Performance Evaluation Report

L.A. Care Health Plan

July 1, 2011–June 30, 2012

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 program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] 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 designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more 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.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, 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.

This report is specific to DHCS'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, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, 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 operating 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, DHCS contracts with two managed care plans to provide medical services to Medi-Cal beneficiaries. Most Two-Plan Model counties offer an LI plan and a nongovernmental, commercial health plan.

Medi-Cal Managed Care beneficiaries in Los Angeles County may enroll in L.A. Care, the LI plan, or in the alternative commercial plan. L.A. Care became operational to provide MCMC services in March 1997. As of June 30, 2012, L.A. Care had 995,128 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period 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.

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 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from 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. DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of DHCS's Medi-Cal Managed Care Division (MMCD) have historically worked in conjunction with the Department of Managed Health Care to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or the Department of Managed Health Care. These medical audits assess plans' compliance with

contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

The most recent medical performance review for L.A. Care was completed in October 2008, covering the review period of August 1, 2007, through July 31, 2008. HSAG initially reported the findings from this review in L.A. Care's 2008–2009 plan-specific evaluation report.[4] Additionally, HSAG reported that the DHCS *Medical Audit Close-Out Report* letter dated July 29, 2009, noted that the plan had corrected all audit deficiencies.

It was indicated in the plan's 2010–2011 plan-specific evaluation report that L.A. Care was scheduled for an audit in September 2011; however, DHCS did not provide documentation to HSAG demonstrating that an audit occurred.

Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current medical performance reviews and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

MR/PIU conducted on-site reviews of L.A. Care in December 2009 and April 2010, covering the review period of January 1, 2008, through June 30, 2009. HSAG initially reported the detailed

[4] California Department of Health Care Services. *Performance Evaluation Report, L.A. Care Health Plan, July 1, 2008 – June 30, 2009*. December 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

findings from these reviews in L.A. Care's 2009–2010 plan-specific evaluation report.[5] The findings were in the areas of Member Grievances and Prior Authorization Notification. L.A. Care was not required to respond to the findings. MR/PIU will follow up with the plan on the findings during its next review. Listed below are the findings.

Member Grievances

- One of the 22 member grievance case files reviewed for one of L.A. Care's plan partners contained a resolution letter that was sent to the member with an incorrect "Your Rights" attachment that belonged to the Healthy Families Program.
- One of the 50 member grievance case files reviewed for one of L.A. Care's plan partners contained a resolution letter that exceeded the 30-day time frame. Additionally, there was one instance where the resolution was not reached within 30 days and the member was not notified in writing regarding the status of the grievance or estimated completion date for the resolution, as required.

Prior Authorization Notification

- Two of 40 prior authorization notification case files reviewed contained a Notice of Action (NOA) letter for denial or modification that was sent to the member after the 14-day maximum time frame from receipt of the prior authorization request.
- One of 54 prior authorization notification case files reviewed for one of L.A. Care's medical groups contained an NOA letter for denial or modification that was not sent to the member within 14 days of receipt of the prior authorization request as required.
- Three of 45 prior authorization notification case files reviewed for one of L.A. Care's plan partners contained an NOA letter for denial or modification that was not sent to the member within 14 days of receipt of the prior authorization request as required.

HSAG found the following information regarding actions the plan has taken that appear to address some of the findings:

- L.A. Care's 2012 Quality Improvement Program document describes a quality structure with mechanisms to ensure timely resolution of grievances.
- The plan's 2011 4th Quarter Quality Improvement Work Plan includes a goal to resolve all grievances within 30 days, and the 2011 Quality Improvement Program Evaluation indicates that the plan met the goal during the third quarter of 2011. In the fourth quarter, however, one grievance was not resolved in the 30-day time frame.

