Performance Evaluation Report

Kern Family Health Care

July 1, 2012–June 30, 2013

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

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Performance Evaluation Report – Kern Family Health Care

July 1, 2012 – June 30, 2013

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and

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

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

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

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Kern Family Health Care ("KFHC" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

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

KFHC became operational in Kern County to provide MCMC services effective July 1996. As of June 30, 2013, KFHC had 128,912 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP's compliance with standards established by the state related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers 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, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's 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.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits and Member Rights Reviews

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

DHCS did not conduct any audits or reviews with KFHC during the review period for this report, and the MCP has no outstanding findings or deficiencies from previous reviews or audits.

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP 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 the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

Strengths

KFHC has no outstanding findings or deficiencies from DHCS's reviews or audits.

Opportunities for Improvement

Since KFHC has no outstanding findings or deficiencies from DHCS's reviews or audits, HSAG does not have any recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

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

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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

Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for Kern Family Health Care* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that KFHC followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A review of the MCP's HEDIS audit report revealed the following observations:

- KFHC had a robust pay-for-performance program, which reinforced data submission requirements and promoted quality measure reporting.
- KFHC's information technology department performed enrollment reconciliations daily for Medi-Cal, which helped ensure enrollment data accuracy.
- KFHC is encouraged to continue close oversight of all supplemental data sources, including two new non-standard supplemental data sources, to ensure validation is conducted and HEDIS measure specifications are followed.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

Table 3.1—Name Key for Performance Measures in External Accountability Set

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions* ‡
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient 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)*
CBP	*Controlling High Blood Pressure*
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*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MMA–75	*Medication Management for People with Asthma—Medication Compliance 75% Total*
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*

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.
‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Table 3.2 below presents a summary of KFHC's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.2 shows the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

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 2012 and 2013 Performance Measure Results
KFHC—Kern County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	15.69%	23.02%	★★	↑	18.98%	33.33%
ACR	Q, A	--	8.77%	--	Not Comparable	--	--
AMB–ED	‡	46.64	51.02	‡	Not Comparable	‡	‡
AMB–OP	‡	282.07	255.50	‡	Not Comparable	‡	‡
CAP–1224	A	94.23%	92.37%	★	↓	95.56%	98.39%
CAP–256	A	84.12%	82.18%	★	↓	86.62%	92.63%
CAP–711	A	79.80%	79.43%	★	↔	87.56%	94.51%
CAP–1219	A	81.78%	82.20%	★	↔	86.04%	93.01%
CBP	Q	--	64.96%	--	Not Comparable	--	--
CCS	Q,A	65.69%	64.72%	★★	↔	61.81%	78.51%
CDC–BP	Q	72.81%	75.36%	★★	↔	54.48%	75.44%
CDC–E	Q,A	52.55%	45.80%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	45.26%	47.45%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	45.99%	44.53%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	82.12%	80.29%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	34.31%	33.58%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	79.38%	76.28%	★★	↔	70.34%	83.45%
CDC–N	Q,A	80.11%	77.55%	★★	↔	73.48%	86.93%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
KFHC—Kern County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
CIS–3	Q,A,T	68.61%	65.45%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	62.53%	75.67%	★★	↑	50.36%	80.91%
LBP	Q	76.45%	74.07%	★★	↔	72.04%	82.04%
MMA–50	Q	--	45.85%	--	Not Comparable	--	--
MMA–75	Q	--	21.75%	--	Not Comparable	--	--
MPM–ACE	Q	83.81%	87.71%	★★	↑	83.72%	91.33%
MPM–DIG	Q	NA	90.74%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	84.24%	87.62%	★★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	81.27%	83.70%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	60.34%	62.04%	★★	↔	58.70%	74.73%
W-34	Q,A,T	69.10%	67.64%	★★	↔	65.51%	83.04%
WCC–BMI	Q	61.80%	64.23%	★★	↔	29.20%	77.13%
WCC–N	Q	51.58%	66.42%	★★	↑	42.82%	77.61%
WCC–PA	Q	38.44%	48.91%	★★	↑	31.63%	64.87%

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[8] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

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

The final selected SPD measures are listed below. Following the list of measures are Tables 3.3 and 3.4, which present a summary of KFHC's 2013 SPD measure results. Table 3.3 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.4 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*

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

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.3.

- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *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)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Table 3.3—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
KFHC—Kern County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	6.27%	17.07%	▼	8.77%
CAP–1224	92.43%	87.76%	↔	92.37%
CAP–256	82.13%	86.32%	↔	82.18%
CAP–711	79.38%	85.00%	↔	79.43%
CAP–1219	82.19%	85.37%	↔	82.20%
CDC–BP	75.73%	73.72%	↔	75.36%
CDC–E	43.98%	48.18%	↔	45.80%
CDC–H8 (<8.0%)	46.53%	56.57%	↑	47.45%
CDC–H9 (>9.0%)	46.35%	36.31%	▲	44.53%
CDC–HT	77.37%	83.21%	↑	80.29%
CDC–LC (<100)	31.39%	40.69%	↑	33.58%
CDC–LS	72.99%	83.76%	↑	76.28%
CDC–N	76.09%	84.85%	↑	77.55%
MPM–ACE	85.38%	92.05%	↑	87.71%
MPM–DIG	NA	NA	Not Comparable	90.74%
MPM–DIU	85.34%	91.17%	↑	87.62%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

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

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

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

Not comparable = A rate comparison could not be made because data were not available for both populations.

Table 3.4—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
KFHC—Kern County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
240.89	48.21	487.16	95.53

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

Performance Measure Result Findings

Overall, KFHC performed average on its measures in 2013. No measures had rates above the HPLs. The rates for the four *Children and Adolescents' Access to Primary Care Practitioners* measures were below the MPLs and the rates for two of the measures—*12–24 Months* and *25 Months–6 Years*—declined significantly from 2012 to 2013. Additionally, the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure declined significantly from 2012 to 2013, moving the rate to less than 1 percentage point below the MPL.

The rates for the following six measures had statistically significant improvement from 2012 to 2013:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Immunizations for Adolescents—Combination 1*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*

The rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was below the MPL in 2011 and 2012. The significant improvement in the rate from 2012 to 2013 resulted in the rate for this measure moving from below the MPL to above the MPL.

Seniors and Persons with Disabilities Findings

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

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*

- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The SPD rate for the *All-Cause Readmissions* measure was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had significantly more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

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

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs

or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

KFHC had an IP in place for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure during the review period. Below is a summary of the IP and HSAG's assessment of the progress the MCP made toward the MPL on the measure.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

The barriers identified in the 2012 IP for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure were similar to those identified in the 2011 IP and included the following:

- The MCP 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 the measure.
- Members have a tendency to demand that an antibiotic be prescribed as treatment for an acute bronchitis diagnosis.
- The MCP 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 continued to focus 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. KFHC also introduced two new interventions in 2012. The MCP provided incentives to practitioners who do not prescribe antibiotics to patients with bronchitis and added a member newsletter discussing bronchitis and other cough illnesses in adults to its member education efforts.

KFHC's efforts resulted in statistically significant improvement on this measure's rate from 2012 to 2013, which led to the rate being above the MPL. KFHC will not be required to continue the IP for this measure in 2013.

Although KFHC's rates on all four *Children and Adolescents' Access to Primary Care Practitioners* measures were below the MPLs in 2013, the MCP will not be required to submit IPs for these measures. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact.

Strengths

KFHC had six measures with rates that had statistically significant improvement from 2012 to 2013. The MCP had one IP, and it was successful at bringing the performance measure rate above the MPL in 2013.

Opportunities for Improvement

KFHC has the opportunity to assess the factors leading to the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure to decline significantly to prevent this measure's rate from moving from above the MPL to below the MPL. The rate for this measure improved significantly from 2011 to 2012, and the MCP may benefit from identifying the strategies that led to the improvement so they can be implemented, as appropriate, moving forward. Additionally, the MCP has the opportunity to assess the factors leading to a significantly higher rate of readmissions for the SPD population and identify interventions to be implemented that will result in a decrease in readmissions for this population. Finally, KFHC has the opportunity to assess the factors leading to the rates for the four *Children and Adolescents' Access to Primary Care Practitioners* measures being below the MPLs.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[10] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

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

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

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

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

Quality Improvement Project Objectives

KFHC participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2012–June 30, 2013.

