

Performance Evaluation Report
L.A. Care Health Plan
July 1, 2008–June 30, 2009

Medi-Cal Managed Care Division
California Department of
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Performance Evaluation Report – L.A. Care Health Plan

July 1, 2008 – June 30, 2009

1. EXECUTIVE SUMMARY

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.4 million beneficiaries in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Plan-specific reports are issued in tandem with the technical report. This report is unique to the MCMC Program's contracted plan, L.A. Care Health Plan ("LA Care" or "the plan"), for the review period July 1, 2008, to June 30, 2009. The plan-specific reports include findings for each plan regarding its organizational assessment and structure, performance measures, and QIPs as they relate to the quality, access, and timeliness domains. Actions taken by the plan subsequent to June 30, 2009, regarding findings identified within this report will be included in the next annual plan-specific evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPLs indicate low performance, rates at or above the HPLs indicate high performance, and rates at the MPLs or between the MPLs and HPLs demonstrate average performance.

HSAG found that LA Care demonstrated average performance for the quality of care domain. This was based on the plan's 2009 performance measure rates (which reflected 2008 measurement data), QIP outcomes, and compliance review standards related to measurement and improvement.

All but one of LA Care's performance measure rates fell between the established MPLs and HPLs. LA Care exceeded the HPL for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* measure. Between 2008 and 2009, three measures had statistically significant increases, *Adolescent Well-Child Visits (AWC)*, *Breast Cancer Screening (BCS)*, and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*. The plan had no below-average performance for any performance measures.

LA Care participated in a small-group collaborative QIP that targeted appropriate treatment for children with URI. Both study indicator Remeasurement 1 rates had a statistically significant increase from the Baseline rate. The plan improved the percentage of primary care physicians with a 90 percent compliance rate for treating URI from 52.5 percent to 62.2 percent. Additionally, the plan's rate increased to 80.0 percent for children who were diagnosed with URI and not dispensed an antibiotic.

The plan's 2009 performance measure rates and QIP outcomes demonstrated its strength in providing quality care for members. The plan can improve quality of care to members by increasing performance measure rates, which have remained relatively stable. HSAG also noted the plan has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs.

While Member Rights/Program Integrity Unit (MRPIU) findings showed substantial opportunities to improve quality of care provided to members by improving plan compliance with State and federal standards, more recent joint audit findings found the plan to be fully compliant with standards reviewed in the area of quality management. The plan demonstrated marked improvement in complying with federal and State standards and resolving many repeat deficiencies noted in the 2005 joint audit report.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members.

The DHCS's plan contracts require that plans ensure access to and the availability of services to members. The Department uses monitoring processes, including audits, to assess plans' compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Many performance measures fall under more than one domain. Measures such as well-care visits for children and adolescents, childhood immunizations, prenatal and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

LA Care demonstrated average performance for the access domain of care based on its 2009 performance measure rates that related to access, QIP outcomes that addressed access, and compliance review standards related to the availability of and access to care.

The plan's performance measure rates in 2009 related to access fell primarily between the MPLs and HPLs. LA Care exceeded the HPL for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*. The plan showed statistically significant improvement from 2008 to the 2009 performance measure rates for *Adolescent Well-Care Visits (AWC)* and *Breast Cancer Screening (BCS)*, which demonstrates good access to and availability of these services in addition to quality of care.

Joint audit findings showed that LA Care had good processes in place to monitor the availability and accessibility of services. While MRPIU review results indicated plan challenges with

procedures to track specialty referrals and compliance with cultural and linguistic-related services, more recent joint audit findings found the plan compliant in both areas. Joint audit deficiencies were due to inconsistent application of claims payment for emergency transportation and lack of monitoring procedures for ensuring members' access to medications in an emergency. However, the DHCS noted in a July 2009 medical audit close-out report that the plan corrected its deficiencies in both areas.

Timeliness

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

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures in areas 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.