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[5] California Department of Health Care Services. *Performance Evaluation Report – L.A. Care Health Plan, July 1, 2009 – June 30, 2010*. December 2011. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

- In relation to the one member not being notified at all, the plan partner indicated that the reason the member was not notified was related to an internal oversight in the processing of the case. MR/PIU reported that the partner had implemented a quality control check to ensure timelines are met.
- L.A. Care's 2012 Quality Improvement Program Description document indicates that a written denial notification will be mailed to the member within three days of the denial.

Technical Assistance Feedback

In addition to the identified findings, MR/PIU identified the following technical assistance feedback to the plan in the areas of Member Grievances and Prior Authorization Notification:

- Two of L.A. Care's plan partners and L.A. Care indicated in their NOA letters that members have up to 180 days to file an appeal rather than the 90-day required time frame.
- L.A. Care's NOA letters indicated that members have up to 180 days to request a State Fair Hearing rather than the 90-day required time frame.

HSAG's review of the plan's submitted documents did not locate evidence that the plan or its partners have revised their NOAs to be in compliance with State requirements.

Strengths

L.A. Care was fully compliant with most areas under review of the most recent medical performance review and successfully resolved all noted deficiencies.

Opportunities for Improvement

Although L.A. Care appears to have taken some actions to address the findings identified in the most recent MR/PIU review, the plan has an opportunity to improve in the areas of Member Grievances and Prior Authorization Notification. These areas can have an impact on the quality, accessibility, and timeliness of care provided to members. L.A. Care should document how the plan will address each of the findings and how progress on addressing the findings will be monitored.

Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). 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 DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by DHCS for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the plan's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of L.A. Care in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

Performance Measure Validation Findings

HSAG found that L.A. Care submitted measures that were prepared according to the HEDIS Technical Specifications and were valid for reporting.

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

Performance Measure Results

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

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions (internally developed measure)*
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
AWC	*Adolescent Well-Care Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
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*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*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 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

DHCS based the MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the CDC–H9 (>9.0 percent) measure. 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—Comparison of 2011 and 2012 Performance Measure Results for L.A. Care Health Plan—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	40.7%	32.3%	★★★	↓	18.8%	31.6%
AMB–ED	‡	--	31.0	--	Not Comparable	--	--
AMB–OP	‡	--	191.4	--	Not Comparable	--	--
AWC	Q,A,T	49.2%	58.1%	★★	↑	39.6%	64.1%
CAP–1224	A	--	95.2%	--	Not Comparable	--	--
CAP–256	A	--	87.0%	--	Not Comparable	--	--
CAP–711	A	--	88.2%	--	Not Comparable	--	--
CAP–1219	A	--	86.4%	--	Not Comparable	--	--
CCS	Q,A	67.9%	72.5%	★★	↔	64.0%	78.7%
CDC–BP	Q	58.5%	64.3%	★★	↔	54.3%	76.0%
CDC–E	Q,A	50.7%	50.7%	★★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	45.7%	42.3%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	41.5%	42.0%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	85.0%	83.8%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	37.4%	37.0%	★★	↔	27.3%	45.9%
CDC–LS	Q,A	79.0%	79.2%	★★	↔	70.4%	84.2%
CDC–N	Q,A	78.3%	79.5%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	80.0%	81.4%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	60.5%	--	Not Comparable	--	--
LBP	Q	80.2%	81.6%	★★	↔	72.3%	82.3%
MPM–ACE	Q	--	73.4%	--	Not Comparable	--	--
MPM–DIG	Q	--	78.8%	--	Not Comparable	--	--
MPM–DIU	Q	--	72.3%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	82.1%	80.6%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	55.3%	61.3%	★★	↔	59.6%	75.2%
W-34	Q,A,T	80.6%	77.5%	★★	↔	66.1%	82.9%
WCC–BMI	Q	65.6%	64.6%	★★	↔	19.7%	69.8%
WCC–N	Q	68.3%	70.2%	★★	↔	39.0%	72.0%
WCC–PA	Q	58.4%	57.6%	★★	↔	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
[6] DHCS'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] DHCS'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.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, L.A. Care demonstrated average performance on measures in 2012, with most of the performance measure rates falling between the MPLs and the HPLs.

