Performance Evaluation Report

Health Net Community Solutions

July 1, 2010–June 30, 2011

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

June 2012

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

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

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

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

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

This report is specific to the MCMC Program's contracted plan, 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 July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

Health Net, also known as Health Net Community Solutions, is a full-scope Medi-Cal managed care plan operating in six counties: Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare. Additionally, Health Net was operational in Fresno County prior to March 1, 2011.

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 Los Angeles, Kern, Stanislaus, and Tulare counties under the Two-Plan model. The plan also served members in Fresno County until March of 2011 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, 2011, Health Net had 638,297 enrolled members under the MCMC Program for all of its contracted counties combined.[2]

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

Conducting the Review

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

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

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

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

Findings

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

For this report, HSAG reviewed the most current audit reports available as of June 30, 2011, to assess plans' compliance with State-specified standards. The DHCS's A&I Division had a tentative date of May 2011 for the next scheduled audit; however, that audit was not completed. Therefore, the last non-joint medical performance review was conducted in May 2008 covering the review period of May 1, 2007, through April 30, 2008. These findings were reported in the 2009–2010 Plan Specific Report.[3]

The review showed that Health Net had audit findings in the areas of utilization management, continuity of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity.

The DHCS's *Medical Audit Close-Out Report* letter dated April 23, 2009, noted that the plan had fully corrected several audit deficiencies; however, some issues remained unresolved at the time of the audit close-out report. Deficiencies needing continued attention were in the access and availability category.

At the time of the *Medical Audit Close-Out Report* 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.)

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.

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

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

MRPIU conducted an on-site review of Health Net in June 2009, covering the review period of January 1, 2008, through June 1, 2009. The scope of the review included grievances, prior authorization notifications, cultural and linguistic services, marketing, and the False Claims Act. MRPIU noted one finding in the area of member grievance. Health Net's policies and procedures were not in compliance with Medi-Cal requirements and must be updated to include a clear and concise explanation of plan decisions, and must ensure that medical information is not released to anyone other than the member or an authorized representative. The next on-site review of the plan is scheduled to occur in 2012.

Strengths

Health Net showed strength in addressing and resolving nearly all medical performance audit deficiencies. 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

Health Net has the opportunity to work with the DHCS to fully resolve the issue concerning State regulations for denied, modified, or deferred claims. The plan should also ensure that it has updated policies and procedures in the area of grievances.

Conducting the Review

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

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

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

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about 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 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[4] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of Health Net in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. The audit showed that the plan was fully compliant, and there were no identified areas of concern.

While Health Net no longer operates in Fresno County, the plan did serve members throughout the 2010 measurement year; therefore, the plan was required to report performance measure results for this county.

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

Performance Measure Results

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

Table 3.1—HEDIS® 2011 Performance Measures Name Key

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

Tables 3.2–3.8 present a summary of Health Net's HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. The table shows the plan's HEDIS 2011 performance compared to the MCMC-established MPLs and HPLs.

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

Table 3.2—2010–2011 Performance Measure Results for Health Net—Fresno County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	33.2%	26.8%	★★	↔	19.7%	35.9%
AWC	Q,A,T	50.9%	51.8%	★★	↔	38.8%	63.2%
BCS	Q,A	52.8%	54.5%	★★	↔	46.2%	63.8%
CCS	Q,A	72.1%	80.2%	★★★	↑	61.0%	78.9%
CDC–BP	Q	65.3%	69.7%	★★	↔	53.5%	73.4%
CDC–E	Q,A	63.4%	49.5%	★★	↓	41.4%	70.1%
CDC–H8 (<8.0%)	Q	51.0%	49.1%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	36.8%	43.7%	★★	↓	53.4%	27.7%
CDC–HT	Q,A	85.9%	83.3%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	35.9%	33.6%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	80.6%	76.5%	★★	↔	69.3%	84.0%
CDC–N	Q,A	78.2%	78.9%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	79.9%	78.2%	★★	↔	63.5%	82.0%
LBP	Q	84.1%	81.0%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	96.1%	95.1%	★★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	69.7%	69.2%	★★	↔	58.7%	74.4%
URI	Q	88.4%	88.3%	★★	↔	82.1%	94.9%
W34	Q,A,T	86.0%	84.8%	★★★	↔	65.9%	82.5%
WCC–BMI	Q	56.7%	63.7%	★★★	↑	13.0%	63.0%
WCC–N	Q	70.1%	69.2%	★★★	↔	34.3%	67.9%
WCC–PA	Q	40.7%	49.1%	★★	↑	22.9%	56.7%

