Performance Evaluation Report

L.A. Care Health Plan

July 1, 2010–June 30, 2011

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

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 million beneficiaries (as of June 2011)[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, 2010–June 30, 2011*, 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 2011*. 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 July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, 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. 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, 2011, L.A. Care had 888,333 MCMC members.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2011*. 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, 2010–June 30, 2011*, 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 have historically worked in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits have been 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.

For this report, HSAG reviewed the most current audit reports available as of June 30, 2011, to assess plans' compliance with State-specified standards . The most recent medical performance review was completed in October 2008 covering the review period of August 1, 2007, through July 30, 2008. HSAG reported the review findings in the 2008–2009 plan evaluation report for L.A. Care. HSAG reported findings from this audit in the 2009–2010 plan evaluation report.[3]

The review found L.A. Care fully compliant with medical audit standards for the areas of continuity of care and quality management. According to the July 28, 2009, medical performance review CAP response, L.A. Care fully resolved all deficiencies noted from the review, which included all of the original findings in the areas of availability and accessibility, member rights, utilization management, and administrative and organizational capacity.

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.

The DHCS's next scheduled audit for the plan is September 2011. The results of this audit will be included in the next evaluation report.

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, 2011.

[3] California Department of Health Care Services. *Performance Evaluation Report, LA Care Health Plan – July 1, 2009, through June 30, 2010*. October 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

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. The scope of the review included member grievances, prior authorization, cultural and linguistic services, and marketing.

In the category of grievances, MRPIU 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 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.

In the prior authorization category, 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.

Strengths

L.A. Care demonstrated 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 medical performance review corrective action plan.

Opportunities for Improvement

L.A. Care has an opportunity to improve its timeliness functions within both authorizations and grievances; the plan should ensure that 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, 2010–June 30, 2011*, 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 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[4] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of L.A. Care in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. While the audit found all performance measure rates valid for reporting, the auditor did observe that not all codes were reported with the appropriate specificity and recommended that the plan address this.

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

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® 2011 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2011 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 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). 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. The table shows the plan's HEDIS 2011 performance compared to the MCMC-established MPLs and 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—2010–2011 Performance Measure Results for L.A. Care Health Plan—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	30.4%	40.7%	★★★	↑	19.7%	35.9%
AWC	Q,A,T	53.1%	49.2%	★★	↔	38.8%	63.2%
BCS	Q,A	54.8%	53.4%	★★	↓	46.2%	63.8%
CCS	Q,A	71.8%	67.9%	★★	↔	61.0%	78.9%
CDC–BP	Q	60.8%	58.5%	★★	↔	53.5%	73.4%
CDC–E	Q,A	52.8%	50.7%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	45.0%	45.7%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	42.1%	41.5%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	82.1%	85.0%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	36.8%	37.4%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	80.1%	79.0%	★★	↔	69.3%	84.0%
CDC–N	Q,A	83.3%	78.3%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	80.9%	80.0%	★★	↔	63.5%	82.0%
LBP	Q	79.6%	80.2%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	85.5%	82.1%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	61.5%	55.3%	★	↔	58.7%	74.4%
URI	Q	84.6%	86.5%	★★	↑	82.1%	94.9%
W34	Q,A,T	78.5%	80.6%	★★	↔	65.9%	82.5%
WCC–BMI	Q	59.1%	65.6%	★★★	↔	13.0%	63.0%
WCC–N	Q	64.9%	68.3%	★★★	↔	34.3%	67.9%
WCC–PA	Q	54.2%	58.4%	★★★	↔	22.9%	56.7%

[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 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.

[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.

★ = 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.

Performance Measure Result Findings

Overall, L.A. Care demonstrated above average performance, with only one measure (*Postpartum Care)* falling below the MPL, and four measures exceeding the HPLs. Two measures achieved a statistically significant improvement and one measure had a statistically significant decline.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at, or above, established MPLs. The DHCS assesses each plan's rates against MPLs and requires plans with 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 requiring a 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with 2011 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 developing new improvement plans.

