Performance Evaluation Report

L.A. Care Health Plan

July 1, 2012–June 30, 2013

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

April 2014

TABLE OF CONTENTS

Performance Evaluation Report – L.A. Care Health Plan

July 1, 2012 – June 30, 2013

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs 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 provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and

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

[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.

operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, L.A. Care Health Plan ("L.A. Care" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

L.A. Care is a full-scope MCP delivering services to its MCMC members as a "Local Initiative" (LI) MCP under the Two-Plan Model (TPM). In most TPM counties, there is an LI and a "commercial plan" (CP). DHCS contracts with both plans. The LI is designed—with the input of local government, community groups, and health care providers—to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. MCMC beneficiaries may enroll in L.A. Care; the LI MCP; or in Health Net Community Solutions, Inc., the alternative CP.

L.A. Care became operational in Los Angeles County to provide MCMC services effective March 1997. As of June 30, 2013, L.A. Care had 1,156,578 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP'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 MCPs' 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, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

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.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP'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. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits and Member Rights Reviews

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

Department of Managed Health Care Routine Medical Survey and SPD Enrollment Survey

The most recent on-site DMHC Routine Medical Survey for L.A. Care was conducted July 10, 2012, through July 13, 2012. DMHC closed the survey on September 19, 2012; however, on November 28, 2012, DMHC determined that additional information was required for the

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP 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 the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

completion of the survey and reopened the survey review process. DMHC evaluated the following elements specifically related to the MCP's delivery of care to the SPD population:

- Utilization Management
- Continuity of Care
- Availability and Accessibility
- Member Rights
- Quality Management

DMHC identified one potential deficiency in the area of Member Rights. Specifically, DMHC indicated that the MCP does not consistently ensure adequate consideration of enrollee grievances.

On June 27, 2013, L.A. Care submitted a CAP to DHCS, addressing the member rights deficiency. The MCP indicated that it had taken the following actions to address the deficiency:

- Initiated a process to outline each specific issue when seeking a response from the involved provider or delegated entity.
- Assigned a nurse to review all outbound grievance letters to ensure that each specific grievance issue is addressed.
- Designed a new monthly training program to reinforce the importance of identifying each issue in a member complaint.
- Redesigned the MCP's grievance resolution letters to ensure inclusion of all issues listed in a member grievance.
- Implemented quarterly regulatory compliance refresher training for the appeals and grievance department.

DMHC responded to L.A. Care's CAP in a letter dated July 16, 2013. Although the letter was sent outside the review dates for this report, since the time frame is only two weeks and it provides DMHC's assessment of the MCP's CAP, HSAG includes the information from the letter. DMHC acknowledged receipt of the following from L.A. Care:

- The proposed request for information fax L.A. Care will send to providers and/or delegated entities that outlines each specific issue raised by the member.
- The proposed revised grievance resolution letter template with a numbering format that allows for resolution of multiple grievance issues in a single grievance response.

DMHC indicated that while the revised grievance resolution letter format allows for resolution of multiple grievance issues in a single response, each issue raised must contain a clear and concise explanation of the MCP's decision. Additionally, DMHC indicated that the MCP is expected to

fully implement, in a timely manner, all proposed actions necessary to achieve full and ongoing compliance with all regulatory and contractual requirements.

Strengths

During the most recent SPD enrollment survey, DMHC did not identify any deficiencies in the areas of Utilization Management, Continuity of Care, Availability and Accessibility, and Quality Management. Although L.A. Care has not fully corrected the deficiency in the area of Member Grievances, the MCP has provided DMHC with documentation of efforts the MCP has made to correct the deficiency.

Opportunities for Improvement

L.A. Care has the opportunity to demonstrate to DMHC that it has fully implemented all actions necessary to be fully compliant with all regulatory and contractual requirements in the area of Member Grievances.

Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal Managed Care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

HSAG conducts validation of the External Accountability Set performance measures as required by DHCS to evaluate the accuracy of the MCPs' reported results. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[5] The CMS EQR Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for L.A. Care Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that L.A. Care followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A review of the MCP's HEDIS audit report revealed the following observations:

- L.A. Care monitors its MCP partners' encounters by volume, quality, and timeliness. The MCP has taken steps to ensure encounter submission for its heavily capitated model through benchmarking, monitoring and oversight, and incentives.
- Due to initial non-compliance during the medical record review process for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, the auditor suggested that L.A. Care revise its abstraction training program to be more in alignment with the NCQA *Well-Child* measure specifications.
- The auditor recommended that, in future years, L.A. Care complete a separate Roadmap supplemental data section for each data source and carefully document the information specific to each data source and the measures impacted by each data source.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

Table 3.1—Name Key for Performance Measures in External Accountability Set

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions* ‡
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient 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)*
CBP	*Controlling High Blood Pressure*
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*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MMA–75	*Medication Management for People with Asthma—Medication Compliance 75% Total*
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*

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.
‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Table 3.2 below presents a summary of L.A. Care's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.2 shows the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

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 2012 and 2013 Performance Measure Results
L.A. Care—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	32.31%	35.44%	★★★	↑	18.98%	33.33%
ACR	Q, A	--	17.05%	--	Not Comparable	--	--
AMB–ED	‡	31.02	32.23	‡	Not Comparable	‡	‡
AMB–OP	‡	191.44	185.93	‡	Not Comparable	‡	‡
CAP–1224	A	95.16%	91.06%	★	↓	95.56%	98.39%
CAP–256	A	86.98%	82.93%	★	↓	86.62%	92.63%
CAP–711	A	88.20%	87.15%	★	↓	87.56%	94.51%
CAP–1219	A	86.43%	85.89%	★	↓	86.04%	93.01%
CBP	Q	--	61.59%	--	Not Comparable	--	--
CCS	Q,A	72.46%	66.34%	★★	↔	61.81%	78.51%
CDC–BP	Q	64.25%	65.94%	★★	↔	54.48%	75.44%
CDC–E	Q,A	50.72%	49.76%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	42.27%	48.07%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	42.03%	39.37%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	83.82%	84.30%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	36.96%	37.68%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	79.23%	79.95%	★★	↔	70.34%	83.45%
CDC–N	Q,A	79.47%	81.64%	★★	↔	73.48%	86.93%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
L.A. Care—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
CIS–3	Q,A,T	81.45%	80.15%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	60.53%	72.15%	★★	↑	50.36%	80.91%
LBP	Q	81.64%	80.14%	★★	↔	72.04%	82.04%
MMA–50	Q	--	79.80%	--	Not Comparable	--	--
MMA–75	Q	--	57.70%	--	Not Comparable	--	--
MPM–ACE	Q	73.44%	73.03%	★	↔	83.72%	91.33%
MPM–DIG	Q	78.85%	78.09%	★	↔	87.93%	95.56%
MPM–DIU	Q	72.28%	72.87%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	80.63%	85.75%	★★	↑	80.54%	93.33%
PPC–Pst	Q,A,T	61.26%	55.80%	★	↔	58.70%	74.73%
W-34	Q,A,T	77.54%	72.46%	★★	↔	65.51%	83.04%
WCC–BMI	Q	64.65%	71.91%	★★	↑	29.20%	77.13%
WCC–N	Q	70.22%	74.58%	★★	↔	42.82%	77.61%
WCC–PA	Q	57.63%	67.31%	★★★	↑	31.63%	64.87%

[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] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[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. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = 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.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[8] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Tables 3.3 and 3.4, which present a summary of L.A. Care's 2013 SPD measure results. Table 3.3 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.4 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*

[8] Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care plan and for the subset of enrollees who are seniors and persons with disabilities. Managed care plan performance measures may include measures from HEDIS; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.3.

- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Table 3.3—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population

L.A. Care—Los Angeles County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	10.99%	19.69%	▼	17.05%
CAP–1224	91.20%	77.40%	↓	91.06%
CAP–256	82.97%	81.54%	↓	82.93%
CAP–711	87.12%	87.85%	↔	87.15%
CAP–1219	85.96%	84.37%	↓	85.89%
CDC–BP	57.66%	54.01%	↔	65.94%
CDC–E	43.55%	47.69%	↔	49.76%
CDC–H8 (<8.0%)	41.61%	43.80%	↔	48.07%
CDC–H9 (>9.0%)	48.42%	45.26%	↔	39.37%
CDC–HT	79.56%	81.51%	↔	84.30%
CDC–LC (<100)	29.68%	36.98%	↑	37.68%
CDC–LS	75.67%	78.83%	↔	79.95%
CDC–N	76.64%	82.97%	↑	81.64%
MPM–ACE	72.80%	73.17%	↔	73.03%
MPM–DIG	75.57%	78.75%	↔	78.09%
MPM–DIU	71.64%	73.59%	↑	72.87%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

Table 3.4—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
L.A. Care—Los Angeles County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
169.83	27.42	284.56	61.70

* Member months are a member's "contribution" to the total yearly membership.

