Performance Evaluation Report

Health Net Community Solutions

July 1, 2009–June 30, 2010

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

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1. Introduction

Purpose of Report

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

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

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

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

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

This report is specific to the MCMC Program's contracted plan, Health Net Community Solutions ("Health Net" or "the plan"), which delivers care in Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

Health Net, also known as Health Net Community Solutions, is a full-scope Medi-Cal managed care plan operating in seven counties: Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare. Health Net has been Knox-Keene licensed since 1991. Knox-Keene licensure is granted by the Department of Managed Health Care (DMHC) to plans that meet minimum required standards according to the Knox-Keene Health Care Service Plan Act of 1975. The act includes a set of laws that regulate managed care organizations (MCOs).

Health Net delivers care to members using the Two-Plan model type for five counties and the Geographic Managed Care (GMC) model type for two counties. In a Two-Plan model county, the DHCS contracts with two managed care plans to provide health care services to members. In most Two-Plan model counties, Medi-Cal beneficiaries in both mandatory and voluntary aid codes can choose between a local initiative (LI) plan and a nongovernmental commercial health plan. In the GMC model, Medi-Cal beneficiaries in both mandatory and voluntary aid codes can choose between several commercial plans within a specified county.

Health Net delivers care to members as a commercial plan (CP) in Fresno, Los Angeles, Kern, Stanislaus, and Tulare counties under the Two-Plan model. Health Net serves members under the GMC model type in Sacramento and San Diego counties.

Health Net began services under the MCMC Program beginning in Sacramento County in 1996 and then expanded into its additional contracted counties. As of June 30, 2010, Health Net had 708,863 enrolled members under the MCMC Program for all of its contracted counties combined.[2]

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

Conducting the Review

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

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

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

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

Findings

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

Medical Performance Review

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

HSAG reviewed the most current medical performance review reports available as of June 30, 2010, to assess plans' compliance with State-specified standards. The DHCS's A&I Division conducted a non-joint medical performance review in May 2008 covering the review period of May 1, 2007, through April 30, 2008.[3] The report was not available at the time HSAG prepared the last evaluation report; therefore, the findings are included in this year's report.

The scope of the review covered utilization management (UM), continuity of care, availability and accessibility, members' rights, quality management, and administrative and organizational capacity. Under each area audited, HSAG lists the key findings, plan actions to address the findings, and the final outcome.

Utilization Management (UM)

A review of utilization management standards showed both strengths and opportunities for improvement. Health Net's UM program used written criteria to determine medical necessity. The UM program also measured indicators for under- and overutilization of services. The plan was compliant with delegated UM activities.

Findings under this category showed that the plan was not compliant with having a physician review pharmacy denials, a repeat finding from the 2003 audit. The plan's policy, member evidence of coverage, and provider operations manual did not list preventive services as excluded from prior authorization. The plan did not track prior authorization requests, a repeat finding from 2000 and 2003 audits. A review of eight member appeals showed that, while the plan was compliant with sending acknowledgement and notification letters to members, they were not compliant with sending these letters to providers appealing on behalf of a member.

The plan submitted corrective action plans for each area of deficiency, and the DHCS *Medical Audit Close Out Report* dated April 23, 2009, considered all findings fully addressed.

Continuity of Care

Overall, Health Net met the requirements related to continuity of care. The plan had policies and procedures in place for care coordination including referrals for children with eligible conditions for California Children's Services (CCS), Early Start programs for children with developmental delays or disabilities, and regional centers for members with developmental disabilities.

The review showed that Health Net was not compliant with making three outreach attempts to members to complete the initial health assessment and initial health education behavioral assessment.

The *Medical Audit Close Out Report* noted that Health Net resolved this area of deficiency.

[3] *California Department of Health Services. Medical Review – Northern Section, Audits and Investigations. Health Net Community Solutions, Inc.*, November 25, 2009.

Access and Availability

The review found that Health Net had appropriate procedures in place for monitoring access to appointments for routine care, urgent care, specialty care, prenatal care, and preventive services. In monitoring access, the plan identified a shortage of dermatology specialists in Fresno and Stanislaus counties.

While the plan was compliant with ensuring access to urgent, emergent, after-hours care, a review of 21 emergency service claims showed 20 of 21 claims were denied and redirected to the responsible payer more than ten working days after receipt of the claim. Additionally, no letters were sent to members notifying them of a denied, adjusted, or deferred claim.

At the time of the *Medical Audit Close Out Letter*, the DHCS indicated that Health Net had not fully resolved issues securing access to a dermatology specialist group in Fresno and Stanislaus counties. In addition, there was no evidence that the plan developed and implemented an action letter to send to members that was compliant with State regulations for denied, modified, or deferred claims, as requested. (It should be noted that Health Net is not in agreement with the need for such notices and believes that sending these letters causes "undue member confusion." However, the DHCS indicated that this audit finding still stands as these action letters are required by State regulations.)

Member Rights

A review of 30 grievances found Health Net deficiencies as follows:

- Resolution letters were sent to members before grievances were reviewed by qualified staff.
- The average 89-day time frame to resolve grievances exceeded the 30-day requirement.
- Members were not notified when a grievance resolution exceeded 30 days.
- Potential quality of care grievances were not submitted to the medical director timely.
- Policies and procedures did not assign the responsibility for determining the appropriate level of review for administrative versus clinical grievances.

In addition to the grievance findings, the medical performance review also noted that the plan's privacy policies lacked the DHCS's reporting requirements. The plan failed to report a suspected breach of personal health information.

Despite the multiple findings, the *Medical Audit Close Out Report* found the plan to have provided corrective action plans sufficient to address all of these deficiencies.

Quality Management

The audit showed that while Health Net identified timeliness of grievance resolution as a potential quality issue, the plan did not show evidence of taking action to address this issue as part of its overall quality management program. The *Medical Audit Close Out Report* indicated the plan addressed this deficiency.

Administrative and Organizational Capacity

The plan did not have policies and procedures in place to comply with contract requirements to report suspected cases of fraud and abuse; however, the DHCS noted that the plan corrected this finding in its *Medical Audit Close Out Report*.