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

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.3—2010–2011 Performance Measure Results for Health Net—Kern County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	17.6%	18.2%	★	↔	19.7%	35.9%
AWC	Q,A,T	32.4%	38.0%	★	↔	38.8%	63.2%
BCS	Q,A	43.5%	44.0%	★	↔	46.2%	63.8%
CCS	Q,A	66.2%	63.7%	★★	↔	61.0%	78.9%
CDC–BP	Q	58.4%	58.4%	★★	↔	53.5%	73.4%
CDC–E	Q,A	54.0%	50.2%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	49.1%	40.6%	★★	↓	38.7%	58.8%
CDC–H9 (>9.0%)	Q	39.8%	48.8%	★★	↓	53.4%	27.7%
CDC–HT	Q,A	83.3%	79.1%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	38.1%	36.5%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	81.4%	76.4%	★★	↔	69.3%	84.0%
CDC–N	Q,A	87.2%	82.7%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	66.2%	70.4%	★★	↔	63.5%	82.0%
LBP	Q	79.0%	73.5%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	85.5%	86.3%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	61.5%	62.4%	★★	↔	58.7%	74.4%
URI	Q	78.4%	82.6%	★★	↑	82.1%	94.9%
W34	Q,A,T	66.3%	72.0%	★★	↔	65.9%	82.5%
WCC–BMI	Q	49.4%	53.2%	★★	↔	13.0%	63.0%
WCC–N	Q	59.7%	69.7%	★★★	↑	34.3%	67.9%
WCC–PA	Q	23.8%	41.7%	★★	↑	22.9%	56.7%

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

Table 3.4—2010–2011 Performance Measure Results for Health Net—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	31.0%	20.2%	★★	↓	19.7%	35.9%
AWC	Q,A,T	40.1%	46.2%	★★	↔	38.8%	63.2%
BCS	Q,A	52.3%	50.1%	★★	↓	46.2%	63.8%
CCS	Q,A	75.4%	69.5%	★★	↔	61.0%	78.9%
CDC–BP	Q	61.7%	63.9%	★★	↔	53.5%	73.4%
CDC–E	Q,A	64.6%	55.3%	★★	↓	41.4%	70.1%
CDC–H8 (<8.0%)	Q	50.2%	46.3%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	39.0%	40.7%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	86.8%	84.0%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	36.4%	37.3%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	81.6%	80.8%	★★	↔	69.3%	84.0%
CDC–N	Q,A	82.1%	86.6%	★★★	↔	72.5%	86.2%
CIS–3	Q,A,T	73.1%	77.1%	★★	↔	63.5%	82.0%
LBP	Q	77.8%	80.0%	★★	↑	72.0%	84.1%
PPC–Pre	Q,A,T	85.3%	86.6%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	58.1%	58.2%	★	↔	58.7%	74.4%
URI	Q	83.8%	81.3%	★	↓	82.1%	94.9%
W34	Q,A,T	77.2%	79.1%	★★	↔	65.9%	82.5%
WCC–BMI	Q	62.6%	63.6%	★★★	↔	13.0%	63.0%
WCC–N	Q	73.3%	71.3%	★★★	↔	34.3%	67.9%
WCC–PA	Q	46.7%	53.7%	★★	↑	22.9%	56.7%