One performance measure, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, performed above the HPL. Although this measure performed above the HPL, it was the only measure to show a statistically significant decline in performance from 2011 to 2012.

The *Adolescent Well-Care Visits* measure was the only measure that had statistically significant improvement from its 2011 performance measure rate.

HEDIS Improvement Plans

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

HSAG compared the plan's 2011 IP (if one was required) with the plan's 2012 HEDIS rate for that measure 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 had one IP in 2012. Following is a summary of the IP and HSAG's assessment of the IP's effectiveness in moving the performance on this measure to above the MPL.

Prenatal and Postpartum Care—Postpartum Care

L.A. Care identified several challenges and barriers to the plan performing above the MPL on the *Prenatal and Postpartum Care—Postpartum Care* measure, including:

- Operating as a delegated, capitated model results in challenges obtaining claims/encounter data from providers.
- Providers are not aware of the appropriate timing of postpartum visits.
- Members do not understand the importance of obtaining care within 21–56 days after delivery.
- Members do not have transportation to get to their medical appointments.
- Difficulty of L.A. Care in effecting the care of members subcontracted to plan partners.

To address the identified challenges, L.A. Care described several interventions, including:

- Implementing a pay-for-performance model which includes incentives for providers to provide postpartum care visits and collect thorough and accurate encounter data.
- Auditing providers' compliance with postpartum care visits. Providers showing poor performance were placed on corrective action plans.
- Increasing member awareness of the free opt-in text messaging program, Text4baby, that sends weekly text messages with various pregnancy and parenting tips, including information on postpartum care.
- Revising the plan's 2010 Preventative Health Guidelines to be more member-friendly in order to increase awareness of postpartum care visits.

L.A. Care's efforts resulted in improvement on the measure that resulted in performance above the MPL in 2012. The plan will not be required to continue the IP for this measure in 2013.

Strengths

L.A. Care showed consistent performance across all measures, with no rates falling below the MPLs in 2012. The plan had one measure, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, perform above the HPL in 2012.

The *Adolescent Well-Care Visits* measure showed a statistically significant improvement in 2012. Additionally, the *Prenatal and Postpartum Care—Postpartum Care* measure showed an improvement that moved its performance level from below the MPL in 2011 to above the MPL in 2012.

Opportunities for Improvement

Although the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure performed above the HPL in 2012, it also showed a statistically significant decline in performance. The plan should identify the factors that led to a decline in performance on this measure and implement strategies to prevent further decline in 2013. In addition, the plan should identify other measures that could be prioritized for improvement despite meeting minimal performance requirements, since the plan's performance has remained relatively unchanged for the last several years.

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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). 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 Project Objectives

L.A. Care had two clinical QIPs and one clinical QIP proposal in progress during the review period of July 1, 2011–June 30, 2012. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the *Reducing Avoidable ER Visits* DHCS statewide collaborative QIP project. 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. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative which focused on reducing readmissions for members aged 21 years and older. The three QIPs fell under the quality and access domains of care.

The *Reducing Avoidable ER Visits* 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. At the initiation of the QIP, L.A. Care had identified 40,069 ER room visits that were avoidable, which was 16.0 percent of its ER visits. The plan's objective was to reduce this

rate by 10 percent with the use of member, provider, and system improvement strategies. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

The new statewide collaborative QIP proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members leading to improved health outcomes.

The plan's diabetes project attempted to increase HbA1c testing and retinal eye exams by implementing member and provider interventions. At the initiation of the QIP, L.A. Care identified 15,649 diagnosed diabetic adult members. 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.

Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status across 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, 2011, through June 30, 2012

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 ER Visits	Annual Submission	97%	100%	*Met*
*All-Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIPs				
Improving HbA1c and Diabetic Retinal Exam Screening Rates	Annual Submission	94%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a 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*.