Other Contract Requirements

In addition to A&I's joint medical performance audit, A&I audited Health Net's compliance with the requirements of the plan's MCMC Hyde contract which covers abortion services funded only with State funds, as these services do not qualify for federal funding. The contract review period was May 1, 2007, through April 30, 2008.[4] The plan was fully compliant with this contract requirement.

Medi-Cal Managed Care Member Rights and Program Integrity Review

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

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2010. The most current MRPIU review for Health Net was conducted in June 2009, covering the period of June 1, 2008, through June 1, 2009.

[4] *California Department of Health Care Services Medical Review – Northern Section, Audits and Investigations, State Supported Services, Health Net Community Solutions, Inc.,* November 25, 2008.

HSAG reported findings from the June 2009 MRPIU review in the prior year's evaluation report.[5] The review found Health Net compliant for all areas of review with the exception of a grievance policy that the plan needed to modify to include a clear explanation of the plan's decision. No further information was available to determine whether the deficiency was adequately resolved by the plan.

Strengths

Health Net showed strength in addressing and resolving nearly all medical performance audit deficiencies. While the non-joint audit showed many plan deficiencies related to member grievances, the MRPIU review conducted more recently in June 2009 provides evidence that the plan adequately resolved issues with the grievance system and has sustained its efforts. The MRPIU found the plan fully compliant in the areas of prior-authorization notifications, marketing and enrollment programs, cultural and linguistic services and program integrity.

Opportunities for Improvement

The plan provided its status on the follow-up of recommendations provided by HSAG as part of the 2008–2009 plan evaluation report, attached as Appendix A of this report. The plan indicated that it is still in dispute with the DHCS regarding notification to members for denied, modified, or deferred claims. HSAG recommends that the plan continue to work with the DHCS to resolve the issue as the plan is currently not compliant with this contract requirement.

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

Conducting the Review

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

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

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

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about Health Net's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed an NCQA HEDIS Compliance Audit™ of Health Net in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[6] Based on the results of the compliance audit, HSAG found all measures to be reportable across all Health Net counties and did not identify any areas of concern.

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

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. Table 3.1 displays a HEDIS performance measure name key.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

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

Tables 3.2–3.8 present a summary of Health Net's HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan's HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

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

Table 3.2—2009–2010 Performance Measure Results for Health Net—Fresno County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	45.7%	33.2%	★★	↓	20.2%	33.4%
AWC	Q,A,T	49.3%	50.9%	★★	↔	37.9%	59.4%
BCS	Q,A	47.8%	52.8%	★★	↔	45.0%	63.0%
CCS	Q,A	69.9%	72.1%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	65.3%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	64.8%	63.4%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	51.0%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	39.9%	36.8%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	85.2%	85.9%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	34.2%	35.9%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	79.2%	80.6%	★★	↔	71.5%	82.5%
CDC–N	Q,A	77.3%	78.2%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	77.4%	79.9%	★★	↔	62.4%	80.6%
LBP	Q	‡	84.1%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	90.2%	96.1%	★★★	↑	78.5%	92.2%
PPC–Pst	Q,A,T	62.3%	69.7%	★★	↑	57.9%	72.7%
URI	Q	87.1%	88.4%	★★	↔	81.1%	94.5%
W34	Q,A,T	85.3%	86.0%	★★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	56.7%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	70.1%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	40.7%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).

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

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

[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

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

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

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

‡ The DHCS did not require plans to report this measure in 2009.

NA = The DHCS does not establish an MPL/HPL for first year measures.

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

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

Table 3.3—2009–2010 Performance Measure Results for Health Net—Kern County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	21.4%	17.6%	★	↔	20.2%	33.4%
AWC	Q,A,T	39.3%	32.4%	★	↓	37.9%	59.4%
BCS	Q,A	44.5%	43.5%	★	↔	45.0%	63.0%
CCS	Q,A	64.3%	66.2%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	58.4%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	54.8%	54.0%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	49.1%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	43.9%	39.8%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	80.3%	83.3%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	37.1%	38.1%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	76.6%	81.4%	★★	↔	71.5%	82.5%
CDC–N	Q,A	82.3%	87.2%	★★★	↑	73.4%	85.4%
CIS–3	Q,A,T	65.6%	66.2%	★★	↔	62.4%	80.6%
LBP	Q	‡	79.0%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	87.4%	85.5%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	59.7%	61.5%	★★	↔	57.9%	72.7%
URI	Q	77.7%	78.4%	★	↔	81.1%	94.5%
W34	Q,A,T	66.8%	66.3%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	49.4%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	59.7%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	23.8%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

‡ The DHCS did not require plans to report this measure in 2009.

NA = The DHCS does not establish an MPL/HPL for first year measures.

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

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

Table 3.4—2009–2010 Performance Measure Results for Health Net—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	29.2%	31.0%	★★	↔	20.2%	33.4%
AWC	Q,A,T	38.4%	40.1%	★★	↔	37.9%	59.4%
BCS	Q,A	49.2%	52.3%	★★	↑	45.0%	63.0%
CCS	Q,A	73.2%	75.4%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	61.7%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	64.4%	64.6%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	50.2%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	40.9%	39.0%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	84.7%	86.8%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	36.5%	36.4%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	80.2%	81.6%	★★	↔	71.5%	82.5%
CDC–N	Q,A	82.5%	82.1%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	77.2%	73.1%	★★	↔	62.4%	80.6%
LBP	Q	‡	77.8%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	83.0%	85.3%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	56.2%	58.1%	★★	↔	57.9%	72.7%
URI	Q	80.3%	83.8%	★★	↑	81.1%	94.5%
W34	Q,A,T	78.6%	77.2%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	62.6%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	73.3%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	46.7%	Not Comparable	Not Comparable	NA	NA

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

Table 3.5—2009–2010 Performance Measure Results for Health Net—Sacramento County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	21.7%	22.3%	★★	↔	20.2%	33.4%
AWC	Q,A,T	46.7%	39.6%	★★	↓	37.9%	59.4%
BCS	Q,A	44.6%	46.3%	★★	↔	45.0%	63.0%
CCS	Q,A	65.1%	66.8%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	64.7%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	57.9%	53.8%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	49.9%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	38.4%	39.7%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	81.3%	79.8%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	33.5%	34.8%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	75.8%	74.9%	★★	↔	71.5%	82.5%
CDC–N	Q,A	79.9%	81.3%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	66.0%	63.3%	★★	↔	62.4%	80.6%
LBP	Q	‡	85.7%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	84.9%	85.7%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	57.0%	66.4%	★★	↑	57.9%	72.7%
URI	Q	80.0%	84.3%	★★	↑	81.1%	94.5%
W34	Q,A,T	73.6%	79.2%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	62.8%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	67.0%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	33.0%	Not Comparable	Not Comparable	NA	NA