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

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.5—2010–2011 Performance Measure Results for Health Net—Sacramento County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	22.3%	28.5%	★★	↔	19.7%	35.9%
AWC	Q,A,T	39.6%	44.5%	★★	↔	38.8%	63.2%
BCS	Q,A	46.3%	45.3%	★	↔	46.2%	63.8%
CCS	Q,A	66.8%	59.5%	★	↓	61.0%	78.9%
CDC–BP	Q	64.7%	59.6%	★★	↔	53.5%	73.4%
CDC–E	Q,A	53.8%	45.6%	★★	↓	41.4%	70.1%
CDC–H8 (<8.0%)	Q	49.9%	49.2%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	39.7%	40.0%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	79.8%	83.8%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	34.8%	37.8%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	74.9%	76.4%	★★	↔	69.3%	84.0%
CDC–N	Q,A	81.3%	81.6%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	63.3%	67.3%	★★	↔	63.5%	82.0%
LBP	Q	85.7%	87.8%	★★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	85.7%	87.9%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	66.4%	60.6%	★★	↔	58.7%	74.4%
URI	Q	84.3%	84.5%	★★	↔	82.1%	94.9%
W34	Q,A,T	79.2%	81.8%	★★	↔	65.9%	82.5%
WCC–BMI	Q	62.8%	67.9%	★★★	↔	13.0%	63.0%
WCC–N	Q	67.0%	73.5%	★★★	↑	34.3%	67.9%
WCC–PA	Q	33.0%	41.6%	★★	↑	22.9%	56.7%

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

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.6—2010–2011 Performance Measure Results for Health Net—San Diego County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	24.8%	18.1%	★	↔	19.7%	35.9%
AWC	Q,A,T	32.1%	37.1%	★	↔	38.8%	63.2%
BCS	Q,A	44.2%	42.2%	★	↔	46.2%	63.8%
CCS	Q,A	68.2%	58.1%	★	↓	61.0%	78.9%
CDC–BP	Q	64.3%	53.8%	★★	↓	53.5%	73.4%
CDC–E	Q,A	65.2%	47.4%	★★	↓	41.4%	70.1%
CDC–H8 (<8.0%)	Q	51.6%	42.0%	★★	↓	38.7%	58.8%
CDC–H9 (>9.0%)	Q	39.1%	46.5%	★★	↓	53.4%	27.7%
CDC–HT	Q,A	88.7%	84.6%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	38.0%	31.4%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	80.7%	73.4%	★★	↓	69.3%	84.0%
CDC–N	Q,A	83.6%	82.2%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	75.3%	69.8%	★★	↔	63.5%	82.0%
LBP	Q	78.4%	74.1%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	93.6%	88.8%	★★	↓	80.3%	92.7%
PPC–Pst	Q,A,T	65.9%	62.5%	★★	↔	58.7%	74.4%
URI	Q	93.7%	92.3%	★★	↔	82.1%	94.9%
W34	Q,A,T	68.4%	72.8%	★★	↔	65.9%	82.5%
WCC–BMI	Q	56.0%	51.3%	★★	↔	13.0%	63.0%
WCC–N	Q	64.6%	61.3%	★★	↔	34.3%	67.9%
WCC–PA	Q	36.1%	43.1%	★★	↑	22.9%	56.7%

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

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.7—2010–2011 Performance Measure Results for Health Net—Stanislaus County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	26.5%	26.5%	★★	↔	19.7%	35.9%
AWC	Q,A,T	31.5%	32.9%	★	↔	38.8%	63.2%
BCS	Q,A	52.2%	49.6%	★★	↔	46.2%	63.8%
CCS	Q,A	68.9%	64.0%	★★	↔	61.0%	78.9%
CDC–BP	Q	68.6%	67.8%	★★	↔	53.5%	73.4%
CDC–E	Q,A	57.1%	48.7%	★★	↓	41.4%	70.1%
CDC–H8 (<8.0%)	Q	60.1%	52.8%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	29.0%	37.1%	★★	↓	53.4%	27.7%
CDC–HT	Q,A	86.5%	82.0%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	38.6%	37.4%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	79.5%	75.4%	★★	↔	69.3%	84.0%
CDC–N	Q,A	81.8%	82.0%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	67.1%	67.8%	★★	↔	63.5%	82.0%
LBP	Q	85.5%	77.6%	★★	↓	72.0%	84.1%
PPC–Pre	Q,A,T	92.3%	93.2%	★★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	54.9%	62.3%	★★	↑	58.7%	74.4%
URI	Q	90.1%	92.0%	★★	↔	82.1%	94.9%
W34	Q,A,T	74.9%	75.6%	★★	↔	65.9%	82.5%
WCC–BMI	Q	40.4%	55.2%	★★	↑	13.0%	63.0%
WCC–N	Q	50.6%	63.3%	★★	↑	34.3%	67.9%
WCC–PA	Q	19.5%	41.1%	★★	↑	22.9%	56.7%

