



PROVIDER *bulletin*

April 6, 2010

Dear Provider:

This is to announce some beneficial changes to Kern Health Systems' (KHS) member primary care physician (PCP) selection policy, the PCP assignment policy for new members who do not select a PCP upon enrollment, and a forthcoming amendment to the quality incentive program in your participation agreement.

One of the primary goals of KHS is to create a "medical home" for our members to improve their quality and continuity of care. PCPs provide the important initial health care access for our members, and are vital to the success and quality of their care. Developing win-win long-term patient and physician relationships create a healthy working relationship that improves health outcomes and satisfaction for members and providers. Below is an outline and explanation of some of the changes we have made and future plans to help achieve this goal.

As you know, KHS recently implemented changes to our member PCP selection policy. These changes included limiting our members to one PCP change per month, and requiring members to seek care from their assigned PCP for non-emergent services. We encourage participating providers to enforce this policy. At a future date, we will deny payment for providing a member primary care services when the provider is not the member's PCP. Providers will be notified of this date in advance.

The next step in improving a medical home for our members is by altering how members who do not choose a PCP upon enrollment are assigned to a PCP. Under KHS policy # 5.06, these members were auto-assigned based upon tiers to safety-net providers, then traditional, and so-on. In November of this year, the KHS Board of Directors approved changes to that policy that provides for auto-assignment of defaulted members to providers based on certain quality performance rankings. PCPs will be ranked according to their performance in KHS selected quality measures. Each ZIP code and geographical area will have its own ranking set consisting of providers within that area. The highest performers in each area will be the primary choice when auto-assigning members. This designation will occur on an annual basis and will be effective for one year.

Even with the implementation of the aforementioned criteria, many factors, including practice limitations, panel size, member age, member gender, other family member(s) assigned, and previous PCP, are taken into consideration before an assignment is made. This may result in the highest ranking provider for a certain zip code not receiving auto-assigned members; some examples would be having a closed panel, having family members assigned to another PCP, and age restrictions. In such cases, the next highest ranked or appropriate PCP will be given the assignment.



As we continue to refine our processes, we will work to provide support and tools to our providers. The most useful tool currently available is the KHS Provider Connection Internet portal. The portal allows you to check member eligibility, authorization status, claim status, receive updated membership lists and, in the coming weeks, access to the Provider Scoreboard. The Provider Scoreboard is an interface that allows providers to monitor their performance on the selected quality measures in real time. It enables providers to see which patients have met the criteria for a certain measure and identify those who have not. The list can be exported to a spreadsheet for easy sorting and management of those members who have not met the criteria for a selected measure. By easily identifying and contacting non-compliant members, providers should be able to increase their quality scores.

The Quality Incentive Program for 2010 will measure Provider's performance on five HEDIS measures and 2 KHS-determined non-HEDIS measures. Provider's performance will be measured by encounter data received by KHS (i.e., not medical record review). Each PCP, or contracting group of PCPs in the case of Provider being a KHS contracting entity of more than one PCP (e.g., a clinic of more than one PCPs), must meet the specified MPL for each measure in order to be eligible for distribution of an incentive payment for that measure. The MPL for each the five HEDIS measures will be the higher of: (a) the DHCS-determined 2009 MPL for the HEDIS measure for California Medi-Cal Plans that should be published by the DHCS in mid 2010, or (b) the average level of performance of the measure in 2009 by all KHS PCPs to be determined by KHS in mid 2010. The criteria for the HEDIS measures can be found in the State defined HEDIS guidelines. KHS will also make the HEDIS Specification available to providers via the Provider Connection. The seven measures are summarized as follows:

4.1 HEDIS Measures for 2010:

a. **Well Child Visits in the Third, Fourth, Fifth, and Sixth year of Life.**

The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.

b. **Adolescent Well-Care Visits**

The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

c. **Childhood Immunization Status – Combo 3**

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

d. **Breast Cancer Screening for Women Age 52 through 69.**

The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer

e. **Comprehensive Diabetes Care**

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:





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- Hemoglobin A1c (HbA1c) testing
- Eye exam (retinal) performed
- LDL-C screening
- Medical attention for nephropathy

4.2 KHS-Defined non-HEDIS Measures for 2010:

120-Day Initial Health Assessment (IHA) and Individual Health Education and Behavioral Assessment (IHEBA). This measure counts: (1) new Medi-Cal members who were over eighteen months of age and continuously enrolled for 120 days during the calendar year and received an IHA and IHEBA during the first 120 days of their enrollment with KHS; and (2) new Medi-Cal members who were under eighteen months of age and continuously enrolled for 60 days during the calendar year and received an IHA and IHEBA within 60 days of enrollment with KHS.

Ratio of Urgent Care/Avoidable Emergency Room Visits by Assigned Members

Contract PCPs are expected to provide adequate access to ensure delivery by the assigned PCP of all necessary non-emergent services to his/her assigned members.

KHS has many exciting ideas on the horizon, and we will continue to develop and share these ideas to support our participating providers. If you have any questions, please contact our Provider Relations Department at (661)664-5146.

Sincerely,

Jake Hall
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Kern Health Systems

