Performance Evaluation Report

Inland Empire Health Plan

July 1, 2009–June 30, 2010

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

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

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

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

This report is specific to the MCMC Program's contracted plan, Inland Empire Health Plan ("IEHP" or "the plan"), which delivers care in Riverside and San Bernardino counties, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

Inland Empire Health Plan (IEHP) is a full-scope managed care plan operating in Riverside and San Bernardino counties. IEHP serves members in both counties as a local initiative (LI) under the Two-Plan Model. IEHP has been Knox-Keene licensed since 1996. Knox-Keene licensure is granted by the Department of Managed Health Care (DMHC) to plans that meet minimum required standards according to the Knox-Keene Health Care Service Plan Act of 1975. The act includes a set of laws that regulate managed care organizations (MCOs).

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

Members of the MCMC Program in both counties may enroll in either the LI plan operated by IEHP or in the alternative commercial plan. IEHP became operational in both counties with the MCMC Program in September 1996; and as of June 30, 2010, IEHP had 387,688 MCMC members in both the Riverside and San Bernardino counties, collectively.[2]

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

Conducting the Review

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

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

This report section covers the DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

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

Findings

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

Medical Performance Review

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

HSAG reviewed the most current medical performance review reports available as of June 30, 2010, to assess plans' compliance with State-specified standards. A&I and DMHC conducted a medical performance review of IEHP in August 2009 covering the review period of July 1, 2008, through June 30, 2009.[3] HSAG reported the review findings in the 2008–2009 plan evaluation report for IEHP.

The 2009 review found IEHP fully compliant in the areas of member grievances, quality management, administrative and organizational capacity, and Hyde contract requirements. The Hyde contract covers abortion services funded only with State funds, as these services do not qualify for federal funding.

The review noted deficiencies in the areas of utilization management, continuity of care, and availability and accessibility, some of which were not resolved based on corrective actions taken by the plan.

Under the utilization management area, the plan was cited for not sending a written notification letter to the member when a pharmaceutical service was modified. Within its corrective action plan (CAP), IEHP revised the policy and procedure to require a written notification letter for modification of pharmacy services. The plan would begin implementing the new policy in March of 2010. The DHCS determined that the deficiency remained unresolved because the plan did not submit a copy of the notification of action (NOA) letter with its CAP. In addition, since the implementation would take longer than a 45-day time period, the DHCS indicated that it would evaluate the implementation and monitoring during the next medical performance review cycle.

Under continuity of care, IEHP had an unresolved finding related to low initial health assessment rates despite the plan's intervention strategies. Within its CAP, IEHP described changes to multiple internal and external policies that would be implemented in the future. The DHCS determined that the deficiency remained open because the plan did not submit evidence of the revisions made nor actions taken to resolve the deficiencies.

The final open issue was under the area of availability and accessibility, specifically related to access to prescription medications in emergency circumstances. Although the plan had a policy for monitoring the provision of medications by ensuring that hospitals and emergency departments has a sufficient supply of emergency medications for IEHP members, the plan did not perform the monitoring according to the policy. Within the plan's CAP, IEHP indicated that it would monitor emergency medication requirements by reviewing member grievances and evaluating the GeoAccess report to ensure sufficient 24-hour pharmacy coverage. The DHCS determined the CAP did not correct the issues as it was unclear how the GeoAccess report would be used to monitor this area. The DHCS required that IEHP provide evidence of monitoring of 24-hour access to prescription medications at the time of the next medical performance review.

[3] *California Department of Health Care Services Medical Review – Northern Section, Audits and Investigations, IEHP*, January 5, 2010.

Medi-Cal Managed Care Member Rights and Program Integrity Review

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

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2010.

MRPIU conducted an on-site review of IEHP in June 2009 covering the review period of March 1, 2008, through March 1, 2009. HSAG reported the findings from the review in the 2008–2009 plan evaluation report.

