Performance Evaluation Report

L.A. Care Health Plan

July 1, 2009–June 30, 2010

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

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TABLE OF CONTENTS

1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] 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 the 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. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, L.A. Care Health Plan ("L.A. Care" or "the plan"), which delivers care in Los Angeles County, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

L.A. Care is a full-scope managed care plan in Los Angeles County. L.A. Care serves members as a local initiative (LI) under the Two-Plan Model. L.A. Care has been Knox-Keene licensed since 1997. Knox-Keene licensure is granted by the Department of Managed Health Care (DMHC) to plans that meet minimum required standards according to the Knox-Keene Health Care Service Plan Act of 1975. The act includes a set of laws that regulate managed care organizations (MCOs).

In a Two-Plan Model county, the DHCS contracts with two managed care plans in each county to provide medical services to members. Most counties offer a local initiative (LI) plan and a nongovernmental, commercial health plan.

Members of the MCMC Program may enroll in either the LI plan operated by L.A. Care or in the alternative commercial plan. L.A. Care became operational with the MCMC Program in March 1997, and as of June 30, 2010, L.A. Care had 819,065 MCMC members.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2010*. 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 that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the 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 Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about L.A. Care's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division often work in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits are conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

HSAG reviewed the most current medical performance review reports available as of June 30, 2010, to assess plans' compliance with State-specified standards. A&I and DMHC conducted a medical performance review of L.A. Care in October 2008 covering the review period of August 1, 2007, through July 30, 2008.[3] HSAG reported the review findings in the 2008–2009 plan evaluation report for L.A. Care. The review found L.A. Care fully compliant with medical audit standards for the areas of continuity of care and quality management. In addition, L.A. Care demonstrated full compliance with the MCMC Hyde contract requirements. The Hyde contract covers abortion services funded only with State funds, as these services do not qualify for federal funding.

According to the July 2009 medical performance review close-out letter, L.A. Care fully resolved all deficiencies noted from the review, which included such areas as availability and accessibility, member rights, utilization management, and administrative and organizational capacity.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's 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 member rights reviews are conducted 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 member rights 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, 2010.

MRPIU conducted an on-site review of L.A. Care in December 2009 and April 2010 covering the review period of January 1, 2008, through June 30, 2009. The review covered L.A. Care and four of its plan partners, with site visits to the plan and plan partner locations.

Grievances and Appeals

The review identified deficiencies related to the processing of grievances by plan partners and L.A. Care. The MRPIU found that L.A. Care and one plan partner had incorrect time frames within their Notice of Action (NOA) letters for grievances. The NOAs indicated that members had up to

[3] *California Department of Health Care Services Medical Review – Northern Section, Audits and Investigations, L.A. Care*, February 27, 2009.

180 days to file an appeal or request a State hearing; however, the MCMC policy stated 90 days. Another plan partner exceeded the time frame for both resolving a grievance and notifying the member of the status and expected completion date, based on a review of 50 grievance case files. The review also found that in one of 22 grievance case files, one plan partner had included the incorrect "your rights" attachment.

Prior Authorizations

The MRPIU also noted deficiencies related to prior authorization notification. A review of prior authorization files found instances in which the plan, one plan partner, and one medical group had sent out the NOA letter for denial or modification after the maximum time frame had passed.

Fraud and Abuse

L.A. Care and its plan partners were fully compliant with requirements for prevention, detection, reporting and investigation of any suspected fraud and abuse.

Strengths

Based on the review findings, L.A. Care showed strong performance as demonstrated by full compliance with most contract requirements, including quality management, continuity of care, cultural and linguistic services, marketing, program integrity, and Hyde contract requirements. In addition, the plan fully resolved all deficiencies noted on the previous medical performance review, which suggests that L.A. Care has sufficient programs and internal practices in place to support the provision of quality health care that is available and accessible to its members.

Opportunities for Improvement

L.A. Care has an opportunity to improve within the timeliness domain. The plan should ensure that when processing grievances and authorizations, all time frames are met internally as well as by all plan partners.