Based on 2009 performance measure rates for providing timely care and compliance review standards related to timeliness, LA Care demonstrated average performance in the timeliness domain of care:

- ◆ LA Care performed above the MCMC MPLs for all timeliness-related performance measures in 2009.
- ◆ The plan's performance related to compliance with State and federal standards related to enrollee rights and protections, the grievance system, continuity and coordination of care, and utilization management showed mixed results.
- ◆ The joint medical audit found opportunities for the plan to update policies and procedures related to fraud and abuse and reporting suspected and actual breaches of member confidentiality. The review also showed deficiencies in utilization management practices related to prior authorization for injectable medications and pharmacy denials.
- ◆ The MRPIU review revealed deficiencies in prior-authorization notifications and grievance systems for both LA Care and its plan partners. Additionally, the plan lacked sufficient oversight of its delegated entities to ensure timely notification and timely resolution. The plan's notice of action letters did not include required language and lacked notice to members of State fair hearing rights. However, the more recent joint audit showed timely resolution of member grievances, good oversight of its delegated entities, and full compliance with continuity-of-care standards.

Conclusions and Recommendations

Overall, LA Care demonstrated average performance in providing quality, accessible, and timely health care services to MCMC members.

The plan's performance measure rates were between the established MPLs and HPLs, with one exception. LA Care exceeded the HPL for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*. Three measures showed statistically significant improvement in 2009: *Adolescent Well-Care Visits (AWC)*, *Breast Cancer Screening (BCS)*, and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*.

LA Care's URI QIP showed improvement in the percentage of providers with a 90 percent compliance rate for treating URI. The plan also increased the percentage of children who were diagnosed with URI and not dispensed an antibiotic.

LA Care demonstrated substantial improvement in complying with federal and State standards across the quality, access, and timeliness domains of care. The plan showed adequate resolution of all joint audit deficiencies.

Based on the overall assessment of LA Care in the areas of quality and timeliness of and access to care, HSAG recommends the following:

- ◆ Analyze performance measure data and explore opportunities to increase rates for measures where performance had remained stable.
- ◆ Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.
- ◆ Ensure appropriate implementation and monitoring of all areas noted as audit deficiencies to achieve ongoing compliance.

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

Plan Overview

L.A. Care Health Plan (LA Care) is a full-scope managed care plan in Los Angeles County. LA Care became operational with the MCMC Program in March 1997, and as of June 30, 2009, had 764,985 MCMC members.¹

LA Care serves members as a local initiative plan under the Two-Plan Model. In a Two-Plan model county, the DHCS contracts with two managed care plans to provide health care services to members. Most Two-Plan model counties offer Medi-Cal beneficiaries in both mandatory and voluntary aid codes the choice between a local initiative plan and a nongovernmental commercial health plan.

¹ *Medi-Cal Managed Care Enrollment Report*, June 2009. Available at:
<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process to assess plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about LA Care's performance in providing quality, accessible, and timely health care services to its MCMC members. Compliance monitoring standards primarily fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Joint Audit Review

The DHCS's Audits and Investigations Division (A&I) works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A joint audit is conducted of each MCMC plan approximately once every three years. In addition, A&I periodically conducts non-joint medical audits of five MCMC plans.

When preparing this report, HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards.

A joint audit by DMHC and A&I was conducted in October 2008, covering the review period of August 1, 2007, through July 30, 2008. The scope of this audit included utilization management,

continuity and coordination of care, availability and accessibility, members' rights, quality management, and administrative and organizational capacity. Results from this audit identified strengths as well as opportunities for improvement.

Under the utilization management (UM) category of review, LA Care demonstrated a UM program that used written criteria to determine medical necessity. The plan had mechanisms to assess under- and over-utilization of services and demonstrated review and discussion of these data within its quality improvement program committees. The audit resulted in two findings in the area of UM. The first related to the lack of plan policies and procedures for handling prior-authorization requests for injectable medications within pharmaceutical authorization time frames. The second finding, a repeat area of noncompliance, indicated that the plan did not use a qualified physician for seven of eight pharmaceutical denial decisions. A DHCS follow-up medical audit close-out report noted that the corrective action plans (CAPs) submitted by the plan adequately addressed the areas of deficiency.

A review of standards related to continuity of care found the plan fully compliant with all category requirements. LA Care demonstrated noted improvement in this area compared to the previous 2005 joint audit findings. Policies and procedures were in place to support case management and coordination of services for both in- and out-of-network services. Additionally, the plan implemented a mechanism to identify members eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and members with developmental disabilities to ensure linkage to medically necessary services.

