Performance Evaluation Report

Inland Empire Health Plan

July 1, 2008–June 30, 2009

Medi-Cal Managed Care Division
California Department of
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Purpose of Report

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

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

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

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

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

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

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

All of IEHP's rates fell between the MPLs and HPLs for all of its reported performance measures in 2009. The plan did not exceed the HPL for any measure and did not have below-average performance in any area.

IEHP had statistically significant and sustained improvement in providing appropriate treatment to children with an upper respiratory infection (URI) through its QIP. Additionally, IEHP had a statistically significant increase over the previous year for *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*. These results demonstrated ongoing plan efforts to provide care consistent with practice guidelines—thus improving the quality of care delivered to members.

IEHP was fully compliant with the Department of Managed Health Care's (DMHC) non-joint audit, which included independent medical review, grievances process, and standing referrals.

The plan demonstrated strength in its quality management program. IEHP had a structure that supported the tracking and trending of data, analyzing data, identifying opportunities for

improvement, implementing targeted intervention, and conducting ongoing monitoring. IEHP was fully compliant with audit areas related to quality management and administrative and organizational capacity.

IEHP can improve the quality of care delivered to members by improving its rates for *Use of Appropriate Medications for People With Asthma (ASM)* and *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)* measures, which are only slightly above the MPL. To prevent further decline, the plan has an opportunity to determine factors that contributed to two measures with statistically significant decreases from 2008 to 2009: *Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N)* and *Well-Child Visits in the First 15 Months of Life (W15)*.

HSAG noted that the plan has an opportunity to improve its documentation of both QIPs to meet compliance with federal requirements for conducting a QIP. Following the Centers for Medicare & Medicaid Services (CMS) protocol for conducting a QIP increases the likelihood that the plan will achieve real and sustained improvement of health outcomes.

Access

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

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

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

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

Performance measure rates related to access all fell between the MPLs and HPLs.

IEHP monitored provider network thresholds and was compliant with the DHCS, DMHC, and internal plan standards. IEHP monitored access for well-child, routine, physical examination, prenatal, urgent, and routine specialty care.

The plan identified a high percentage of access-related grievances. While the network met appropriate thresholds for adequacy, the plan has an opportunity to continue efforts to reduce access-related grievances. Access-related issues may prevent the plan from achieving higher performance measure rates and reducing avoidable emergency room (ER) visits.

Timeliness

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

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

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

The plan performed within the MCMC-established thresholds for all performance measures under the timeliness domain of care.

Audit findings showed that the plan was compliant with its grievance processes. IEHP demonstrated good oversight of its delegated entities to ensure compliance with denials, including the review of turnaround times, language requirements, and guidelines used to base the determination.

To assist with continuity and coordination of care for members, the plan had good processes in place that included the monitoring of coordination between primary care physicians and behavioral health. The plan noted some concern with members' family practice and general practitioners transferring care to an OB/GYN late in the pregnancy, which has a significant impact on continuity and coordination of care for the member. This may contribute to the low rate of members returning for appropriate and timely postpartum care.

IEHP has been unable to demonstrate significant improvement with completion of initial health assessments and initial health education behavioral assessments for new members. This may prevent or delay members from receiving necessary care.

Conclusions and Recommendations

Overall, IEHP demonstrated average performance in providing quality, accessible, and timely health care services to its MCMC members. All of IEHP's performance measure rates were between the established MPL and HPL.

IEHP had statistically significant and sustained improvement in providing appropriate treatment to children with an upper respiratory infection (URI) through its QIP.

The DMHC audited IEHP's compliance with the requirements of the plan's MCMC Hyde contract, which covers State-funded abortion services. (These services do not qualify for federal funding.) DMHC found IEHP fully compliant with the Medi-Cal Hyde contract audit standards related to the grievance process, standing referrals, and independent medical review. The MRPIU's review showed that IEHP was fully compliant with all areas covered under the scope of the review. Opportunities exist for IEHP to build on its stable performance measure rates and stretch its goals to achieve the HPLs, to address access-related concerns, and to improve initial health assessment completion rates.