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

Table 3.6—2009–2010 Performance Measure Results for Health Net—San Diego County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	31.7%	24.8%	★★	↔	20.2%	33.4%
AWC	Q,A,T	37.1%	32.1%	★	↔	37.9%	59.4%
BCS	Q,A	45.3%	44.2%	★	↔	45.0%	63.0%
CCS	Q,A	60.6%	68.2%	★★	↑	60.9%	79.5%
CDC–BP	Q	‡	64.3%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	60.2%	65.2%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	51.6%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	36.0%	39.1%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	89.6%	88.7%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	52.6%	38.0%	★★	↓	27.2%	44.7%
CDC–LS	Q,A	83.7%	80.7%	★★	↔	71.5%	82.5%
CDC–N	Q,A	85.1%	83.6%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	75.5%	75.3%	★★	↔	62.4%	80.6%
LBP	Q	‡	78.4%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	88.5%	93.6%	★★★	↑	78.5%	92.2%
PPC–Pst	Q,A,T	58.5%	65.9%	★★	↑	57.9%	72.7%
URI	Q	93.0%	93.7%	★★	↔	81.1%	94.5%
W34	Q,A,T	67.6%	68.4%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	56.0%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	64.6%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	36.1%	Not Comparable	Not Comparable	NA	NA

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

Table 3.7—2009–2010 Performance Measure Results for Health Net—Stanislaus County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	20.5%	26.5%	★★	↔	20.2%	33.4%
AWC	Q,A,T	36.6%	31.5%	★	↔	37.9%	59.4%
BCS	Q,A	48.4%	52.2%	★★	↔	45.0%	63.0%
CCS	Q,A	65.1%	68.9%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	68.6%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	60.8%	57.1%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	60.1%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	31.3%	29.0%	★★★	↔	50.6%	29.2%
CDC–HT	Q,A	85.4%	86.5%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	34.0%	38.6%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	78.0%	79.5%	★★	↔	71.5%	82.5%
CDC–N	Q,A	81.3%	81.8%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	74.6%	67.1%	★★	↓	62.4%	80.6%
LBP	Q	‡	85.5%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	90.9%	92.3%	★★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	66.3%	54.9%	★	↓	57.9%	72.7%
URI	Q	89.4%	90.1%	★★	↔	81.1%	94.5%
W34	Q,A,T	73.2%	74.9%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	40.4%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	50.6%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	19.5%	Not Comparable	Not Comparable	NA	NA

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

Table 3.8—2009–2010 Performance Measure Results for Health Net—Tulare County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	25.6%	26.7%	★★	↔	20.2%	33.4%
AWC	Q,A,T	36.5%	35.2%	★	↔	37.9%	59.4%
BCS	Q,A	41.5%	46.7%	★★	↔	45.0%	63.0%
CCS	Q,A	71.1%	72.0%	★★	↔	60.9%	79.5%
CDC–BP	Q	‡	68.6%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	69.8%	66.3%	★★	↔	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	48.5%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	37.9%	42.7%	★★	↔	50.6%	29.2%
CDC–HT	Q,A	86.4%	85.2%	★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	31.5%	29.4%	★★	↔	27.2%	44.7%
CDC–LS	Q,A	79.6%	77.0%	★★	↔	71.5%	82.5%
CDC–N	Q,A	85.1%	84.0%	★★	↔	73.4%	85.4%
CIS–3	Q,A,T	76.1%	76.5%	★★	↔	62.4%	80.6%
LBP	Q	‡	82.9%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	91.1%	93.0%	★★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	65.0%	63.1%	★★	↔	57.9%	72.7%
URI	Q	84.0%	84.3%	★★	↔	81.1%	94.5%
W34	Q,A,T	79.3%	76.3%	★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	53.0%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	56.7%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	28.8%	Not Comparable	Not Comparable	NA	NA

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

Performance Measure Result Findings

Overall, Health Net demonstrated average to above-average performance across its counties for reported 2010 performance measures. Health Net demonstrated stable performance across its counties in 2010 compared to 2009 performance measure rates. The plan had a small number of statistically significant improvements and significant declines in performance.

Fresno County had the best 2010 performance when compared with all other counties, achieving the MPLs for all measures and exceeding the HPLs for two measures. Both Los Angeles and Sacramento counties also showed performance above the MPLs for all measures. Kern County showed the greatest opportunity for improvement when comparing its 2010 performance measures rates with all other counties' rates, with four measures falling below the MPLs in 2010.

HEDIS Improvement Plans

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

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need for continuing existing improvement plans and/or developing new improvement plans.

Based on Health Net's 2010 performance measure rates, the DHCS required the plan to submit 2009 HEDIS improvement plans for four measures:

- *Appropriate Treatment for Children with Upper Respiratory Infection*—Kern County
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*—Stanislaus County
- *Use of Appropriate Medications for People With Asthma*—Sacramento County
- *Breast Cancer Screening*—Tulare County

HSAG reviewed Health Net's 2009 HEDIS improvement plans using HEDIS 2010 rates, and assessed whether the plan improved its performance in 2010. HSAG provides the following analysis of the plan's 2009 HEDIS improvement plans.

Appropriate Antibiotic Use

Health Net in Kern County submitted an improvement plan for its 2009 *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* rate, which was below the MPL. The plan collaborated with the California Medical Association's Alliance Working for Antibiotic Resistance Education (AWARE) and other health plans to develop and disseminate an antibiotic awareness provider tool kit. In 2008, the plan mailed providers the names of their patients with a URI diagnosis for whom they may have inappropriately prescribed antibiotics.