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

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.8—2010–2011 Performance Measure Results for Health Net—Tulare County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	26.7%	17.5%	★	↓	19.7%	35.9%
AWC	Q,A,T	35.2%	42.9%	★★	↑	38.8%	63.2%
BCS	Q,A	46.7%	45.5%	★	↔	46.2%	63.8%
CCS	Q,A	72.0%	77.7%	★★	↔	61.0%	78.9%
CDC–BP	Q	68.6%	71.3%	★★	↔	53.5%	73.4%
CDC–E	Q,A	66.3%	56.4%	★★	↓	41.4%	70.1%
CDC–H8 (<8.0%)	Q	48.5%	48.6%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	42.7%	41.7%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	85.2%	86.5%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	29.4%	32.2%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	77.0%	77.5%	★★	↔	69.3%	84.0%
CDC–N	Q,A	84.0%	82.9%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	76.5%	76.3%	★★	↔	63.5%	82.0%
LBP	Q	82.9%	73.1%	★★	↓	72.0%	84.1%
PPC–Pre	Q,A,T	93.0%	93.2%	★★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	63.1%	68.4%	★★	↔	58.7%	74.4%
URI	Q	84.3%	85.5%	★★	↔	82.1%	94.9%
W34	Q,A,T	76.3%	81.3%	★★	↔	65.9%	82.5%
WCC–BMI	Q	53.0%	73.4%	★★★	↑	13.0%	63.0%
WCC–N	Q	56.7%	66.7%	★★	↑	34.3%	67.9%
WCC–PA	Q	28.8%	49.2%	★★	↑	22.9%	56.7%

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

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

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

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

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, Health Net demonstrated average to above-average performance across its counties for reported 2011 performance measures. Health Net demonstrated stable performance across its counties in 2011 compared to 2010 performance measure rates. Fresno County was the top-performing county for the second consecutive year with five measures above the HPLs and zero measures below the MPLs. San Diego County was the lowest-performing county with zero measures above the HPLs and four measures below the MPLs. Across all counties, the plan had a similar number of measures that had statistically significant improvements and declines in performance.

HEDIS Improvement Plans

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

For plan measure rates that required a 2010 HEDIS improvement plan, HSAG compared the plan's 2010 improvement plan with the plan's 2011 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

Adolescent Well-Care Visits

Four counties (Kern, San Diego, Stanislaus, and Tulare) were required to submit improvement plans for *Adolescent Well-Care Visits*. The plan identified several barriers that may have caused the deficient scores. These barriers included:

- Adolescents are more often healthy, and parents/adolescents feel that they do not need to see a provider.
- Privacy of adolescent patient health information pertaining to peers and parents.
- Physicians have limited resources to conduct member outreach for the teen well-child visits.

To address these barriers, the plan established a system to assist providers in identifying members in need of an annual well-care visit, and facilitated provider outreach to these members. Health Net also provided incentives for members to visit a PCP for adolescent well-care visits.

Out of the four counties that were required to conduct 2010 improvement plans, Tulare was the only county to achieve the 2011 MPL. The other three counties will need to continue their improvement plans for their 2011 rates.

Appropriate Antibiotic Use

Health Net in Kern County submitted an improvement plan for its 2010 *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* rate, which was below the MPL for the second consecutive year. The plan continued to collaborate 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. The plan also continued to mail providers the names of their patients with a URI diagnosis for whom they may have inappropriately prescribed antibiotics.

Kern County did achieve a statistically significant increase in 2011 over its 2010 rate; the plan was able to increase its rate from 78.4 to 82.6 percent. This increase was enough to bring Kern County above the MPL; therefore, an improvement plan based on 2011 results will not be needed.