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 provide 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.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about L.A. 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.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed a HEDIS Compliance Audit™ of L.A. Care in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[4] Based on the results of the compliance audit, HSAG found all measures to be reportable. The audit team noted that for the diabetes care measures, L.A. Care excluded some cases when the diagnosis code indicated "rule-out diabetes" and the medical record did not substantiate the diagnosis of diabetes. Since this was not an allowable exclusion, the auditor assessed the impact and determined the issue did not result in a bias to the final rates. The auditor also noted a best

[4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

practice in L.A. Care's monitoring of encounter data submission and the establishment of encounter data submission benchmarks.

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Table 3.2.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
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*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*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*

Table 3.2 presents a summary of L.A. Care's HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan's HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national Medicaid 25th percentile and 90th percentile, respectively. 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—2009–2010 Performance Measure Results for L.A. Care Health Plan—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	30.9%	30.4%	★★	↔	20.2%	33.4%
AWC	Q,A,T	45.7%	53.1%	★★	↑	37.9%	59.4%
BCS	Q,A	52.2%	54.8%	★★	↑	45.0%	63.0%
CCS	Q,A	72.0%	71.8%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	60.8%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	57.2%	52.8%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	45.0%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	47.0%	42.1%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	79.3%	82.1%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	34.7%	36.8%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	76.2%	80.1%	★★	↔	71.5%	82.5%
CDC–N	Q,A	74.0%	83.3%	★★	↑	73.4%	85.4%
CIS–3	Q,A,T	78.0%	80.9%	★★★	↔	62.4%	80.6%
LBP	Q	‡	79.6%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	84.3%	85.5%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	59.9%	61.5%	★★	↔	57.9%	72.7%
URI	Q	81.2%	84.6%	★★	↑	81.1%	94.5%
W34	Q,A,T	80.1%	78.5%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	59.1%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	64.9%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	54.2%	Not Comparable	Not Comparable	NA	NA

[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] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[5] Performance comparisons are based on the Chi-Square 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 DHCS did not require plans to report this measure in 2009.
NA= The DHCS does not establish an MPL/HPL for first year measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.
Not Comparable = Performance could not be compared due to either significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, L.A. Care demonstrated above average performance, with no performance measure results below the MPL, and one measure exceeding the HPL. Four of the plan's measures achieved a statistically significant improvement, and no statistically significant declines were noted.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline steps to improve care.

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

L.A. Care did not have any 2009 performance measure rates that required an improvement plan.

Strengths

L.A. Care showed consistent performance across all measures, with no rates falling below the MPL. The plan achieved statistically significant improvement with its *Adolescent Well-Care Visits*, *Breast Cancer Screening, Comprehensive Diabetes Care—Medical Attention for Nephropathy*, and *Appropriate Treatment for Children With Upper Respiratory Infection* performance measures. The plan also achieved the HPL with the *Childhood Immunization Status* measure.

Opportunities for Improvement

Although L.A. Care did not have any measures with a statistically significant decline, several measures had a decrease in their rate, with the plan performance remaining flat. These include *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB), Cervical Cancer Screening (CCS), Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC-E),* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34).* In particular, the *AAB* measure has demonstrated a very slight decline in the past two years. According to the plan's annual quality improvement program evaluation[5], L.A. Care conducted a barrier analysis and identified key factors related to physician and member behaviors that impacted its performance on the measure. The plan implemented several actions to address these barriers and should evaluate their success in subsequent years.

[5] *L.A. Care Health Plan Quality Improvement Program Annual Report and Evaluation 2009*

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Quality Improvement Projects Conducted

For L.A. Care, two clinical QIPs and one clinical QIP proposal were 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. L.A. 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 third project, an internal QIP, sought to improve the health care services provided to diabetic members 18 to 75 years of age. The ER collaborative QIP and the diabetes care 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. L.A. Care's project attempted to improve the quality of care delivered to children with URIs.

