schedule an appointment as a result of the outreach calls were sent a mailing reminding them to schedule their appointment.
- ◆ Distributed well-child visit schedules to parents.

The following new interventions were implemented in 2012:

- ◆ Added information about well-child visits to the outreach list so staff members making outreach calls could remind members to schedule the well-child appointments.
- ◆ Evaluated the option of implementing automated telephone appointment reminders.

The plan's interventions were successful. The rate on this measure had statistically significant improvement from 2011 to 2012 and improved from performing below the MPL to above the MPL.

## Strengths

Kaiser–San Diego County continues to demonstrate excellent performance on providing quality, accessible, and timely services to members. Most measures performed above the HPLs, and no measures performed below the MPLs. The plan was able to successfully execute the IP for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, moving performance from below the MPL in 2011 to above the MPL in 2012.

## Opportunities for Improvement

Kaiser–San Diego County has an opportunity to formally document a process for conducting and using a questionnaire for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* and *Physical Activity Counseling: Total* measures if the plan will use it in subsequent years. In addition, the plan should ensure that denied claims are used consistent with the technical specifications when calculating rates, as this might have a slight impact of underreporting.

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

### Quality Improvement Project Objectives

Kaiser–San Diego County had four clinically-focused QIPs in progress during the review period of July 1, 2011, through June 30, 2012.

Two of the four QIPs were statewide collaborative QIPs. 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. The 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, Kaiser–San Diego County had identified 534 ER room visits that were avoidable, which was 11.5 percent of its ER visits. The plan's objective was to reduce this rate by using member, provider, and system 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 QIP, which focused on reducing readmissions for members aged 21 years and older. The new collaborative QIP 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.

Kaiser–San Diego County’s current internal QIP, *Improving Postpartum Care*, targeted increasing the rate of postpartum visits for women between 21 and 56 days after delivery. When the QIP began, only 50.5 percent of the eligible women were receiving timely postpartum care. Ensuring that women have the appropriate follow-up care after delivery is important to the physical and mental health of the mother.

The plan’s *Children and Adolescents’ Access to PCP* QIP focused on children’s and adolescents’ access to primary care providers (PCP). This new QIP proposal targeted children 25 months to 6 years of age and sought to increase the percentage of these children who had a visit with a PCP. An annual visit with a PCP indicates the ability to access care and provides the proper care setting to receive preventive services.

All four QIPs fell under the quality and access domains of care. Additionally, the *Improving Postpartum Care* QIP fell under the timeliness domain of care.

**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 Kaiser–San Diego County July 1, 2011, through June 30, 2012**

Name of Project/Study	Type of Review <sup>1</sup>	Percentage Score of Evaluation Elements <i>Met</i> <sup>2</sup>	Percentage Score of Critical Elements <i>Met</i> <sup>3</sup>	Overall Validation Status <sup>4</sup>
<b>Statewide Collaborative QIP</b>				
<i>Reducing Avoidable ER Visits</i>	Annual Submission	85%	100%	<i>Met</i>
<i>All-Cause Readmissions*</i>	Proposal	Not Applicable	Not Applicable	<i>Pass</i>
<b>Internal QIPs</b>				
<i>Improving Postpartum Care</i>	Annual Submission	32%	45%	<i>Not Met</i>
	Resubmission 1	79%	100%	<i>Partially Met</i>
	Resubmission 2	82%	100%	<i>Met</i>
<i>Children and Adolescents’ Access to Primary Care Practitioners (PCP)</i>	Proposal	100%	100%	<i>Met</i>
<sup>1</sup> <b>Type of Review</b> —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 <i>Met</i> validation status. <sup>2</sup> <b>Percentage Score of Evaluation Elements <i>Met</i></b> —The percentage score is calculated by dividing the total elements <i>Met</i> (critical and noncritical) by the sum of the total elements of all categories ( <i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i> ). <sup>3</sup> <b>Percentage Score of Critical Elements <i>Met</i></b> —The percentage score of critical elements <i>Met</i> is calculated by dividing the total critical elements <i>Met</i> by the sum of the critical elements <i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i> . <sup>4</sup> <b>Overall Validation Status</b> —Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> . *During the review period, the <i>All-Cause Readmissions</i> QIP was reviewed as a <i>Pass/Fail</i> 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 Kaiser–San Diego County’s annual submission of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. Similarly, its *Children and Adolescents’ Access to PCP* QIP proposal received an overall validation status of *Met*. Kaiser–San Diego County’s initial submission of its *Improving Postpartum Care* QIP received a *Not Met* validation status. The plan had not addressed prior recommendations and inaccurately documented a different method of data collection than it had reported in the prior submission. As of July 1, 2009, DHCS began requiring plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback and HSAG technical assistance, the plan resubmitted the QIP and received a *Partially Met*

validation status. While the plan had addressed all of the critical evaluation elements, it had not addressed all of the elements with deficiencies. With its second resubmission of the QIP, the plan addressed one additional evaluation element and achieved an overall *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 Kaiser–San Diego County’s QIPs across CMS protocol activities during the review period.

