Performance Evaluation Report

Inland Empire Health Plan

July 1, 2011–June 30, 2012

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

June 2013

TABLE OF CONTENTS

Performance Evaluation Report – Inland Empire Health Plan

July 1, 2011 – June 30, 2012

Purpose of Report

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

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

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

- The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

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

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

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

This report is specific to DHCS's contracted plan, Inland Empire Health Plan ("IEHP" or "the plan"), which delivers care in Riverside and San Bernardino counties, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

Plan Overview

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) plan under the Two-Plan Model. In a Two-Plan Model county, DHCS contracts with two managed care plans to provide medical services to Medi-Cal beneficiaries. Most Two-Plan Model counties offer an LI plan and a nongovernmental, commercial health plan.

Medi-Cal Managed Care beneficiaries in Riverside and San Bernardino counties may enroll in IEHP, the LI plan, or in the alternative commercial plan. IEHP became operational in both counties to provide MCMC services in September 1996. As of June 30, 2012, IEHP had 500,133 MCMC members in Riverside and San Bernardino counties, collectively.[3]

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

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

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

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

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

Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from DHCS's compliance monitoring reviews to draw conclusions about 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. DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of DHCS's Medi-Cal Managed Care Division (MMCD) have historically worked in conjunction with the Department of Managed Health Care to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or the Department of Managed Health Care. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

The most recent medical performance review 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.[4]

As previously reported by HSAG, the 2010 medical performance 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.

Listed below are the unresolved deficiencies followed by actions the plan has taken to resolve those deficiencies:

Deficiency

Ensure implementation of a timely and consistent process for notifying members when pharmacy services are denied, deferred, or modified.

Plan Response:

- IEHP's self-report of actions taken to resolve this issue indicates that the plan implemented an automated modified notice of action (NOA) letter process in March 2010. The plan's process is to generate and mail an NOA letter to the member the following business day when a decision regarding pharmaceutical services is modified. Although the plan submitted a policy to DHCS stating members will receive an NOA letter for pharmacy denials or modifications, the July 2010 audit close-out letter indicates that the NOA letter was not submitted to DHCS for review; and no evidence was provided that implementation of the new process would begin in March 2010 as stated in the plan's corrective action plan (CAP).

Deficiency

Implement mechanisms to ensure completion of initial health assessments (IHAs).

Plan Response:

- IEHP's self-report of actions taken to address this issue indicates that the Quality Management Department monitors IHA rates and tracks all interventions that are implemented. IEHP states that the plan has implemented several IHA improvement strategies and that the plan will continue to monitor the interventions and modify as needed.
- The plan's 2012 work plan includes a goal of increasing by 10 percent each quarter the number of new members receiving an IHA within the required time frame. This goal also was included in the plan's 2010 and 2011 work plans. The plan's 2011 internal quality management annual

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

evaluation noted that the plan tracks IHA rates and noted a 58.85 percent and 57.27 percent rate for Quarter 1 and Quarter 2 of 2011, respectively; however, the plan did not achieve its goal in 2010 and did not meet the goal for the first two quarters of 2011.

Deficiency

Address specific time and distance standards to ensure members have 24-hour access to pharmaceutical services.

Plan Response:

- IEHP's 2011 Quality Management Evaluation report includes a network status report for the period ending December 2011. The report indicates that 97 percent of IEHP network members and 96 percent of Special Needs Plan (SNP) network members are within 15 miles of a pharmacy that is open 24 hours.

Member Rights and Program Integrity Review

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

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

MR/PIU conducted a monitoring visit with IEHP in January 2012 for the period of April 2009 through December 2011. The MR/PIU 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. Additionally, no findings were noted in the review of 60 member grievance files, 60 prior-authorization files, and visits to five provider offices.

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. The plan has policies and procedures and a comprehensive quality management program to support compliance with federal and State requirements and ensure timeliness of and access to health care services. The plan provided evidence that it is tracking member access to 24-hour pharmacy services and that it is meeting the established standard.