Performance Measure Result Findings

Overall, L.A. Care demonstrated a decline in performance on measures compared to 2012. In 2012, the rate for one measure was above the HPL, and no measures had rates below the MPLs. In 2013, two measures had rates above the HPLs, and eight measures had rates below the MPLs. In 2012, the rate for one measure improved significantly from 2011, and the rate for one measure declined significantly. Although in 2013 L.A. Care had five measures with rates that had significant improvement from 2012, four measures had rates that declined significantly from 2012 to 2013.

The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was one of the measures with a rate above the HPL in 2013. L.A. Care has performed well on this measure, with the rate being above the HPL since 2011. Additionally, the rate for this measure improved significantly from 2012 to 2013.

The rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* measure improved significantly from 2012 to 2013, moving the rate to above the HPL in 2013.

In addition to the two measures mentioned above with rates that improved significantly from 2012 to 2013, the rates for the following measures improved significantly from 2012 to 2013:

- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*

The rates for the following measures were below the MPLs in 2013:

- All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- All three *Annual Monitoring for Patients on Persistent Medications* measures
- *Prenatal and Postpartum Care—Postpartum Care*

In addition to the rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures being below the MPLs in 2013, the rates for all of these measures declined significantly from 2012 to 2013.

Seniors and Persons with Disabilities Findings

The SPD rates for the following measures were significantly better than the non-SPD rates:

- *Comprehensive Diabetes Care—LDL-Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The SPD rates for the following measures were significantly worse than the non-SPD rates:

- *All-Cause Readmissions*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however, rates should be interpreted with caution as high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures, and HSAG does not provide comparative analysis.

Improvement Plans

MCP's have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs

or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

Since L.A. Care did not have any rates below the MPLs during 2012, no IPs were required. The MCP will be required to submit IPs for the following measures that had rates below the MPLs in 2013:

- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Prenatal and Postpartum Care—Postpartum Care*

Although L.A. Care's rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures were below the MPLs in 2013, the MCP will not be required to submit IPs for these measures. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MPC efforts on other areas of poor performance that have clear improvement paths and direct population health impact.

Strengths

Two measures, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total,* had rates above the HPLs in 2013, and five measures had rates with statistically significant improvement from 2012 to 2013. In addition to being one of the measures with a rate that improved significantly from 2012, the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure's rate has been above the HPL for three consecutive years.

Opportunities for Improvement

Although the MCP followed appropriate specifications to produce valid performance measure rates, the HEDIS auditor indicated that the MCP has the following opportunities for improvement:

- To ensure full compliance with the medical review process, revise the MCP's abstraction training program to be more in alignment with the NCQA *Well-Child* measure specifications.
- In future audit years, complete a separate Roadmap supplemental data section for each data source and carefully document the information specific to each data source and the measures impacted by each data source.

L.A. Care has an opportunity to improve its performance measure rates by identifying the factors contributing to the rates for eight measures being below the MPLs. Additionally, for four of these measures, the MCP also has the opportunity to assess the factors leading to a significant decline in performance. Finally, for measures with SPD rates that were significantly worse than the non-SPD rates, L.A. Care has the opportunity to assess the factors leading to the rates being significantly worse for the SPD population and identify strategies to ensure the MCP is meeting this population's needs.

Conducting the EQRO 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 CMS validation protocol[10] to ensure that MCPs 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.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county.

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* 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 MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

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

[10] The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Quality Improvement Project Objectives

L.A. Care participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2012–June 30, 2013.

Table 4.1 below lists L.A. Care's QIPs and indicates whether the QIP is clinical or nonclinical and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

Table 4.1—Quality Improvement Projects for L.A. Care—Los Angeles County July 1, 2012, through June 30, 2013

QIP	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Clinical	Q, A
Improving HbA1c and Diabetic Retinal Exam Screening Rates	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. 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.

Prior to initiation of the statewide collaborative QIP, L.A. Care had a 30-day readmission rate of 15.19 percent among Medi-Cal beneficiaries. L.A. Care also found that the readmission rate for the SPD population was 19.81 percent, which was higher than the 11.58 percent rate for the non-SPD population.