**Table 4.2—Quality Improvement Project Average Rates\* for Kaiser–San Diego County  
(Number = 5 QIP Submissions, 3 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	93%	0%	7%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	97%	3%	0%
	IV: Correctly Identified Study Population	86%	14%	0%
<b>Design Total</b>		<b>94%</b>	<b>4%</b>	<b>2%</b>
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	54%	8%	38%
	VII: Appropriate Improvement Strategies	69%	23%	8%
<b>Implementation Total</b>		<b>59%</b>	<b>13%</b>	<b>28%</b>
Outcomes	VIII: Sufficient Data Analysis and Interpretation	34%	25%	41%
	IX: Real Improvement Achieved	56%	0%	44%
	X: Sustained Improvement Achieved	50%	0%	50%
<b>Outcomes Total**</b>		<b>42%</b>	<b>15%</b>	<b>42%</b>
*The activity average rate represents the average percentage of applicable elements with a <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> finding across all the evaluation elements for a particular activity.				
**The stage and/or activity totals may not equal 100 percent due to rounding.				

Kaiser–San Diego County progressed through Activity V for its *Children and Adolescents’ Access to PCP* QIP proposal. The plan submitted Remeasurement 3 data for its *Reducing Avoidable ER Visits* QIP and Remeasurement 2 data for its *Improving Postpartum Care* QIP; therefore, HSAG validated Activities I through X. Kaiser–San Diego County demonstrated an adequate understanding of the design stage for all three QIPs, scoring 94 percent of all applicable evaluation elements *Met*.

Both the *Reducing Avoidable ER Visits* QIP and the *Improving Postpartum Care* QIP progressed through the implementation and outcomes stages.

In the implementation stage, Kaiser–San Diego County scored 59 percent of the applicable evaluation elements *Met*. In Activity VI of the *Improving Postpartum Care* QIP, Kaiser–San Diego County documented using the hybrid methodology; however, it did not include any documentation related to manual data collection. In its resubmission, the plan revised its methodology to be consistent with prior years and reported using only administrative data, so all evaluation elements related to manual data collection were rescored *Not Applicable*. Additionally in Activity VI of both QIPs, the plan did not include a timeline for the data collection. Furthermore, this deficiency was not addressed in the subsequent two resubmissions of the *Improving Postpartum Care* QIP.

In Activity VII of the implementation stage, the plan did not include a barrier analysis or a narrative description of the interventions for its *Improving Postpartum Care* QIP. These deficiencies were addressed in the plan's first resubmission. For both QIPs, the plan did not provide an evaluation of the interventions; however, for the *Improving Postpartum Care* QIP, the plan did make the required changes in its first resubmission.

Additionally, for the *Improving Postpartum Care* QIP, the plan initially did not indicate whether there were factors that affected the validity or comparability of the data. Kaiser–San Diego County incorrectly documented the outcome and provided an incomplete interpretation of the results and the success of the project, all of which were addressed in its resubmission. In Activities IX and X, the plan was scored lower for not achieving statistically significant improvement for both QIPs and for not achieving sustained improvement for its *Reducing Avoidable ER Visits* QIP and sustained improvement. 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 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 Kaiser–San Diego County  
July 1, 2011, through June 30, 2012**

<b>QIP #1—Reducing Avoidable Emergency Room Visits</b>					
<b>QIP Study Indicator</b>	<b>Baseline Period 1/1/07–12/31/07</b>	<b>Remeasurement 1 1/1/08–12/31/08</b>	<b>Remeasurement 2 1/1/09–12/31/09</b>	<b>Remeasurement 3 1/1/10–12/31/10</b>	<b>Sustained Improvement<sup>‡</sup></b>
Percentage of ER visits that were avoidable <sup>^</sup>	11.5%	13.1%*	15.9%*	15.4%	No
<b>QIP #2—Improving Postpartum Care</b>					
<b>QIP Study Indicator</b>	<b>Baseline Period 1/1/08–12/31/08</b>	<b>Remeasurement 1 1/1/09–12/31/09</b>	<b>Remeasurement 2 1/1/10–12/31/10</b>	<b>Sustained Improvement<sup>‡</sup></b>	
Percentage of women who had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery	50.5%	67.9%*	68.5%	Yes	
<b>QIP #3—Children and Adolescents' Access to Primary Care Practitioners</b>					
<b>QIP Study Indicator</b>	<b>Baseline Period 1/1/11–12/31/11</b>	<b>Remeasurement 1 1/1/12–12/31/12</b>	<b>Remeasurement 2 1/1/13–12/31/13</b>	<b>Sustained Improvement<sup>‡</sup></b>	
Percentage of members 25 months–6 years of age who had a visit with a PCP	‡	‡	‡	‡	
<sup>^</sup> A lower percentage indicates better performance. <sup>‡</sup> 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. <sup>*</sup> A statistically significant difference between the measurement period and prior measurement period ( <i>p</i> value < 0.05). <sup>‡</sup> 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, the plan did not meet its objective of a 10 percent decrease in the percentage of avoidable ER visits over the course of the project. Instead, Kaiser–San Diego County demonstrated a statistically significant decline in performance from the baseline to the first remeasurement period and from the first to the second remeasurement period (1.6 and 2.8 percentage points, respectively). An increase in the rate for this project outcome represents a decline in performance. The plan did not demonstrate sustained improvement since the most recent measurement period’s rate was higher than the baseline rate. A critical analysis of the plan’s improvement strategy led to the following observations:

- ◆ The plan did not provide any results of its annual barrier analyses except for the results of the member and provider surveys. The plan discussed the survey results, although interventions were not implemented to address the identified barriers.
- ◆ The only two plan-specific interventions were implemented prior to the start of the project and were carried over throughout the project; however, the plan did not provide evaluation results of the effectiveness of these interventions.
- ◆ Most of the plan’s improvement efforts were focused on the collaborative interventions. The collaborative interventions were initiated in early 2009; however, they were not associated with any improvement in the outcome. The plan documented taking part in the statewide collaborative interventions; however, it only discussed provider educational mailings and member educational materials, and it did not report any results of the plan-hospital data collection collaboration.

### ***Improving Postpartum Care QIP***

For the *Improving Postpartum Care* QIP, the plan’s objective was to increase the percentage of deliveries that had a postpartum visit between 21 and 56 days after delivery to a rate greater than 54.3 percent. The plan met its objective and was only 2.6 percentage points below DHCS’s HPL of 71.1 percent. Additionally, the plan demonstrated statistically significant improvement from baseline to the first remeasurement period, which it maintained through the second remeasurement period. Therefore, the plan achieved sustained improvement for its project. A critical analysis of the plan’s improvement strategy identified the following:

- ◆ The plan conducted appropriate barrier analyses to identify barriers for each measurement period and discussed the results, although it did not provide data-specific results of the analyses.
- ◆ The plan identified interventions to address the barriers and provided a general evaluation for each intervention. Specifically, the plan used a multi-pronged approach:
  - A postpartum appointment was made for the member prior to delivery or before the member was discharged.

- The appointment was scheduled within five to six weeks of delivery to allow for rescheduling of the appointment, if necessary.
  - Providers were notified of the appointment and a nurse would call the member to emphasize the importance of the appointment and ensure the member could keep the appointment.
  - Additionally, providers were notified monthly of their performance related to timely postpartum visits for their members.
- ◆ Kaiser–San Diego County’s improvement strategy was well defined, and the plan provided a rationale for modifications to existing interventions and implementation of new interventions.

### ***Children and Adolescents’ Access to Primary Care Practitioner QIP***

The plan had not progressed to point of reporting baseline data, conducting barrier analyses, or developing an improvement strategy.

## **Strengths**

Kaiser–San Diego County accurately documented the four activities in the design stage.

The plan implemented a strong improvement strategy for its *Improving Postpartum Care* QIP. Through its concentrated efforts, the plan was able to achieve and sustain statistically significant improvement for the project, which resulted in a greater percentage of women receiving timely postpartum care in San Diego County.

## **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 lowered scores for the applicable evaluation elements.

For all of its QIPs, Kaiser–San Diego County should consistently conduct annual barrier analyses to ensure that its interventions target existing barriers. The analyses should be data-driven, and the plan should document the results.

Additionally, Kaiser–San Diego County should include a plan to evaluate the efficacy of each intervention for each measurement period and document the results.



## 5. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

for Kaiser–San Diego County

### 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, Kaiser–San Diego County performed above average in the quality domain of care. The plan demonstrates a quality program structure that supports the delivery of quality care to MCMC members.

The plan performed exceptionally on performance measures falling into the quality domain of care. Of the 19 quality measures, 14 had scores above the HPLs, 6 had statistically significant improvement, none had statistically significant decline in performance, and none performed below the MPLs. Kaiser–San Diego County's IP for the *Well-Child Visits in the Third, Fourth, Fifth, and*

*Sixth Years of Life* measure, which falls into the quality domain of care, was successful at moving this measure's performance from below the MPL in 2011 to above the MPL in 2012.

All of Kaiser–San Diego County's QIPs fell into the quality domain of care. The plan accurately documented activities within the QIP design stage and was able to achieve and sustain statistically significant improvement for its *Improving Postpartum Care* QIP. The plan was required to have two resubmissions for its *Improving Postpartum Care* QIP before a *Met* validation status could be achieved because HSAG's recommendations were not incorporated into the QIP documentation.

