

Performance Evaluation Report
Health Net Community Solutions, Inc.
July 1, 2011–June 30, 2012

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

June 2013



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Performance Evaluation Report – Health Net Community Solutions, Inc.

July 1, 2011 – June 30, 2012

1. INTRODUCTION

Purpose of Report

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

The Code of Federal Regulations (CFR) at 42 CFR §438.364² requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

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

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

¹ *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: January 17, 2013.

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

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

This report is specific to DHCS's contracted plan, Health Net Community Solutions, Inc. ("Health Net" or "the plan"), which delivers care in Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

Plan Overview

Health Net, also known as Health Net Community Solutions, is a full-scope 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. In addition to being a full-scope managed care plan, Health Net has an administrative services agreement in place with CalViva Health (CalViva), which operates in Fresno, Kings, and Madera counties. As part of the administrative services agreement, CalViva uses Health Net to perform many functions of the health plan such as claims processing network management, calculation of performance measures, etc. While the administrative functions are handled by Health Net, DHCS has a separate and distinct contract with CalViva, and CalViva is viewed as a separate and distinct Medi-Cal managed care plan; therefore, data for services provided by CalViva are included in CalViva's plan-specific evaluation report.

Health Net serves members in Kern, Los Angeles, Stanislaus, and Tulare counties under the Two-Plan Model. The plan also served members in Fresno County until March 2011 under the Two-Plan Model. In a Two-Plan Model county, DHCS contracts with two managed care plans to provide medical services to Medi-Cal beneficiaries. Most Two-Plan Model counties offer a Local Initiative (LI) plan and a nongovernmental, commercial health plan. Health Net serves the four counties listed above as a commercial plan.

Health Net serves members in Sacramento and San Diego counties under the Geographic Managed Care (GMC) model. In the GMC model, DHCS contracts with several commercial health plans within a specified geographic area. This provides MCMC enrollees with more choices.

Health Net became operational in Sacramento County to provide MCMC services in 1996 and then expanded into its additional contracted counties. As of June 30, 2012, Health Net had 717,718 MCMC members for all of its contracted counties combined.³

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

2. HEALTH PLAN STRUCTURE AND OPERATIONS

for Health Net Community Solutions, Inc.

Conducting the Review

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

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

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

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

Assessing Structure and Operations

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

The last medical performance review was conducted by A&I in May 2008, covering the review period of May 1, 2007, through April 30, 2008. The findings from this review were reported in Health Net's 2009–2010 plan-specific report.⁴

As previously reported, 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.

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. Deficiencies needing attention were in the Access and Availability category.

Since the medical performance audit was conducted more than three years prior to the review period for this report, HSAG includes a summary of the findings in this report for historical purposes of the most recent audit; however, HSAG does not include these outdated results when assessing overall plan performance during the review period. As part of the development of this report, HSAG reviewed documentation from the plan to determine what actions the plan has taken to resolve the outdated deficiencies and, when applicable, HSAG has included a description of those actions. A summary of each deficiency and actions the plan has taken is provided below.

Deficiency

Health Net had not fully resolved issues regarding securing access to a dermatology specialist group in Fresno and Stanislaus counties. Although the plan indicated that it expected to execute contracts with specialists in these counties by the end of April 2009, no evidence was submitted that the contracts were executed.

Plan Response:

Although Health Net did not submit documentation showing that this specific issue had been resolved, HSAG's review of the plan's 2012 Quality Improvement Program Description document revealed that the plan has established access to care standards for health care services that are applicable to each state and line of business. This includes standards for availability of practitioners, providers and health care facilities including primary care physicians, and specialty care physicians.

⁴ 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/MMCDQualPerfMsRpts.aspx>.

Member Rights and Program Integrity Review

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

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

MR/PIU conducted an on-site review of Health Net in June 2009, covering the review period of June 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. HSAG initially reported on the findings from this review in Health Net's 2008–2009 plan-specific evaluation report,⁵ and updates regarding the finding in the area of grievances were included in the plan's subsequent years' plan-specific evaluation reports. Health Net was not required by MR/PIU to respond to the finding, and MR/PIU will follow up with the plan on the finding during its next review. Following is a description of the finding:

In the area of grievances, Health Net's policies and procedures were not in compliance with the Medi-Cal requirements that resolution letters must contain a clear and concise explanation of the plan's decision and that the plan must ensure that medical information is not released to anyone other than the member or an authorized representative.