In the category of availability and accessibility of services, LA Care had standards in place to monitor for access to care. The plan used facility site reviews, member surveys, grievance reports, usage reports, reasons for PCP change requests, disenrollment information, and network capacity reports as indicators to evaluate network adequacy. Additionally, in 2009 the plan updated its Provider Network Adequacy policy, which described its process for maintaining adequate numbers of health care providers. The audit found inconsistent application of claims payment policies for emergency transportation, which resulted in the denial of acceptable claims and delayed claims payment. This issue was noted as likely due to changes within the plan's payment policies for emergency transportation during the review period. In addition, the plan did not demonstrate "monitoring procedures to ensure members' access to medications prescribed in emergency circumstances," which was a repeat audit finding.²

Audit results in the member rights area found LA Care to be compliant with timely processing of grievances. The plan demonstrated good oversight of grievance monitoring of delegated plan partners. Cultural and linguistic service standards were met. A review of grievance files found that a medical director appropriately reviewed member grievances related to medical concerns. A&I

² Department of Health Care Services, Audits and Investigations. *Medical Review - L.A. Care Health Plan*. February 27, 2009, page ii.

identified two policy issues. The first finding indicated that the plan's Independent Medical Review (IMR) policies did not include standards for submission time frames and implementation of IMR decisions. The second issue noted that the plan's confidentiality policies lacked notification time frames for suspected or actual Health Insurance Portability and Accountability Act of 1996 (HIPAA) breaches.

The plan was fully compliant with standards reviewed in the quality management area. The plan demonstrated implementation and maintenance of a quality management program to monitor, evaluate, and take action to address needed improvements. For administrative and organizational capacity standards, the audit found the plan deficient in the area of identifying potential fraud and abuse issues and monitoring plan partners for compliance with fraud and abuse contract requirements. A medical audit close-out report from the DHCS in July 2009 showed that LA Care sufficiently addressed all areas of noncompliance identified as part of A&I's medical audit.

In addition to A&I's joint medical audit, A&I audited LA Care's compliance with the requirements of the plan's MCMC Hyde contract, which covers abortion services that are funded only with State funds, as these services do not qualify for federal funding. The contract review period was August 1, 2007, through July 31, 2008. The audit found LA Care compliant.

Member Rights and Program Integrity Monitoring Review

The Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These reviews are done before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2009.

MRPIU conducted a review of LA Care in April 2006 covering the period of January 1, 2005, through December 31, 2005. The scope of the audit covered grievances, prior authorization notification, cultural and linguistic services, and marketing.

The review noted 11 deficiencies with the grievance system, as follows:

- ◆ Not all files reviewed contained a statement notifying members of their right to request a State fair hearing.
- ◆ State fair hearing information did not include a department address for requesting hearings.
- ◆ Acknowledgement letters exceeded the notification time frames.
- ◆ Resolution letters exceeded the 30 calendar-day time frame.
- ◆ For grievances that exceeded 30 days, the plan lacked member notification as to the status of the grievance and the estimated completion date of resolution.
- ◆ Plan partners' policies and procedures for grievances did not include all required information.
- ◆ Plan partners' grievance procedures for recording a grievance lacked all required components.
- ◆ Not all plan partners made grievance forms available to members.
- ◆ Not all resolution letters to members included a clear and concise explanation of the plan's decision and/or did not include the correct 90-day time frame information for requesting a State fair hearing.
- ◆ The plan lacked a procedure to review quality of care grievances by the medical director for action.
- ◆ Not all plan partners' grievance procedures included information for addressing cultural and linguistic requirements.

MRPIU noted several findings for prior authorization notifications. These findings included the plan partners not using MMCD notice of action (NOA) letter templates; NOA letters without information regarding expedited State fair hearings; prior authorization notifications exceeding the required time frame; NOA letters without a citation of the specific regulations or procedures supporting the action team; and some denials without documentation that a qualified physician reviewed the denials.