## 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, Kaiser–San Diego County performed above average in the access domain of care. Measures falling into the access domain of care performed above average, with seven of the 10 comparable access measures performing above the HPLs in 2012. Additionally, the following access measures had statistically significant improvement from 2011 to 2012:

- ◆ *Adolescent Well-Care Visits*
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

No access measures performed below the MPLs in 2012, and none had statistically significant decline from 2011 to 2012. As mentioned above, Kaiser–San Diego County's IP for the *Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure was successful at moving this measure's performance from below the MPL in 2011 to above the MPL in 2012. In addition to falling into the quality domain of care, this measure also falls into the access domain.

In addition to falling into the quality domain of care, all of Kaiser–San Diego County's QIPs fell into the access domain of care. The *Reducing Avoidable Emergency Room Visits* QIP did not meet its objective of decreasing the percentage of avoidable ER visits over the course of the project, which

suggests that MCMC members may be having difficulty accessing health care services through their primary care providers.

### **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, Kaiser–San Diego County performed above average in the timeliness domain of care. Kaiser–San Diego County provided evidence that the plan had addressed the deficiency in the area of Grievances from its most recent MR/PIU review; however, one deficiency related to timeliness of NOA letters remained unresolved.

Two of the five comparable timeliness measures (*Childhood Immunization Status—Combination 3* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*) performed above the HPLs in 2012. Three measures falling into the timeliness domain of care had statistically significant improvement from 2011 to 2012:

- ◆ *Adolescent Well-Care Visits*
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

As mentioned above, Kaiser–San Diego County's IP for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure was successful at moving this measure's performance from below the MPL in 2011 to above the MPL in 2012. In addition to falling into the quality and access domains of care, this measure falls into the timeliness domain.

In addition to falling into the quality and access domains of care, the plan's *Improving Postpartum Care* QIP fell into the timeliness domain. As stated above, the plan was required to have two resubmissions for this QIP before a *Met* validation status could be achieved; however, the plan was able to achieve and sustain statistically significant improvement for this QIP, which means a greater number of eligible women received timely postpartum care over the course of the project.

## 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. Kaiser–San Diego County’s self-reported responses are included in Appendix B.

## Recommendations

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

- ◆ Fully resolve the deficiency from the most recent MR/PIU review in the area of Prior Authorization Notification. Specifically:
  - Provide clarification on how NOA letters are managed within the plan’s system, along with prior authorization letters in general and how the plan ensures NOA letters are sent within the required time frames.
- ◆ Formally document the process used to implement the questionnaire during member visits to boost the rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* and *Physical Activity Counseling: Total* measures.
- ◆ Ensure that denied claims are used consistent with the technical specifications for measures.
- ◆ Address prior recommendations in QIP resubmission documentation.
- ◆ Consistently conduct annual barrier analyses for all QIPs to ensure that interventions target existing barriers. The analyses should be data-driven, and the plan should document the results.
- ◆ Include a plan to evaluate the efficacy of each QIP intervention for each measurement period and document the results.

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

## Quality, Access, and Timeliness

<p><b>Scale</b> 2.5–3.0 = Above Average 1.5–2.4 = Average 1.0–1.4 = Below Average</p>
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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**

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*for Kaiser–San Diego County*

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with Kaiser–San Diego County’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 Kaiser–San Diego County’s Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report**

2010–2011 EQR Recommendation	Kaiser–San Diego County’s Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Strengthen procedures relating to acknowledgement letters and timeliness in the prior authorization category.	Acknowledgement letters are sent out within five days of notice and tracked by SCAL region for compliance. This notification is very detailed with member rights including State fair hearings.
Evaluate why the HEDIS measure, <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i> , fell below the MPL.	The plan initially fell below the MPL as the result of change in management for the pediatric department. Interventions in place for this specific population were lost as a result of this transition. The plan did have a 2011 goal to improve this measure above 64.0%, the 2010 reported MPL. Although the plan met goal with a rate of 64.7%, the 2011 MPL was increased to 65.9%. Additionally, interventions were implemented late in the year and were not given enough time to make a significant impact.
Conduct annual barrier analyses to ensure that QIP interventions target specific barriers and evaluate the efficacy of the interventions using subgroup analysis to determine if the initiatives are affecting the entire study population in the same way.	Beginning first quarter 2013, an enhanced annual barrier analysis will be conducted to evaluate the prior year focusing on members who did not obtain a well visit. Interventions will be implemented based on these findings.
Evaluate QIP outcomes by gender, age, provider, etc., to understand any disparities that may exist in the study population in relationship to the study outcomes.	Data analysis used for barrier analysis above will include at minimum gender, age, demographics, provider, clinic, language, etc.