⁵ *Performance Evaluation Report—Health Net Community Solutions—July 1, 2008 – June 30, 2009*. California Department of Health Care Services. December 2010. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>

As part of the plan-specific evaluation report process, Health Net provided documentation to HSAG that indicated the required revisions were made to the plan's policies and procedures to ensure the grievance resolution letters contain the required information and that it is clear medical information should not be released to anyone other than the member or an authorized representative.

MR/PIU's follow-up with the plan will be included in Health Net's 2012–2013 plan-specific evaluation report.

Strengths

Health Net appears to have addressed the finding identified by MR/PIU in the area of grievances by modifying the plan's policies and procedures to include all required information. Additionally, the plan established access to care standards for health care services to ensure member access to needed care.

Opportunities for Improvement

Health Net should ensure that it provides documentation to DHCS showing that the plan has secured access to a dermatology specialist group in Stanislaus County. Since the plan is no longer providing services in Fresno County, evidence of an executed contract in Fresno County is no longer applicable.

Conducting the Review

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

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

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

Validating Performance Measures and Assessing Results

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

Performance Measure Validation

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)⁶ measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of Health Net in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

Performance Measure Validation Findings

The audit showed that the plan followed the appropriate specifications to produce valid rates, and there were no identified areas of concern.

⁶ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

After validating the plan's performance measure rates, HSAG assessed the results. The following table displays a performance measure name key with abbreviations contained in Tables 3.2 through 3.7.

Table 3.1—Performance Measures Name Key

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

Tables 3.2 through 3.7 present a summary of Health Net's HEDIS 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The table shows the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

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

Table 3.2—Comparison of 2011 and 2012 Performance Measure Results for Health Net Community Solutions, Inc.—Kern County

Performance Measure ¹	Domain of Care ²	2011 HEDIS Rates ³	2012 HEDIS Rates ⁴	Performance Level for 2012	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	18.2%	17.2%	★	↔	18.8%	31.6%
AMB-ED	‡	--	47.5	--	Not Comparable	--	--
AMB-OP	‡	--	269.4	--	Not Comparable	--	--
AWC	Q,A,T	38.0%	49.9%	★★	↑	39.6%	64.1%
CAP-1224	A	--	93.8%	--	Not Comparable	--	--
CAP-256	A	--	80.8%	--	Not Comparable	--	--
CAP-711	A	--	78.2%	--	Not Comparable	--	--
CAP-1219	A	--	81.2%	--	Not Comparable	--	--
CCS	Q,A	63.7%	67.2%	★★	↔	64.0%	78.7%
CDC-BP	Q	58.4%	65.8%	★★	↑	54.3%	76.0%
CDC-E	Q,A	50.2%	54.0%	★★	↔	43.8%	70.6%
CDC-H8 (<8.0%)	Q	40.6%	40.9%	★★	↔	39.9%	59.1%
CDC-H9 (>9.0%)	Q	48.8%	50.6%	★★	↔	52.1%	29.1%
CDC-HT	Q,A	79.1%	78.5%	★★	↔	77.6%	90.9%
CDC-LC (<100)	Q	36.5%	35.6%	★★	↔	27.3%	45.9%
CDC-LS	Q,A	76.4%	73.2%	★★	↔	70.4%	84.2%
CDC-N	Q,A	82.7%	83.1%	★★	↔	73.9%	86.9%
CIS-3	Q,A,T	70.4%	71.3%	★★	↔	64.4%	82.6%
IMA-1	Q,A,T	--	60.6%	--	Not Comparable	--	--
LBP	Q	73.5%	75.3%	★★	↔	72.3%	82.3%
MPM-ACE	Q	--	77.7%	--	Not Comparable	--	--
MPM-DIG	Q	--	NA	--	Not Comparable	--	--
MPM-DIU	Q	--	79.6%	--	Not Comparable	--	--
PPC-Pre	Q,A,T	86.3%	89.5%	★★	↔	80.3%	93.2%
PPC-Pst	Q,A,T	62.4%	62.4%	★★	↔	59.6%	75.2%
W-34	Q,A,T	72.0%	69.2%	★★	↔	66.1%	82.9%
WCC-BMI	Q	53.2%	55.3%	★★	↔	19.7%	69.8%
WCC-N	Q	69.7%	71.2%	★★	↔	39.0%	72.0%
WCC-PA	Q	41.7%	51.2%	★★	↑	28.5%	60.6%

