Performance Evaluation Report

Inland Empire Health Plan

July 1, 2010–June 30, 2011

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

June 2012

TABLE OF CONTENTS

1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 million beneficiaries (as of June 2011)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

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

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

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2011.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Inland Empire Health Plan ("IEHP" or "the plan"), which delivers care in Riverside and San Bernardino counties, for the review period July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

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. 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, 2011, IEHP had 441,352 MCMC members in both the Riverside and San Bernardino counties, collectively.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

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

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about 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 have historically worked in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits have been conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

HSAG reviewed the most current medical performance audit reports available as of June 30, 2011, to assess plans' compliance with State-specified standards.

The most recent medical performance review was completed in January 2010, covering the review period of July 1, 2008, through June 30, 2009. HSAG reported findings from this audit in the 2009–2010 plan evaluation report.[3]

The review showed that IEHP had audit findings in the areas of utilization management, continuity of care, and availability and accessibility. The DHCS *Medical Audit Close-Out Report* letter dated July 8, 2010, noted that the plan had fully corrected several audit deficiencies; however, some issues remained unresolved at the time of the audit close-out report.

Deficiencies needing continued attention were in the following areas:

- Ensure implementation of a timely and consistent process for notifying members when pharmacy services are denied, deferred, or modified
- Implement mechanisms to ensure completion of initial health assessments
- Address specific time and distance standards to ensure members have 24-hour access to pharmaceutical services

Medi-Cal Managed Care Member Rights and Program Integrity Review

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

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2011.

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

MRPIU conducted an on-site review of IEHP in June 2009 covering the review period of March 1, 2008, through March 31, 2009. HSAG reported the findings from the review in the 2008–2009 plan evaluation report.[4]

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 demonstrated 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. Both IEHP's 2010 and 2011 quality improvement work plans target initial health assessments by setting a goal of a 10 percent increase each quarter in the number of new members receiving an initial health assessment within 120 days of enrollment. Additionally, IEHP's 2010 work plan includes a review of pharmacy grievances with details addressing providing staff with training and ensuring member access to medication in emergency situations.

Opportunities for Improvement

While IEHP's corrective action plans adequately resolved some of the medical performance review deficiencies, the plan did not resolve all deficiencies. Moving forward, IEHPs corrective action plans should strive to implement immediate remedial actions and include evidence of actions taken in the corrective action plan, rather than listing future actions to resolve issues. IEHP has additional opportunities for improvement; specifically, IEHP should provide evidence of implementation of mechanisms to ensure members are sent written notification letters when pharmaceutical services are modified, provide evidence of implementation of the numerous internal and external interventions IEHP has used to address low initial health assessment rates, and ensure IEHP's GeoAccess report sufficiently monitors 24-hour access to prescription medications.

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

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about 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 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of IEHP in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. There were no concerns identified by the audit team.

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

Performance Measure Results

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

Table 3.1—HEDIS® 2011 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2011 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of IEHP's HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. The table shows the plan's HEDIS 2011 performance compared to the MCMC-established MPLs and HPLs.

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

Table 3.2—2010–2011 Performance Measure Results for Inland Empire Health Plan—San Bernardino/Riverside Counties

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	26.3%	23.9%	★★	↔	19.7%	35.9%
AWC	Q,A,T	45.1%	43.1%	★★	↔	38.8%	63.2%
BCS	Q,A	50.6%	51.3%	★★	↔	46.2%	63.8%
CCS	Q,A	69.6%	71.7%	★★	↔	61.0%	78.9%
CDC–BP	Q	71.3%	70.9%	★★	↔	53.5%	73.4%
CDC–E	Q,A	52.6%	42.3%	★★	↓	41.4%	70.1%
CDC–H8 (<8.0%)	Q	45.9%	45.9%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	45.3%	43.8%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	79.4%	79.5%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	36.0%	37.4%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	79.4%	79.7%	★★	↔	69.3%	84.0%
CDC–N	Q,A	81.0%	80.3%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	70.1%	69.4%	★★	↔	63.5%	82.0%
LBP	Q	76.4%	78.4%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	86.7%	85.1%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	60.8%	62.9%	★★	↔	58.7%	74.4%
URI	Q	88.0%	88.4%	★★	↔	82.1%	94.9%
W34	Q,A,T	74.1%	74.3%	★★	↔	65.9%	82.5%
WCC–BMI	Q	67.4%	57.6%	★★	↓	13.0%	63.0%
WCC–N	Q	69.0%	66.0%	★★	↔	34.3%	67.9%
WCC–PA	Q	61.3%	38.2%	★★	↓	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, IEHP demonstrated average performance, with all performance measure results falling between the MPL and HPL for the second consecutive year. Three of the plan's measures incurred a statistically significant decrease, and there were no measures that had a statistically significant increase.

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 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with the plan's 2011 HEDIS scores to assess whether the plan was successful in achieving the MPL and progressing toward the HPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans. In 2010, since no performance measure rates were below the MPLs, no improvement plans were required.