Health Net's Kern County 2010 rate of 17.6 percent for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)* measure fell just below the MPL of 20.2 percent. The plan distributed AWARE provider tool kits in Kern County during 2009, produced an article related to *AAB* in its newsletter, and distributed a tip sheet to providers. The 2011 rate increased but did not achieve the MPL. Kern, along with San Diego and Tulare counties, will need to submit improvement plans for their 2011 rates.

Breast Cancer Screening

To improve breast cancer screening rates, Health Net implemented provider and member interventions in Kern and San Diego counties. The plan documented that there were a few key barriers that affected performance. Health Net believes that members may have been confused by conflicting *BCS* recommendations released by the media. The plan also documented that providers have limited resources to outreach to members, and some providers are not aware which members may need *BCS*.

To counteract these barriers, Health Net instituted several interventions. 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 Kern and San Diego counties and distributed well woman notepads that providers could share with members reminding them to schedule their well woman checkup. Also Health Net worked with the Participating Physician Group (PPG) to create a list of members needing a screening and had radiology centers call members to set up appointments.

2011 HEDIS results show that Health Net will need to continue their improvement plans for Kern and San Diego counties as well as add improvement plans for Sacramento and Tulare counties.

Postpartum Care

Based on 2010 performance, Health Net in Stanislaus County initiated an improvement plan for its *Timeliness of Postpartum Care*. Interventions implemented by the plan included:

- Partnered in the Text4Baby Initiative and conducted promotion of a campaign to members and providers.
- Set up postpartum visits for new mothers while they were still in the hospital.
- Implemented IVR call system to automatically contact mothers as a reminder for postpartum care visits.

While these measures were effective in bringing Stanislaus County above the MPL in its 2011 HEDIS performance, Los Angeles County fell below the MPL and will need to conduct an improvement plan in 2012.

Strengths

Once again, Fresno County earned the highest results for the second consecutive year with five measures above the HPLs and zero measures below the MPLs. The plan did have one more measure that performed above the HPLs than it had performing below the MPLs.

Just like 2010 HEDIS measures, Health Net performed above the MPLs 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

Across all counties, Health Net had 23 statistically significant declines between 2010/2011 compared with only six between 2009/2010. 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 2011. The plan will need to submit 14 improvement plans for its 2011 performance in 2012, as opposed to submitting nine improvement plans in 2011. This shows that the plan has an urgent opportunity to address the declining performance.

Adolescent Well-Care Visits continued to be the measure with the lowest performance. San Diego County was the lowest-performing county with four measures below the MPL. Health Net has the opportunity to modify its HEDIS improvement plan interventions and implement a rapid-cycle of improvement to allow the plan to continue successful interventions and eliminate efforts that did not result in improvement.

Conducting the Review

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

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

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

Findings

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

Quality Improvement Projects Conducted

Health Net had two clinical QIPs in progress during the review period of July 1, 2010–June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS's statewide collaborative QIP. The second QIP focused on improving the cervical cancer screening rates among seniors and persons with disabilities. Both QIPs fell under the quality and access domains of care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a PCP in an office or clinic setting. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

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.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for both QIPs across CMS protocol activities during the review period. HSAG validated QIPs at the county level beginning July 1, 2010, for new QIP projects and validated existing projects at the overall plan level; therefore, HSAG validated one QIP submission for the *Reducing Avoidable Emergency Room Visits* QIP and seven county-level QIP submissions for the *Cervical Cancer Screening* QIP. For the current submission, each county received the same score for the *Cervical Cancer Screening* QIP.

Table 4.1—Quality Improvement Project Validation Activity for Health Net—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, Tulare Counties (Number = 8 QIPs, 2 QIP Topics) July 1, 2010, through June 30, 2011

Name of Project/Study	County	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)	All Counties	Annual Submission	95%	100%	*Met*
Internal QIPs					
Improving Cervical Cancer Screening Among Seniors and Persons With Disabilities (Individual County Rates)	All Counties	Annual Submission	100%	100%	*Met*

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

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

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

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

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that the initial submissions by Health Net of its *Reducing Avoidable Emergency Room Visits* QIP and its *Improving Cervical Cancer Screening Among Seniors and Persons with Disabilities* QIPs all received an overall validation status of *Met*. Based on the validation feedback, the plan was not required to resubmit these QIPs.