Opportunities for Improvement

While it appears IEHP has made some progress toward addressing unresolved deficiencies, HSAG provides the following opportunities for improvement:

- IEHP should provide evidence of implementation of mechanisms to ensure members are sent NOA letters when pharmaceutical services are modified. Specifically, the plan should provide evidence that an NOA letter addressing pharmaceutical denials, deferrals, and modifications is being sent to members when appropriate.
- IEHP should conduct a barrier analysis related to completion of IHAs since the plan's completion rates have remained relatively flat for 2010 and the first two quarters reported for 2011. IEHP should implement new interventions to address any actionable identified barriers as a mechanism to drive improvement.

Conducting the Review

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

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

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

Validating Performance Measures and Assessing Results

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

Performance Measure Validation

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[5] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of IEHP in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

Performance Measure Validation Findings

There were no concerns identified by the HSAG audit team during the HEDIS Compliance Audit, and all rates were valid; however, two recommendations were made in the area of supplemental data-capture, transfer, and entry within the information systems capabilities standards. Specifically, HSAG recommended that IEHP consider adding a field to capture potential exclusions information such as hysterectomy documentation for the *Cervical Cancer Screening* measure.

Performance Measure Results

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

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions (internally developed measure)*
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
AWC	*Adolescent Well-Care Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
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 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

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

Table 3.2—Comparison of 2011 and 2012 Performance Measure Results for Inland Empire Health Plan—Riverside and San Bernardino Counties

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	23.9%	22.1%	★★	↔	18.8%	31.6%
AMB–ED	‡	--	49.5	--	Not Comparable	--	--
AMB–OP	‡	--	326.4	--	Not Comparable	--	--
AWC	Q,A,T	43.1%	49.9%	★★	↑	39.6%	64.1%
CAP–1224	A	--	96.3%	--	Not Comparable	--	--
CAP–256	A	--	86.9%	--	Not Comparable	--	--
CAP–711	A	--	83.5%	--	Not Comparable	--	--
CAP–1219	A	--	86.3%	--	Not Comparable	--	--
CCS	Q,A	71.7%	72.0%	★★	↔	64.0%	78.7%
CDC–BP	Q	70.9%	75.8%	★★	↔	54.3%	76.0%
CDC–E	Q,A	42.3%	52.7%	★★	↑	43.8%	70.6%
CDC–H8 (<8.0%)	Q	45.9%	48.7%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	43.8%	40.8%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	79.5%	83.0%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	37.4%	38.7%	★★	↔	27.3%	45.9%
CDC–LS	Q,A	79.7%	81.1%	★★	↔	70.4%	84.2%
CDC–N	Q,A	80.3%	83.7%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	69.4%	77.8%	★★	↑	64.4%	82.6%
IMA–1	Q,A,T	--	63.7%	--	Not Comparable	--	--
LBP	Q	78.4%	75.6%	★★	↓	72.3%	82.3%
MPM–ACE	Q	--	84.2%	--	Not Comparable	--	--
MPM–DIG	Q	--	89.4%	--	Not Comparable	--	--
MPM–DIU	Q	--	83.5%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	85.1%	86.4%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	62.9%	63.2%	★★	↔	59.6%	75.2%
W-34	Q,A,T	74.3%	72.2%	★★	↔	66.1%	82.9%
WCC–BMI	Q	57.6%	77.5%	★★★	↑	19.7%	69.8%
WCC–N	Q	66.0%	79.6%	★★★	↑	39.0%	72.0%
WCC–PA	Q	38.2%	52.8%	★★	↑	28.5%	60.6%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

DHCS requires that contracted plans calculate and report HEDIS rates at the county level unless otherwise approved by DHCS; however, exceptions to this requirement were approved several years ago for plans operating in certain counties. IEHP was one of the plans approved for combined county reporting for Riverside and San Bernardino counties; therefore, Table 3.2 reflects combined reporting for those two counties.

Overall, IEHP demonstrated average performance, with most of the performance measure results falling between the MPLs and HPLs. The plan saw statistically significant increases in performance on three measures that had statistically significant decreases in performance between 2010 and 2011:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total.*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total.*

Two measures performed above the HPLs. Both were *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures: *BMI Assessment: Total* and *Nutrition Counseling: Total.*

Six of the plan's measures had a statistically significant increase in performance; and only one measure, *Use of Imaging Studies for Low Back Pain*, had a statistically significant decrease from 2011's rate.