*During the review period, the *All-Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that the initial submission of L.A. Care's *Reducing Avoidable Emergency Room Visits* QIP and *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP both received an overall validation status of *Met*. For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

Due to unique one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

Table 4.2 summarizes the aggregate validation results for 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, 2011, through June 30, 2012

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	100%	0%	0%
	IX: Real Improvement Achieved**	63%	25%	13%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total**		85%	8%	8%

*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 stage and/or activity totals may not equal 100 percent due to rounding.

For the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP, Remeasurement 1 data were submitted; therefore, HSAG validated Activities I through IX. The *Reducing Avoidable ER Visits* QIP included Remeasurement 3 data and progressed through Activity X. L.A. Care demonstrated

an accurate application of the design and implementation stages and received *Met* scores for 100 percent of all applicable evaluation elements.

For the outcomes stage, L.A. Care was scored lower in Activity IX for the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP, since the project outcomes did not demonstrate statistically significant improvement. For Activity X of the *Reducing Avoidable Emergency Room Visits* QIP, the plan did not achieve sustained improvement. 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 and Interventions

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 July 1, 2011, through June 30, 2012

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	Remeasurement 3 1/1/10–12/31/10	Sustained Improvement¥
Percentage of ER visits that were avoidable^	16.0%	15.9%	22.4%*	19.4%*	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	82.1%	85.0%	‡	‡
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	52.8%	50.7%	‡	‡

^A lower percentage indicates better performance.

¥ 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.

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

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

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, L.A. Care set an overall objective to achieve a 10 percent reduction in ER visits designated as avoidable. For this project outcome, a lower rate demonstrates improved performance. While the plan did not meet its overall objective, it was able to maintain the percentage of avoidable ER visits for one measurement period. From baseline to the first remeasurement period, the plan's avoidable ER visit rate did not demonstrate a statistically significant change.

Conversely, the plan reported a statistically significant decline in performance from the first to the second remeasurement period (6.5 percentage points). The plan did not achieve overall improvement; rather, it demonstrated a decline in performance over the course of the project as evidenced by the increased rate of avoidable ER visits at the final remeasurement period compared to the baseline rate. A critical analysis of the plan's improvement strategy identified some weaknesses, which may have led to the lack of improvement in outcomes:

- L.A. Care documented that an ER Collaborative Steering Committee and four separate subcommittees provided quarterly reports to a Quality Oversight Committee. Barrier and intervention feedback from the committees was compiled into a fishbone diagram by the Quality Improvement project manager. The plan did not provide data-driven results for any of the barrier analyses. Additionally, the plan did not describe how the identified barriers were prioritized or how interventions were selected for implementation.
- L.A. Care reported continuing two plan-specific interventions deemed successful that had begun before the start of the project.
  - The Nurse Advice Line was continued since the plan's evaluation showed that over 90 percent of calls by members with the intent to visit the ER were redirected to another source of care; however, approximately 17 percent of these callers visited the ER within the following two days. Additionally, the actual number of callers was not reported.
  - The plan provided a fax notification to PCPs and provider groups for their members that had called the Nurse Advice Line and were instructed to go to the ER. The plan did not provide any evaluation of the intervention's efficacy. The notifications were limited to members who had first called the Nurse Advice line and did not include members that visited the ER without contacting the advice line.
- In April 2008, the plan awarded 14 providers with grants to subsidize start-up costs of adding evening and/or weekend hours. The plan did not report the amount, duration, or success of the grant awards.
- Also in 2008, physician groups were offered a one-time incentive for demonstrating and promoting urgent care centers or newly contracting with urgent care centers. The program

ended after one year; however, the plan did not document any evaluation of the intervention or the rationale for ending the program.