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

Table 4.2—Quality Improvement Project Average Rates* for Health Net—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, Tulare Counties (Number = 8 QIPs, 2 QIP Topics) July 1, 2010, through June 30, 2011

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection†	98%	3%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**98%**	**2%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved†	100%	0%	0%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total		**98%**	**0%**	**2%**

*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 for the *Reducing Avoidable Emergency Room Visits* QIP and seven county-level QIP submissions for the *Cervical Cancer Screening* QIP. Health Net submitted Remeasurement 2 data for the *Reducing Avoidable Emergency Room Visits* QIP; therefore, HSAG validated Activity I through Activity X. For the *Cervical Cancer Screening* QIP, the plan submitted only baseline data, so HSAG assessed Activities I through VIII.

Health Net demonstrated an excellent understanding of the design and implementation stages, scoring 100 percent on all applicable evaluation elements for five of the six applicable activities. For the outcomes stage, Health Net correctly analyzed and interpreted the results for the two QIP topics. Additionally, the plan demonstrated improvement for its *Reducing Avoidable Emergency Room Visits* QIP outcome. Health Net was scored lower in Activity X for the plan's inability to achieve sustained improvement for its *Reducing Avoidable Emergency Room Visits* QIP. Sustained

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

Quality Improvement Project Outcomes

Table 4.3 summarizes 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, Tulare Counties (Number = 8 QIPs, 2 QIP Topics) July 1, 2010, through June 30, 2011

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%***	**21.2%***	**No**
	Fresno	17.4%	22.2%*	19.8%*	No
	Kern	15.3%	21.5%*	21.7%	No
	Los Angeles	15.5%	21.7%*	21.7%	No
	Sacramento	15.9%	19.0%*	18.8%	No
	San Diego	16.2%	20.5%*	17.8%*	No
	Stanislaus	14.5%	23.5%*	23.3%	No
	Tulare	19.4%	22.5%*	22.1%	No

Table 4.3—Quality Improvement Project Outcomes for Health Net—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, Tulare Counties (Number = 8 QIPs, 2 QIP Topics) July 1, 2010, through June 30, 2011

QIP #2—Improving Cervical Cancer Screening among Seniors and Persons with Disabilities					
QIP Study Indicator	**County^**	**Baseline Period (1/1/09–12/31/09)**	**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**	**47.5%**	**‡**	**‡**	**‡**
	Fresno	40.2%	‡	‡	‡
	Kern	40.9%	‡	‡	‡
	Los Angeles	50.8%	‡	‡	‡
	Sacramento	39.6%	‡	‡	‡
	San Diego	42.1%	‡	‡	‡
	Stanislaus	44.7%	‡	‡	‡
	Tulare	40.6%	‡	‡	‡

†The county-specific rates are provided for informational purposes since only the overall rate was included in the validation.
^The overall rate is provided for informational purposes since only the county-specific rates were included in the validation.
¥ Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.
*A statistically significant difference between the measurement period and the prior measurement period (p value < 0.05).
‡The QIP did not progress to this phase during the review period and could not be assessed.

Collaborative interventions were initiated in early 2009 and corresponded to Health Net's statistically significant decrease in avoidable ER visits for the overall rate from Remeasurement 1 to Remeasurement 2, which was an increase in the performance for this measure. However, the plan did not achieve sustained improvement since the Remeasurement 2 rate remained above the baseline rate. The plan attributed the lack of improvement for the overall rate to the high number of new members who had not yet established a primary care provider. Only Fresno and San Diego counties demonstrated statistically significant improvement from Remeasurement 1 to Remeasurement 2. None of the counties achieved sustained improvement from baseline to Remeasurement 2.