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

Table 4.1—Quality Improvement Projects for KFHC
July 1, 2012, through June 30, 2013

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

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

Prior to initiation of the statewide collaborative QIP, KFHC had a 30-day readmission rate of 11.24 percent among Medi-Cal beneficiaries. KFHC also found that the readmission rate for the SPD population was 17.14 percent, which was higher than the 10.96 percent rate for the non-SPD population.

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

Quality Improvement Project Validation Findings

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

Table 4.2—Quality Improvement Project Validation Activity
KFHC—Kern County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Comprehensive Diabetic Quality Improvement Plan	Annual Submission	100%	100%	*Met*

[1] **Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by KFHC of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 90 percent of evaluation elements met. KFHC also received an overall validation status of *Met* for its *Comprehensive Diabetic Quality Improvement Plan* QIP annual submission, with 100 percent of both the critical and evaluation elements being met.

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

Table 4.3—Quality Improvement Project Average Rates*
KFHC—Kern County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	90%	10%	0%
Design Total		**96%**	**4%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

*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.

HSAG validated Activities I through VI for KFHC's *All-Cause Readmissions* QIP study design submission and Activities I through VIII for the MCP's *Comprehensive Diabetic Quality Improvement Plan* QIP annual submission.

KFHC demonstrated a strong understanding of the Design stage, meeting 96 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP did not fully describe the data analysis plan for the *All-Cause Readmissions* QIP, which resulted in a lower score in Activity VI. KFHC met 100 percent of the requirements for all applicable evaluation elements in the Design stage for the *Comprehensive Diabetic Quality Improvement Plan* QIP.

The Implementation stage activities (VII and VIII) were only assessed for the *Comprehensive Diabetes Quality Improvement Plan* QIP. KFHC demonstrated an excellent understanding of the Implementation stage, meeting 100 percent of the requirements for all applicable evaluation elements within this stage.

Activities IX and X were not assessed for either QIP since neither QIP reached the outcomes stage.

Quality Improvement Project Outcomes and Interventions

The *All-Cause Readmissions* QIP did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information is included in this report for this QIP.

The *Comprehensive Diabetic Quality Improvement Plan* QIP did not progress to the Outcomes stage; however, since the QIP progressed to the Implementation stage during the reporting period, HSAG includes information in this report related to the MCP's interventions for this QIP.

Comprehensive Diabetic Quality Improvement Plan QIP

KFHC's objective for the *Comprehensive Diabetic Quality Improvement Plan* QIP is to increase HbA1c testing, LDL-C screening, and retinal eye exams. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- KFHC completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process.
- Although the QIP received a *Met* score on all applicable evaluation elements, the QIP reviewer noted that KFHC did not document the QIP goal consistently throughout the QIP and that the MCP did not document the interventions and barriers in the intervention table in the QIP Summary Form.
- The QIP included system interventions that were likely to have a long-term effect, including:
  - Mailed report cards to diabetic members summarizing their compliance with receiving HbA1c testing, LDL-C screening, microalbumin urine testing, and diabetic eye exams. Members who were not compliant were encouraged to contact their primary care physician to schedule an appointment.
  - Sent reports to providers that detailed their rates for each HEDIS measure reported to DHCS by the MCP. In addition to informing the providers about their rates, KFHC used the reports to identify low-performing providers so the MCP can offer them education.
  - Implemented a pay-for-performance program to motivate providers to ensure diabetic members receive appropriate assessments and treatments.

Strengths

KFHC demonstrated an excellent application of the QIP Design and Implementation stages. The MCP was able to achieve a *Met* validation status for both QIPs on the first submission.

