Performance Evaluation Report

Inland Empire Health Plan

July 1, 2012–June 30, 2013

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

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Performance Evaluation Report – Inland Empire Health Plan

July 1, 2012 – June 30, 2013

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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

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

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

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

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

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

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

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

Managed Care Plan Overview

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

IEHP became operational in both counties to provide MCMC services effective September 1996. As of June 30, 2013, IEHP had 297,490 MCMC members in Riverside County and 326,680 in San Bernardino County—for a total of 624,170 MCMC members.[3]

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

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP's compliance with standards established by the state related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

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

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

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's compliance monitoring reviews to draw conclusions about 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.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

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

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

Medical Performance Audits and Member Rights Reviews

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

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

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

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

SPD Enrollment Survey

The most recent on-site SPD Enrollment Survey for IEHP was conducted from August 6, 2012, through August 9, 2012, covering the review period of March 1, 2011, through April 30, 2012. The survey evaluated the following elements specifically related to the care of the SPD population:

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

Utilization Management, Continuity of Care, Availability and Accessibility, Member Rights, and Quality Management. DMHC identified one potential deficiency in the area of Availability and Accessibility. IEHP submitted a corrective action plan (CAP) to DHCS on January 18, 2013, in response to the potential deficiency. In a letter from DHCS dated March 14, 2013, DHCS indicated it had reviewed IEHP's CAP and determined that the MCP corrected the deficiency.

Routine Medical Survey

During the August 6, 2012, through August 9, 2012, on-site visit with IEHP, DMHC also conducted a Routine Medical Survey with the MCP. DMHC assessed the areas of Quality Management, Grievances and Appeals, Access and Availability of Services, Utilization Management, Continuity of Care, Access to Emergency Services and Payment, Prescription (RX) Drug, and Language Assistance. DMHC did not identify any deficiencies in any of the areas assessed during the survey.

Strengths

Although one potential deficiency was identified through the SPD Enrollment Survey, IEHP fully resolved the deficiency in the required time frame.

Opportunities for Improvement

Since IEHP resolved all areas of concern identified through the SPD Enrollment Survey and has no outstanding deficiencies, HSAG does not have any recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

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

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

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

Validating Performance Measures and Assessing Results

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

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

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

Performance Measure Validation

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

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

Performance Measure Validation Findings

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

- In the 2012 audit report, the auditor recommended that IEHP consider adding a field to capture potential excluded information. IEHP addressed this issue and was able to pass the medical record review validation process by including "Exclusions."
- IEHP had highly automated processes, including a preprocessor that ensured enrollment data in the transactional system were consistent with the State's enrollment files.
- To ensure accurate and complete data, IEHP's transactional and credentialing systems were reconciled on a weekly basis and comprehensive error reports comparing the two systems were generated.

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

Performance Measure Results

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

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

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions*‡
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
CBP	*Controlling High Blood Pressure*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MMA–75	*Medication Management for People with Asthma—Medication Compliance 75% Total*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

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

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

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

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

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. Tables 3.2 through 3.4 reflect the combined reporting for these two counties.