Blood glucose monitoring and retinopathy screening assist in developing appropriate treatment plans to decrease the risk of diabetes complications. Lack of appropriate testing in diabetics indicates suboptimal care and case management. The plan's project attempted to increase HbA1c testing and retinal eye exams to minimize the development of diabetes complications.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for L.A. Care Health Plan—Los Angeles County July 1, 2009, through June 30, 2010

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				
Reducing Avoidable Emergency Room Visits	Annual Submission	84%	100%	*Met*
Small-Group Collaborative QIPs				
Appropriate Treatment for Children With Upper Respiratory Infection	Annual Submission	100%	100%	*Met*
Internal QIPs				
Improving HbA1c and Diabetic Retinal Exam Screening Rates	Proposal	96%	100%	*Met*

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

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met, Partially Met,* or *Not Met*. In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided

training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that L.A. Care's annual submission of its three QIPs all received an overall validation status of *Met.* As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status; therefore, the plan did not have to resubmit any of its QIPs.

Table 4.2 summarizes the validation results for both of L.A. Care's QIPs across the CMS protocol activities during the review period. The validation scores presented in Table 4.2 reflect the last submission validated before June 30, 2010.

Table 4.2—Quality Improvement Project Average Rates*
for L.A. Care Health Plan—Los Angeles County
(Number = 3 QIP Submissions, 3 QIP Topics)
July 1, 2009, through June 30, 2010

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	94%	6%	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%
Design Total		**98%**	**2%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	83%	17%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	83%	0%	17%
Implementation Total†		**91%**	**5%**	**5%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	94%	6%	0%
	IX: Real Improvement Achieved†	63%	0%	38%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**84%**	**4%**	**12%**

* 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.

† The sum may not equal 100 percent due to rounding.

L.A. Care accurately applied the QIP process for the Design stage; however, the plan did not include a discussion of the eligible population in Activity I for the *Reducing Avoidable Emergency Room Visits* QIP. In the Implementation stage, Activity V for the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP, the plan did not provide the population size and diabetes prevalence. For the *Reducing Avoidable Emergency Room Visits* QIP, the plan did not revise its interventions even though the study indicator outcome did not improve. In the Outcomes stage,

the *Reducing Avoidable Emergency Room Visits* QIP outcome did not demonstrate statistically significant improvement; therefore, Activity IX received a *Partially Met* score. Only the *Appropriate Treatment for Children With Upper Respiratory Infection* QIP had progressed to a second remeasurement period and was able to demonstrate sustained improvement. Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3—Quality Improvement Project Outcomes for L.A. Care Health Plan—Los Angeles County (Number = 2 QIPs, 2 QIP Topics) July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable	16.0%	15.9%	‡	‡
QIP #2—Appropriate Treatment for Children With a URI				
QIP Study Indicator	**Baseline Period 7/1/05–6/30/06**	**Remeasurement 1 7/1/06–6/30/07**	**Remeasurement 2 7/1/07–6/30/08**	**Sustained Improvement¥**
The 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%*	81.2%*	Yes
QIP #3—Improving HbA1c and Retinal Eye Exam Screening Rates				
QIP Study Indicator	**Baseline Period (TBD)**	**Remeasurement 1 (TBD)**	**Remeasurement 2 (TBD)**	**Sustained Improvement¥**
The percentage of members 18–75 years of age with diabetes who received HbA1c testing as of December 31 of the measurement year	‡	‡	‡	‡
The percentage of members 18–75 years of age with diabetes who received a retinal eye exam in the measurement year or a negative retinal eye exam in the year prior to the measurement year	‡	‡	‡	‡

* A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05)

‡ The QIP did not progress to this phase during the review period and could not be assessed.

¥ Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

In the *Reducing Avoidable ER Visits* QIP, L.A. Care reported a decline in the percentage of avoidable ER visits; however, the decline was not statistically significant and could have been due to chance. Since collaborative interventions were not initiated until early 2009, HSAG could not evaluate the effectiveness of those interventions.