Opportunities for Improvement

Although KFHC understands the QIP process as evidenced by both QIPs achieving a fully *Met* validation status on the first submission, the MCP has the opportunity to ensure all required documentation is included in the QIP Summary Form and that all the information is accurate.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

KFHC's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about KFHC's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

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

CAHPS Global Rating Measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

CAHPS Composite Measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

Table 5.1—CAHPS Measures Domains of Care

Measure	Domains of Care
Rating of Health Plan	Q
Rating of All Health Care	Q
Rating of Personal Doctor	Q
Rating of Specialist Seen Most Often	Q
Getting Needed Care	Q, A
Getting Care Quickly	Q, T
How Well Doctors Communicate	Q
Customer Service	Q
Shared Decision Making	Q

National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

Star Rating	Adult and Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or above the 75th and below the 90th percentiles
★★★ Good	At or above the 50th and below the 75th percentiles
★★ Fair	At or above the 25th and below the 50th percentiles
★ Poor	Below the 25th percentile

Table 5.3 through Table 5.4 present the star ratings for the global ratings and composite measures for KFHC's adult and child Medicaid populations.[15]

Table 5.3—Medi-Cal Managed Care County-Level Global Ratings
KFHC—Kern County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★	★
Child	★★	★	★	★★+
+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.				

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.
[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.
[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

Table 5.4—Medi-Cal Managed Care County-Level Composite Measures
KFHC—Kern County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★	★★★
Child	★	★	★	★★★

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Strengths

KFHC received a *Good* rating on the *Customer Service* measure for both the adult and child populations and improved its rating on the adult *Customer Service* measure from *Poor* in 2010 to *Good* in 2013.

Opportunities for Improvement

KFHC's CAHPS results showed below-average performance for the majority of the child and adult global ratings and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as KFHC's highest priorities: *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 KFHC CAHPS MCP-Specific Report.* Areas for improvement spanned the quality, access, and timeliness domains of care.

Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[16] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[16] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

KFHC's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

Encounter Data Validation Findings

Review of Encounter Systems and Processes

The information provided in KFHC's Roadmap and supplemental questionnaire demonstrates that the MCP has procedures in place for the creation, validation, correction, and ongoing monitoring of encounter data. However, KFHC does not have a process to monitor or ensure that its capitated providers submit timely, accurate, and complete encounters. Claims submitted with errors are generally corrected and processed within 30 days.

Record Completeness

Overall, KFHC had low record omission and record surplus rates for the Medical/Outpatient and Pharmacy claim types, indicating relatively complete data when comparing DHCS's data and the encounter data extracted from KFHC's data system for this study. The MCP's rates performed better than the statewide rates for all claim types except for one. With a Hospital/Inpatient record omission rate of 16.6 percent, KFHC underperformed compared to the statewide omission rate of 10.1 percent. The record omission for the Hospital/Inpatient records was mainly due to the Claim Control Numbers (CCNs) being populated in the data KFHC submitted to HSAG but not in the DHCS data warehouse.

Data Element Completeness

KFHC had very high data element completeness results with element omission and element surplus rates of 0.3 percent or lower for all key data elements except the data element *Drug/Medical Supply*. This element had an element omission rate of 21.1 percent, which was much higher than the statewide rate of 1.0 percent. This was due to the *Drug/Medical Supply* value of "9999MZZ" being in the KFHC's data system and not in the DHCS data warehouse.

Data Element Accuracy

KFHC had very high element-level accuracy with accuracy rates of 99.4 percent or above for all key data elements. The all-element accuracy rates for the Medical/Outpatient and Hospital/Inpatient claim types were also nearly perfect, with rates of 99 percent or above, which were higher than the statewide rate by approximately 35 percentage points. Due to the high element omission rate for *Drug/Medical Supply*, the all-element accuracy rate for the Pharmacy records was 78.9 percent and slightly better than the statewide rate of 78.8 percent.

Recommendations

Based on its review, HSAG recommends the following:

- For both data sources, there were no long-term care (LTC) records. However, in KFHC's response to HSAG's preliminary file review results, KFHC indicated that its LTC records were mixed in with the Hospital/Inpatient records. KFHC should clarify with DHCS whether the LTC records should be submitted with the value "L" for the data element *Format Code* so that the LTC records can be separated from the Hospital/Inpatient records in the future.
- KFHC should investigate the reason(s) for the high record omission rate for the Hospital/Inpatient claim type and create strategies for future improvement on this indicator.
- KFHC should investigate the *Drug/Medical Supply* value of "9999MZZ" which was populated in the file KFHC submitted to HSAG, but there were no instances of this value in the DHCS file.
- Although the record omission rate for the Pharmacy claim type was almost the same as the statewide rate, more than two-thirds of the omitted records had dates of service in February 2011. KFHC should investigate the reason why a particular month (i.e., February 2011) of the pharmacy data was missing from the DHCS data warehouse and apply appropriate quality control procedures to avoid similar issues occurring in future data submissions.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[17]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, DHCS monitors aspects of an MCP's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems. DHCS also uses the results

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

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

HSAG reviewed KFHC's 2013 Quality Improvement Program Description and 2013 Quality Improvement Work Plan, which include descriptions of processes, activities, and goals that support the delivery of quality health care services to the MCP's Medi-Cal members.