- Collaborative interventions were initiated in early 2009; however, they did not correspond to any improvement in performance. Specifically, for the plan-hospital data collection collaborative intervention in 2010, the plan documented not receiving any of the ER visit data from the participating hospital within 5 days of the ER visit and only receiving 10.3 percent of the data within 15 days. The plan reported contacting at most 42 percent of the members within 14 days of their ER visit. Additionally, the rate of avoidable ER visits at the participating hospital was higher than the non-participating hospitals' rate (21.0 percent versus 19.4 percent).
- The plan-specific improvement efforts from 2009 to 2011 focused on member and provider education delivered through member and provider newsletters. This non-targeted education did not lend itself to evaluation and was not associated with any improvement in performance.

Improving HbA1c and Retinal Eye Exam Screening Rates QIP

For the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP, L.A. Care set a project goal to exceed DHCS's MPL rates for both the HbA1c screening (84.1 percent) and retinal eye exam (55.8 percent). From baseline to the first remeasurement period, the plan's rates for both outcomes did not demonstrate a statistically significant change; however, the HbA1c screening rate did meet the project's goal. A critical analysis of the plan's improvement strategy led to the following observations:

- L.A. Care documented that three separate subcommittees provided quarterly reports to a Quality Oversight Committee. Barrier and intervention feedback from the committees was compiled into a fishbone diagram by the Quality Improvement project manager. The plan did not provide data-driven results for any of the barrier analyses. Additionally, the plan did not describe how the identified barriers were prioritized or how interventions were selected for implementation.
- The plan implemented a comprehensive diabetes incentive program for providers that ended in December 2010, although the plan stated that those results would not be available until July 2012. Similarly, the plan initiated a provider group incentive program in 2010, which included the project outcomes. Results for this program will also not be available until 2012.
- The plan documented supplying providers and provider groups with annual report cards of their performance on HEDIS measures including the list of members requiring services. The plan expected the providers to reach out to the members in need of services.
- The plan offered incentives to providers that completed the NCQA Diabetes Recognition Program, which consisted of two providers in 2010 and one provider in 2011.
- L.A. Care implemented reminder postcards and reminder calls in November 2010 to members who had not received their HbA1c screening and/or retinal eye exam. The process was repeated in April 2011. Evaluation results were not reported.

Strengths

L.A. Care demonstrated a strong application 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.

For the third remeasurement period, L.A. Care was able to achieve a statistically significant reduction in the percentage of avoidable ER visits.

Opportunities for Improvement

L.A. Care has an opportunity to improve its intervention strategies in order to achieve and sustain improvement of its QIP outcomes. At a minimum, barrier analyses 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 annual analyses alone. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

With the implementation of any intervention and especially for multiple interventions, the plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care. A more detailed description of HSAG's scoring process is included in Appendix A.

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for its MCMC beneficiaries through the provision of health care services and the plan's structural and operational characteristics.

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries 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, 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.

Overall, L.A. Care showed average performance in the quality domain of care. HSAG's HEDIS auditor determined that L.A. Care had valid rates for all 2012 performance measures, and overall performance on measures in the quality domain of care was average. One measure in the quality domain of care performed above the HPL.

L.A. Care's two QIPs fell within the quality domain of care. L.A. Care demonstrated a strong application 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.

The plan reached full compliance with all audited elements of the most recent medical performance review, which demonstrates a strong structure and the organizational resources necessary to deliver quality care.

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 MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and 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. Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes 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 beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Overall, L.A. Care showed average performance in the access domain of care. Measures falling in the access domain of care performed average, with no measures performing above the HPLs or below the MPLs.

L.A. Care's two QIPs also fall within the access domain of care. The plan's *Reducing Avoidable Emergency Room Visits* QIP showed statistically significant improvement in performance. However, the plan did not achieve sustained improvement on this QIP since the first remeasurement outcome was not improved over the baseline outcome.

Although some access-related findings from the plan's most recent MR/PIU reviews were not fully addressed, L.A. Care demonstrated some efforts to resolve them.

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.

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.

Overall, L.A. Care showed average performance in the timeliness domain of care. Measures within the timeliness domain of care performed average, with no measures performing above the HPLs or below the MPLs.