L.A. Care's *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP 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

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Validation Activity
L.A. Care—Los Angeles County
July 1, 2012, through June 30, 2013

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				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Improving HbA1c and Diabetic Retinal Exam Screening Rates	Annual Submission	89%	100%	*Met*

[1] **Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP 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*.

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by L.A. Care of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 90 percent of evaluation elements met. L.A. Care's *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP annual submission also received an overall validation status of *Met* with 100 percent of critical elements and 89 percent of evaluation elements being met.

Table 4.3 summarizes the aggregated validation results for L.A. Care's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
L.A. Care—Los Angeles County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

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%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	90%	0%	10%
Design Total		**96%**	**0%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	89%	11%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**92%**	**8%**	**0%**
Outcomes	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**25%**	**0%**	**75%**

*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.

HSAG validated Activities I through VI for L.A. Care's *All-Cause Readmissions* study design submission and Activities I through IX for the MCP's *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP annual submission.

L.A. Care demonstrated a strong application of the Design stage, meeting 96 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP did not describe the data analysis plan for the *All-Cause Readmissions* QIP, resulting in a lower score in Activity VI.

Only the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP progressed to the Implementation and Outcomes stages during the reporting period. The MCP demonstrated a strong application of the Implementation stage, meeting 92 percent of the requirements for all applicable evaluation elements within the study stage. Activity VII received a lower score because some of the *p* values and their interpretations were incorrect. The QIP also received a lower score in Activity IX because the rate for Study Indicator 1 declined from the first remeasurement period

to the second remeasurement period, and neither study indicator achieved statistically significant improvement above baseline. Activity X was not assessed since sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved.

Quality Improvement Project Outcomes and Interventions

Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

The *All-Cause Readmissions* QIP did not progress to the Implementation or Outcomes stages during the reporting period; therefore, no intervention or outcome information for this QIP is included in the table or report.

Table 4.4—Quality Improvement Project Outcomes
L.A. Care—Los Angeles County
July 1, 2012, through June 30, 2013

QIP #1			
Study Indicator 1: The percentage of members 18–75 years of age with diabetes who received HbA1c testing as of December 31 of the measurement year			
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¥**
82.1%	85.0%	83.8%	‡
Study Indicator 2: 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			
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¥**
52.8%	50.7%	50.7%	‡
¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. ‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.			

Improving HbA1c and Retinal Eye Exam Screening Rates QIP

L.A. Care's initial goal for the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP was to increase HbA1c screening rates to 84.1 percent and retinal eye exam rates to 55.8 percent in three years. The HbA1c screening rate met the project's goal in Remeasurement 1, but the rate declined in Remeasurement 2, falling below the project's goal. The rate for the retinal eye exam indicator declined in the first remeasurement period and had no change in its rate in the second remeasurement period. Neither indicator has achieved statistically significant improvement over

baseline. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- The MCP's automated call vendor continued to conduct reminder calls and mail postcards (in English and Spanish) to diabetic members to remind them to obtain their HbA1c testing and retinal eye exams.
- L.A. Care implemented several provider interventions, including incentive programs, sending report cards to physicians with a summary of their performance, and provider education.
- Although the interventions were not successful in improving the QIP outcomes, L.A. Care included narrative descriptions of each intervention.
- L.A. Care did not accurately interpret the statistical testing and documented some of the *p* values incorrectly.

Strengths

L.A. Care demonstrated an excellent application of the QIP Design and Implementation stages. The MCP was able to achieve a *Met* validation status for both QIPs on the first submission.

Opportunities for Improvement

Although L.A. Care understands the QIP process as evidenced by both QIPs achieving a fully *Met* validation status on the first submission, the MCP has the opportunity to ensure all required documentation is included in the QIP Summary Form.

Since L.A. Care's *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP has not been successful at increasing HbA1c screening and diabetic eye exam rates, the MCP should conduct a new barrier analysis and assess if it needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

L.A. Care's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about L.A. Care's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

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

CAHPS Global Rating Measures:

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

CAHPS Composite Measures:

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

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

Table 5.1—CAHPS Measures Domains of Care

Measure	Domains of Care
Rating of Health Plan	Q
Rating of All Health Care	Q
Rating of Personal Doctor	Q
Rating of Specialist Seen Most Often	Q
Getting Needed Care	Q, A
Getting Care Quickly	Q, T
How Well Doctors Communicate	Q
Customer Service	Q
Shared Decision Making	Q

National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

Star Rating	Adult and Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or above the 75th and below the 90th percentiles
★★★ Good	At or above the 50th and below the 75th percentiles
★★ Fair	At or above the 25th and below the 50th percentiles
★ Poor	Below the 25th percentile

Table 5.3 and Table 5.4 present the star ratings for the global ratings and composite measures for L.A. Care's adult and child Medicaid populations.[15]

Table 5.3—Medi-Cal Managed Care County-Level Global Ratings
L.A. Care—Los Angeles County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★	★
Child	★★★	★	★★	★★★★+
+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.				