Strengths

IEHP showed consistent performance across all measures, with no rates falling below the MPL for the second straight year.

Opportunities for Improvement

IEHP should evaluate the factors that led to a statistically significant decline for three performance measures: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total,* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total.* Also, the plan may consider ways to boost performance of all measures since all measure rates fell short of the HPLs.

Conducting the Review

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

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Quality Improvement Projects Conducted

IEHP had two clinical QIPs in progress during the review period of July 1, 2010–June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 years 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 QIPs across 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, 2010, through June 30, 2011

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	84%	100%	*Met*
Internal QIPs				
Attention Deficit Hyperactivity Disorder (ADHD) Management	Annual Submission	86%	90%	*Partially Met*
	Resubmission	100%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that IEHP's annual submission of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. The plan received a *Partially Met* validation status for its *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP submission. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, IEHP resubmitted the *ADHD Management* QIP and upon subsequent validation, achieved an overall *Met* validation status.

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

Table 4.2—Quality Improvement Project Average Rates*
Inland Empire Health Plan—San Bernardino/Riverside Counties
(Number =2 QIP Submissions, 2 QIP Topics)
July 1, 2010, through June 30, 2011

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	90%	10%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**93%**	**7%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	92%	0%	8%
	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**71%**	**0%**	**29%**

*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.

IEHP demonstrated an excellent understanding of the design and implementation stages, scoring 100 percent on all applicable evaluation elements for five of the six activities. In Activity VI of the implementation stage for the *Reducing Avoidable Emergency Room Visits* 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. Additionally, the plan was scored lower for not achieving statistically significant improvement in Activity IX and sustained improvement in Activity X. Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

Table 4.3 summarizes 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
Inland Empire Health Plan—San Bernardino/Riverside Counties
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2010, through June 30, 2011

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period (1/1/07–12/31/07)**	**Remeasurement 1 (1/1/08–12/31/08)**	**Remeasurement 2 (1/1/09–12/31/09)**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable	22.8%	20.3%*	23.0%	No

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 Start Date	17.7%	‡	‡	‡
The number 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	17.0%	‡	‡	‡

¥ Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

*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.

Although the collaborative interventions for the *Reducing Avoidable ER Visits* QIP were initiated in 2009, the plan reported an increase in avoidable ER visits, which reflected a decline in performance from Remeasurement 1 to Remeasurement 2. While the decline was not statistically significant, the Remeasurement 2 rate was higher than the baseline rate. The plan was unable to sustain the initial improvement achieved from baseline to Remeasurement 1.

For the *ADHD Management* QIP, the plan had only progressed to the point of reporting baseline data; therefore, real or sustained improvement could not be assessed.

Strengths

IEHP accurately documented the QIP process as evidenced by a *Met* validation status for the initial submission of the *Reducing Avoidable ER Visits* QIP. In addition, IEHP followed all recommendations provided in the initial submission of the *ADHD Management* QIP and scored 100 percent *Met* for applicable evaluation elements and critical evaluation elements.

Opportunities for Improvement

The plan implemented the collaborative interventions in 2009 for the *Reducing Avoidable ER Visits* QIP; however, when multiple interventions are implemented, the plan should incorporate a method to evaluate the effectiveness of each intervention. The plan should also conduct subgroup analyses to determine why and for what groups the current interventions did not produce improvement in Remeasurement 2.

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* measure. 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 conduct a barrier analysis annually, at a minimum, to identify and prioritize the barriers. The plan should then develop targeted interventions to address the barriers.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

The plan showed average performance, with all performance measure results falling between the MPL and HPL for the second consecutive year, based on IEHP's 2011 performance measure rates (which reflect 2010 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement. IEHP achieved a statistically significant decline in three quality domain measures, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total,* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total.*

IEHP did not have any deficiencies in the area of quality for the MRPIU review. The plan's medical performance review audit showed deficiencies in implementing mechanisms to ensure completion of initial health assessments.

QIP results showed that the IEHP received an overall validation status of *Met* in its *Reducing Avoidable Emergency Room Visits* QIP. IEHP demonstrated an excellent understanding of the design and implementation stages; however, the plan reported an increase in avoidable ER visits and was unable to sustain improvements achieved from baseline to Remeasurement 1. While the decline

was not statistically significant, it demonstrates opportunities IEHP has to improve its QIP documentation in the implementation and outcome phases.

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

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 2011 performance measure rates that related to access, QIP outcomes, and results of the medical performance and member rights reviews related to the availability and accessibility of care. IEHP had a statistically significant decrease in one measure related to access (*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*). This measure exceeded the MPL by only 0.9 percent.

IEHP was compliant with most access-related areas. However, one area that remained an open deficiency involved plan monitoring to ensure sufficient 24-hour access to pharmaceutical services.

MRPIU review results showed IEHP achieved full compliance with respect to all access-related standards including cultural and linguistic service requirements, an area of deficiency for many MCMC plans.