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

- Focus efforts to improve the *Use of Appropriate Medications for People With Asthma (ASM)* and *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)* measures, which are at risk for falling below the MPL. Although the *ASM* measure was discontinued as a required measure as of reporting year 2009, HSAG recommends that the plan continue to improve this aspect of chronic care for its members with asthma.
- Identify factors that contributed to the statistically significant decrease for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N)* and *Well-Child Visits in the First 15 Months of Life (W15)* measures to prevent further decline.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.
- Continue efforts to increase the network capacity for same-day appointments and urgent care access to increase the likelihood of success with reducing avoidable ER visits.
- Analyze access-related grievances for actionable trends.
- Monitor and evaluate the effectiveness of the revised prenatal care policy to ensure members are receiving appropriate and timely care.
- Conduct barrier analysis and evaluate the effectiveness of existing interventions to address the unchanged rates for initial health assessments and initial health education behavioral assessments for new members.

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

Plan Overview

Inland Empire Health Plan (IEHP) is a full-scope managed care plan operating in Riverside and San Bernardino counties. IEHP became operational in both counties with the MCMC Program in September 1996, and as of June 30, 2009, IEHP had a total of 344,461 MCMC members in Riverside and San Bernardino counties combined.[1]

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

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

Conducting the Review

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

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

Findings

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

Joint Audit Review

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

When preparing this report, HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. Two audits of IEHP were conducted simultaneously in August 2009. A&I performed an on-site medical audit, and DMHC conducted a routine, desk-level medical survey. A&I's medical audit covered plan activity during the review period of July 1, 2008, through June 30, 2009. A&I issued two reports from the August 2009 on-site medical audit—one for the audit of the plan's main Medi-Cal contract and the other for the plan's Medi-Cal Hyde contract covering abortion services.

The scope of A&I's on-site medical audit covered the areas of utilization management (UM), continuity of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity.

In the UM area, IEHP showed that it developed and maintained a UM program and monitored for over- and underutilization of health care services. IEHP demonstrated strong oversight of its delegated entities and complied with prior-authorization review requirements and procedures. The audit found that IEHP did not send the required written notification to members when a pharmaceutical service request was modified.

For continuity of care, the plan had policies and procedures in place for coordination and continuity of care for its members, including the identification of members who were receiving Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and members with developmental disabilities. The audit noted low initial health assessment completion rates despite the plan's evaluation of intervention strategies.

For availability and accessibility, the audit showed that the plan's policy documented the times to obtain various appointments, including primary care, urgent care, emergency care, and prenatal care. The plan had adequate processes to monitor wait times. Audit findings showed that IEHP's emergency service claims payment policy was not compliant with contract requirements. Additionally, three of five family planning claims reviewed were incorrectly denied. Follow-up documentation from the DHCS showed that the plan sufficiently addressed both findings in this area.

In the member grievances area, the audit showed that IEHP was fully compliant with all requirements. The plan had a process in place to track and resolve grievances. All grievance files reviewed for the audit were acknowledged in a timely manner, and the files showed that the issues were resolved appropriately.

IEHP was fully compliant with all requirements reviewed under the quality management area. The plan demonstrated implementation and maintenance of a quality management program to monitor, evaluate, and take action to address needed improvements.

Audit results showed that the plan was fully compliant with all requirements reviewed related to administrative and organizational capacity.

The review of the plan's Medi-Cal Hyde contract included three areas: independent medical review, the grievance process, and standing referrals. Results from this audit found IEHP fully compliant with all areas reviewed under the scope of the audit. DMHC provided no recommendations as a result of the evaluation.