While not statistically significant, the plan had a slight increase between 2009 and 2010 from 77.7 percent to 78.4 percent, although the 2010 rate remained below the MPL of 81.1 percent. Despite not achieving the MPL, the plan demonstrated a statistically significant increase of 3.5 percentage points between 2008 and 2009 and sustained that initial improvement in 2010. The improvement plan will need to continue and may require modification for the plan to show additional improvement.

Health Net's Stanislaus County 2009 rate of 20.5 percent for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)* measure fell just below the MPL of 20.6 percent. The plan distributed AWARE provider tool kits in Stanislaus County during 2009. The 2010 rate increased to 26.5 percent, which achieved the MPL.

Asthma

Based on 2009 performance, Health Net in Sacramento County initiated an improvement plan for its *Use of Appropriate Medications for People With Asthma* measure. Interventions implemented by the plan included:

- Provider mailings including lists of members whose controller medications were not filled.
- Identification of members with asthma and recruitments efforts into the plan's disease management program.
- Member education and outreach.
- Provider outreach and education by the medical director for providers with three or more members with asthma that did not receive controller medications.

This measure was not required for reporting by the DHCS in 2010; therefore, HSAG was unable to assess whether the plan achieved improvement.

Breast Cancer Screening

To improve breast cancer screening rates, Health Net implemented provider and member interventions in Tulare County, similar to those used successfully in the past with Sacramento and Kern counties. The plan initiated reminder calls to women who had not had a mammogram in one

to two years to schedule a mammogram. .Additionally, the Community Solutions Specialist team and facility site reviewers contacted all PCPs in Tulare County in 2009 and distributed well woman notepads that providers could share with members reminding them to schedule their well woman check-up. Tulare County's *Breast Cancer Screening* measure rate increased from 41.5 percent in 2009 to 46.7 percent in 2010 and met the MPL.

Strengths

Overall, Health Net continued to demonstrate stable performance measures rates in 2010 for most counties. The plan successfully achieved the MPL for two of the four measures that required an improvement plan in 2009.

Health Net continued to perform above the MPL for all diabetes-related measures across its counties in 2010, which showed the plan's ability to manage a chronic disease such as diabetes, and provided evidence of both quality care and appropriate access to care. Health Net's diabetes disease management program offered to MCMC members may contribute to the plan's overall success with comprehensive diabetes care, reflecting an effective management strategy.

Opportunities for Improvement

Health Net had six statistically significant declines between 2009 and 2010. Additionally, while not statistically significant, the plan had many slight decreases, which resulted in an increased number of measures that fell below the MPLs in 2010. The plan will need to submit nine improvement plans for its 2010 performance. Of the nine rates below the MPLs, four of the nine were related to the *Adolescent Well-Care Visits* measure in Kern, San Diego, Stanislaus, and Tulare counties. Therefore, this measure offers the greatest opportunity for improvement. Additionally, the plan has an opportunity to improve its *Breast Cancer Screening* rates in Kern and San Diego counties. Kern County had four measures below the MPL, which suggests a need for greater quality improvement resources at the county-level.

Conducting the Review

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

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

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

Findings

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

Quality Improvement Projects Conducted

Health Net had three clinical QIPs in progress during the review period of July 1, 2009–June 30, 2010. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS's statewide collaborative QIP. Health Net's second project, *Appropriate Treatment for Children With Upper Respiratory Infection*, was part of a small-group collaborative effort among several of the other MCMC plans focused on decreasing inappropriate antibiotic use for the treatment of a URI for members three months through 18 years of age. The third was a QIP proposal to improve the cervical cancer screening rates among seniors and persons with disabilities.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider in an office or clinic setting. The ER collaborative falls under both the quality and access domains of care.

The URI QIP targeted high-volume providers as a means of decreasing inappropriate antibiotic use for which an individual can develop a resistance to antibiotics over time, making the medication ineffective. The *URI* QIP falls under the quality domain of care.

For the cervical cancer screening QIP, Health Net focused on women with disabilities over the age of 21 years since research has shown that a lower percentage of adults with disabilities receive cancer screening. Increasing access to necessary screenings has the potential to prevent or reduce the impact of the disease. The cervical cancer screening QIP falls under the quality and access domains of care.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for all three of Health Net's QIPs across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Health Net—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties July 1, 2009, through June 30, 2010

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits (Combined Plan Rate)	Annual Submission	86%	100%	*Met*
Small-Group Collaborative QIPs				
Appropriate Treatment for Children With Upper Respiratory Infection (Combined Plan Rate)	Annual Submission	97%	100%	*Met*
Internal QIPs				
Improving Cervical Cancer Screening Among Seniors and Persons With Disabilities (Individual County Rates)	Proposal	89%	90%	*Partially 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*.

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

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that the initial submissions by Health Net of its *Reducing Avoidable Emergency Room Visits* QIP and its URI QIP both received an overall validation status of *Met*. Based on the validation feedback, the plan was not required to resubmit these QIPs. Health Net received a *Partially Met* validation status for its *Improving Cervical Cancer Screening Among Seniors and Persons With Disabilities* QIP proposal submission; however, HSAG requested that the plan address the *Not Met* and *Partially Met* evaluation elements as part of its next baseline QIP submission since there were no concerns with the overall study design. HSAG will include the baseline QIP submission validation results as part of the next evaluation report.

Table 4.2 summarizes the validation results for all three of Health Net's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* Health Net—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties (Number = 9 QIPs, 3 QIP Topics) July 1, 2009, through June 30, 2010

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	87%	13%	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		**95%**	**5%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	64%	36%	0%
	IX: Real Improvement Achieved†	50%	13%	38%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**62%**	**32%**	**6%**

*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 sum of an activity may not equal 100 percent due to rounding.

HSAG validated QIPs at the county level beginning July 1, 2009, for new QIP projects and validated existing projects at the overall plan level; therefore, HSAG validated one QIP submission each for the *Reducing Avoidable Emergency Room Visits* QIP and the *URI* QIP and nine county-level QIP submissions for the *Cervical Cancer Screening* QIP. For the *Reducing Avoidable Emergency Room Visits* QIP, the plan did not discuss the statistical differences between measurement periods. In the *Cervical Cancer Screening* QIP, Health Net did not fully describe how the study indicator is a subset of the population included in the corresponding HEDIS measure. Additionally, the plan did not discuss its county-specific results.