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
IEHP—San Bernardino/Riverside County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	22.10%	22.53%	★★	↔	18.98%	33.33%
ACR	Q, A	--	14.24%	--	Not Comparable	--	--
AMB–ED	‡	49.54	51.67	‡	Not Comparable	‡	‡
AMB–OP	‡	326.35	347.94	‡	Not Comparable	‡	‡
CAP–1224	A	96.33%	96.75%	★★	↑	95.56%	98.39%
CAP–256	A	86.92%	86.91%	★★	↔	86.62%	92.63%
CAP–711	A	83.53%	83.18%	★	↔	87.56%	94.51%
CAP–1219	A	86.30%	86.72%	★★	↑	86.04%	93.01%
CBP	Q	--	62.91%	--	Not Comparable	--	--
CCS	Q,A	72.03%	68.53%	★★	↔	61.81%	78.51%
CDC–BP	Q	75.76%	71.00%	★★	↔	54.48%	75.44%
CDC–E	Q,A	52.68%	59.40%	★★	↑	45.03%	69.72%
CDC–H8 (<8.0%)	Q	48.72%	50.81%	★★	↔	42.09%	59.37%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
IEHP—San Bernardino/Riverside County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
CDC–H9 (>9.0%)	Q	40.79%	36.19%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	82.98%	85.61%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	38.69%	42.00%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	81.12%	83.53%	★★★	↔	70.34%	83.45%
CDC–N	Q,A	83.68%	84.45%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	77.78%	78.24%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	63.66%	71.99%	★★	↑	50.36%	80.91%
LBP	Q	75.58%	77.47%	★★	↔	72.04%	82.04%
MMA–50	Q	--	44.25%	--	Not Comparable	--	--
MMA–75	Q	--	21.96%	--	Not Comparable	--	--
MPM–ACE	Q	84.22%	86.98%	★★	↑	83.72%	91.33%
MPM–DIG	Q	89.45%	91.99%	★★	↔	87.93%	95.56%
MPM–DIU	Q	83.53%	86.07%	★★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	86.42%	88.40%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	63.23%	59.63%	★★	↔	58.70%	74.73%
W-34	Q,A,T	72.19%	75.69%	★★	↔	65.51%	83.04%
WCC–BMI	Q	77.55%	78.94%	★★★	↔	29.20%	77.13%
WCC–N	Q	79.63%	74.54%	★★	↔	42.82%	77.61%
WCC–PA	Q	52.78%	47.69%	★★	↔	31.63%	64.87%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

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

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

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

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

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

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

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

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

IEHP—San Bernardino/Riverside County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.82%	16.95%	▼	14.24%
CAP–1224	96.76%	96.12%	↔	96.75%
CAP–256	86.92%	86.54%	↔	86.91%
CAP–711	82.97%	87.66%	↑	83.18%
CAP–1219	86.73%	86.60%	↔	86.72%
CDC–BP	68.19%	67.12%	↔	71.00%
CDC–E	52.94%	60.59%	↑	59.40%
CDC–H8 (<8.0%)	42.70%	57.43%	↑	50.81%
CDC–H9 (>9.0%)	46.19%	31.31%	▲	36.19%
CDC–HT	79.74%	86.49%	↑	85.61%
CDC–LC (<100)	34.64%	48.65%	↑	42.00%
CDC–LS	76.03%	86.49%	↑	83.53%
CDC–N	75.60%	86.71%	↑	84.45%
MPM–ACE	83.14%	89.22%	↑	86.98%
MPM–DIG	96.23%	91.32%	↔	91.99%
MPM–DIU	81.24%	88.78%	↑	86.07%

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

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

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

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

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

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

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

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

Table 3.4—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
IEHP—San Bernardino/Riverside County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
308.23	48.29	630.72	75.75

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

Performance Measure Result Findings

Overall, IEHP performed average on its performance measures in 2013. The following two measures had rates above the HPLs:

- *Comprehensive Diabetes Care—LDL-C Screening*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*

The rates for the following six measures had statistically significant improvement from 2012 to 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Immunizations for Adolescents—Combination 1*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

Although IEHP had one measure with a rate below the MPL—*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* 2013 is the first year that IEHP had any measure with a rate below the MPL.

Seniors and Persons with Disabilities Findings

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

- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*

- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

The SPD rate for the *All-Cause Readmissions* measure was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had more readmissions—due to all causes within 30 days of an inpatient discharge—than the non-SPD population.

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

Improvement Plans

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

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

Since IEHP did not have any rates below the MPLs in HEDIS 2012, no IPs were required. Although IEHP's rate on the *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*

measure was below the MPL in HEDIS 2013, the MCP will not be required to submit an IP for this measure. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts in other areas of poor performance that have clear improvement paths and direct population health impact.

Strengths

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* measure's rate was above the HPL for the second consecutive year and the rate for the *Comprehensive Diabetes Care—LDL-C Screening* measure was above the HPL in 2013. IEHP demonstrated statistically significant improvement on six measures and no measure had a statistically significant decline in rates. The MCP has shown consistent performance over the past five measurement years, with only one measure falling below the MPL in that time.