L.A. Care has opportunities to improve its compliance with member rights and timely notification of prior authorization decisions, which were areas where findings were noted during the most recent MR/PIU reviews.

Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. L.A. Care's self-reported responses are included in Appendix B.

Recommendations

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

- Ensure that all findings and technical assistance feedback from the MR/PIU reviews are fully addressed. Specifically:
  - Ensure that all grievance resolution letters include the correct "Your Rights" attachment.
  - Ensure grievances are resolved within the 30-day required time frame.
  - Provide evidence that all NOA letters include the required information and are sent within the required time frames.
- Assess the factors that led to a statistically significant decline in performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure to prevent further decline in performance.
- Identify and prioritize other measures performing above the MPLs that are still in need of improvement, since the plan's performance has remained relatively unchanged for the last several years.
- Perform QIP barrier analyses to identify and prioritize barriers for each measurement period. At a minimum, barrier analyses 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 annual analyses alone. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

- Ensure that each QIP intervention includes an evaluation plan so that any identified adjustments may be implemented to increase the likelihood of achieving project objectives and improving performance.

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

Quality, Access, and Timeliness

Scale
2.5–3.0 = Above Average
1.5–2.4 = Average
1.0–1.4 = Below Average

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) greater than negative three, if there are two or less measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than three.
3. To be considered ***Below Average***, a plan will have three or more measures below the MPLs than it has above the HPLs.

Access Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus and the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Timeliness Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

- **Validation** *(Table 4.1)*: For each QIP submission and subsequent resubmission(s), if applicable.
  - **Above Average** is not applicable.
  - **Average** = *Met* validation status.
  - **Below Average** = *Partially Met* or *Not Met* validation status.
- **Outcomes** *(Table 4.3)*: Activity IX, Element 4—**Real Improvement**
  - **Above Average** = All study indicators demonstrated statistically significant improvement.
  - **Average** = Not all study indicators demonstrated statistically significant improvement.
  - **Below Average** = No study indicators demonstrated statistically significant improvement.

- **Sustained Improvement** *(Table 4.3)*: Activity X—**Achieved Sustained Improvement**
  - **Above Average =** All study indicators achieved sustained improvement.
  - **Average =** Not all study indicators achieved sustained improvement.
  - **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain.

Appendix B. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

for **L.A. Care Health Plan**

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with L.A. Care's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table B.1—Grid of L.A. Care's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	L.A. Care's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Improve timeliness functions within both authorizations and grievances.	
Ensure that all time frames related to medical performance review are met internally as well as by all plan partners.	
Ensure that 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.	Health Ed continued its perinatal program sending member information by trimester to identified pregnant members. This included reminders about the postpartum visit. L.A. Care also promoted the Text4Baby program to L.A. Care members, an opt-in program with perinatal and infant well care reminders including postpartum visits. L.A. Care met the MPL in HEDIS 2012.
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.	Confusion regarding the change in guideline from the U.S. Preventive Services Task Force (USPSTF), which does not align with the HEDIS specifications, continues to cause confusion among providers and members. Our efforts in this measure have focused on reducing disparities with reminder postcards, a mobile mammogram event in 2011 and 2012, and preventive guideline distribution to members annually.
For QIPs, 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.	Barrier analysis takes place in multiple committees including our Physician committee when HEDIS results are available. We obtain a mid-year status report from our vendor and send opportunity reports off this data pull to help physicians identify and bring in members in need of services. We are considering more frequent, timely data pulls in future contracts with our HEDIS vendor.
Implement a method to evaluate the effectiveness of each intervention relating to QIPs.	There are always confounding factors when evaluating the effectiveness of each intervention. However, with our diabetes QIP, we will be able to evaluate the effectiveness of the incentive programs for HEDIS 2013. It can take several years for this type of intervention to show effectiveness by reaching a critical mass. For example, we continued our hospital intervention for 2 years after the QIP ended and are now seeing the effectiveness with an 18% reduction in avoidable ER visits.