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.
[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.
[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

Table 5.4—Medi-Cal Managed Care County-Level Composite Measures
L.A. Care—Los Angeles County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★	★★
Child	★	★	★	★★★

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Strengths

The MCP received a *Very Good* rating on the child *Rating of Specialist Seen Most Often* measure. Please note that since the MCP had fewer than 100 respondents for this measure, caution should be exercised when evaluating these results. The child *Rating of Health Plan* and *Customer Service* measures received a *Good* rating.

L.A. Care improved its ratings on the following measures from 2010 to 2013:

- *Rating of Health Plan*—child population
- *Customer Service*—adult population

Opportunities for Improvement

L.A. Care's CAHPS results showed below-average performance for the majority of the child and adult global ratings and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as L.A. Care's highest priorities: *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 L.A. Care CAHPS MCP-Specific Report.* Areas for improvement spanned the quality, access, and timeliness domains of care.

Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[16] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[16] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

L.A. Care's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

Encounter Data Validation Findings

Review of Encounter Systems and Processes

Overall, the information provided in L.A. Care's Roadmap and supplemental questionnaire indicates that the MCP has established operational policies and practices for the creation, validation, correction, and ongoing monitoring of encounter data submission. L.A. Care's processes for collecting and submitting claims and encounter data files are designed to support both L.A. Care's claims and encounter activities and those of its Plan Partners. The Plan Partners submit encrypted encounter files in both the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and State proprietary format to L.A. Care's secure FTP site. L.A. Care requires the Plan Partners to submit encounter data within 60 days of the encounter month of service, although L.A. Care will process all encounters submitted regardless of the month of service. L.A. Care has established encounter submission benchmarks for its Plan Partners.

L.A. Care states that 90 percent of its provider network is capitated and accounts for the majority of claims/encounters. L.A. Care has established claim/encounter filing deadlines for providers; and when a claim is denied for untimely filing, the data elements are still captured for the denied claim. The capitated providers are incentivized for timely encounter data submissions.

L.A. Care's pharmacy benefit manager (PBM) and the Plan Partners' PBMs submit pharmacy encounter data monthly. Vision and dental claims are low in volume and have a corresponding low error rate. L.A. Care gathers all "clean" claims/encounters not previously submitted to DHCS

and assigns unique claim reference numbers (CRNs) when converting from the 5010 format to the State-required format. The reformatted encounters are processed within five to 10 working days from receipt and are submitted to DHCS. L.A. Care fixes the rejected items (less than 1 percent) and stores them in its encounter database.

L.A. Care's encounter data submission processes are more complex because of the dependence on the quality and timeliness of the Plan Partners' claims/encounter data submissions. The information provided by L.A. Care in the questionnaire does not specify the process for integrating, validating, and correcting the Plan Partners' encounter data.

Record Completeness

Overall, L.A. Care had very low record omission and record surplus rates, indicating relatively complete data when comparing DHCS's data and the encounter data extracted from L.A. Care's data system for this study. The highest record omission and record surplus rates were 6.1 percent and 6.7 percent for the Hospital/Inpatient claim type, respectively. For the remaining claim types, the record omission rates were 2.6 percent or lower and the record surplus rates were all 0.0 percent. These rates were better than the statewide rates for all claim types, with the Pharmacy claim type having rates 11.5 percentage points and 15.3 percentage points below the statewide record omission and record surplus rates, respectively.

Data Element Completeness

L.A. Care had perfect data element completeness results, with element omission and element surplus rates of 0.0 percent for all key data elements in the Medical/Outpatient, Hospital/Inpatient, Pharmacy, and Long-Term Care (LTC) encounters.

Data Element Accuracy

L.A. Care had very high element level accuracy, with accuracy rates of 99.9 percent or above for all key data elements. The all-element accuracy rates for all the claim types were also nearly perfect, with rates of 100.0 percent for the Medical/Outpatient, Pharmacy, and LTC claim types and 99.8 percent for the Hospital/Inpatient claim type. L.A. Care greatly exceeded the statewide element accuracy and all-element accuracy rates.