Strengths

L.A. Care showed consistent performance across all measures, with only one rate falling below the MPL. Four of the plan's measures achieved the HPLs in 2011: *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and the three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures—*BMI Assessment: Total*, *Nutrition Counseling: Total,* and *Physical Activity Counseling: Total.*

Opportunities for Improvement

The plan had only one measure fall below the MPL in 2011: *Prenatal and Postpartum Care—Postpartum Care.* The plan should focus its improvement efforts on this measure for 2012 HEDIS performance. L.A. Care should also review the *Breast Cancer Screening* measure and determine what caused the statistically significant decrease in 2011 to ensure that the measure does not continue to slip in 2012. Finally, the plan may consider an overall improvement strategy since most measures are between the MPLs and the HPLs, with no statistically significant improvement in the past year.

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, 2010–June 30, 2011*, 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

L.A. Care had two clinical QIPs in progress during the review period of July 1, 2010–June 30, 2011. 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, 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.

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

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 QIPs across CMS protocol activities during the review period.

Table 5.1—Quality Improvement Project Validation Activity for L.A. Care Health Plan—Los Angeles County July 1, 2010, through June 30, 2011

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	87%	100%	*Met*
Internal QIPs				
Improving HbA1c and Diabetic Retinal Exam Screening Rates	Annual Submission	100%	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 non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

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

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

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that L.A. Care's annual submission of its two QIPs 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 either of its QIPs.

Table 4.2 summarizes the validation results for both of L.A. Care's QIPs across CMS protocol activities during the review period.

Table 4.2––Quality Improvement Project Average Rates*
for L.A. Care Health Plan—Los Angeles County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2010, through June 30, 2011

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	92%	8%	0%
	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**72%**	**6%**	**22%**

* 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.

L.A. Care submitted Remeasurement 2 data for the *Reducing Avoidable Emergency Room Visits* QIP; therefore, HSAG validated Activity I through Activity X. For the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP, the plan submitted baseline data; so validation included Activity I through Activity VIII. L.A. Care demonstrated an excellent understanding of the design and implementation stages, scoring 100 percent on all applicable evaluation elements. Conversely, for the outcomes stage, L.A. Care was scored lower in Activity IX and Activity X for the plan's inability to demonstrate statistically significant improvement and achieve sustained improvement for its *Reducing Avoidable Emergency Room Visits* QIP. Sustained improvement is defined as improvement in performance over baseline that 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 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 QIP Submissions, 2 QIP Topics) July 1, 2010, through June 30, 2011

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%	22.4%*	No
QIP #2—Improving HbA1c and Retinal Eye Exam Screening Rates				
QIP Study Indicator	**Baseline Period (1/1/09–12/31/09)**	**Remeasurement 1 (1/1/10–12/31/10)**	**Remeasurement 2 (1/1/11–12/31/11)**	**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	82.08 %	‡	‡	‡
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	52.78%	‡	‡	‡

* 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.

L.A. Care reported a decline in performance for the *Reducing Avoidable Emergency Room Visits* QIP study indicator from Remeasurement 1 to Remeasurement 2. The increase in the avoidable ER visits indicator outcome was statistically significant. An increase for this measure reflects a decline in performance. Collaborative interventions were initiated in early 2009; however, they did not correspond to any improvement in performance. The plan did not demonstrate overall improvement from baseline to Remeasurement 2; therefore, it did not achieve sustained improvement.

For the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP, the plan had only progressed to the stage of reporting baseline data; so real and sustained improvement could not be assessed. As part of its effort to improve diabetic retinal exam and HbA1c scores, L.A. Care has implemented a few targeted interventions focused on the provider. These primarily include incentives for providers, a provider progress report, and a listing of the providers' patients requiring follow-up to obtain these exams.

Strengths

L.A. Care demonstrated an excellent understanding of the design and implementation stages and received *Met* scores for all evaluation elements. The plan achieved these scores without the benefit of resubmission, indicating proficiency with the QIP validation process.

Opportunities for Improvement

L.A. Care has an opportunity to improve its intervention strategies to order to achieve sustained improvement of its QIP outcomes. At a minimum, barrier analysis should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone. Additionally, HSAG recommends that L.A. Care implement a method to evaluate the effectiveness of each intervention. Based on the evaluation results, the plan can make appropriate revisions or implement new interventions, if necessary. If the intervention evaluation demonstrates that an intervention is successful, the plan should clearly document the process and how it was used to monitor and standardize the intervention in the QIP.

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 project (QIP) 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, quality assessment and performance improvement, and health information systems.