Conversely, the plan reported a statistically significant increase over the prior measurement period and demonstrated sustained improvement from baseline to Remeasurement 2. To improve the appropriate treatment for URI, L.A. 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 partner plans provided feedback to providers and developed common health messages for members. In 2008, L.A. Care targeted high-volume and noncompliant providers. These providers received follow-up calls from the plan's medical director in addition to other faxes and educational materials. The combination of both member and targeted provider interventions may have contributed to L.A. Care's success in sustaining the improvement of the URI measure's rate.

The diabetes QIP proposal had not progressed to the point of reporting study indicator outcomes.

Strengths

L.A. Care accurately documented the QIP process for the Design stage.

L.A. Care's small-group collaborative *Appropriate Treatment for Children With Upper Respiratory Infection* QIP showed statistically significant improvement for the second year of remeasurement and sustained improvement from baseline to Remeasurement 2.

Opportunities for Improvement

L.A. Care has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan use HSAG's QIP Completion Instructions, which will help the plan document all required elements within the CMS protocol activities.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan surveys.[6]

The administration of the CAHPS surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS Surveys be administered to both adult members and the parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

The Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about L.A. Care'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 as follows:

CAHPS Global Rating Measures:

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

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

CAHPS Composite Measures:

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

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance (NCQA)'s HEDIS® benchmarks and thresholds or NCQA's national Medicaid data, when applicable. 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*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 5.1.

Table 5.1—Star Ratings Crosswalk

Stars	Adult Percentiles	Child Percentiles
★★★★★	≥ 90th percentile	≥ 80th percentile
★★★★	75th percentile–89th percentile	60th percentile–79th percentile
★★★	50th percentile–74th percentile	40th percentile–59th percentile
★★	25th percentile–49th percentile	20th percentile–39th percentile
★	< 25th percentile	< 20th percentile

Table 5.2—L.A. Care Health Plan—Los Angeles County Medi-Cal Managed Care County-Level Global Ratings

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★	★★+
Child	★★	★	★★	★★★★+

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Table 5.3— L.A. Care Health Plan—Los Angeles County
Medi-Cal Managed Care County-Level Composite Measures

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Adult	★	★	★	★+	★+
Child	★	★	★	★★★+	★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Strengths

L.A. Care performed well within the child population for both the global *Rating of Specialist Seen Most Often* measure and *Customer Service* composite measure, demonstrating that L.A. Care members are pleased with the plans' customer service functions and pediatric specialist network. Caution should be exercised, however, when evaluating these results since the number of respondents is less than 100.

Opportunities for Improvement

L.A. Care's CAHPS results showed primarily poor performance for most 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 plan'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 L.A. Care's highest priorities: *Rating of All Health Care, Getting Needed Care,* and *How Well Doctors Communicate*. The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 L.A. Care CAHPS Plan-Specific Report*. Areas for improvement spanned the quality, access, and timeliness domains of care.

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 the results of performance measures and quality improvement projects (QIPs) 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. Finally, some member satisfaction measures relate to quality of care.

The plan showed average performance based on L.A. Care's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, member satisfaction survey results, and the results of the medical performance and member rights reviews as they related to measurement and improvement. All performance measures involve the quality domain. L.A. Care exceeded the HPL for its *Childhood Immunization Status* measure, achieved statistically significant improvement in four other measures, and had no measures fall below the MPL. These findings indicate that overall, L.A. Care provides quality care to its members.

L.A. Care performed poorly in both adult and child satisfaction surveys for both the composite and global ratings for measures of quality.

The plan fully met contractual requirements for the prevention, detection, reporting and investigation of any suspected fraud and abuse.