Recommendations

Based on its review, HSAG recommends the following:

- The Medical/Outpatient file had approximately 13 million records. All except 253 records were missing values for the data element *Referring/Prescribing/Admitting Provider Number*. The percentage of records without values for this data element was high compared to the other MCPs. L.A. Care should investigate whether more values for the data element *Referring/Prescribing/Admitting Provider Number* can be submitted to DHCS.
- Although the record surplus rate for the Hospital/Inpatient claim type was better than the statewide rate, HSAG believes there is room for L.A. Care to improve. The main cause for the Hospital/Inpatient record surplus was the extra detail lines in the DHCS data warehouse. For example, the data L.A. Care submitted to HSAG had detail lines 1 to 16 for a specific claim control number (CCN), while the DHCS data had detail lines 1 to 19 for the same CCN.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each MCP in the three domains of care—quality, access, and timeliness. A numerical score is calculated for each domain of care for performance measure rates, CAHPS survey measure ratings, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores, CAHPS survey measure ratings scores, and QIP performance scores, is then calculated for each domain of care and converted to a rating of above average, average, or below average. In addition to the performance score derived from performance measures, CAHPS survey measures, and QIPs, HSAG uses results from the MCPs' medical performance and Medi-Cal Managed Care Division reviews and assessment of the accuracy and completeness of encounter data to determine overall performance within each domain of care, as applicable. A more detailed description of HSAG's scoring process is included in Appendix A.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[17]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP 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 an MCP'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. DHCS also uses the results

[17] This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

HSAG reviewed the quality documents L.A. Care submitted as part of the process for producing this MCP-specific evaluation report. L.A. Care's quality improvement program structure supports the provision of quality care to the MCP's members and includes continuous quality improvement processes.

The two measures with rates above the HPLs in 2013 fall into the quality domain of care. These two measures also had rates with significant improvement from 2012 to 2013:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*

The MCP has performed excellent on the *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* measure, with the rate being above the HPL since 2011.

In addition to the measures above, three other quality measures had rates with significant improvement from 2012 to 2013:

- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*

The following quality measures had rates below the MPLs in 2013:

- All three *Annual Monitoring for Patients on Persistent Medications* measures
- *Prenatal and Postpartum Care—Postpartum Care*

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and three of these measures had SPD rates that were significantly better than the non-SPD rates. These measures were:

- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The SPD rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care, was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years

and older) had significantly more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

All CAHPS measures fall into the quality domain of care. Most of the measures had a *Poor* rating, showing that members' satisfaction with the quality of care being provided by the MCP is below average.

Both of L.A. Care's QIPs fall into the quality domain of care. The *All-Cause Readmissions* QIP did not progress to the Implementation or Outcomes stage, so HSAG was not able to assess the QIP's success at improving the quality of care delivered to the MCP's members. The MCP's *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP progressed to the Implementation and Outcomes stages, with the MCP reporting Remeasurement 2 data during the reporting period. The QIP is not achieving the desired improvement on the MCP's HbA1c screening and diabetes retinal exam rates; however, it should be noted that the rates for both of these measures are above the DHCS-established MPLs.

Overall, L.A. Care showed average performance related to the quality domain of care.

Access

The access domain of care relates to an MCP'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 MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP'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. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results 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.

When reviewing the quality documents L.A. Care submitted as part of the process for producing this MCP-specific evaluation report, HSAG found activities and goals with a focus on ensuring members' access to needed care.

Two access measures had rates with significant improvement from 2012 to 2013:

- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Five access measures had rates below the MPLs—all four *Children and Adolescents' Access to Primary Care Practitioners* measures and the *Prenatal and Postpartum Care—Postpartum Care* measure. Additionally, the rates for the *Children and Adolescents' Access to Primary Care* measures declined significantly from 2012 to 2013.

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and one of the measures, *Comprehensive Diabetes Care—Medical Attention for Nephropathy*, had an SPD rate that was significantly better than the non-SPD rate.

The *All-Cause Readmissions* measure falls into the access domain of care. As indicated above, the SPD rate for this measure was significantly higher than the non-SPD rate. Also as indicated above, this means that the SPD population (aged 21 years and older) had significantly more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population. Additionally, the SPD rates for three of the *Children and Adolescents' Access to Primary Care Practitioners* measures were significantly lower than the non-SPD rates, meaning fewer SPD members in the specified age groups (12–24 Months, 25 Months–6 Years, 12–19 Years) were seen by their primary care practitioners than non-SPD members in the same age group. This suggests that SPD members may not have the same access to non-emergency care services as members in the non-SPD population.