The plan had average performance based on L.A. Care's 2011 performance measure rates (which reflect 2010 measurement data), QIP outcomes, and medical performance and member rights reviews.

Four HEDIS measures related to the quality domain scored above the HPLs, while only one measure scored below the MPL; the remaining measures performed between the MPLs and the HPLs, with no statistically significant improvement during the past year. Two quality measures had statistically significant improvement over 2010 HEDIS results. Overall, L.A. Care HEDIS performance for the quality domain was above average.

The plan demonstrated full compliance with the MCMC Hyde contract requirements and was able to fully correct all deficiencies outlined in the medical performance review close-out CAP letter dated July 28, 2009. However, there were quality-related findings in the MRPIU report related to member grievances and prior authorization.

Both plan QIPs (*Reducing Avoidable Emergency Room Visits* and *Improving HbA1c* and *Diabetic Retinal Exam Screening Rates*) were associated with the quality domain. For the ER QIP, the plan did not demonstrate overall improvement from baseline to Remeasurement 2; therefore, it did not achieve the goal of deterring members from unnecessarily using emergency rooms. The *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP was not validated for significant or sustained improvement.

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 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 access to covered services under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, and results of medical performance and member rights reviews 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 review of 2011 performance measure rates related to access, QIP outcomes, and medical performance and member rights reviews.

The plan's 2011 HEDIS measures related to access demonstrated average performance, with *Prenatal and Postpartum Care—Postpartum Care* falling below the MPL. The July 28, 2009, CAP close-out letter identified correction of the following deficiencies: Time and Distance Standards for PCPs, Hospitals, and Ancillary Services; Specialists and Specialty Services; Emergency Service Providers (Payments); Emergency Transportation Providers; Family Planning (Payments); and Pharmaceutical Services and Prescribed Drugs.

Both QIPs (*Reducing Avoidable Emergency Room Visits* and *Improving HbA1c* and *Diabetic Retinal Exam Screening Rates*) received *Met* scores during the QIP validation process; however, the ER visits QIP was not able to achieve its goal of reducing unnecessary emergency room visits.

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 average performance in the timeliness domain of care based on 2011 performance measure rates for providing timely care, medical performance, and member rights reviews.

Again, *Prenatal and Postpartum Care—Postpartum Care* was the only timeliness measure to fall below the MPL, indicating a majority of members did not receive postpartum care within recommended time frames.

L.A. Care had deficiencies in the prior authorization category. MRPIU found instances in which the plan, plan partner, or medical group had sent out the NOA letter for denial or modification after the maximum time frame had passed.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations in the 2009–2010 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, access, and timeliness. These findings suggest L.A. Care provides adequate health care services of sufficient quality to its MCMC members but has room for improvement in all three domains of care.

L.A. Care demonstrated 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 medical performance review CAP. The plan also had four HEDIS measures outperform the HPL in 2011.

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

- Improve timeliness functions within both authorizations and grievances.
- Ensure all time frames related to medical performance review are met internally as well as by plan partners.
- Ensure the plan's transactional systems capture claims data to the appropriate specificity for the purposes of HEDIS reporting.

- Focus 2012 HEDIS improvement efforts on the *Prenatal and Postpartum Care—Postpartum Care* measure.
- Review the *Breast Cancer Screening* measure and determine what caused the statistically significant decrease in 2011 to ensure that the measure does not continue to slip in 2012.
- For QIPs, barrier analysis should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow identification of changes, or trends, not evident in annual analysis alone.
- Implement a method to evaluate the effectiveness of each intervention relating to QIPs.

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

Appendix A. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

for L.A. Care Health Plan

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with L.A. Care's self-reported actions that address the recommendations. Neither Health Services Advisory Group, Inc. (the external quality review organization for Medi-Cal Managed Care) nor any State agency has confirmed implementation of the actions that the plan self-reported in the grid.