QIP results showed that the plan achieved a statistically significant improvement in its *Appropriate Treatment for Children With Upper Respiratory Infection* QIP. L.A. Care also demonstrated an improvement in its *Reducing Avoidable ER Visits* QIP, although the improvement was not statistically significant. The plan demonstrated opportunities to improve its QIP documentation,

particularly in the implementation and outcome phases, to ensure compliance with the CMS protocol for conducting valid and reliable QIPs.

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 has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

The plan demonstrated average performance based on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results. L.A. Care showed statistically significant improvement in three measures of access (*Adolescent Well-Care Visits, Breast Cancer Screening and Comprehensive Diabetes Care— Medical Attention for Nephropathy*), indicating members are receiving care that is accessible. Conversely, member satisfaction related to access was low across adult and child global and composite ratings, with the exception of *Rating of Specialist Seen Most Often* and *Customer Service*. Health plan performance in customer service impacts access to care. These results indicate that L.A. Care members are less than satisfied with access to care.

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 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.

L.A. Care exhibited below average to average performance in the timeliness domain of care based on 2010 performance measure rates for providing timely care, medical performance and member rights reviews related to timeliness, and member satisfaction results related to timeliness.

Performance measure rates regarding timeliness showed that the plan achieved the HPL for one measure that impacts timeliness (*Childhood Immunization Status*) and performed between the MPL and HPL for all other measures of timeliness.

Member satisfaction results showed that the plan had poor performance in the global and composite ratings related to timeliness for both adult and child populations, suggesting that members perceive that they do not always receive timely care. L.A. Care performed better; however, in the customer service area in the child survey results, suggesting that the plan had sufficient mechanisms to address and promptly resolve member inquiries.

L.A. Care demonstrated deficiencies related to sending notice of action letters which exceeded the allowable time frame for grievances and contained incorrect time frame requirements within the letters for filing an appeal.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. L.A. Care's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, L.A. Care achieved average performance during this review period in the areas of quality and access, and below average performance in the area of timeliness. These findings suggest that L.A. Care provides accessible health care services of sufficient quality to its MCMC members but has an opportunity to improve the timeliness of these services.

L.A. Care continued to strengthen its 2009 performance by improving 2010 performance measure rates. The plan achieved a successful outcome with one QIP and had promising improvement in the other. L.A. Care experienced some challenges, however, with ensuring time frame requirements were met internally as well as by its plan partners when processing grievances, appeals, and prior authorizations.

Based on the overall assessment of L.A. Care in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following:

- Ensure that all MRPIU-identified deficiencies are fully resolved and maintain clear evidence of the implementation of corrective actions.
- Address QIP data elements that were *Not Met* in the QIP validation results. Ensure future QIP submissions include all necessary documentation required for a valid QIP.
- Proactively focus on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure and implement targeted improvement efforts to prevent further decline. Consider expanding the Rewarding Results incentive program to include this measure.
- Review the 2010 plan-specific CAHPS results report and develop strategies to address the *Rating of All Health Care, Getting Needed Care,* and *How Well Doctors Communicate* priority areas.

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

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
Analyze performance measure data and explore opportunities to increase rates for measures where performance had remained stable.	The HEDIS results were analyzed by several variables including plan partner, region, language, gender, ethnicity, and age cohort. This information was shared with Quality Improvement and the plan partners as well as community outreach and health education. In addition, L.A. Care has a HEDIS intervention table and work plan that is monitored in the Clinical Improvement Committee for plan-wide interventions. The QI work plan also has HEDIS measures and activities that are presented to the Quality Oversight Committee on a quarterly basis. Finally, the QI annual evaluation examines the HEDIS measures and does a detailed quantitative and qualitative analysis of all the measures.
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.	L.A. Care has been using the HSAG QIP Summary Form since 2009.
Ensure appropriate implementation and monitoring of all areas noted as audit deficiencies to achieve ongoing compliance.	As part of L.A. Care's Compliance Plan, L.A. Care performs annual audits of subcontractors who are identified to be non-compliant with State laws, regulations and other requirements. Additionally, L.A. Care performs annual internal Member Rights and Claims audits to ensure compliance with State requirements.