Quality Improvement Project Outcomes

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 Health Net—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties (Number = 9 QIPs, 3 QIP Topics) July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits					
QIP Study Indicator	**County**	**Baseline Period (1/1/07–12/31/07)**	**Remeasurement 1 (1/1/08–12/31/08)**	**Remeasurement 2 (1/1/09–12/31/09)**	**Sustained Improvement**
Percentage of avoidable ER visits^	**Overall**	**15.8%**	**21.6%***	‡	‡
	Fresno	17.4%	22.2%*	‡	‡
	Kern	15.3%	21.5%*	‡	‡
	Los Angeles	15.5%	21.7%*	‡	‡
	Sacramento	15.9%	19.0%*	‡	‡
	San Diego	16.2%	20.5%*	‡	‡
	Stanislaus	14.5%	23.5%*	‡	‡
	Tulare	19.4%	22.5%*	‡	‡

^County-level outcomes are provided for informational purposes since only the overall rate was validated.
*A statistically significant difference between baseline and Remeasurement 1 (p value < 0.05).
‡The QIP did not progress to this phase during the review period and could not be assessed.

QIP #2—Appropriate Treatment for Children With Upper Respiratory Infection					
QIP Study Indicator	**County**	**Baseline Period (7/1/05–6/30/06)**	**Remeasurement 1 (7/1/06–6/30/07)**	**Remeasurement 2 (7/1/07–6/30/08)**	**Sustained Improvement**
Percentage of high-volume PCPs for whom 80 percent of their *eligible URI patients ha*d the appropriate treatment for URI	All Counties	49.4%	66.2%*	69.9%	Yes
Percentage of members 3 months of age through 18 years of age who were given a diagnosis of upper respiratory infection and who were not dispensed an antibiotic prescription	All Counties	73.9%	79.4%*	81.3%*	Yes
*A statistically significant difference between baseline and Remeasurement 1 (*p* value < 0.05).					

QIP #3—Improving Cervical Cancer Screening among Seniors and Persons with Disabilities					
QIP Study Indicator	**County**	**Baseline Period¥ (1/1/09–11/1/09)**	**Remeasurement 1 (1/1/10–12/31/10)**	**Remeasurement 2 (1/1/011–12/31/11)**	**Sustained Improvement**
The percentage of SPD women who received one or more pap tests during the measurement year or prior year.	**Overall**	**37.9%**	‡	‡	‡
	Fresno	33.8%	‡	‡	‡
	Kern	32.0%	‡	‡	‡
	Los Angeles	40.4%	‡	‡	‡
	Sacramento	30.6%	‡	‡	‡
	San Diego	31.4%	‡	‡	‡
	Stanislaus	38.9%	‡	‡	‡
	Tulare	35.5%	‡	‡	‡
¥ Pre-baseline data 1/1/09–11/31/09. The full year of baseline data 1/1/09–12/31/09 will be reported in next year's report. ‡The QIP did not progress to this phase during the review period and could not be assessed.					

Health Net demonstrated a statistically significant increase in avoidable ER visits for every county, which was a decrease in the performance for this measure. Although the plan participated in the collaborative interventions, the lack of improvement was attributed to the high number of new members who had not yet established a primary care provider.

To improve appropriate treatment for URIs in children, Health Net participated as a collaborative partner with 16 other health plans in the California Medical Association's Alliance Working for Antibiotic Resistance Education (AWARE) to develop and disseminate an antibiotic awareness provider tool kit. Other plan-specific interventions included mailing providers the names of their patients with a URI diagnosis for whom they may have inappropriately prescribed antibiotics.

Health Net showed improvement for both study indicators for its URI QIP. The plan increased the percentage of its high-volume primary care physicians that achieved appropriate treatment of URI for 80 percent of their patients. Additionally, the plan demonstrated statistically significant improvement for the overall percentage of children not prescribed an antibiotic for an upper respiratory infection. For both study indicators, the improvement was sustained through the second remeasurement period. Health Net's concerted effort with the California Medical Association may have increased Health Net's likelihood of success. HSAG recommended that Health Net retire this QIP as a formal project. The plan retired the URI QIP and initiated its cervical cancer screening QIP.

Only baseline results were reported for the cervical cancer screening QIP. Health Net plans on implementing provider and member interventions; however, county-specific barriers and interventions were not identified.

Strengths

Through its QIP validation findings, Health Net demonstrated a good understanding of documenting support for its QIP study design and implementation of improvement strategies. Given its low performance measure rates and need for improvement in this area, the plan selected appropriate treatment for URI as its study topic. The plans in the small-group collaborative QIP conducted analysis of URI data by age group, race/ethnicity, and language. Health Net found that the greatest improvements across all counties were among members 12–18 years of age, among Spanish-speaking members, and among Black members. In addition, the plan conducted analysis at the county level. All of these efforts helped to target interventions by examining factors that may have led to increased or decreased performance for a given population.

In addition, the plan showed that real improvement was achieved with a statistically significant increase for one of its URI QIP study indicators for the first remeasurement period and sustained improvement from baseline through Remeasurement 2.

The plan has demonstrated that it gained some proficiency with QIP validation during the review period despite the *Partially Met* validation score for the cervical cancer screening QIP. Overall, Health Net's documentation in its *Reducing Avoidable Emergency Room Visits* QIP and URI QIP was sufficient to meet evaluation element criteria for producing a valid QIP.

Opportunities for Improvement

Health Net should appropriately conduct all county-specific activities including identification of barriers, implementation of interventions, statistical testing between measurement periods, and interpreting results.