For cultural and linguistic services, MRPIU noted that LA Care did not have required marketing materials translated into all of the plan's threshold languages and that not all provider offices made language interpreter services available to members on a 24-hour basis. Additionally, some provider offices encouraged the use of family members or friends as interpreters, and not all plan partners were aware of procedures for referring members to culturally and linguistically appropriate services.

Findings under the marketing category related to the plan's lack of a marketing orientation and training program for marketing representatives and lack of formal measures to monitor the performance of marketing representatives.

Strengths

LA Care demonstrated full compliance with A&I's medical audit standards for the areas of continuity of care and quality management. The plan demonstrated good monitoring of the availability and accessibility of services using multiple data sources. A&I's audit results, covering the period of August 1, 2007, through July 31, 2008, showed strong improvement by the plan in addressing many areas of noncompliance identified in the previous A&I audit and in the MRPIU review findings from 2005. Additionally, the plan adequately addressed all A&I medical review deficiencies as documented by the DHCS in a medical audit close-out report in July 2009.

Opportunities for Improvement

While LA Care addressed the identified joint medical audit deficiencies, it has an opportunity to ensure appropriate implementation and monitoring of the corrected areas to achieve ongoing compliance.

Conducting the Review

The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provides a standardized method for objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its EAS-specific performance measures when calculating rates.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about LA Care's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Performance Measure Validation

HSAG performed a HEDIS[®] Compliance Audit^{™3} of LA Care in 2009. HSAG found all measures to be reportable and that LA Care's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

³ HEDIS[®] refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS Compliance Audit[™] is a trademark of the NCQA.

Performance Measure Results

The table below presents a summary of LA Care’s county-level HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measures results (based on calendar year 2007 data). In addition, the table shows the plan’s HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the NCQA’s national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—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.

Due to significant methodology changes for the *Comprehensive Diabetes Care—HbA1c Control (<7.0 Percent)* measure for 2009, the MCMC Program was unable to compare 2008 and 2009 performance results for this measure.

Appendix A includes a performance measure name key with abbreviations contained in the following table.

Table 4.1—2008–2009 Performance Measure Results for L.A. Care Health Plan—Los Angeles County

Performance Measure ¹	Domain of Care ²	2008 HEDIS Rates ³	2009 HEDIS Rates ⁴	Performance Level for 2009	Performance Comparison ⁵	MMCD's Minimum Performance Level ⁶	MMCD's High Performance Level (Goal) ⁷
AAB	Q	32.5%	30.9%	★★	↔	20.6%	35.4%
ASM	Q	88.7%	88.0%	★★	↔	86.1%	91.9%
AWC	Q,A,T	37.0%	45.7%	★★	↑	35.9%	56.7%
BCS	Q,A	49.4%	52.2%	★★	↑	44.4%	61.2%
CCS	Q,A	67.3%	72.0%	★★	↔	56.5%	77.5%
CDC–E	Q,A	50.8%	57.2%	★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	28.9%	23.4%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	42.7%	47.0%	★★	↔	52.5%	32.4%
CDC–HT	Q,A	83.9%	79.3%	★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	32.3%	34.7%	★★	↔	25.1%	42.6%
CDC–LS	Q,A	79.3%	76.2%	★★	↔	66.7%	81.8%
CDC–N	Q,A	74.2%	74.0%	★★	↔	67.9%	85.4%
CIS–3	Q,A,T	74.3%	78.0%	★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	81.4%	84.3%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	55.9%	59.9%	★★	↔	54.0%	70.6%
URI	Q	80.0%	81.2%	★★	↑	79.6%	94.1%
W15	Q,A,T	54.1%	52.2%	★★	↔	44.5%	73.7%
W34	Q,A,T	78.5%	80.1%	★★★	↔	59.8%	78.9%

¹ DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the full name of each HEDIS measure.

² HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

³ HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.

⁴ HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.

⁵ Performance comparisons are based on the z test of statistical significance with a p value of <0.05.

⁶ The MMCD'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 The MMCD'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.

†The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↑ = Statistically significant increase.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

Not Comparable = Performance could not be compared due either to significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, LA Care demonstrated average performance, falling between the MPLs and HPLs for all but one of its reported performance measures in 2009. The plan exceeded the MCMC goal for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*. The plan did not have below-average performance in any areas.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. Plans that have rates below these minimum levels must submit an improvement plan to the DHCS for each area of deficiency, outlining the steps they will take to improve care.