Member Rights and Program Integrity Monitoring Review

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

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

MRPIU conducted an on-site review of IEHP in June 2009 covering the review period of March 1, 2008, through March 31, 2009. MRPIU's review found that IEHP was fully compliant with all areas covered under the review, including the member grievance process, prior-authorization notification process, cultural and linguistic services, marketing, and program integrity.

Strengths

The DMHC's review of the plan's Medi-Cal Hyde contract found that IEHP was fully compliant in the areas of independent medical review, the grievance process, and standing referrals. The MRPIU review, covering the main Medi-Cal contract, found the plan compliant in all areas reviewed. Additionally, the plan was compliant in the areas reviewed for the joint audit, which were member rights, quality management, and administrative organizational capacity.

Based on audit result findings and IEHP's internal quality management program evaluation, the plan demonstrated a quality management program and structure that supported monitoring, analyzing, and reporting of clinical and service initiatives.[2] The plan demonstrated tracking and trending of data for action.

IEHP demonstrated good oversight of its Independent Physician Associations (IPAs) related to concurrent denials. The plan's thorough reviews ensured compliance with requirements that included the review of turnaround times, language requirements, and guidelines used to base determinations.

[2] Inland Empire Health Plan, *2008 Quality Management Program Evaluation.*

The plan had good processes in place to assist with continuity and coordination of care for members. These included the monitoring of coordination between primary care physicians and behavioral health providers.

IEHP monitored assigned member thresholds for network providers and was compliant with the DHCS, DMHC, and internal plan standards. The plan also monitored access to well-child, routine, physical examination, prenatal, urgent, and routine specialty care.

Through the quality management program, the plan demonstrated use of data and analysis to drive program decisions, identify opportunities for improvement, and act on areas of low performance.

Opportunities for Improvement

IEHP's grievance subcommittee conducted thorough barrier analyses and identified that access-related issues were responsible for over half of all grievances received. To address this trend, the plan implemented targeted interventions, including member and provider education, referrals to the case management program to assist members with more complex needs, and follow-up from the quality improvement department to perform access audits. The plan has an opportunity to continue to monitor this initiative. Issues with access to care may prevent the plan from achieving higher performance measure rates and reducing avoidable ER visits.

The plan's peer review subcommittee identified a concern with family practice and general practitioners administering OB/GYN services as members' primary care physicians until transferring the members at 36 weeks for the remainder of care and delivery. This has had an impact on the continuity and coordination of care for members and may contribute to the plan's low postpartum care rate. The plan noted that it revised its policy and written procedures with providers to improve this practice. IEHP has an opportunity to evaluate the effectiveness of this policy change.

IEHP's rates for completion of initial health assessments and initial health education behavioral assessment for new members remained unchanged despite plan efforts to improve these rates. The plan should conduct a barrier analysis to identify additional factors that may contribute to the low rates and develop new, targeted interventions that address the identified barriers.

Conducting the Review

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

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

Findings

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

Performance Measure Validation

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

Recommendations from the audit indicated that the plan should capture provider specialty information during the claims submission and adjudication process. This step would support more accurate and timely gathering of data for HEDIS reporting.

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

Performance Measure Results

Table 4.1 presents a summary of IEHP's county-level HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measures results (based on calendar year 2007 data). In addition, the table shows the plan's HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs. While the DHCS requires that plans report county-level data, the DHCS provided IEHP and the other plans operating in Riverside and San Bernardino counties with an exception to continue to report one combined rate for these counties.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the NCQA's national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

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

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

Table 4.1—2008–2009 Performance Measure Results for Inland Empire Health Plan Riverside and San Bernardino Counties (Combined County Rate)