Table A.1—Grid of L.A. Care's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	L.A. Care's Self-Reported Actions That Address the EQR Recommendation
Ensure that all MRPIU-identified deficiencies are fully resolved and maintain clear evidence of the implementation of corrective actions.	L.A. Care has reviewed internal and plan partner policies and procedures to ensure consistency with State rules and contractual requirements. Additionally, during the annual internal and plan partner audit, L.A. Care staff assessed compliance with grievance and authorizations time frames.
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.	**Statewide Collaborative QIP—*Reducing Avoidable Emergency Room Visits*—2009–2010 Report**: Annual submission scored 84%. Overall validation status was *Met*. L.A. Care worked diligently using the QIP guide and sought technical assistance from HSAG in order to meet the QIP writing requirements. In December, 2011, HSAG completed validation of the 2011 annual submission of *Reducing Avoidable Emergency Room Visits* QIP. L.A. Care **scored 97%** of evaluation elements met and **100% of the critical elements met** showing improvement in necessary documentation. The only element not met was on "not sustained improvement" and not on necessary documentation. The QIP received an overall *Met* validation status and was considered closed. **Internal QIP—*Improving AIC and DRE Screening Rates*—2009–2010 Report:** Proposal scored 96%. Overall validation status was *Met*. L.A. Care worked diligently using the QIP guide and sought technical assistance from HSAG in order to meet the QIP writing requirements. In October, 2011, HSAG completed validation of the 2011 annual submission of *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP. L.A. Care **scored 94%** of evaluation elements met and **100% of the critical elements met** showing improvement in necessary documentation. The only elements not met (1) or partially met (2) were in the areas of "plan for real improvement" due to a decline in study indicator 2 (2 partials) and the Not Met where none of the study indicators demonstrated statically significant improvement from baseline to the first remeasurement. The QIP received an overall *Met* validation status with no further action required until next submission in August 2012. **Small-group collaborative QIP—*Appropriate Treatment for Children With URI*—2009-2010 Report**: Annual submission scored 100%. Overall validation status was met with no opportunities identified.

Table A.1—Grid of L.A. Care's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

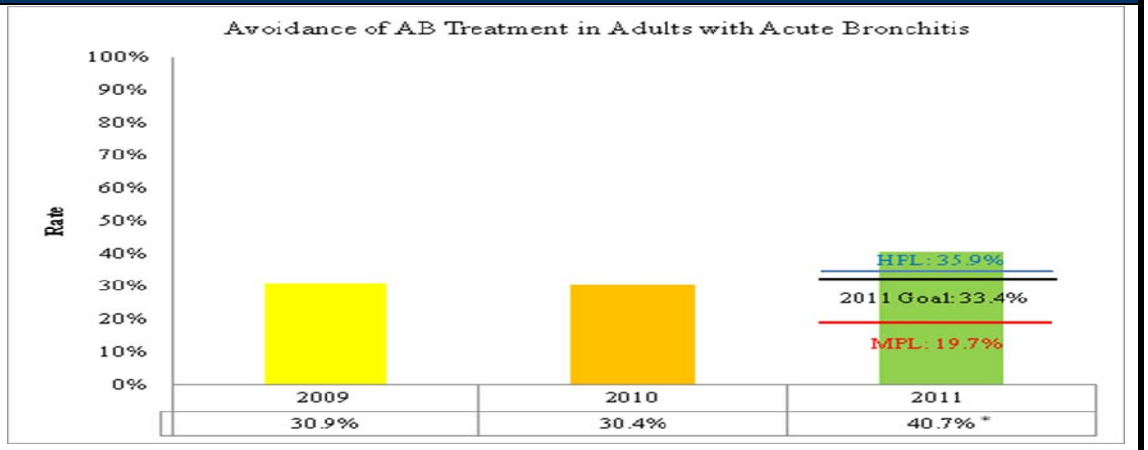
2009–2010 EQR Recommendation	L.A. Care's Self-Reported Actions That Address the EQR Recommendation
Proactively focus on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure and implement targeted improvement efforts to prevent further decline. Consider expanding the Rewarding Results incentive program to include this measure.	 ***Quantitative Analysis*** Between 2010 and 2011, L.A. Care's rate for avoidance of antibiotic treatment in adults with acute bronchitis rate increased by 10.3 percentage points. The difference was statistically significant ($p<0.05$). This stopped a three-year downward trend from 2008 to 2010. L.A. care exceeded the 2011 goal of 33.4% by 7.3 percentage points and even exceeded the HPL (benchmark). ***Interventions Update*** 2011 (Note: Some continued from 2010 and some were new in 2011): • In November 2011, L.A. Care faxed high-volume providers a quick reference on clinical guidelines, including URI, Acute Bronchitis and Pharyngitis measures. • 2011 was the baseline data collection phase of the L.A. Care Provider Group Improvement Program (LAP4P) which measures, reports, and rewards contracted provider group performance in an effort to engage provider groups (e.g., IPAs) to improve clinical quality, medical cost management, and member satisfaction. Pharyngitis and acute bronchitis measures are included in this program, which is to be implemented over the next three years. • The Physician P4P program was launched in October 2011. This new program offers performance-based incentive payments and is targeted at solo and small group physicians with 250 or more L.A. Care members. URI, pharyngitis and acute bronchitis are measures included in this program.