The rates for all measures falling into the quality domain of care were average. Six quality measures had rates with statistically significant improvement from 2012 to 2013. The improvement on one of the measures, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, resulted in the rate for this measure moving from below the MPL in 2012 to above the MPL in 2013. The rate for one quality measure, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, declined significantly from 2012 to 2013.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and eight of these measures had SPD rates that were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The SPD rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care, was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had significantly more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

All CAHPS measures fall into the quality domain of care. KFHC received below-average ratings for most of the adult and child CAHPS measures. Only the *Customer Service* measure received a *Good* rating for both the adult and child populations. The results of the survey suggest that members are not satisfied with the quality of care they are receiving.

Both of KFHC's QIPs fall into the quality domain of care. Neither of the QIPs progressed to the Outcomes stage, so HSAG was not able to assess the QIPs' success at improving the quality of care delivered to the MCP's Medi-Cal members.

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

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with

access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HSAG review of KFHC's 2013 Quality Improvement Program Description and 2013 Quality Improvement Work Plan found descriptions of quality improvement activities designed to ensure members' access to needed health care services.

Overall, the MCP's performance on access measures was below average. The rate for the *Immunizations for Adolescents—Combination 1* measure, which falls into the access domain of care, improved significantly from 2012 to 2013; however, the rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures were below the MPLs, and the rates for two of the measures, *12–24 Months* and *25 Months–6 Years*, significantly declined from 2012 to 2013. The rate for one other access measure, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, also declined significantly from 2012 to 2013.

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and three of these measures had SPD rates that were significantly better than the non-SPD rates. The *All-Cause Readmissions* measure falls into the access domain of care. As indicated above, the SPD rate for this measure was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had significantly more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

Overall, KFHC performed below average on the access-related CAHPS measure, *Getting Needed Care*, with this measure receiving a *Poor* rating for both the adult and child populations. These ratings suggest that members are not satisfied with their level of access to needed services.

Both of KFHC's QIPs fall into the access domain of care. Since neither of the QIPs progressed to the Outcomes stage, HSAG was not able to assess the QIPs' success at improving members' access to needed services.

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

Timeliness

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

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

KFHC's 2013 Quality Improvement Program Description provides details about the MCP's activities related to member rights and responsibilities, grievances, continuity and coordination of care, and utilization management, which all impact the timeliness of care delivered to members.

KFHC performed average on all timeliness measures. No timeliness measures had rates above the HPLs, and no measures had rates below the MPLs. The rate for one timeliness measure, *Immunizations for Adolescents—Combination 1*, improved significantly from 2012 to 2013, and no measures had rates that declined significantly.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. This measure received a *Poor* rating for both the adult and child populations, suggesting that members are not satisfied with the time it takes to receive health care services.

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

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-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 MCP:

- Continue close oversight of all supplemental data sources, including two new non-standard supplemental data sources, to ensure validation is conducted and HEDIS measure specifications are followed.
- Related to improving performance measure rates:
  - Assess the factors leading to the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure to decline significantly to prevent this measure's rate from moving from above the MPL to below the MPL. The rate for this measure improved significantly from 2011 to 2012, and the MCP may benefit from identifying the strategies that led to the improvement so they can be implemented, as appropriate, moving forward.
  - Assess the factors leading to a significantly higher rate of readmissions for the SPD population when compared to the non-SPD population to ensure the MCP is meeting the needs of the SPD population.
  - Assess the factors leading to the rates for the four *Children and Adolescents' Access to Primary Care Practitioners* measures being below the MPLs, including the factors leading to the rates for the *12–24 Months* and *25 Months–6 Years* measures declining significantly from 2012 to 2013.
- Ensure all required documentation is included in the QIP Summary Form and that all the information is accurate.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly* priority areas.
- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