Opportunities for Improvement

IEHP has the opportunity to improve the rate on the *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* measure by focusing on the factors that have caused this measure's rate to be below the MPL.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[10] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

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

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

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

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

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

Quality Improvement Project Objectives

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

Table 4.1 below lists IEHP's QIPs and indicates the counties in which the QIP is being conducted, whether the QIP is clinical or nonclinical, and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

Table 4.1—Quality Improvement Projects for IEHP
July 1, 2012, through June 30, 2013

QIP	County	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	San Bernardino/ Riverside	Clinical	Q, A
Attention Deficit Hyperactivity Disorder (ADHD) Management	San Bernardino/ Riverside	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members, leading to improved health outcomes.

Prior to initiating the statewide collaborative QIP, IEHP had a 30-day readmission rate of 11.71 percent among Medi-Cal beneficiaries. IEHP did not specify the readmission rates for the SPD and non–SPD populations.

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 *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP, IEHP identified 174 children in the eligible population (17.7 percent) who did not have a 30-day follow-up visit and 47 children in the eligible population (17.0 percent) who did not have the appropriate follow-up over the subsequent nine months. IEHP's project attempted to improve the quality of care delivered to children with ADHD and who were prescribed ADHD medications with the implementation of targeted physician interventions.

Quality Improvement Project Validation Findings

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

Table 4.2—Quality Improvement Project Validation Activity
IEHP—San Bernardino/Riverside County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	80%	100%	*Met*
Internal QIPs				
Attention Deficit Hyperactivity Disorder (ADHD) Management	Annual Submission	84%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that IEHP's study design submission of its *All-Cause Readmissions* QIP received an overall validation status of *Met*, with 100 percent of critical elements and 80 percent of evaluation elements receiving a *Met* status. IEHP also received an overall validation status of *Met* for its *Attention Deficit Hyperactivity Disorder (ADHD) Management* annual submission, with 100 percent of critical elements and 84 percent of evaluation elements being met.

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

Table 4.3—Quality Improvement Project Average Rates*
IEHP—San Bernardino/Riverside County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	75%	13%	13%
Design Total		**90%**	**5%**	**5%**
Implementation	VII: Sufficient Data Analysis and Interpretation	88%	13%	0%
	VIII: Appropriate Improvement Strategies	67%	33%	0%
Implementation Total		**82%**	**18%**	**0%**
Outcomes	IX: Real Improvement Achieved	50%	50%	0%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**50%**	**50%**	**0%**

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

HSAG validated Activities I through VI for IEHP's *All-Cause Readmissions* study design submission and Activities I through IX for the MCP's *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP annual submission.

IEHP demonstrated a strong application of the Design stage, meeting 90 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. However, IEHP struggled somewhat with the Implementation stage, meeting 82 percent for the requirements across both QIP submissions. IEHP did not provide a comprehensive and clearly defined systematic process for collecting baseline and remeasurement data and did not describe its data analysis plan for the *All-Cause Readmissions* QIP, which resulted in a lower score for Activity VI. IEHP met 100 percent of the requirements of the Design stage for its *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP. HSAG could not replicate the *p* values that IEHP documented in the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP and the MCP did not specifically document in the QIP that successful interventions were standardized and monitored, which resulted in a lower score for Activities VII and VIII.

Only the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP progressed to the Outcomes stage during the reporting period. Study Indicator 1 achieved statistically significant improvement over baseline at Remeasurement 2; however, since Study Indicator 2 did not achieve statistically significant improvement over baseline, the QIP received a lower score in Activity IX. Activity X was not assessed for this QIP since sustained improvement cannot be assessed until at least one study indicator has demonstrated both statistically significant improvement over baseline and has reported a rate in a subsequent measurement period. Activity X will be assessed for Study Indicator 1 at this QIP's next annual submission.