HEDIS Improvement Plans

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

HSAG compared the plan's 2011 IP (if one was required) with the plan's 2012 HEDIS rate for that measure to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

IEHP did not have any measures that performed below the MPLs in 2011; therefore, there were no improvement plans required in 2012. IEHP will not be required to implement any

improvement plans in 2013 since the plan had no measures that performed below the MPLs in 2012.

Strengths

IEHP showed consistent performance across all measures, with no rates falling below the MPLs for the second straight year. The plan had statistically significant increases on six measures, demonstrating continued improvement in the area of performance measures.

Opportunities for Improvement

IEHP should evaluate the factors that led to a statistically significant decrease for *Use of Imaging Studies for Low Back Pain* to prevent continued decline in performance on the 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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about IEHP's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Project Objectives

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

The current statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. At the initiation of the QIP, IEHP had identified 29,863 ER visits that were avoidable, which was 22.8 percent of the plan's ER visits. IEHP's objective was to reduce this rate by

implementing both member and provider improvement strategies. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

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

For most children, treatment of ADHD with psychostimulants and other psychiatric medications without appropriate follow-up visits is an indicator of suboptimal care. At the start of the QIP, IEHP identified 174 children (17.7 percent) who did not have a 30-day follow-up visit and 47 children (17.0 percent) who did not have the appropriate follow-up over the next 9 months. IEHP's project attempted to improve the quality of care delivered to children with ADHD who were prescribed ADHD medications with the implementation of targeted physician interventions.

Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Inland Empire Health Plan—San Bernardino/Riverside Counties July 1, 2011, through June 30, 2012

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	95%	100%	*Met*
*All Cause Readmissions**	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIP				
Attention Deficit Hyperactivity Disorder (ADHD) Management	Annual Submission	92%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.
[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.
*During the review period, the *All Cause Readmissions* QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that IEHP's annual submission of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. Additionally, the plan received a ***Met*** validation status for its *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP submission. For the *All Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

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

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

Table 4.2—Quality Improvement Project Average Rates* for Inland Empire Health Plan—San Bernardino/Riverside Counties (Number = 2 QIP Submissions, 2 QIP Topics) July 1, 2011, through June 30, 2012

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	90%	0%	10%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**94%**	**0%**	**6%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	94%	0%	6%
	IX: Real Improvement Achieved	63%	25%	13%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total**		**84%**	**8%**	**8%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

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

IEHP demonstrated an appropriate application of the design and implementation stages overall, scoring 100 percent on all applicable evaluation elements for five of the six activities. The plan had one area that received a *Not Met* score in the implementation stage. In Activity VI for the *Reducing*

Avoidable Emergency Room Visits QIP, IEHP did not address the recommendations provided in the prior year's validation and once again omitted the data collection timeline in its most recent submission.

For the outcomes stage of the *Reducing Avoidable Emergency Room Visits* QIP, the plan did not identify whether there were any factors that affected the validity of its results. Additionally, for its *ADHD Management* QIP, the plan was scored lower for not achieving statistically significant improvement for the outcomes in Activity IX.

Only the *Reducing Avoidable Emergency Room Visits* QIP had at least a second remeasurement period and could be assessed for sustained improvement in Activity X. For this QIP, the plan was able to achieve sustained improvement from baseline to the third remeasurement period. Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes and Interventions

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

Table 4.3—Quality Improvement Project Outcomes for Inland Empire Health Plan—San Bernardino/Riverside Counties (Number = 2 QIP Topics) July 1, 2011, through June 30, 2012

QIP #1—Reducing Avoidable Emergency Room Visits					
QIP Study Indicator	**Baseline Period (1/1/07–12/31/07)**	**Remeasurement 1 (1/1/08–12/31/08)**	**Remeasurement 2 (1/1/09–12/31/09)**	**Remeasurement 3 (1/1/10–12/31/10)**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable^	22.8%	20.3%*	23.0%*	21.5%*	Yes

QIP #2—Attention Deficit Hyperactivity Disorder (ADHD) Management				
QIP Study Indicator	**Baseline Period (1/1/09–12/31/09)**	**Remeasurement 1 (1/1/10–12/31/10)**	**Remeasurement 2 (1/1/11–12/31/11)**	**Sustained Improvement¥**
The percentage of eligible members who had an outpatient follow-up visit within 30 days after the Index Prescription Start Date	17.7%	19.3%	‡	‡
The percentage of eligible members 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%	15.2%	‡	‡

^A lower rate indicates better performance.