IEHP's internal QIP aimed to improve the management of ADHD in children 6 to 12 years of age, which falls under the access domain of care. While the plan's initial QIP submission did not achieve an overall *Met* validation status, its resubmission successfully achieved an overall *Met* validation status. It should be noted that the plan's *ADHD Management* QIP had only progressed to the point of reporting baseline data, so real or sustained improvement could not be assessed.

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 2011 performance measure rates for providing timely care, medical performance, and member rights reviews related to timeliness, and member satisfaction results related to timeliness. For the second consecutive year, performance measure rates regarding timeliness showed that the plan performed between the MPLs and HPLs for all measures. The MRPIU review found IEHP did not have any deficiencies in the area of timeliness. In the medical performance review audit, IEHP had an unresolved deficiency related to notice of action letters when there was a modification, deferral, or denial of pharmaceutical services.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 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.

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.
- Develop mechanisms to ensure immediate remedial actions and include evidence of actions taken in the corrective action plan, rather than listing future actions to resolve issues.

- Implement a process to evidence that members are sent written notification letters when pharmaceutical services are modified.
- Develop mechanisms to evidence implementation of the numerous internal and external interventions IEHP has used to address low initial health assessment rates, and ensure IEHP's GeoAccess report sufficiently monitors 24-hour access to prescription medications.
- Explore and evaluate the factors that led to a statistically significant decline for three performance measures: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total,* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total.*
- Consider strategies to improve all performance measures since all measure rates fell short of the HPLs.
- Incorporate a mechanism to evaluate the effectiveness of each intervention when implementing multiple QIP interventions and conduct subgroup analyses to determine why and for what groups the interventions did not produce improvement.
- Conduct an annual barrier analysis to identify and prioritize barriers to improvement in the plan's *Follow-Up Care for Children Prescribed ADHD Medications* QIP.

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

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

for Inland Empire Health Plan

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

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

2009–2010 EQR Recommendation	IEHP's Self-Reported Actions That Address the EQR Recommendation
Ensure that all open medical performance review deficiencies are fully resolved and maintain clear evidence of the implementation of corrective actions.	1. **IHA** – IEHP continues to strive to improve IHA rates. Providers are made aware of their members needing IHAs through the provider website in a roster format. IPAs receive a list of their new members on a monthly basis. The IHA rates are assessed on a quarterly basis and broken down by IPA and age ranges. Beginning 1st qtr 2012, IEHP will be reporting IHA rates to the IPAs on a monthly basis and will compare them to the overall IEHP rate. IEHP is considering ways to collect outbound calls, letters/mailings from the IPAs and PCPs to capture as an "attempt". 2. **Monitor access to drugs prescribed in emergency circumstances as described in Plan policy.** a. IEHP will monitor grievance cases specific to "medication access in emergency circumstances" through the quarterly Grievance Committee. b. The IEHP Quarterly QM Committee will review the presence/absence of Member complaint or grievance cases specific to "medication access in emergency circumstances" received from the Grievance Committee. IEHP revised the policy MED_PHR 25, Emergency Department Discharge Medication Requirements. 3. **When a pharmaceutical service request is modified or denied, the Plan will send a NOA letter to the member, in addition to notifying the provider and the pharmacy.** a. IEHP revised the policy, MED_PHR 07, Notification of Prior Authorization/Coverage Determination Modification and Denial – Non-Medicare, to include language that states that IEHP notifies members of denial and modification of PERs within two working days of decision in writing by the pharmacy staff. b. IEHP began implementation of this revised policy and procedure in March 2010 and began sending the NOA letter to the member when a pharmaceutical service request is modified or denied.
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.	◆ IEHP participated in the statewide ER QIP. Reducing avoidable ER rates was an enormous challenge for the health plan when during this time hospitals were "marketing" their reduced ER wait times as well as texting for ER wait times and even a program to "schedule" an ER visit. IEHP has developed many interventions to reduce avoidable ER visits. The UC network was increased; IEHP took back the financial responsibility of ER from the IPAs and made it a health plan responsibility. In

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

2009–2010 EQR Recommendation	IEHP's Self-Reported Actions That Address the EQR Recommendation
	addition, IEHP has partnered with several hospitals to introduce a "navigator" program that assists members in navigating the health care system. Education was provided to the members in the form of member newsletters, targeted mailings to those that had an avoidable visit, member handbook, and phone scripts. Reducing avoidable ER visits still continues to be a challenge, and IEHP will continue to look for ways to encourage members to see their PCP for non emergent conditions.
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.	◆ This rate continues to be challenging. Physicians are either using the wrong codes when billing or do not feel comfortable sending a member home without an antibiotic because they will then seek care at an ER asking for medication and or file a grievance. IEHP has put many processes into place to improve this measure. We participate in the CMAF AWARE collaboration, distribute cough and cold kits to the poorly performing physicians, and provide education to members and providers through newsletters, fax blasts, and provider report cards.