Overall, L.A. Care performed below average on the access-related CAHPS measure, *Getting Needed Care*, with this measure receiving a *Poor* rating for both the adult and child populations. These ratings suggest that members are not satisfied with their level of access to needed services.

Both of L.A. Care's QIPs fall into the quality domain of care. As indicated above, the *All-Cause Readmissions* QIP did not progress to the Implementation or Outcomes stage; therefore, HSAG was not able to assess the QIP's success at improving access to needed services for the MCP's members. Also as indicated above, the MCP's *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP progressed to the Implementation and Outcomes stages, with the MCP reporting Remeasurement 2 data during the reporting period. While the QIP is not achieving the desired improvement on the MCP's HbA1c screening and diabetes retinal exam rates, the rates for both of these measures are above the DHCS-established MPLs.

Overall, L.A. Care showed below-average performance related to the access domain of care.

Timeliness

The timeliness domain of care relates to an MCP'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 MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' 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. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

L.A. Cares quality improvement program description provides details about the MCP's activities related to member rights and responsibilities, grievances, continuity and coordination of care, and utilization management, which all impact the timeliness of care delivered to members.

During the November 2012 SPD Enrollment Survey with L.A. Care, DMHC identified a potential deficiency in the area of Member Grievances. Although L.A. Care provided documentation of the actions the MCP had taken to correct the deficiency to DMHC subsequent to the survey, DMHC indicated that the MCP did not demonstrate full compliance with the requirements.

The MCP performed average on all but one timeliness measure, with the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure falling below the MPL in 2013. Two timeliness measures had rates with significant improvement from 2012 to 2013:

- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. This measure received a *Poor* rating for both the adult and child populations, suggesting that members are not satisfied with the time it takes to receive health care services.

Overall, L.A. Car showed average performance in the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-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 MCP:

- Ensure that the deficiency in the area of Member Grievances from the November 2012 SPD Enrollment Survey is fully resolved.
- For HEDIS audits:
  - Revise the MCP's abstraction training program to be more in alignment with the NCQA *Well-Child* measure specifications to ensure full compliance with the medical review process.
  - Complete a separate Roadmap supplemental data section for each data source and carefully document the information specific to each data source and the measures impacted by each data source.
- Since L.A. Care had eight measures with rates below the MPLs, four of which had rates that declined significantly from 2012 to 2013, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than trying to make improvements on all measures at once.
  - The MCP may benefit from assessing the factors leading to the rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure improving significantly from 2012 to 2013 to determine if strategies showing success for getting members in for prenatal care are appropriate to use for getting members in for postpartum care, since the *Postpartum Care* measure's rate fell below the MPL in 2013.
- For the *All-Cause Readmissions* and three *Children and Adolescents' Access to Primary Care Practitioners* measures, assess the factors leading to the SPD rates for these measures being significantly worse than the non-SPD rates and identify strategies to ensure the MCP is meeting the needs of the SPD population.
- Engage in the following efforts to improve performance on QIPs:
  - Reference the QIP Completion Instructions to ensure all required documentation is included in the QIP Summary Form.
  - Since the *Improving HbA1c and Diabetic Retinal Exam Screening Rates* QIP has not been successful at increasing HbA1c screening and diabetic eye exam rates, conduct a new barrier analysis and assess if the MCP needs to discontinue or modify existing interventions or identify new interventions to better address the priority barriers.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly* priority areas.
- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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 Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the 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**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.
   - If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.

[18] The CMS protocols specify that the EQRO must include an assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

Access and Timeliness Domains

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.
   - If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

CAHPS Survey Measures

(Refer to Tables 5.3 and 5.4)

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

Quality Domain

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

Access Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

Timeliness Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

Quality Improvement Projects (QIPs)

Validation *(Table 4.2)*: For each QIP submission and subsequent resubmission(s), if applicable.

1. **Above Average** is not applicable.
2. **Average** = *Met* validation status.
3. **Below Average** = *Partially Met* or *Not Met* validation status.

Outcomes *(Table 4.4)*: Activity IX, Element 4—Real Improvement

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Not all study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

Sustained Improvement *(Table 4.4)*: Activity X—Achieved Sustained Improvement

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **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.