Table A.1—Grid of L.A. Care's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	L.A. Care's Self-Reported Actions That Address the EQR Recommendation
	• L.A. Care continues to participate in the AWARE (Alliance Working for Antibiotic Resistance Education) initiative sponsored by California Medical Association Foundation. In 2011, the collaborative distributed toolkits to 28,397 providers in the top 20th percentile of antibiotic prescribers. • In 2011, L.A. Care's pharmacy department sent out 2,194 provider mailings which included the 2011 AWARE Pediatric and Adult Acute Respiratory Tract Infection Guidelines. • In 2011 there were about 6,200 outreach encounters made by RCAC members focused on antibiotic misuse.
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.	L.A. Care Health Plan demonstrates its commitment to improving member satisfaction by our annual assessment of the CAHPS Adult Medicaid 4.0H survey results. L.A. Care summarizes the results and activities related to member satisfaction. The Service Improvement Committee (SIC) is the cross-departmental multidisciplinary committee responsible for the process of identifying quality improvement needs, and reports its findings and recommendations to the Quality Oversight Committee (QOC). The following provides a summary of interventions that address the priority areas targeted to improve overall member satisfaction: **Group Level Member Satisfaction Survey**: As part of LA P4P, (L.A. Care's pay-for-performance program for provider groups), L.A. Care fielded its first member satisfaction survey at the provider group level, using the Patient Assessment Survey (PAS), which is used by CA P4P and is based on NCQA's CG CAHPS Survey. L.A. Care contracted with an NCQA-Certified vendor to field the PAS survey in Fall 2011, and it will be fielded again in February 2013. These results will be used to score the patient experience measures. Each eligible provider group will receive a detailed survey report to assist in identifying areas of strength and opportunities for improvement. Provider groups will be rewarded for improvement, and results will be publicly reported. **Patient Centered Medical Home Project (PCMH):** L.A. Care is sponsoring collaboration with at least 10 network provider sites to improve access, care coordination and patient engagement in compliance with NCQA's medical home standards. The goal is to achieve a minimum of 10% improvement from baseline scores of the nine NCQA PCMH standards at each six-month evaluation. Partners in Care, our external evaluator, submitted an Interim Report II that represented the results of the first data collection. As such, it had a number of limitations, including a small sample size for patient and clinician/staff surveys and no comparison data. Overall, clinics received very positive feedback from their patients, but the small sample size made the results less reliable. The goal for the next round of data collection will be to obtain a larger sample size.

Table A.1—Grid of L.A. Care's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	L.A. Care's Self-Reported Actions That Address the EQR Recommendation
	eConsult Pilot Program: Following a successful pilot program, L.A. Care is rolling out its eConsult portal to nearly 50 clinics. The Internet-based system allows L.A. Care's primary care providers to send specific data on their patients to a specialist prior to referring them to care. The program will improve specialty access to members through an exchange of electronically clinical information and consultation exchange between primary care and specialty physicians (curbside consults). The goal is to improve quality and communication, improve access, improve efficiency through decreased unnecessary specialist visits, and to improve pre-visit work ups. eConsult is initiated by a PCP's office through an automated authorization request to a specialist, including the patient's background information, photos, and lab results. In addition, the PCP provides clinical questions for the specialist to review and respond. The PCP, in turn, manages/treats the patient or orders the tests recommended by the specialist. Approximately 60% reduction in wait time for appointments. Approximately one half (383) of the 829 eConsults generated resulted in communication between the PCP and specialist, with up to 48% of face-to-face-visits deferred. Expansion of the program has been approved for an additional 18 months to 50 safety-net clinic sites.