The MRPIU found IEHP fully compliant with all areas covered under the review, including member grievances, prior-authorization notification processes, cultural and linguistic services, marketing, and program integrity.

Strengths

Based on the review findings, IEHP showed strong performance as demonstrated by full compliance with most contract requirements, including member grievances, quality management, administrative and organizational capacity, authorization notification processes, cultural and linguistic services, marketing, program integrity, and Hyde contract requirements.

Opportunities for Improvement

While IEHP adequately resolved some of the medical performance review deficiencies, the plan did not resolve all deficiencies. IEHP should re-evaluate the process for developing corrective action plans. Rather than listing future actions to resolve issues, the plan should strive to implement immediate remedial actions and include evidence of actions taken in the corrective action plan.

Conducting the Review

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

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

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

Findings

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

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed a HEDIS Compliance Audit™ of IEHP in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[4] Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

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

Performance Measure Results

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

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

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

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national Medicaid 25th percentile and 90th percentile, respectively. For the CDC–H9 (>9.0 percent) measure, a low rate indicates better performance and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the national Medicaid 10th percentile.

Table 3.2—2009–2010 Performance Measure Results for Inland Empire Health Plan—San Bernardino/Riverside Counties

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	29.9%	26.3%	★★	↓	20.2%	33.4%
AWC	Q,A,T	40.0%	45.1%	★★	↔	37.9%	59.4%
BCS	Q,A	49.0%	50.6%	★★	↑	45.0%	63.0%
CCS	Q,A	61.9%	69.6%	★★	↑	60.9%	79.5%
CDC–BP	Q	‡	71.3%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	50.2%	52.6%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	45.9%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	46.9%	45.3%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	80.2%	79.4%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	36.9%	36.0%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	79.5%	79.4%	★★	↔	71.5%	82.5%
CDC–N	Q,A	78.7%	81.0%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	69.7%	70.1%	★★	↔	62.4%	80.6%
LBP	Q	‡	76.4%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	84.5%	86.7%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	57.1%	60.8%	★★	↔	57.9%	72.7%
URI	Q	85.7%	88.0%	★★	↑	81.1%	94.5%
W34	Q,A,T	73.1%	74.1%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	67.4%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	69.0%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	61.3%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ The DHCS did not require plans to report this measure in 2009.
NA = The DHCS does not establish an MPL/HPL for first year measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.
Not Comparable = Performance could not be compared due to either significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, IEHP demonstrated average performance, with all performance measure results falling between the MPL and HPL. Three of the plan's measures achieved a statistically significant improvement, and one measure experienced a statistically significant decline.

HEDIS Improvement Plans

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

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans. IEHP did not have any 2009 performance measure rates that required an improvement plan.

Strengths

IEHP showed consistent performance across all measures, with no rates falling below the MPL. The plan achieved statistically significant improvement with its *Breast Cancer Screening, Cervical Cancer Screening*, and *Appropriate Treatment for Children With Upper Respiratory Infection* performance measures.

Opportunities for Improvement

IEHP should evaluate the factors that led to a statistically significant decline in its performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure.

Conducting the Review

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

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

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

Findings

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

Quality Improvement Projects Conducted

IEHP had one clinical QIP and one internal QIP proposal in progress during the review period of July 1, 2009, through June 30, 2010. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. IEHP's second project, an internal QIP, aimed to improve the management of Attention Deficit Hyperactivity Disorder (ADHD) in children 6 to 12 years of age.

Both QIPs fell under the quality and access domains of care. The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a 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 ADHD with psychostimulants and other psychiatric medications without appropriate follow-up visits is an indicator of suboptimal care. IEHP's project attempted to improve the quality of care delivered to children with ADHD by targeted physician interventions.

