About the care gap report

What is the care gap report?
The care gap report provides patient-level information for HEDIS® clinical quality measures that are important to Kaiser Permanente. These patients are past due for certain care, tests or medications.

What do the marks in the care gap report mean?
- *Met* (M) indicates the measure is relevant to the patient and the requirements for the measure have been fulfilled.
- *Not Met* (N) indicates the measure is relevant to the patient and the requirements for the measure have not been fulfilled.
- A *Blank* cell means the patient does not belong to the population in that column.

How are the measures chosen?
Kaiser Permanente selects measures for the care gap report that are considered the highest priority based on populations, impact on patients, and current performance. The data are collected through claims coding, so some measures that are also important, such as HbA1c values, aren't included.

Measures

My patient has a care gap for retinal eye screening but they have no retinopathy and have had screening within the last two years. Why is this?
Eye exams that are older than 1 year aren’t counted using claims data. In order for a patient to only need a biannual exam, there must be documentation of negative retinopathy. There is currently no HEDIS® code for this that can be used for the Care gap report. This documentation is collected during chart review for annual HEDIS® reporting.

How do I learn more about the codes used for these measures?
Kaiser Permanente offers annual HEDIS® Documentation and Coding Guidelines at kp.org/wa/provider > Quality > Care Team Training.

Why are some measures included that are too late for me to address?
Some measures, such as immunizations and antidepressant medication management, reflect care that didn’t occur within a strict timeframe. The care is still important to provide, even if the timing won’t qualify to meet a measure. These measures also raise awareness of possible clinical trends and can be compared to your own clinical data to assess accuracy.

Providers

What do I do if I find a physician being printed in the wrong clinic?
The physician clinic location is determined by provider files in our database. If you find a physician that is in the wrong clinic report, contact your Provider Services Consultant to update the physician’s location.
Patients

Why are some of my patients not listed?
The report does not list patients for whom none of the measures are relevant, or who are completely up to date on all of their services. All measures in the care gap report also have criteria applied, including age ranges and continuous enrollment rule that patients may not meet yet.

Additionally, the care gap report lists patients based on attribution through claims for evaluation and management (E&M) visits. If no E&M visits took place in the last 24 months, the patient will not be attributed and will not appear on reports.

Some of these patients aren’t mine. Why are they in my report?
The care gap report lists patients based on attribution. Attribution is assigned based on claims for evaluation and management (E&M) visits in the past 24 months. If there are multiple practitioners with the same highest number of visits, whoever had the most RVUs is the attributed provider for that patient.

I provided this care for my patient last month. Why is it still a gap on the report?
Claims may take up to 90 days to be reflected in reporting.

My chart notes indicate that a patient did have this care. How can I report this?
Patients may have had care at another provider or a claim may have been submitted to a different plan. Kaiser Permanente offers a Screening Fax Back program to report these instances for your patients. Please ask your Provider Services Consultant for information about this program.

When can patients be removed from the care gap report?
Patients are identified as eligible for a measure using claims per HEDIS® specifications. Sometimes the coding for a claim is incorrect and the information passes into our administrative systems. For diabetes and heart care, these codes will age out after the second calendar year.

Due to strict HEDIS® rules there are very few circumstances where a patient can be removed from eligibility for a given measure. The most common circumstances where patients can be removed are:
- Cervical Cancer Screening – Patients who have had their cervixes removed
- Breast Cancer Screening – Patients who had double mastectomy or two unilateral mastectomies
- Colon Cancer Screening – Patients who have undergone colectomy (removal of the colon)
Kaiser Permanente offers a Screening Fax Back program to report these instances for your patients. Please ask your Provider Services Consultant for information about this program.

Is care received outside of my practice reflected in the care gap report?
Services rendered by any practitioner are included. If a patient’s care is billed to Kaiser Permanente and codes (procedure, diagnosis, etc.) are supplied, it will be reflected in the care gap report after the claim is processed.

What do I do if I find a deceased patient on the care gap report?
Providers can report deceased patients to Kaiser Permanente Customer Service at 1-888-901-4636.

What if a patient on the care gap report no longer has Kaiser Permanente coverage?
Sometimes it takes several cycles for membership updates to be reflected on the care gap report.

Questions

Contact your Provider Services Consultant or Kaiser Permanente Quality at KPWAQuality@kp.org.