Quality Improvement Project Outcomes and Interventions

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

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

Table 4.4—Quality Improvement Project Outcomes
IEHP—San Bernardino/Riverside County
July 1, 2012, through June 30, 2013

QIP #1—Attention Deficit Hyperactivity Disorder (ADHD) Management			
Study Indicator 1: The percentage of eligible members who had an outpatient follow-up visit within 30 days after the Index Prescription Start Date			
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¥**
17.7%	19.3%	22.3%*	‡
Study Indicator 2: 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			
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¥**
17.0%	15.2%	21.4%**	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement over the baseline period (*p* value < 0.05).

** 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 therefore could not be assessed.

Attention Deficit Hyperactivity Disorder Management QIP

Study Indicator 1 for the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP had statistically significant improvement over baseline. Although Study Indicator 2 for this QIP had statistically significant improvement from Remeasurement 1 to Remeasurement 2, the improvement in Remeasurement 2 was not statistically significant over the baseline rate. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following:

- IEHP completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process.
- HSAG was unable to replicate any of the *p* values IEHP reported for the second remeasurement period for the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP, and HSAG provided feedback to the MCP that it should ensure the correct *p* values are reported.
- For the *All-Cause Readmissions* QIP, the MCP did not fully and clearly define a systematic process for collecting baseline and remeasurement data or describe the MCP's data analysis plan.
- IEHP did not specifically document that successful interventions were standardized and monitored.

Strengths

IEHP demonstrated an excellent understanding of the Design and Implementation stages. The MCP accurately documented the QIP process, as evidenced by both QIPs achieving an overall *Met* validation status. In response to HSAG's recommendations in IEHP's MCP-specific Evaluation Report, the MCP reported that it will only document barriers that can be adequately measured and will target high-volume ADHD providers as a way to impact the outcomes of the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP. Study Indicator 1 for this QIP achieved statistically significant improvement over baseline, and although Study Indicator 2 did not achieve statistically significant improvement over baseline, the rate had statistically significant improvement from Remeasurement 1 to Remeasurement 2.

Opportunities for Improvement

IEHP should ensure that it accurately calculates and reports *p* values on the QIP Summary Form. IEHP also should ensure that it provides a complete, detailed description of the data collection process and data analysis plan for all QIPs. Finally, IEHP should monitor and evaluate interventions to determine if they have positively affected the QIP outcomes. Interventions that are deemed successful in improving the outcomes should be standardized and monitored for continued success.

Conducting the EQRO Review

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

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

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

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

Findings

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

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

CAHPS Global Rating Measures:

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

CAHPS Composite Measures:

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

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

Table 5.1—CAHPS Measures Domains of Care

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

National Comparisons

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

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

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

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

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

Table 5.3—Medi-Cal Managed Care County-Level Global Ratings
IEHP—San Bernardino/Riverside County

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

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

Table 5.4—Medi-Cal Managed Care County-Level Composite Measures
IEHP—San Bernardino/Riverside County

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

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

Strengths

IEHP received a *Very Good* rating on the adult and child *Customer Service* measures. The *Rating of Health Plan* and *Rating of Specialist Seen Most Often* measures received *Good* ratings for both the adult and child populations. Please note that since the MCP had fewer than 100 respondents for the child *Rating of Specialist Seen Most Often* measure, caution should be exercised when evaluating these results. IEHP improved its ratings on the following measures from 2010 to 2013:

- *Rating of Health Plan*—adult and child populations
- *Rating of Specialist Seen Most Often*—adult and child populations
- *Customer Service*—child population

Opportunities for Improvement

Overall, IEHP's CAHPS results showed below-average performance for both the adult and child populations. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities, based on the MCP's CAHPS results. The purpose of the analysis was to help decision-makers identify specific aspects of care that were most likely to benefit from quality improvement activities. Based on the key driver analysis, HSAG identified the following measures as IEHP's highest priorities: *Rating of Personal Doctor, How Well Doctors Communicate,* and *Rating of All Health Care*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 IEHP CAHPS MCP-Specific Report.* Areas for improvement spanned the quality domain of care.