For the *Reducing Avoidable Emergency Room Visits* QIP, Health Net should implement interventions that would address the barriers associated with new members' use of the ER.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan surveys.[7]

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

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

Findings

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

CAHPS Global Rating Measures:

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

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

CAHPS Composite Measures:

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

National Comparisons

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

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

Table 5.1—Star Ratings Crosswalk

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

Table 5.2—Health Net Adult Medi-Cal Managed Care County-Level Global Ratings

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Fresno	★	★★	★	★★+
Kern	★	★	★	★
Los Angeles	★	★	★	★
Sacramento	★	★	★	★★+
San Diego	★	★	★	★+
Stanislaus	★	★	★	★★+
Tulare	★★	★	★★★★	★★★★+

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

Table 5.3—Health Net Child Medi-Cal Managed Care County-Level Global Ratings

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Fresno	★★★★	★★	★★	★★★+
Kern	★	★	★	★+
Los Angeles	★★★★	★★★	★★★	★★★★+
Sacramento	★	★	★	★+
San Diego	★	★★	★★★★★	★★★★+
Stanislaus	★	★	★	★+
Tulare	★★★★	★★★★	★★★★★	★★★★★+

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

Table 5.4—Health Net Adult Medi-Cal Managed Care County-Level Composite Measures

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Fresno	★★	★	★	★+	★
Kern	★	★	★	★+	★+
Los Angeles	★	★	★	★+	★
Sacramento	★+	★	★	★★+	★+
San Diego	★	★	★	★+	★+
Stanislaus	★	★	★	★+	★★+
Tulare	★	★	★★★★	★+	★

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

Table 5.5—Health Net Child Medi-Cal Managed Care County-Level Composite Measures

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Fresno	★	★	★	★★★+	★★★
Kern	★+	★	★	★+	★
Los Angeles	★+	★	★	★★★★★+	★
Sacramento	★+	★	★	★+	★+
San Diego	★	★	★★	★★★	★
Stanislaus	★+	★	★	★+	★
Tulare	★★	★	★	★★★★+	★★

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

Strengths

Health Net performed best on the child global ratings scores when compared with adult global ratings and child and adult composite measure scores. Tulare County had the highest member satisfaction scores across both child and adult members when compared to all other counties. *Rating of Specialist Seen Most Often* and *Customer Service* were measures that had the highest percentile rankings for the child population.

Opportunities for Improvement

Health Net's CAHPS results showed primarily poor performance for all adult global rating categories and composite measures for adult surveys with the exception of Tulare County. Child survey CAHPS results showed generally poor performance for all child composite ratings.

While the plan showed a need for improvement in all areas of member satisfaction across both adult and child populations, HSAG conducted a key drivers of satisfaction analysis that focused on the top three highest priorities based on the plan's CAHPS results. The purpose of the key drivers of satisfaction analysis was to help decision makers identify specific aspects of care most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as Health Net's highest priority: *Rating of Health Plan*, *Rating of Personal Doctor,* and *How Well Doctors Communicate*. The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program – 2010 Health Net for Health CAHPS Plan-Specific Report*. Areas for improvement spanned the quality, access, and timeliness domains of care.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

Overall, Health Net demonstrated average to above-average performance for the quality domain of care based on its 2010 performance measure rates (reflecting the measurement period of January 1, 2009, through December 31, 2009), its QIP outcomes, medical performance review results related to measurement and improvement, and member satisfaction.

Most 2010 performance measure rates were between the MPLs and HPLs. Nine of the 2010 performance measure rates fell below the MCMC-established MPLs, an increased number from four in 2009. Seven measures were above the HPLs. While the plan had few statistically significant changes between 2009 and 2010 rates, the slight decreases in performance resulted in the plan having more rates below the MPLs. Of the nine measures below the MPLs, four were for the *Adolescent Well-Care Visits* measure. Fresno County had the best performance across Health Net counties and Kern County showed the greatest opportunity for improvement.

Health Net showed mixed results with its QIP outcomes. The plan had sustained improvement for both study indicators for its *Appropriate Treatment for Children With Upper Respiratory Infection* QIP. The plan had a statistically significant decline in performance for the *Reducing Avoidable ER Visits* QIP. The decrease was attributed to barriers with new members using the ER before they have established care with a PCP. Despite the mixed outcome results, the plan did well on the technical

aspects of documenting QIPs to meet HSAG's validation requirements for its existing QIPs. For the new *Improving Cervical Cancer Screening Among Seniors and Persons with Disabilities* QIP, the plan received *Not Met* scores for lack of documentation of county-specific activities.

Medical performance review results showed that Health Net addressed all but one deficiency to DHCS' satisfaction. More recent MRPIU results found Health Net fully compliant in all areas of the review with the exception of grievance policy and procedure revisions.

Improving member satisfaction is the greatest opportunity for improvement for Health Net across counties. Both adult and child populations rated *Getting Needed Care* as poor. Adult results showed the *Rating of All Health Care* as poor. Tulare County showed the best member satisfaction results; however, opportunity to improve results spans across all counties.

Access

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

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

Health Net demonstrated average to above-average performance for the access domain of care based on its 2009 performance measure rates related to access, its QIP outcomes that address access, medical performance review results related to availability and access to care, and member satisfaction results.

Diabetes care continues to be an area of strength for Health Net. The plan met all diabetes-related performance measure MPLs across all of its seven counties. The plan's access-related performance measure rates that fell below the MPLs were for *Adolescent Well-Care Visits*, *Breast Cancer Screening* and *Prenatal and Postpartum Care—Postpartum Care* measures. The low performance rates for these measures present opportunities for improvement.

For access-related standards, the review by the MCMC Member Rights/Program Integrity Unit showed that Health Net was compliant with all areas related to cultural and linguistic services and

marketing requirements. The plan addressed its deficiency related to low completion rates for health assessments from the prior review period's medical performance review. The MRPIU found the plan fully compliant in the areas of prior-authorization notifications, marketing and enrollment programs, cultural and linguistic services and program integrity.

Timeliness

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

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

Health Net demonstrated average performance in the timeliness domain of care based on 2009 performance measure rates related to providing timely care, medical performance reviews standards related to timelines, and members satisfaction results. Performance measure results for childhood immunizations achieved the 2010 MPL across all counties; however, rates for some counties fell below the MPLs for the well-care visits and postpartum care areas.

The DHCS's *Medical Performance Audit Close Out Report* indicated that Health Net addressed all one but deficient area. The plan indicated that it is still in dispute with the DHCS regarding notification to members for denied, modified, or deferred claims. The MRPIU review results showed that the plan was fully compliant with prior authorization notifications.

Member satisfaction results showed that the plan had poor performance in the *Getting Care Quickly* category for both adult and child populations. This suggests that members perceive that they do not always receive timely care.