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

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

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

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, IEHP set an overall objective to achieve a 5 percent reduction of ER visits designated as avoidable. For this project outcome, a lower rate demonstrates improved performance. While the plan did not meet its overall objective, it was able to reduce the percentage of avoidable ER visits by a statistically significant amount from baseline to the first remeasurement period (2.5 percentage points) and then again from the second to the third remeasurement period (1.5 percentage points). The third remeasurement period results remained improved over baseline, demonstrating sustained improvement for the project.

While the plan did achieve overall improvement, there was a decline in performance from the first to the second remeasurement period; the rate of avoidable ER visits increased by a statistically significant amount. A critical analysis of the plan's improvement strategy led to the following observations:

- The plan conducted reviews based on access-related data to identify barriers and develop interventions; however, the results were not documented. Based on these reviews, the plan implemented both provider and member interventions to reduce avoidable ER visits. The plan did not provide a list of the identified barriers or the rationale for how they were prioritized.
- The plan did not report success with the plan-hospital data collection collaboration. IEHP reported that the participating hospital reported only 11.9 percent of ER visit data to the plan within 15 days. Similarly, IEHP reported that it did not contact any members within 14 days of receiving notice of their first ER visit. Evaluation of this intervention showed that the avoidable ER visit rates were approximately the same between the participating and non-participating hospitals.
- The plan implemented plan-specific interventions to which it attributed improvement in the percentage of avoidable ER visits. Health navigators were added to educate members on health care topics including ER utilization during home visits. Also, the hospital hired a navigator to assist members with their follow-up care and in making necessary appointments after an ER visit. In addition, comprehensive provider profiles reports were distributed monthly. The plan did not provide specific data to support the interventions' effectiveness.
- Over 30 interventions were documented without a specific evaluation plan for each intervention. Fewer interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

Attention Deficit Hyperactivity Disorder Management QIP

For the *ADHD Management* QIP, the plan set the project objective to the 2009 NCQA Medicaid 90th percentiles for the two outcomes. From baseline to the first remeasurement period, the plan did not achieve the project objective or even statistically significant improvement for either outcome. An analysis of the plan's improvement strategy identified the following weaknesses which may have led to the lack of improvement in outcomes:

- The plan conducted brainstorming sessions to identify barriers and develop interventions. Based on these sessions, the plan implemented provider interventions to improve the appropriate follow-up for members with ADHD who were prescribed ADHD medications. The plan did not provide any specific results of the barrier analysis or any data-driven rationale for the selection of the interventions. The plan did not conduct any subgroup analysis to identify providers with the lowest performance; instead, the interventions included all PCP and behavioral health providers.
- Two interventions involved offering continuing medical education (CME) credits for ADHD focused events. One event addressed coordination of care between PCPs and IEHP's Behavioral Health Unit. The other intervention referred PCPs to NCQA's ADHD Performance Program. For either intervention, the plan did not identify how many PCPs participated, or more importantly, the plan did not report whether there was a difference in the ADHD follow-up rates between PCPs that did or did not participate in the CME events.
- The plan distributed an ADHD toolkit to all PCPs and behavioral health providers; however, it did not describe the contents of the toolkit or how it would affect the ADHD follow-up rates. Similarly, the plan created and posted monthly ADHD roster lists on the provider Web portal that designated the follow-up status for each member. The plan did not document how this intervention would be evaluated. Additionally, the plan did not describe any process to identify specific providers that could be targeted for more intense one-on-one education.

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

Strengths

IEHP accurately documented the QIP process as evidenced by a *Met* validation status for the annual submissions of both the *Reducing Avoidable ER Visits* QIP and the *ADHD Management* QIP.

The plan was able to reduce the percentage of avoidable ER visits and sustain that improvement through the final remeasurement period.

Opportunities for Improvement

IEHP should improve the documentation of the barrier analysis, providing the data, the identified barriers, and the rationale for how the barriers are prioritized.

The interventions implemented should address the high-priority barriers. The plan should document a method to evaluate each intervention as well as provide the results of the interventions' evaluation for each measurement period.