Conducting the EQRO Review

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

Methodology

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

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

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

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

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

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

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

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

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

Encounter Data Validation Findings

Review of Encounter Systems and Processes

Overall, the information provided in IEHP's Roadmap and the supplemental questionnaire consistently demonstrates that the MCP has sound operational policies and practices for the creation, validation, correction, and ongoing monitoring of encounter data submission. The MCP uses internally developed software as well as contracts with outsourced vendors to ensure the accuracy of data transmission and submission. The MCP uses monetary incentives, technical assistance, corrective actions, and report cards to encourage timely and accurate submission of encounter data by its capitated providers.

Record Completeness

Overall, IEHP had very low record omission and record surplus rates for the Pharmacy claim type, indicating very complete data when comparing DHCS's data and the encounter data extracted from IEHP's data system for this study. For the Medical/Outpatient and Hospital/Inpatient claim types, the record omission rates exceeded the respective statewide rates (i.e., the MCP's rates were lower than the statewide rates) and had minimal variation at the county level. However, the record surplus rates were fairly high, with a rate of 25.9 percent for the Medical/Outpatient claim type and a rate of 34.3 percent for the Hospital/Inpatient claim type. Both record surplus rates were worse than the respective statewide rates by more than 15 percentage points. IEHP re-queried its system in November/December 2011 as part of an encounter data cleanup effort, which resulted in IEHP submitting a large amount of data to

DHCS during this time period. Since more than 95 percent of the surplus records in the DHCS file were processed by DHCS in or before October 2011, the main cause for the record surplus might be because some of the records IEHP sent to DHCS before the encounter data cleanup effort were not in the file IEHP submitted to HSAG for this study.

Data Element Completeness

IEHP had very high data element completeness results with element omission and element surplus rates of 0.0 percent for all but two of the key data elements. The notable elements included the *Rendering Provider Number* for the Medical/Outpatient claim type and the *Drug/Medical Supply* for the Pharmacy claim type. These two key data elements had element omission rates above their respective statewide rates by 85.3 and 1.1 percentage points, respectively. There was minimal variation at the county level.

Data Element Accuracy

Overall, IEHP had very high element accuracy rates of 100 percent for nearly all of the data elements across the three claim types. For the Medical/Outpatient claim type, the *Rendering Provider Number* element had an accuracy rate of 0.0 percent and was the only key data element without a rate of 100 percent. However, the denominator for the low accuracy rate was only 10 records and the reader should use caution when interpreting the results.

IEHP had a high all-element accuracy rate of 100 percent for the Hospital/Inpatient claim type and 97.9 percent for the Pharmacy claim type. The high element omission for the *Rendering Provider Number* caused the Medical/Outpatient claim type to have a low all-element accuracy rate of 3.0 percent, which fell below the statewide rate of 64.0 percent. There was minimal county level variation in the accuracy rates.

Recommendations

Based on its review, HSAG recommends the following:

- For DHCS's data and the data IEHP submitted to HSAG, there were no long-term care (LTC) records. However, in its response to HSAG's preliminary file review results, IEHP indicated that it had very few LTC records and that these records were submitted with the Hospital/Inpatient records. IEHP should clarify with DHCS whether the LTC records should be submitted with the value "L" for the data element Format Code so they can be separated from the Hospital/Inpatient records.

- IEHP should investigate the reason(s) for the high record surplus rates for the Medical/Outpatient and Hospital/Inpatient claim types and create strategies for future improvement on the record surplus rate.
- Although the file from the DHCS data warehouse was missing nearly all *Rendering Provider Number* information, IEHP was able to provide rendering provider numbers to HSAG for approximately 97 percent of the Medical/Outpatient records. IEHP should evaluate whether the encounter data submitted to DHCS should contain more values for the data element *Rendering Provider Number*.
- IEHP should investigate the *Drug/Medical Supply* value of "9999MZZ," which was populated in the file IEHP submitted to HSAG but which did not appear in the DHCS file.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

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

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

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

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

HSAG reviewed IEHP's 2013 Quality Management Program Description, which includes an outline of the MCP's goals, objectives, and structure. The program description includes evaluation and monitoring activities designed to ensure quality care for the MCP's members.