Follow-Up on Prior Year Recommendations

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

Conclusions and Recommendations

Overall, Health Net had average performance in providing quality and timely services to its MCMC members and average to above-average performance for providing accessible services.

Health Net showed a slight decline in its performance measures rates in 2010 compared with 2009 rates. The small decreases resulted in nine measures with rates below the MPL. The plan was extremely successful in its URI QIP and achieved sustained performance for both study indicators. The plan adequately addressed nearly all medical performance review deficiencies and was generally compliant with the MRPIU review.

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

- Continue to work with the DHCS to resolve the disputed audit finding regarding notification to members for denied, modified or deferred claims.
- Explore factors that contributed to the decline in performance for the *Adolescent Well-Care Visits* measure for Kern, San Diego, Stanislaus, and Tulare counties and implement improvement strategies.
- Determine whether previous interventions used to successfully improve *Breast Cancer Screening* measure rates can be applied to Kern and San Diego counties.
- Document QIP activities at the county-specific level including the identification of barriers, implementation of interventions, statistical testing between measurement periods, and interpreting results.
- Increase quality improvement resources to Kern County until performance is meeting the DHCS's requirements.
- Explore implementation interventions that would address barriers associated with new members' use of the ER as a strategy for decreasing avoidable ER visits.

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

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

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

EQR Recommendation	Plan Actions That Address the Recommendation
Explore factors that contributed to the low rates for the four performance measures that fell below the MCMC MPL which include appropriate treatment for acute bronchitis, upper respiratory infection in children, and asthma.	**I. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Stanislaus County)** A. Factors that Contributed to the Low Rate (Barriers): ◆ Providers may have limited resources to provide educational materials to their members ◆ Members are not aware that they could be resistant to antibiotics through overuse ◆ Members are so used to receiving antibiotics whenever they have any upper respiratory problems B. Interventions Implemented: ◆ Medi-Cal member newsletter titled, "Know Your Medicine" discussed inappropriate use of antibiotics for viruses and developing antibiotic resistance (Winter 2009) ◆ Statewide (including Stanislaus County) mailing of AWARE toolkit to 1,778 physicians identified as high prescribers of antibiotics. The toolkit included CPG for URI, Pharyngitis and Brochiolitis (October 2009) ◆ The Health Net Medi-Cal Community Solution Specialists (CSS)Team and the FSR Nurses distributed copies of AWARE posters and flyers on October 2009 to Health Net members. These materials were also distributed statewide to the providers.The flyers include: ▪ Careful Antibiotic Use: 845 ▪ Bronchitis & Other Cough Illnesses: 845 ▪ CDC Says "Take 3 Steps to Fight the Flu": 845 Poster ▪ Feel Better Soon Child: 1.290 ▪ Feel Better Soon Adult: 1,210 ◆ Health Net developed prescription pads with self-care instructions where providers can check off information. On these prescription pads, blank fields were added to allow providers to fill in information on other self-care and over-the-counter medications. This helps to decrease the pressure of having to provide prescription for antibiotic. The CSS and FSR nurses distributed these to providers during their monthly visits. If more materials are needed providers were asked to call the Health Education Department. **Please note:** It is believed that HEDIS 2010 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis in Tulare County met the DHCS 2010 MPL as a result of the interventions.
	II. Appropriate Treatment for Children with Upper Respiratory Infection (Kern County) A. Factors that Contributed to the Low Rate (Barriers): ◆ Providers may not be aware of the most current CPG for URI ◆ Providers have limited funds to produce educational materials for their members ◆ PCPs may not be aware that other providers are prescribing antibiotics inappropriately to their patients ◆ Members are accustomed to receiving antibiotics for URI ◆ Members expect a prescription when they see a practitioner and providers feel pressured to write a prescription.

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

EQR Recommendation	Plan Actions That Address the Recommendation
	B. Interventions Implemented: ◆ Participates in the statewide AWARE collaborative. The collaborative promotes appropriate prescription of antibiotics to avoid antibiotic resistance, and develops and mails toolkit to providers that include Kern County. The 2009–2010 AWARE collaborative developed materials addressing URI appropriate management and treatment. In October 2009, 1,778 providers were mailed the toolkit. ◆ At all Health Net contracted counties (including Kern County) the PCPs and PPGs are sent a letter quarterly. The letter includes the list of their patients diagnosed with URI who were inappropriately prescribed with antibiotics (based on a rolling 12-month pull for each quarter). The letter includes the PCP's rate of inappropriate antibiotic prescription compared to peers' rates in their PPG and health plan. Letters sent in all HN counties statewide (including Kern county): ▪ May 2009: Providers—99 ▪ August 2009: Providers—69 ▪ November: Providers—58 ▪ April 2010: PCP—56; Clinic—10 ▪ July 2010: PCP—142; Clinic—44 ◆ During their meetings the CSS and FSR nurses distributed to providers (including those in Kern County), Health Net-developed prescription pads with self-care instructions and blank fields for providers to write other instructions or over-the-counter medicines as needed. In addition, re-printed AWARE materials are also distributed during their regular monthly meetings. AWARE materials include: Careful Antibiotic Use—845; Bronchitis & Other Cough llnesses in Children—845; CDC Says "Take 3 Steps to Fight the Flu"—845; Poster: Feel Better Soon (Child)—1.290; Poster: Feel Better Soon Adult—1,210 **Please note:** It is believed that HEDIS 2010 Appropriate Treatment for Children with URI in Kern County improved (over one percentage point) when compared to HEDIS 2009 result, even if the DHCS 2010 MPL was not met as a result of the interventions.