Health Net had not progressed to the point of reporting remeasurement data for the county-level *Cervical Cancer Screening* QIPs, so HSAG could not assess for real and sustained improvement. Health Net plans on implementing provider and member interventions; however, the plan did not identify county-specific barriers and interventions.

Strengths

The plan demonstrated a greater proficiency with QIP validation during the review period. Overall, Health Net's documentation in its *Reducing Avoidable Emergency Room Visits* QIP and *Cervical Cancer Screening* QIP was sufficient to meet evaluation element criteria for producing a valid QIP without requiring any resubmissions.

Through its QIP validation findings, Health Net accurately provided the documentation to support its QIP study design and implementation of improvement strategies. In addition, the plan showed that real improvement was achieved with a statistically significant increase for its *Reducing Avoidable Emergency Room Visits* QIP study indicator for the second remeasurement period.

Opportunities for Improvement

For the next submission of its *Cervical Cancer Screening* QIP, Health Net should appropriately conduct all county-specific activities including identification of barriers, implementation of interventions, statistical testing between measurement periods, and interpretation of 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. The plan should evaluate the efficacy of its interventions and revise or implement new interventions as needed to sustain improvement in this area.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

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

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

Overall, Health Net demonstrated average performance for the quality domain of care based on 2011 performance measure rates (reflecting the measurement period of January 1, 2010, through December 31, 2010), QIP outcomes, and medical performance review results related to measurement and improvement.

Across Health Net's seven counties, a majority of the performance measures fell between the MPLs and HPLs; therefore, the plan exhibited average performance. Diabetes care continued to be an area of strength and concern for Health Net as the plan reached the MPLs for all of the comprehensive diabetes care-related performance measures across all seven counties. Despite the noted strength, in all seven counties there was at least one statistically significant decrease for a diabetes measure, and San Diego County had a statistically significant decrease in six of the eight diabetes measures; therefore, the plan has opportunities to ensure that its performance does not continue in the direction of decreased performance.

Medical performance review results showed 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. MRPIU results indicated that Health Net's policies and procedures were not in compliance with Medi-Cal requirements and must be updated to include a

clear and concise explanation of plan decisions, and must ensure that medical information is not released to anyone other than the member or an authorized representative.

In its QIP outcomes, Health Net's documentation in its *Reducing Avoidable Emergency Room Visits* QIP and *Cervical Cancer Screening* QIP was sufficient to meet evaluation element criteria for producing a valid QIP without requiring any resubmissions.

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 below-average performance for the access domain of care based on 2010 performance measure rates related to access, QIP outcomes that address access, and medical performance review results related to availability and access to care.

Across the seven counties, *Adolescent Well-Care Visits* and *Breast Cancer Screening* were the most frequent measures to fall below the MPL. The plan had a decline in performance between 2010 and 2011.

Through its QIP validation findings, Health Net accurately provided the documentation to support its QIP study design and implementation of improvement strategies. In addition, the plan showed that real improvement was achieved with a statistically significant increase for its *Reducing Avoidable Emergency Room Visits* QIP study indicator for the second remeasurement period.

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 2010 performance measure rates related to providing timely care and medical performance review standards related to timelines. The *Adolescent Well-Care Visits* measure fell below the MPL in three of seven counties. The *Prenatal and Postpartum Care—Postpartum Care* measure fell below the MPL in one county. The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure exceeded the HPL in three counties. Across all seven counties, most measures met the MPL or HPL.

The DHCS's Medical Performance Audit and the MRPIU review results showed that the plan was fully compliant in standards pertaining to timeliness.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 plan-specific evaluation report. Health Net's self-reported responses are included in Appendix A.

Conclusions and Recommendations

In the next annual review, HSAG will evaluate Health Net's progress with these recommendations along with its continued successes. Based on the overall assessment of Health Net in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following:

- Work with the DHCS to resolve the outstanding issue regarding State regulations for denied, modified, or deferred claims.
- Update policies and procedures in the area of grievances for the MRPIU audit.
- Determine factors that contributed to the decline in performance measure rates, including 23 statistically significant declines between 2010/2011, and develop a plan for improvement.