The following quality measures had rates above the HPLs in 2013:

- *Comprehensive Diabetes Care—LDL-C Screening*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*

The following quality measures had rates with statistically significant improvement from 2012 to 2013:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Immunizations for Adolescents—Combination 1*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

Zero quality measures had a statistically significant decline in rates and zero measures falling into the quality domain of care had rates below the MPLs.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care and nine of these measures had SPD rates that were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. The SPD rate for the *All-Cause Readmissions* measure, which is in the quality domain of care, was significantly higher than the non-SPD rate, showing that more of the MCP's members in the SPD population (aged 21 years and older) were readmitted within 30 days of an inpatient discharge than members in the non-SPD population.

All CAHPS measures fall into the quality domain of care. Most of the measures had a *Fair* rating; however, the *Customer Service* measure received a *Very Good* rating for both the adult and child populations and the *Rating of Health Plan* and *Rating of Specialist Seen Most Often* measures received a *Good* rating for both populations.

Both of IEHP's QIPs fall into the quality domain of care. Only the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP progressed to the Outcomes stage. Study Indicator 1 for the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP, which measures the percentage of

eligible members who had an outpatient follow-up visit within 30 days after the index prescription start date, achieved statistically significant improvement over baseline. Study Indicator 2, which measures the percentage of eligible members who had 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 after the initiation phase ended, did not achieve statistically significant improvement over baseline but the rate had statistically significant improvement from Remeasurement 1 to Remeasurement 2.

Overall, IEHP showed average performance related to the quality domain of care.

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HSAG reviewed IEHP's available quality improvement information and found that the MCP included several access goals in its 2013 Quality Improvement Work Plan. Additionally, the MCP's 2013 Quality Management Program Description included goals and objectives related to ensuring member access to care.

One access performance measure—*Comprehensive Diabetes Care—LDL-C Screening*—had a rate above the HPL, and the rate for the *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* measure was below the MPL. The following four access measures had rates with statistically significant improvement from 2012 to 2013:

- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Immunizations for Adolescents—Combination 1*

Nine of the performance measures stratified for the SPD population fall into the access domain of care and five of these had SPD rates that were significantly better than the non-SPD rates. As indicated above, the better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in providers seeing them more regularly and leading to better monitoring of care. The SPD rate for the *All-Cause Readmissions* measure, which falls into the access domain of care, was significantly higher than the non-SPD rate.

The *Getting Needed Care* CAHPS measure falls into the access domain of care. IEHP received a *Fair* rating on this measure for the adult population and a *Poor* rating for the child population.

Both of IEHP's QIPs fell into the access domain of care. As indicated above, the MCP saw improvement in both indicators for the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP. Improvement on both indicators suggests that more of the MCP's MCMC members with ADHD were able to access the physicians who were monitoring their ADHD medication.

Overall, IEHP showed average performance related to the access domain of care.

Timeliness

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

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

IEHP's 2013 Quality Management Program Description includes activities related to the areas of grievances and appeals, coordination and continuity of care, and utilization management. Each of these areas has an impact on the timeliness of services delivered to members.

No measures falling into the timeliness domain of care had rates above the HPLs or below the MPLs. The rate for the *Immunizations for Adolescents—Combination 1* measure, which is a timeliness measure, had statistically significant improvement from 2012 to 2013.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. This measure received a *Poor* rating for both the adult and child populations.

Overall, IEHP showed average performance in the timeliness domain of care.

Follow-Up on Prior Year Recommendations

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

- Assess the factors that are leading to the rate on the *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* measure being below the MPL and identify interventions that will result in an improvement on performance.
- Assess the factors that are leading to a significantly higher rate of readmissions for the SPD population when compared to the non-SPD population and identify strategies to ensure the MCP is meeting the needs of the SPD population.
- Ensure the following related to QIPs:
  - Provide accurate calculation and reporting of *p* values on the QIP Summary Form.
  - Provide a complete, detailed description of the data collection process and data analysis plan for all QIPs.
  - Monitor and evaluate interventions to determine if the interventions have positively affected the QIP outcomes. Interventions that are deemed successful in improving the outcomes should be standardized and monitored for continued success.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Rating of Personal Doctor, How Well Doctors Communicate,* and *Rating of All Health Care* priority areas.
- Review the *2012–13 MCP-Specific Encounter Data Validation Study Report* and identify strategies for addressing the recommendations to ensure accurate and complete encounter data.