LA Care did not have any measures in 2008 or 2009 that were below the MPLs. Therefore, the DHCS did not require LA Care to submit improvement plans for any measure for either year.

Strengths

LA Care performed above the MCMC Program goal and the national Medical 90th percentile on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* measure. Well-child visits span the domains of quality, access, and timeliness.

In addition, the plan showed statistically significant improvement in three measures from the 2008 to the 2009 HEDIS rates: *Adolescent Well-Care Visits (AWC)*, *Breast Cancer Screening (BCS)*, and *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*. The plan's performance demonstrated efforts to improve the quality of and access to care. No performance measures rates had statistically significant declines.

Opportunities for Improvement

While the plan has demonstrated stable performance with no measures falling below the MPLs, it has shown little improvement for most of its measures. The plan has an opportunity to improve its average performance to above-average performance.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas.

HSAG reviews each QIP using CMS' validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about LA Care's performance in providing quality, accessible, and timely care and services to its MCMC members. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, provides an overview of the objectives and methodology for conducting the EQRO review.

Quality Improvement Projects Conducted

LA Care had two clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. LA Care's second project, a small-group collaborative QIP, sought to increase the appropriate treatment of upper respiratory infection (URI) in children three months to 18 years of age. The ER collaborative QIP fell under both the quality and access domains of care, while the URI QIP fell under the quality domain of care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider in an office or clinic setting. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

Prescribing antibiotics for children with URI in many cases is an indicator of poor prescribing practices and suboptimal care. LA Care’s project attempted to improve the quality of care delivered to children with URIs.

Quality Improvement Project Validation Findings

The DHCS contracted with HSAG as its new EQRO in the second half of 2008. HSAG began validation for QIPs submitted by the plans after July 1, 2008.

The table below summarizes the validation results for both of LA Care’s QIPs across CMS protocol activities during the review period.

Table 5.1—QIP Validation Results for L.A. Care Health Plan—Los Angeles County (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	Partially Met	Not Met
I.	Appropriate Study Topic	100%	0%	0%
II.	Clearly Defined, Answerable Study Question(s)	0%	0%	100%
III.	Clearly Defined Study Indicator(s)	57%	29%	14%
IV.	Correctly Identified Study Population	0%	33%	67%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	33%	42%	25%
VII.	Appropriate Improvement Strategies	67%	33%	0%
VIII.	Sufficient Data Analysis and Interpretation	69%†	19%†	13%†
IX.	Real Improvement Achieved	100%	0%	0%
X.	Sustained Improvement Achieved	‡		
Percentage Score of Applicable Evaluation Elements Met		60%		
Validation Status		Not Applicable*		
‡The QIP did not progress to this activity during the review period and could not be assessed.				
* QIPs were not given an overall validation status during the review period.				
† The sum may not equal 100 percent due to rounding.				

LA Care submitted Remeasurement 1 data for the URI project during the review period; therefore, HSAG assessed for real improvement but could not yet assess for sustained improvement.

During the period covered by this report, HSAG’s application of the CMS validation requirements was more rigorous than previously experienced by the MCMC plans. As a result, many plans had difficulty complying fully with these requirements during the first cycle of QIP validations by HSAG. This was the case with LA Care’s QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided LA Care, as well as other plans, with an overall validation status of “Not Applicable” for both QIPs. This allowed time for plans to receive technical assistance and training with HSAG’s validation requirements without holding up the ongoing progress of QIPs that were already underway.

Quality Improvement Project Outcomes

Table 5.2 shows LA Care’s data for its QIPs. For the ER collaborative QIP, LA Care’s goal was to reduce the overall rate of avoidable ER visits by 10 percent from the baseline period by the year 2011. The plan’s first remeasurement year data will be included in the next performance evaluation report (July 1, 2009, through June 30, 2010) with HSAG’s assessment of real improvement.