Quality Improvement Project Validation Findings

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

Table 4.1—Quality Improvement Project Validation Activity for Inland Empire Health Plan—San Bernardino/Riverside Counties July 1, 2009, through June 30, 2010

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	89%	100%	*Met*
Internal QIPs				
Attention Deficit Hyperactivity Disorder (ADHD) Management	Proposal	100%	100%	*Met*

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

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

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

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

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met, Partially Met,* or *Not Met*. In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that IEHP's annual submission of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. The plan also received a *Met* validation status for its *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP proposal submission. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status; therefore, IEHP was not required to resubmit either QIP.

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

Table 4.2—Quality Improvement Project Average Rates*
for Inland Empire Health Plan—San Bernardino/Riverside Counties
(Number = 2 QIPs, 2 QIP Topics)
July 1, 2009, through June 30, 2010

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	83%	0%	17%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**94%**	**0%**	**6%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	80%	20%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total†		**88%**	**13%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation†	88%	0%	13%
	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		**92%**	**0%**	**8%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.
‡ The QIP did not progress to this activity during the review period and could not be assessed.
†The sum of an activity or stage may not equal 100 percent due to rounding.

IEHP accurately applied the QIP process for the Design stage; however, the plan was noncompliant in addressing a recommendation from the prior year's submission to discuss the eligible population in Activity I for the *Reducing Avoidable Emergency Room Visits* QIP. In Activity VI of the Implementation stage for the same QIP, the plan did not include the data collection timeline. For the Outcomes stage, the *Reducing Avoidable Emergency Room Visits* QIP did not address any factors which could affect the ability to compare measurement periods in Activity VIII. The plan had not progressed to a second remeasurement period for either QIP; therefore, both QIPs could not be assessed for sustained improvement.

Quality Improvement Project Outcomes

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

Table 4.3—Quality Improvement Project Outcomes for Inland Empire Health Plan—San Bernardino/Riverside Counties (Number = 2 QIPs, 2 QIP Topics) July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Sustained Improvement**
Percentage of ER visits that were avoidable	22.8%	20.3%*	‡	‡
QIP #2—Attention Deficit Hyperactivity Disorder (ADHD) Management				
QIP Study Indicator	**Baseline Period 1/1/08–12/31/08**	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Sustained Improvement**
The percentage of members 6–12 years of age as of the Index Prescription Episode Start Date with an ambulatory prescription dispensed for ADHD medication, who had one outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority within 30 days after the Index Prescription Episode Start Date	‡	‡	‡	‡
The percentage of members 6–12 years of age as of the Index Prescription Episode Start Date with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended	‡	‡	‡	‡

*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05)
‡The QIP did not progress to this phase during the review period and could not be assessed.

The plan demonstrated a statistically significant decrease in the avoidable ER visits rate between baseline and the first remeasurement period. For the statewide ER collaborative QIP, IEHP implemented plan-specific interventions in addition to the statewide collaborative interventions to reduce avoidable ER visits. Interventions that supported improvement in this area focused on expanding the urgent care network and educating members on when to use an urgent care versus using an emergency room. Providers were educated about the robust urgent care network that was available. Members calling the nurse advise line staff were given up-to-date information on IEHP urgent care facilities. Since collaborative interventions were not initiated until 2009, HSAG could not evaluate the effectiveness of those interventions.

The *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP proposal had not progressed to the point of reporting outcomes.

Strengths

IEHP accurately documented the QIP process in the ongoing QIP and was able to apply the same principles in the new QIP proposal as evidenced by a *Met* validation status for the initial submission of both QIPs. In addition, IEHP's system interventions addressing identified causes/barriers are likely to induce permanent change, demonstrated by the statistically significant improvement for the *Reducing Avoidable Emergency Room Visits* QIP.

Opportunities for Improvement

IEHP identified that proper ADHD follow-up visits were not occurring based on HEDIS 2009 results for the *Follow-Up Care for Children Prescribed ADHD Medications*. IEHP's results for both indicators were below the 2009 NCQA Medicaid 10th percentile, providing an opportunity for improvement. To facilitate improvement, IEHP will need to incorporate methods to evaluate its interventions to determine if they are effective toward achieving improvement.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan surveys.[5]

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

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

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about IEHP's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures as follows:

CAHPS Global Rating Measures:

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

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

CAHPS Composite Measures:

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

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance (NCQA)'s HEDIS® benchmarks and thresholds or NCQA's national Medicaid data, when applicable. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).