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

Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Table 3.2)

Quality Domain

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

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

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

Access and Timeliness Domains

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

CAHPS Survey Measures

(Refer to Tables 5.3 through 5.4)

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

Quality Domain

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

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

Access Domain

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

Timeliness Domain

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

Quality Improvement Projects (QIPs)

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

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

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

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

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

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

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

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

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

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

for Inland Empire Health Plan

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

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

2011–12 External Quality Review Recommendation	IEHP's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. Ensure that all open medical performance review deficiencies are fully resolved. Specifically:	
a. Provide evidence that a notice of action (NOA) letter addressing pharmaceutical denials, deferrals, and modifications is being sent to members when appropriate.	Please see attached samples of the member letters, samples of live de-identified, from this year for Medi-Cal ➢ Medi-Cal o Denied ▪ Not Medically Necessary ▪ Not Covered Benefit ▪ Administrative o Modified **NOTE:** HSAG reviewed the NOA letter, and it appears to include the required information.
b. Conduct barrier analysis related to completion of initial health assessments (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.	Barriers: encounter data issues, invalid phone numbers for new IEHP Medi-Cal members and provider/member training Interventions: Encounter data P4P, encounter data rates now included on the monthly delegate reports to help them identify their rates in comparison to where we expect them to be, capturing of additional phone numbers in our MAX MC system, monthly nurse educator visits to high-volume providers to assist them with accessing the IHA rosters that are available on the IEHP website. An IHA work group has been assembled and includes staff from the following depts.: QM, marketing, provider services, medical services and member services. IEHP continues to reach out to other Medi-Cal managed care plans to determine best practices.
2. Consider adding a data field for capturing potential exclusion information such as a hysterectomy for the *Cervical Cancer Screening* measure.	The HEDIS data team is now collecting hysterectomy and mastectomy data through a supplemental database. This process was implemented in 2012 and will continue through 2013. All supplemental data received will include primary source verification.

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

2011–12 External Quality Review Recommendation	IEHP's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
3. 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.	The Use of Imaging Studies for Low Back Pain was identified as a targeted IEHP HEDIS measure by the HEDIS improvement committee. IEHP has identified a list of high-volume providers who will receive a provider tool kit and 1:1 education with a nurse educator beginning 10/1/13.
4. Provide documentation of the QIP barrier analysis, providing the data, identified barriers, and the rationale for how the barriers are prioritized.	At the recommendation of the technical assistance staff at HSAG, IEHP will only document barriers that can adequately be measured. IEHP will continue to run the ADHD QIP and has developed a provider survey that will be given to all high-volume ADHD providers to adequately assess barriers they encounter in the management of children with ADHD. IEHP did evaluate the use of the ADHD roster that was available on the provider website and found that there were issues with the timelines of the data that were available to our providers. In 2013/2014, IEHP will assess the use of the provider roster on a quarterly basis. Interventions will be developed based on the barriers identified and prioritized in a way that will reach the largest number of providers and members.
5. 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.	At the recommendation of the technical assistance staff at HSAG, IEHP will only document barriers that can adequately be measured. A survey was fielded to IEHP members that will assist IEHP in identifying barriers around hospital discharges/readmissions. The survey will be evaluated fall 2013 and interventions will be put into place to address the barriers found in the readmission surveys.
6. Consider targeting interventions to high-volume providers with low performance for the *ADHD Management* QIP.	IEHP is targeting high-volume ADHD providers about the use of the ADHD roster and will be visited by nurse educators during their quarterly visits. This group of providers will also be assessed on their use of the ADHD roster.