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	27.1%	29.9%	★★	↔	20.6%	35.4%
ASM	Q	89.8%	88.3%	★★	↔	86.1%	91.9%
AWC	Q,A,T	38.4%	40.0%	★★	↔	35.9%	56.7%
BCS	Q,A	50.0%	49.0%	★★	↔	44.4%	61.2%
CCS	Q,A	66.9%	61.9%	★★	↔	56.5%	77.5%
CDC–E	Q,A	54.9%	50.2%	★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	32.3%	30.2%	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	43.2%	46.9%	★★	↔	52.5%	32.4%
CDC–HT	Q,A	80.1%	80.2%	★★	↔	74.2%	88.8%
CDC–LC (<100)	Q	35.7%	36.9%	★★	↔	25.1%	42.6%
CDC–LS	Q,A	80.8%	79.5%	★★	↔	66.7%	81.8%
CDC–N	Q,A	88.3%	78.7%	★★	↓	67.9%	85.4%
CIS–3	Q,A,T	69.0%	69.7%	★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	82.9%	84.5%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	61.2%	57.1%	★★	↔	54.0%	70.6%
URI	Q	80.8%	85.7%	★★	↑	79.6%	94.1%
W15	Q,A,T	58.1%	48.6%	★★	↓	44.5%	73.7%
W34	Q,A,T	73.8%	73.1%	★★	↔	59.8%	78.9%

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

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

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

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

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

[6] The MMCD's minimum performance level (MPL) is based on the NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.

[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

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

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

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

Performance Measure Result Findings

IEHP demonstrated average performance, falling between the MPLs and HPLs for all of its reported performance measures in 2009. The plan did not exceed the HPL for any measure. The plan did not have below-average performance in any area.

HEDIS Improvement Plans

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

In 2008, the DHCS did not require IEHP to submit any improvement plans. Additionally, IEHP was not required to submit any improvement plans based on its 2009 performance.

Strengths

All IEHP performance measure rates were above the MPL in 2008 and 2009. Additionally, the plan showed a statistically significant increase over the prior year for *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*, which demonstrated efforts to provide care consistent with practice guidelines—thus improving the quality of care delivered to members.

Opportunities for Improvement

IEHP had stable rates for *Use of Appropriate Medications for People With Asthma (ASM)* and *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)* measures; however, these rates are only slightly above the MPL (2.2 and 3.1 percentage points, respectively). These areas present an opportunity for improvement and may point to issues with health care quality, access, and/or timeliness.

For two HEDIS measures, *Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N)* and *Well-Child Visits in the First 15 Months of Life (W15),* IEHP had a statistically significant decrease in rates from 2008 to 2009. To prevent further decline, the plan has an opportunity to determine factors that contributed to the deceased rates.

Conducting the Review

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

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

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about IEHP's performance in providing quality, accessible, and timely care and services to its MCMC members. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Quality Improvement Projects Conducted

IEHP had two clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted the reduction of avoidable ER visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. IEHP's second project, an internal QIP, aimed to increase the appropriate treatment of upper respiratory infection (URI) in children 3 months to 18 years of age.

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

For most children, treatment of URI with antibiotics is an indicator of suboptimal care. IEHP's project attempted to improve the quality of care delivered to children with upper respiratory infections by targeted physician intervention.

Quality Improvement Project Validation Findings

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

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

Table 5.1—QIP Validation Results for Inland Empire Health Plan (N=2 QIPs)

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	92%	0%	8%
II.	Clearly Defined, Answerable Study Question(s)	50%	0%	50%
III.	Clearly Defined Study Indicator(s)	77%	15%	8%
IV.	Correctly Identified Study Population	50%	17%	33%
V.	Valid Sampling Techniques (if sampling was used)	--	--	--
VI.	Accurate/Complete Data Collection	58%†	33%†	8%†
VII.	Appropriate Improvement Strategies	100%	0%	0%
VIII.	Sufficient Data Analysis and Interpretation	81%	0%	19%
IX.	Real Improvement Achieved	63%†	0%†	38%†
X.	Sustained Improvement Achieved	100%	0%	0%
Percentage Score of Applicable Evaluation Elements *Met*		**75%**		
Validation Status		***Not Applicable****		

* QIPs were not given an overall validation status during the review period.
† The sum may not equal 100 percent due to rounding.