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

EQR Recommendation	Plan Actions That Address the Recommendation
	III. Use of Appropriate Medication for People with Asthma (Sacramento County) A. Factors that Contributed to the Low Rate (Barriers): ◆ Providers have limited resources to provide educational materials to their members ◆ Physicians may provide sample controller medications to members that are not available to the Health Plan data source ◆ Physicians may not prescribe controllers possibly due to lack of knowledge of the most current clinical practice guideline ◆ Members do not contact their providers when their medications run out ◆ Members lack knowledge about asthma self-care management and the value of taking their medications regularly B. Interventions Implemented: ◆ Providers in all Health Net contracted counties (Statewide) including Sacramento County were mailed: ▪ Lists of members whose controller meds were not filled (mailed 1,283 to providers and 243 to clinics)—March 2009 ▪ List of members whose controller meds were not filled (mailed 582 to providers and 133 to clinics)—October 2009 ▪ List of members who are included in the asthma Be In Charge Desease Manaagement (DM) program from all contracted counties including Sacramento (mailed 1,311 to providers)—May 2009 ◆ Asthma identified members were mailed pre-enrollment letters to participate in the Be In Charge DM program Statewide including those in Sacramento County (May 2009) ◆ Asthma identified members(10,399) were mailed educational materials that included booklets and flyers about taking care of asthma (May–June 2009) ◆ Member newsletter published: " Take Control of Your Asthma" (May 2009) ◆ IVR call was made to asthma members informing them about the Be In Charge DM program and how to participate (May–June 2009) ◆ IVR call to asthma members about asthma self-care and a reminder to get a flu shot and H1N1 vaccines. There were 8,677members called (November 2009) ◆ The Health Net medical director shared with the River City Medical Group (RCMG) medical director the list of their providers who have ≥ 3 asthma patients that did not receive controllers for follow-up. The RCMG medical director planned to share the information with their group and will schedule for patients' visit. **Please note:** It is believed that HEDIS 2010 Appropriate Medication for People with Asthma in Sacramento County met the DHCS 2010 MPL as result of the interventions.

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

EQR Recommendation	Plan Actions That Address the Recommendation
Improve Breast Cancer Screening (BCS) rates across counties.	**IV. IV. Breast Cancer Screening (Tulare County)** A. Factors that Contributed to the Low Rate (Barriers): ◆ Members do not believe that BCS is important and may choose not to have a mammogram ◆ Physicians have limited resources to conduct outreach to members for mammograms ◆ Members may have been confused by conflicting BCS recommendations through highly-publicized mass media outlet. Ex. USPSTF recommendation against HEDIS Specifications ◆ Providers are not aware of who among their members need BCS B. Interventions Implemented: ◆ Reminder calls were made to all BCS-negative members in Tulare county (155)—June 2009 ◆ The Community Solution Specialist (CSS) Team and the FSR nurses during their monthly meetings with providers distributed the well woman pad. Providers can share the sheet with members to remind them of their well woman check-ups. The sheet describes each well woman preventive care visit that includes a mammogram for BCS. Space is provided for the date of last mammogram and the recommended date for the next mammogram appointment ◆ Member Medi-Cal Newsletter published an article about the importance of mammography for BCS and early detection—November 2009 **Please note:** It is believed that HEDIS 2010 Breast Cancer Screening in Tulare County met the DHCS 2010 MPL as a result of the interventions.
Increase quality improvement resources for Health Net in Kern County until performance trends upward and further exceeds the MPL.	Health Net has implemented multiple Statewide initiatives that address quality improvement projects for all Health Net contracted Counties including Kern County from 2009 to the present. These initiatives include: ◆ Adolescent Well-Care Visits: IVR calls are made to remind adolescents due for an annual well-care visit to make an appointment with their doctor. There were 2,719 adolescents who were called in Kern County in August 2010. All teens were also mailed postcards reminding them to have their annual well-care visit with their physician. Those who had an annual well-care visit were given movie tickets and encouraged to submit their name for a weekly drawing to win a gift certificate. High-volume providers (100 adolescent members) are given a list of their adolescent patients who are due for a well-care visit by CSS monthly so they can call and make an appointment for these teens. These high-volume providers are offered $35.00 for each completed PM 160 form. Office staff responsible for PM 160 completion are included in the monthly raffle for a gift certificate. ◆ Reminder calls were made to BCS-negative members (1,334) in Kern County in August 2010 ◆ Meetings between Health Net and Kern Medical Group were held to address the low BCS rate. As a result of the meetings, Kern PPG decided to suspend their practice of requiring members to obtain a referral for BCS. Instead, Health Net sends the medical director the list of BCS-negative members. After reviewing the list the

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

EQR Recommendation	Plan Actions That Address the Recommendation
	medical director sends the list to the contracted radiology provider. The radiology scheduler calls the members and sets an appointment without any referral. This initiative was started in October 2010. ◆ Community Solution Specialists visit the Kern county providers monthly, brings with them educational materials to their patients that include Well Woman Pads, Relief for Cold and Flu Prescription Pads developed by Health Net, AWARE materials, ER posters and brochures, tips for quality preventive care that include a list of HEDIS measures with codes and simplified descriptions of the measures, Text4baby flyers and other materials relevant for the season. ◆ Member and provider newsletters that include several topics related to Quality of Care and Service. Examples include: Description of QIPs with emphasis on provider's participation, disease management program and other quality improvement projects. For members' newsletters, topics include importance of yearly adolescent well-care visits, importance of BCS and CCS, distinguishing between a bacterial and viral infection and its treatment, childhood immunizations, diabetes, asthma and other pertinent topics such as flu and dental care.
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance for increasing compliance with the Centers for Medicare & Medicaid Services (CMS) protocol for conducting QIPs.	The Health Net QIP reported on July 1, 2008, using HSAG's QIP Summary Form for the first time showed opportunities for improvement to meet CMS compliance. However, after HSAG's and the DHCS's technical assistance and training in the use of the new form and standards requirement, Health Net met the required standards as evidenced in the reporting of small group collaborative QIP *Appropriate Treatment for Children with URI* and Statewide collaborative QIP *Reducing Avoidable Emergency Room Visits* in the succeeding reporting period. The QIP and validation scores are: ◆ *Appropriate Treatment for Children with URI*: *2009-2010* validation score = 97%; Met standard ◆ *Reducing Avoidable Emergency Room Visits*: 2009-2010 validation score = 95%; Met standard
Address deficient areas related to audit findings for grievances, member notification, and access.	Health Net addressed the audit findings related to access and grievances in a March 2009 corrective action plan follow-up submission to the Medi-Cal Managed Care Division. In regards to the member notification finding, Health Net continues to request further review and reconsideration of the finding by the DHCS. We continue to believe we are compliant with the regulatory requirements and that implementation of proposed notification would be unnecessarily confusing to our members.