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

Table 5.1—Star Ratings Crosswalk

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

Table 5.2—Inland Empire Health Plan—San Bernardino/Riverside Counties Medi-Cal Managed Care County-Level Global Ratings

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

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

Table 5.3—Inland Empire Health Plan—San Bernardino/Riverside Counties
Medi-Cal Managed Care County-Level Composite Measures

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

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

Strengths

IEHP performed well for both adult and child satisfaction in the composite measure of *Customer Service*, demonstrating that IEHP members are pleased with the plans' customer service functions.

Opportunities for Improvement

IEHP's CAHPS results showed primarily poor performance for all child and adult global rating categories. CAHPS results also showed poor performance for all child and adult composite ratings except *Customer Service*. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the plan's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as IEHP's highest priorities: *Rating of All Health Care, Rating of Personal Doctor,* and *How Well Doctors Communicate*. The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 IEHP CAHPS Plan-Specific Report*. Areas for improvement spanned the quality, access, and timeliness domains of care.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

The plan showed average performance based on IEHP's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, member satisfaction survey results, and the results of the medical performance and member rights reviews as they related to measurement and improvement. The plan achieved statistically significant improvement on three measures and had no measures that fell below the MPL. The plan had one measure, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis,* which experienced a statistically significant decline. This measure falls under the quality domain.

IEHP performed poorly in both adult and child satisfaction surveys in both the composite and global ratings for measures of quality. The plan met all contractual standards that relate to quality, based on the medical performance and MRPIU reviews.

QIP results showed that the plan achieved a statistically significant improvement in its *Reducing Avoidable Emergency Room Visits* QIP. The plan had opportunities to improve its QIP documentation, particularly in the implementation and outcome phases, to ensure compliance with the CMS protocol for conducting valid and reliable QIPs.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

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

The plan demonstrated average performance based on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results. IEHP had statistically significant improvement in two measures of access (*Breast Cancer Screening and Cervical Cancer Screening*) as well as in its *Reducing Avoidable Emergency Room Visits* QIP, which falls under the access domain.

Member satisfaction related to access was low across adult and child global and composite ratings, with the exception of *Customer Service*. Health plan performance in customer service impacts access to care.

For access-related compliance standards, IEHP was compliant with most standards. One area which remained an open deficiency involved plan monitoring to ensure sufficient access to prescription medications in emergency situations. The plan also had a remaining deficiency noted by the medical performance review related to a low percentage of members receiving an initial health assessment.

Timeliness

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

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and

utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

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

Performance measure rates regarding timeliness showed that the plan performed between the MPL and HPL for all measures.

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

IEHP had an unresolved deficiency related to notice of action letters when there was a modification of pharmaceutical services as indicated by the medical performance review results. The plan also had a lower percentage of members receiving an initial health assessment within the required time frame, a finding that crosses both access and timeliness domains. The plan, however, met all other contract requirements that related to timeliness.

Follow-Up on Prior Year Recommendations

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

Conclusions and Recommendations

Overall, IEHP achieved average performance during this review period in all three domains, providing high quality, accessible, timely health care services to its MCMC members.

IEHP made some improvements in its performance measures rates in 2010 compared with 2009 rates, with only one measure's rate declining. The plan was generally compliant with documentation requirements across performance measures, QIPs, and State and federal requirements; however, the plan experienced some challenges with developing corrective action plans to fully resolve performance review deficiencies.

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

- Ensure that all open medical performance review deficiencies are fully resolved and maintain clear evidence of the implementation of corrective actions.
- Address QIP data elements that were not *Met* in the QIP validation results. Ensure future QIP submissions include all necessary documentation required for a valid QIP.
- Explore factors that led to a decline in performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure and implement targeted improvement efforts.
- Review the 2010 plan-specific CAHPS results report and develop strategies to address the *Rating of All Health Care, Rating of Personal Doctor,* and *How Well Doctors Communicate* priority areas.