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

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 and Medi-Cal Managed Care Division reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures, CAHPS measures, and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the encounter data validation (EDV) study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

Appendix B. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

for L.A. Care Health Plan

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with L.A. Care's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table B.1—L.A. Care's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	L.A. Care's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. Ensure that all findings and technical assistance feedback from the MR/PIU reviews are fully addressed. Specifically:	
a. Ensure that all grievance resolution letters include the correct "Your Rights" attachment.	Grievance & Appeal letters have been reviewed/updated accordingly to reflect member rights information. A Grievance & Appeal letter template is attached. *See Folder 1a.* **NOTE:** HSAG reviewed the letter template the MCP submitted for review, and it includes information regarding member rights.
b. Ensure grievances are resolved within the 30-day required time frame.	Daily reports are reviewed by supervisor/manager to ascertain that cases due are flagged and resolved within the 30-day time frame. In addition, L.A. Care is transitioning to a new automated Grievance & Appeals system. The system implementation is targeted for March 2014.
c. Provide evidence that all notice of action (NOA) letters include the required information and are sent within the required time frames.	L.A. Care has processes in place for review of every NOA denial letter prior to issue to ensure the required information is included. Internal audits are done to ensure compliance with letters being sent within required time frames and UM/Pharmacy Delegation is used to review compliance by delegated entities. A NOA template is attached. In addition, L.A. Care conducts annual audits of delegated providers. Copies of internal Regulatory Affairs & Compliance (RA&C) audits and audits performed through UM and Pharmacy Delegation oversight are available in RA&C records. The UM and Pharmacy Plan Partner and Participating Physician Group audit tools are attached. *See Folder 1c.* **NOTE:** HSAG reviewed the documents the MCP submitted for review, and they appear to include the required information. HSAG cannot assess if the NOA letters are sent within the required time frames.

2011–12 External Quality Review Recommendation	L.A. Care's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
2. 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.	In an effort to improve performance, L.A. Care addressed provider education and performance through establishment and promulgation of evidence-based guidelines, development, and implementation for the Alliance Working for Antibiotic Resistance Education (AWARE) program, and posting of a provider toolkit targeting appropriate assessment and antibiotic use. On this measure in 2013, L.A. Care scored 35.44 percent, which is above the HPL of 33.33 percent and an increase above the 32.3 percent reported in HEDIS 2012.
3. 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.	Under the auspices of the Clinical Quality Improvement Committee, L.A. Care develops, implements, and conducts ongoing data analysis to monitor the effectiveness of interventions. Activities focus on improving overall clinical quality, reducing disparities, and improving HEDIS performance. L A. Care currently has the following Quality Improvement and HEDIS Intervention work groups that include provider and member incentive programs to address the following categories of activities: Preventive Services/Well-Care Visits, Perinatal Services, Women's Health Initiatives, Disease Management Programs, and clinical quality improvement projects focused on reducing readmissions and improving diabetes screening. (Full details of the program structure, interventions, and evaluation of effectiveness are included in the attached Quality Improvement Program Annual Report and Evaluation—2012). *See 2012_QI_Annual Eval_FINAL.* **NOTE:** HSAG reviewed the MCP's annual evaluation report, and the report provides information related to the MCP's quality improvement processes and approach to improving performance on measures.
4. 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.	Full details of the process for "Root Cause" analysis and the entire cycle for selection through evaluation described in L.A. Care Policy and Procedure. *See QI – 008 Performance of Quality Improvement Projects.* **NOTE:** HSAG reviewed the policy referenced above, and it includes an outline of the processes used to analyze barriers.

2011–12 External Quality Review Recommendation	L.A. Care's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
5. 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.	Overall program and intervention effectiveness is monitored, tracked, and reported on a monthly to quarterly basis dependent upon the strategy and identified gaps, and is consistent with the QI Work Plan. Detailed work plan is included in the attached Quality Improvement Program Annual Report and Evaluation—2012. (Please note: The 2013 Quality Improvement Program Annual Report and Evaluation is in draft and will be reviewed and approved by Committee and Governance in Jan – Feb 2014). *See 2012_QI_Annual Eval_FINAL* **NOTE:** HSAG reviewed the work plan submitted by the MCP. While it includes quality improvement evaluation processes, the recommendation was related to evaluation of each QIP intervention, which is not specified in the document submitted by the MCP.