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

Table 3.3—Comparison of 2011 and 2012 Performance Measure Results for Health Net Community Solutions, Inc.—Los Angeles County

Performance Measure ¹	Domain of Care ²	2011 HEDIS Rates ³	2012 HEDIS Rates ⁴	Performance Level for 2012	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	20.2%	21.4%	★★	↔	18.8%	31.6%
AMB-ED	‡	--	33.0	--	Not Comparable	--	--
AMB-OP	‡	--	241.2	--	Not Comparable	--	--
AWC	Q,A,T	46.2%	55.4%	★★	↑	39.6%	64.1%
CAP-1224	A	--	96.1%	--	Not Comparable	--	--
CAP-256	A	--	88.2%	--	Not Comparable	--	--
CAP-711	A	--	88.0%	--	Not Comparable	--	--
CAP-1219	A	--	85.9%	--	Not Comparable	--	--
CCS	Q,A	69.5%	68.4%	★★	↔	64.0%	78.7%
CDC-BP	Q	63.9%	67.5%	★★	↔	54.3%	76.0%
CDC-E	Q,A	55.3%	58.8%	★★	↔	43.8%	70.6%
CDC-H8 (<8.0%)	Q	46.3%	48.5%	★★	↔	39.9%	59.1%
CDC-H9 (>9.0%)	Q	40.7%	39.8%	★★	↔	52.1%	29.1%
CDC-HT	Q,A	84.0%	83.5%	★★	↔	77.6%	90.9%
CDC-LC (<100)	Q	37.3%	37.4%	★★	↔	27.3%	45.9%
CDC-LS	Q,A	80.8%	76.5%	★★	↔	70.4%	84.2%
CDC-N	Q,A	86.6%	82.4%	★★	↔	73.9%	86.9%
CIS-3	Q,A,T	77.1%	87.6%	★★★	↑	64.4%	82.6%
IMA-1	Q,A,T	--	65.0%	--	Not Comparable	--	--
LBP	Q	80.0%	81.1%	★★	↔	72.3%	82.3%
MPM-ACE	Q	--	74.0%	--	Not Comparable	--	--
MPM-DIG	Q	--	77.0%	--	Not Comparable	--	--
MPM-DIU	Q	--	74.1%	--	Not Comparable	--	--
PPC-Pre	Q,A,T	86.6%	83.6%	★★	↔	80.3%	93.2%
PPC-Pst	Q,A,T	58.2%	52.3%	★	↔	59.6%	75.2%
W-34	Q,A,T	79.1%	83.1%	★★★	↔	66.1%	82.9%
WCC-BMI	Q	63.6%	71.5%	★★★	↑	19.7%	69.8%
WCC-N	Q	71.3%	79.9%	★★★	↑	39.0%	72.0%
WCC-PA	Q	53.7%	63.7%	★★★	↑	28.5%	60.6%

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

Table 3.4—Comparison of 2011 and 2012 Performance Measure Results for Health Net Community Solutions, Inc.—Sacramento County