For the *ADHD Management* QIP, IEHP could potentially target interventions to high-volume providers with low performance. By targeting improvement efforts to fewer providers and providing more one-on–one education and support, the plan may increase the likelihood of success for the project.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

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

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

IEHP showed overall average performance based on most of the plan's performance measure results falling between the MPLs and HPLs (based on IEHP's 2012 performance measure rates, which reflect 2011 measurement data), QIP outcomes, and the results of the medical performance and member rights reviews as they related to measurement and improvement. The plan saw statistically significant increase in performance on six measures, three of which had seen statistically significant decrease in performance between 2010 and 2011, and one measure had statistically significant decrease in performance. The plan performed above the HPLs on two measures.

IEHP did not have any deficiencies in the area of quality for the MR/PIU review. As indicated in the plan's previous evaluation report, IEHP's medical performance review audit showed that the plan had outstanding deficiencies related to ensuring completion of initial health assessments (IHAs). Review of the plan's quality documents showed that the plan has processes in place to complete the IHAs and track the completion rate; however, the plan has not been successful in improving its rates to achieve the desired goal.

QIP results showed that the IEHP received an overall validation status of *Met* in its *Reducing Avoidable Emergency Room Visits* and *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIPs. The plan received a *Pass* validation status on its initial submission of the study design stage for the *All Cause Readmissions* statewide collaborative proposal. IEHP demonstrated an appropriate application of the design and implementation stages.

The plan showed a statistically significant decrease in avoidable ER visits during the review period and overall sustained improvement from baseline to the third remeasurement period. The plan did not show statistically significant improvement of the outcomes for its *ADHD Management* QIP. The *All Cause Readmissions* QIP did not progress to the implementation stage, so outcomes information was not available for this QIP.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

The plan demonstrated average performance on access-related performance measures, QIP outcomes, and results of the medical performance and member rights reviews related to the availability and accessibility of care. IEHP showed a statistically significant increase in three access-related performance measures in 2012, one of which had a statistically significant decrease in 2011 (*Comprehensive Diabetes Care—Eye Exam [Retinal] Performed*).

IEHP provided documentation on an outstanding access-related deficiency identified in its most recent medical audit related to 24-hour pharmacy services. The plan reported that it is tracking

member access to 24-hour pharmacy services and provided evidence in its 2011 Quality Management Evaluation report that the plan is meeting the established standard related to 24-hour pharmacy services access. MR/PIU review results showed IEHP achieved full compliance with respect to all access-related standards.

The sustained improvement shown for IEHP's *Reducing Avoidable Emergency Room Visits* QIP suggests that members are being provided improved access to primary care providers, thus reducing the number of avoidable visits to the emergency room. The plan did not have statistically significant improvement for the *ADHD Management* QIP.

Timeliness

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

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

IEHP exhibited average performance in the timeliness domain of care based on 2012 performance measure rates for providing timely care, medical performance audit and MR/PIU review areas related to timeliness, and member satisfaction results related to timeliness.

For the third consecutive year, performance measure rates regarding timeliness showed that the plan performed between the MPLs and HPLs for all measures; however, the plan showed statistically significant improvement on two timeliness-related measures in 2012 (*Adolescent Well-Care Visits* and *Childhood Immunization Status—Combination 3*).

The MR/PIU review found IEHP did not have any deficiencies in the area of timeliness. As described in previous plan evaluation reports, IEHP had an unresolved deficiency from the medical performance review audit related to notice of action (NOA) letters when there was a modification, deferral, or denial of pharmaceutical services. This deficiency remains unresolved since the plan has not provided evidence that the NOA letters related to pharmaceutical services are being sent.

Follow-Up on Prior Year Recommendations

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

Recommendations

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. Specifically:
  - Provide evidence that an NOA letter addressing pharmaceutical denials, deferrals, and modifications is being sent to members when appropriate.
  - Conduct barrier analysis related to completion of IHAs since IEHP's completion rates have remained relatively flat for 2010 and the first two quarters reported for 2011. IEHP should implement new interventions to address any actionable identified barriers as a mechanism to drive improvement.
- Consider adding a data field for capturing potential exclusion information such as a hysterectomy for the *Cervical Cancer Screening* measure.
- Evaluate factors that led to a statistically significant decrease for *Use of Imaging Studies for Low Back Pain* to prevent continued decline in performance on this measure.
- Provide documentation of the QIP barrier analysis, providing the data, identified barriers, and the rationale for how the barriers are prioritized.
- Document how QIP interventions address the high-priority barriers and document methods for evaluating the effectiveness of each intervention, as well as the results of the intervention's evaluation for each measurement period.
- Consider targeting interventions to high-volume providers with low performance for the *ADHD Management* QIP.