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

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

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

Access and Timeliness Domains

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

CAHPS Survey Measures

(Refer to Table 5.3 through 5.4)

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

Quality Domain

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

Access Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

Timeliness Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

Quality Improvement Projects (QIPs)

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

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

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

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Not all study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

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 and Medi-Cal Managed Care Division reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures, CAHPS measures, and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the encounter data validation (EDV) study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

Appendix B. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

for Kern Family Health Care

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with KFHC's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table B.1—KFHC's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	KFHC's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. 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.	KFHC assessed several barriers and challenges that may have impacted the HEDIS 2012 rate for the *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)* measure. 1. Kern County Air Quality: The American Lung Association State of the Air Report gave a rating of fail for the ozone, particle pollution (24 hour) and particle pollution (annual) for Bakersfield. Kern County was ranked as number one for cities with the worst air quality in the United States. 2. Members demand an antibiotic prescription for an acute bronchitis diagnosis and may not understand that it is viral as opposed to bacterial. 3. The plan was unable to identify high antibiotic prescribers that have low compliance rates in this measure in order to target these providers and educate them on specifications for this measure. The HEDIS 2013 rate increased to 23.02 percent from the HEDIS 2012 rate of 15.7 percent for a statistically significant improvement of 7.32 percentage points. KFHC would assess that the interventions implemented were effective in changing the behaviors of the members and providers.

<table>
<tr><th>2011–12 External Quality Review Recommendation</th><th>KFHC's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation</th></tr>
<tr><td>2. 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.</td><td>The chief medical officer, quality improvement director, and the QI analyst had ongoing informal meetings to discuss performance and evaluate barriers that exist with the Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis measure. An analysis of reporting outcomes of the currently implemented interventions was done prior to the meetings and was presented to help identify additional barriers. All newly identified or revised interventions resulted from analyzing data, identifying root causes, and brainstorming with various staff members. In addition, the meetings discussed the previous identified barriers to see if they still existed or if the plan was able to successfully address the barrier with the implemented interventions.

KFHC targeted both the provider and member in order to increase the compliance rate in the AAB measure, and the following interventions were implemented in 2013:
Improve provider compliance through education and incentive programs.
1. Using the reporting tool (Quality Reporter), KFHC was able to analyze provider compliance rates from HEDIS data. KFHC notified providers of their HEDIS compliance rates. The intervention was to help facilitate change at the provider level.
2. KFHC is a participant and contributor to the Alliance Working for Antibiotic Resistance Education (AWARE) program. KFHC utilized the AWARE reports to identify the high prescriber providers and utilizes these reports to create trends.
3. Pay for Performance Program: KFHC practitioners were offered an incentive for each eligible KFHC member who did not receive an antibiotic prescription directly related to their acute bronchitis diagnosis. The incentives are paid out quarterly, and the plan will be able to monitor payments to providers and capture these data.</td></tr>
<tr><td>3. 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.</td><td>KFHC stratified member data by age, but this stratification showed little variation.

<table><tr><th>Age</th><th>Number</th><th>Percent</th></tr><tr><td>>60</td><td>38</td><td>5</td></tr><tr><td>50–59</td><td>145</td><td>17</td></tr><tr><td>40–49</td><td>188</td><td>23</td></tr><tr><td>30–39</td><td>254</td><td>30</td></tr><tr><td>20–29</td><td>209</td><td>25</td></tr></table>
KFHC also reviewed provider data specific to prescribing patterns. Those providers with higher prescribing rates were targeted for intensive interventions.</td></tr>
</table>

2011–12 External Quality Review Recommendation	KFHC's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
4. 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.	KFHC's evaluation plan includes ongoing, concurrent review of poor-performing providers via the AWARE reports. In addition to identifying the high prescriber providers and utilizers, these reports also are used to reveal trends. P4P reports are also used to compare performance. P4P financial reports are stratified by high-prescribing providers. PCPs who do not take part in this program are targeted for additional education on the program. Our provider performance database allows us to review 12-month rolling data to evaluate performance both at the provider and plan level to allow quick adjustment to interventions.