- Enhance the quality and effectiveness of its HEDIS improvement plans to avoid having repeat measures on improvement plans.
- Conduct all county-specific activities including identification of barriers, implementation of interventions, statistical testing between measurement periods, and interpretation of results in the next submission of its *Cervical Cancer Screening* QIP.
- Implement interventions that would address the barriers associated with new members' use of the ER for the *Reducing Avoidable Emergency Room Visits* QIP.
- Evaluate the efficacy of its interventions and revise or implement new interventions as needed to sustain improvement in the area of ER utilization reduction.

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

for Health Net Community Solutions

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

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

2009–2010 EQR Recommendation	Health Net's Self-Reported Actions That Address the EQR Recommendation
Continue to work with the DHCS to resolve the disputed audit finding regarding notification to members for denied, modified, or deferred claims.	In regards to the member notification finding, Health Net continues to request further review and reconsideration of the finding by 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.
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.	Barriers that contributed to the decline in the performance for *Adolescent Well Care Visits* were limited access to medical record in San Diego PPGs' offices and lack of incentives for members to submit for the adolescent well visit since they are healthy. To address medical record access in San Diego County, the contracting team will assist in ammending contracts with PPG to include contractual obligation to allow access to charts. In November 2011, the Health Net medical directors and provider network management met with noncompliant providers to address their contractually required compliance to allow access to medical records for QI, compliance, and HEDIS. Similarly, PPGs are encouraged to submit electronic data. In addition, incentive programs were initiated to encourage teens to have a well-child visit. In Kern and Stanislaus counties. Teens who had well-child visits are offered two movie tickets. Teens who had a well-child visit are included in the weekly raffle for a $20.00 gift card in Kern, Stanislaus and San Diego counties. Similarly, providers who submit a completed CHDP PM160 form after an adolescent well-care visit are awarded $35.00 for completing the form in Kern and Stanislaus counties, and plans are to expand the program to San Diego county in 2012.
Determine whether previous interventions used to successfully improve *Breast Cancer Screening* measure rates can be applied to Kern and San Diego counties.	It has been noted that the incentive program for adolescent well-care visits seems to improve results. Consequently, Health Net is initiating the $100.00 gift certificate for members that obtain BCS in 2012 in Kern and San Diego counties. In addition, the multiple interventions that include member newsletter, IVR reminder call for those who are due for mammogram, and distribution of the revised Well Woman Screening Pad to providers to remind their patients for breast cancer screening will continue.

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

2009–2010 EQR Recommendation	Health Net's Self-Reported Actions That Address the EQR Recommendation
Document QIP activities at the county-specific level including the identification of barriers, implementation of interventions, statistical testing between measurement periods, and interpretation of results.	As noted in the supporting ER and SPD-CCS QIP reports, barriers, interventions, and statistical testing were performed in each measurement period and results were analyzed by each of Health Net's Medi-Cal Managed Care contracted counties. Barriers and interventions were similar to all counties.
Increase quality improvement resources to Kern County until performance is meeting DHCS's requirements.	Please see the adolescent well-care visit and breast cancer screening section responses. Initiatives and resources were increased with the goal of improving quality outcomes in Kern county (i.e., Healthy Women Gift Certificate weekly raffle for $100.00).
Explore implementation interventions that would address barriers associated with new members' use of the ER as a strategy for decreasing avoidable ER visits.	ER utilization was noted to have increased in counties with an increase of new membership. To address the ER utilization increase among new members, Health Net developed a flyer and enclosed one in the member packet mailed to all new members. The flyer informs Health Net new members of the availability of the Nurse Advice Line (NAL) which they can call 24 hours a day, seven days a week, for any questions about their health. The NAL telephone number is prominently printed in the flyer. Similarly, the member newsletter prominently shows the NAL telephone number on every issue. In addition, PCPs are provided NAL information flyers and NAL brochures to share with their members; the flyers are distributed to the PCPs in person by Health Net Community Solutions Specialists. Sharing the flyers and brochures offers an opportunity for providers to educate their patients on what to do when the office is closed. PCPs are educated about after-hour information to provide to members on their answering machines. Health Net developed answering machine after-hours script for PCPs in 12 languages.