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

Quality, Access, and Timeliness

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

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

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

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

Access Domain

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

Timeliness Domain

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

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

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

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

Calculating Final Quality, Access, and Timeliness Scores

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

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

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

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

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

for Inland Empire Health Plan

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

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

2010–2011 EQR Recommendation	IEHP's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Ensure that all open medical performance review deficiencies are fully resolved.	◆ Upon receipt of the preliminary report from an external regulatory agency, the chief compliance officer or designee reviews all deficiencies and arranges a meeting with all affected departments to discuss a CAP. The chief compliance officer or designee ensures that all CAP items are received from each director/manager and reviews and compiles the CAP for consistency, clarity, and accuracy. The chief compliance officer or designee ensures that the CAP is submitted to the appropriate agency within the required time frame to ensure that CAP information is included in the Final Audit Report. Within 60 days from the date of a regulatory agency's acceptance of IEHP's CAP, the chief compliance officer or designee will follow up with each responsible person to ensure that specific CAP items are implemented as approved. IEHP has also developed an internal audit system to monitor each internal department to ensure that IEHP is in compliance with federal and State regulations. CAPs are issued to a non-compliant department. The Compliance Department meets with any affected department to develop the CAP, if necessary, to ensure that steps taken to correct deficiencies can be achieved. Follow-up occurs to ensure that the CAP is completed.
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.	◆ Upon receipt of the preliminary report from an external regulatory agency, the chief compliance officer or designee reviews all deficiencies and arranges a meeting with all affected departments to discuss a CAP. The chief compliance officer or designee ensures that all CAP items are received from each director/manager and reviews and compiles the CAP for consistency, clarity, and accuracy. The chief compliance officer or designee ensures that the CAP is submitted to the appropriate agency within the required time frame to ensure that CAP information is included in the Final Audit Report. Within 60 days from the date of a regulatory agency's acceptance of IEHP's CAP, the chief compliance officer or designee will follow up with each responsible person to ensure that specific CAP items are implemented as approved. IEHP has also developed an internal audit system to monitor each internal department to ensure that IEHP is in compliance with federal and State regulations. CAPs are issued to a non-compliant department. The Compliance Department meets with any affected department to develop the CAP, if necessary, to ensure that steps taken to correct deficiencies can be achieved. Follow-up occurs to ensure that the CAP is completed.

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

2010–2011 EQR Recommendation	IEHP's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Implement a process to evidence that members are sent written notification letters when pharmaceutical services are modified.	◆ IEHP implemented the automated Modified NOA letter process of sending letters to all members when pharmaceutical services were modified. This process began on March 23, 2010. When a decision of "Modified" is determined and selected within the processing application, an authorized user selects the NOA letter to generate. The letters are printed and mailed to the member via United States Postal Service (USPS) first-class mail the following business day.
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.	◆ The Quality Management Department monitors IHA rates and tracks all interventions that are implemented. IEHP has implemented several IHA improvement strategies that have been addressed. The plan will continue to monitor these interventions and modify as needed.
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.*	◆ DRE rates—IEHP experienced issues with this rate due to the elimination of the adult vision benefit. Both providers and members were unaware that this exam was a benefit, and IEHP provided education to both the provider network and membership on how to obtain this service. ◆ IEHP will continue to monitor the Counseling for Nutrition and Physical Activity for Children/Adolescents measure and discuss this issue further to try to develop a program to encourage proper nutrition and physical activity in children/adolescents. This is a challenging measure since utilization rates indicate that visits to pediatricians are lower for children over 5 years of age.
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.	◆ QM in collaboration with the Health Care Analytics and Research Team will develop meaningful QIPS that will evaluate all interventions and provide subgroup analysis of the data to evaluate the effectiveness of the interventions.
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.	◆ IEHP will conduct an annual analysis of the ADHD study to identify and prioritize barriers for this study.