For the *Appropriate Treatment for Children With an Upper Respiratory Infection* QIP, LA Care set a Remeasurement 1 goal to increase to 58.3 percent the percentage of PCPs with a compliance rate equal to or greater than 90 percent. The plan set a baseline measurement goal to increase to 89 percent the percentage of children three months to 18 years of age who were diagnosed with a URI and were not dispensed an antibiotic prescription on or three days after the episode date, and set its first remeasurement period at a goal of 92.1 percent.

Table 5.2—QIP Outcomes for L.A. Care Health Plan—Los Angeles County

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	Remeasurement Period		Sustained Improvement
		1 1/1/08–12/31/08	2 1/1/09–12/31/09	
Percentage of ER visits that were avoidable	16.0%	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Appropriate Treatment for Children with an Upper Respiratory Infection				
QIP Study Indicator	Baseline Period 7/1/05–6/30/06	Remeasurement Period		Sustained Improvement
		1 7/1/06–6/30/07	2 7/1/07–6/30/08	
1) Percentage of PCPs with a compliance rate for the URI measure equal to or greater than 90%	52.5%	62.2%*	‡	‡
2) Percentage of children 3 months – 18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription on or three days after the episode date	78.3%	80.0%*	‡	‡
* Designates statistically significant improvement over the prior measurement period. ‡ The QIP did not progress to this phase during the review period and could not be assessed.				

For the ER collaborative QIP, LA Care implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits. LA Care annually assesses after-hours coverage for all of its providers. To address the lack of financial incentive to provide extended hours, the plan developed an extended-hour grant and sent a description of the grant to all high-volume providers. The criteria for the grant included extending a provider's hours and/or adding weekend hours. In April 2008, the plan awarded the grant to 14 providers.

To improve the appropriate treatment for URI, LA Care participated in the Alliance Working for Antibiotic Resistance Education (AWARE) campaign, which distributed provider tool kits and member educational materials. Additionally, small-group collaborative QIP partners from other MCMC plans provided feedback to providers and developed common health messages for members. In 2008, the plan targeted high-volume and noncompliant providers. These providers received follow-up calls from the LA Care medical director in addition to other faxes and educational materials.

The plan showed a statistically significant increase from its Baseline rate to its Remeasurement 1 rate for both indicators. The plan improved the percentage of primary care physicians with a 90 percent compliance rate for treating URI from 52.5 percent to 62.2 percent. Additionally, the plan increased to 80.0 percent the percentage of children who were diagnosed with URI and not dispensed an antibiotic.

The combination of both member and provider interventions and targeted provider interventions may have contributed to the plan's success in improving the URI measure's rate.

Strengths

LA Care demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data. In addition, the plan demonstrated real improvement for both study indicators of the URI QIP.

LA Care's small-group collaborative QIP on URI showed statistically significant improvement for the first year of remeasurement. The plan's successful efforts have impacted its performance on the *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* performance measure rate, which showed a statistically significant increase between HEDIS 2008 and HEDIS 2009.

Opportunities for Improvement

LA Care has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with the DHCS requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

The table below provides abbreviations of HEDIS performance measures used throughout this report.

Table A.1—HEDIS® Performance Measures Name Key

Abbreviation	Full Name of HEDIS® Performance Measure
AAB	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
ASM	<i>Use of Appropriate Medications for People With Asthma</i>
AWC	<i>Adolescent Well-Care Visits</i>
BCS	<i>Breast Cancer Screening</i>
CCS	<i>Cervical Cancer Screening</i>
CDC-E	<i>Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed</i>
CDC-H7	<i>Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)</i>
CDC-H9	<i>Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)</i>
CDC-HT	<i>Comprehensive Diabetes Care—HbA1c Testing</i>
CDC-LC	<i>Comprehensive Diabetes Care—LDL-C Control</i>
CDC-LS	<i>Comprehensive Diabetes Care—LDL-C Screening</i>
CDC-N	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>
CIS-3	<i>Childhood Immunization Status—Combination 3</i>
PPC-Pre	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>
PPC-Pst	<i>Prenatal and Postpartum Care—Postpartum Care</i>
URI	<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>
W15	<i>Well-Child Visits in the First 15 Months of Life (Six or More Visits)</i>
W34	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>