IEHP submitted data for its second remeasurement period for the URI project during the review period; therefore, HSAG assessed the QIP for both real and sustained improvement. The plan's statewide collaborative QIP will be assessed for improvement next year.

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

Quality Improvement Project Outcomes

Table 5.2 shows IEHP's data for its QIPs. For the ER collaborative QIP, IEHP's baseline goal was to reduce the rate of avoidable ER visits to 18.2 percent. The plan's first remeasurement year data will be submitted in time to be included in the next performance evaluation report (July 1, 2009, through June 30, 2010), at which time HSAG will assess for real improvement.

For the *Appropriate Treatment for Children With URI* QIP, IEHP set a goal to increase to 82.7 percent for baseline and both remeasurement periods the percentage of children 3 months to 18 years of age who were diagnosed with an upper respiratory infection and were not dispensed an antibiotic prescription on or three days after the episode date.

Table 5.2—QIP Outcomes for Inland Empire Health Plan

QIP #1—Reducing Avoidable Emergency Room Visits				
		Remeasurement Period		
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	1 1/1/08–12/31/08	2 1/1/09–12/31/09	Sustained Improvement
Percentage of ER visits that were avoidable	22.8%	‡	‡	‡
‡ The QIP did not progress to this phase during the review period and could not be assessed.				

QIP #2—Appropriate Treatment for Children With URI				
		Remeasurement Period		
QIP Study Indicator	Baseline Period 1/1/06–12/31/06	1 1/1/07–12/31/07	2 1/1/08–12/31/08	Sustained Improvement
Percentage of children 3 months to 18 years of age who were diagnosed with an upper respiratory infection and were not dispensed an antibiotic prescription on or three days after the episode date	41.3%∞	73.0%*	80.8%*	Yes
∞ The rate for the baseline period was inverted from the QIP's reported rate, which was 58.6 percent. NCQA changed the methodology in subsequent years; therefore, to compare improvement for the QIP between years, HSAG reported 41.3 percent to allow for appropriate statistical comparisons. * Designates statistically significant improvement over the prior measurement period.				

IEHP implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits. The plan implemented targeted member education interventions and focused efforts to increase access to primary care provider offices and urgent care centers. Additionally, the plan has tried to reduce ER visits by incorporating case management of members who have used the ER multiple times.

IEHP demonstrated a statistically significant increase between baseline and the first remeasurement period and again between the first and second remeasurement periods for the URI QIP. The plan achieved both real and sustained improvement for the URI QIP, improving the initial baseline rate of 41.3 percent (which was inverted from the QIP's reported rate of 58.6 percent to allow for statistical comparison) to 80.8 percent upon the second and final remeasurement.

Strengths

IEHP demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data. In addition, IEHP's interventions to address identified causes/barriers and system interventions are likely to induce permanent change, demonstrated by sustained improvement for the URI QIP.

IEHP's internal QIP on URI has had a positive impact on the plan's *Appropriate Treatment for Children With Upper Respiratory Infection* (URI) performance measure rate, which showed a statistically significant increase between 2008 and 2009. This demonstrates continued improvement despite the plan formally retiring the QIP. The plan's 2009 URI rate exceeded the MCMC Program average of 84.8 percent.[4]

Opportunities for Improvement

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

The plan identified the need to work with ERs to facilitate the exchange of data; however, the intervention is still in the planning stages, so QIP results will not be affected in the next review period. The statewide collaborative member health education campaign attempts to educate members about contacting their providers before going to the ER for many common, non-urgent conditions. IEHP will need to evaluate efforts to gain provider support for treating patients in outpatient rather than ER settings by increasing access to care for same-day appointments and urgent care capacity.

[4] California Department of Health Care Services. *2009 HEDIS Aggregate Report for the Medi-Cal Managed Care Program.* July 2010.

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

Table A.1—HEDIS® Performance Measures Name Key

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