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

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

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

EQR Recommendation	Plan Actions That Address the Recommendation
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.	IEHP has an asthma disease management program that identifies and stratifies asthmatics on a monthly basis. Interventions are done based upon their risk level. Physicians are encouraged to use the IEHP asthma progress note that assists them with identifying severity level and appropriate medication. In addition, IEHP has a variety of asthma education programs such as group classes, home visit programs, and educational materials for members and providers. Annually, all PCPs receive a "report card" on how well they performed on appropriately prescribing long-term controller medications for their asthma members (based on HEDIS specifications). This PCP-level report card compares individual PCPs to their peers within a specific sub-specialty (e.g., Family Practice or Pediatrics) and then also provides comparison to IEHP's overall performance. IEHP also provides PCP Asthma Roster lists to all PCPs via the secure IEHP Provider Portal. This roster list also lists all short-term and long-term asthma medications filled by the member in the past 12 months for the PCPs review. It also indicates whether or not the member has been referred to IEHP's asthma health education programs. Finally, it provides all ER and inpatient stays that the member may have had in the past 12 months with a detail listing of the dates of service and primary diagnoses, if applicable.
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.	IEHP has seen a significant growth in membership over the last few years. Diabetes is the second most common chronic condition seen in our Medi-Cal population. The PCP network has not grown as quickly as the membership has grown. Our provider network is made up of mostly solo practitioners who do not have EMR's or who are not staffed with registered nurses. Chronic disease management for this population is difficult. IEHP has developed an EHR that is available to all PCPs which identifies members with chronic conditions such as diabetes and asthma, and information about preventive services, utilization and pharmacy history. IEHP encourages use of the EHR to assist the provider in managing chronically ill members. In addition, IEHP has a diabetes P4P program for all components of the diabetes HEDIS measure, including medical attention for nephropathy. IEHP has a robust well child physician P4P program that targets compliance with the following HEDIS measures: W15, W34, and AWC. In addition, IEHP provides "alerts" to PCPs when accessing the IEHP member EHR if a member is due for a well-child visit.

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

EQR Recommendation	Plan Actions That Address the Recommendation
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.	IEHP provided training on the HSAG QIP format and now produces all QIPs using this template.
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.	IEHP has grown significantly over the past few years (with a 3,000–5,000 per month member growth). The provider network department is actively reaching out to new providers. IEHP has taken the financial risk for Urgent Cares (UCs) back from the IPAs and it is now a health plan responsibility. This transition has shown to improve our UC access and we now have over 32 UCs in network. Providers are financially compensated if they provide extended hours. IEHP has been a part of the statewide ER collaborative for the past three years. Avoidable ER rates have continued to rise. We find this to be especially challenging because all ER's now are promoting short wait times, have programs in place to "text" for an appointment or schedule an "ER" appointment. More detailed information on how we are addressing ER rates can be found in the ER Collaborative QIP.
Analyze access-related grievances for actionable trends.	IEHP analyzes grievance data for trends. Data have been reviewed for the past two years and access-related grievances were found to be significant; however, when a further analysis was done, the access issues were related to "referral" related grievances. Members were having difficulty accessing specialty care. Many interventions were put into place. For example, a Web based authorization program is being implemented, the IPA report card was changed to increase the penalty for referral related questions, and focused referral audits were conducted for IPAs and PCPs,
Monitor and evaluate the effectiveness of the revised prenatal care policy to ensure members are receiving appropriate and timely care.	Policies for open access to OB care are up to date. All providers are notified of these policies through our annual provider manual submission. Grievances are monitored for prenatal care access. IEHP also has a prenatal and postpartum P4P program. OBs are audited for appointment availability on an annual basis and have done well with these standards. High-risk OB members are managed in the HROB CM program.