Performance Measure ¹	Domain of Care ²	2011 HEDIS Rates ³	2012 HEDIS Rates ⁴	Performance Level for 2012	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	28.5%	20.2%	★★	↔	18.8%	31.6%
AMB-ED	‡	--	38.1	--	Not Comparable	--	--
AMB-OP	‡	--	241.0	--	Not Comparable	--	--
AWC	Q,A,T	44.5%	53.8%	★★	↑	39.6%	64.1%
CAP-1224	A	--	95.4%	--	Not Comparable	--	--
CAP-256	A	--	84.7%	--	Not Comparable	--	--
CAP-711	A	--	84.2%	--	Not Comparable	--	--
CAP-1219	A	--	83.6%	--	Not Comparable	--	--
CCS	Q,A	59.5%	69.3%	★★	↑	64.0%	78.7%
CDC-BP	Q	59.6%	62.9%	★★	↔	54.3%	76.0%
CDC-E	Q,A	45.6%	48.4%	★★	↔	43.8%	70.6%
CDC-H8 (<8.0%)	Q	49.2%	52.8%	★★	↔	39.9%	59.1%
CDC-H9 (>9.0%)	Q	40.0%	35.9%	★★	↔	52.1%	29.1%
CDC-HT	Q,A	83.8%	83.6%	★★	↔	77.6%	90.9%
CDC-LC (<100)	Q	37.8%	33.6%	★★	↔	27.3%	45.9%
CDC-LS	Q,A	76.4%	73.9%	★★	↔	70.4%	84.2%
CDC-N	Q,A	81.6%	82.6%	★★	↔	73.9%	86.9%
CIS-3	Q,A,T	67.3%	69.6%	★★	↔	64.4%	82.6%
IMA-1	Q,A,T	--	54.6%	--	Not Comparable	--	--
LBP	Q	87.8%	87.5%	★★★	↔	72.3%	82.3%
MPM-ACE	Q	--	59.3%	--	Not Comparable	--	--
MPM-DIG	Q	--	NA	--	Not Comparable	--	--
MPM-DIU	Q	--	55.6%	--	Not Comparable	--	--
PPC-Pre	Q,A,T	87.9%	83.6%	★★	↔	80.3%	93.2%
PPC-Pst	Q,A,T	60.6%	60.8%	★★	↔	59.6%	75.2%
W-34	Q,A,T	81.8%	78.2%	★★	↔	66.1%	82.9%
WCC-BMI	Q	67.9%	69.5%	★★	↔	19.7%	69.8%
WCC-N	Q	73.5%	77.6%	★★★	↔	39.0%	72.0%
WCC-PA	Q	41.6%	52.7%	★★	↑	28.5%	60.6%

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

Table 3.5—Comparison of 2011 and 2012 Performance Measure Results for Health Net Community Solutions, Inc.—San Diego County

Performance Measure ¹	Domain of Care ²	2011 HEDIS Rates ³	2012 HEDIS Rates ⁴	Performance Level for 2012	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	18.1%	18.5%	★	↔	18.8%	31.6%
AMB-ED	‡	--	44.1	--	Not Comparable	--	--
AMB-OP	‡	--	258.6	--	Not Comparable	--	--
AWC	Q,A,T	37.1%	45.7%	★★	↑	39.6%	64.1%
CAP-1224	A	--	94.0%	--	Not Comparable	--	--
CAP-256	A	--	85.8%	--	Not Comparable	--	--
CAP-711	A	--	85.4%	--	Not Comparable	--	--
CAP-1219	A	--	83.0%	--	Not Comparable	--	--
CCS	Q,A	58.1%	66.3%	★★	↑	64.0%	78.7%
CDC-BP	Q	53.8%	64.4%	★★	↑	54.3%	76.0%
CDC-E	Q,A	47.4%	51.9%	★★	↔	43.8%	70.6%
CDC-H8 (<8.0%)	Q	42.0%	48.3%	★★	↔	39.9%	59.1%
CDC-H9 (>9.0%)	Q	46.5%	41.5%	★★	↔	52.1%	29.1%
CDC-HT	Q,A	84.6%	84.5%	★★	↔	77.6%	90.9%
CDC-LC (<100)	Q	31.4%	35.6%	★★	↔	27.3%	45.9%
CDC-LS	Q,A	73.4%	76.3%	★★	↔	70.4%	84.2%
CDC-N	Q,A	82.2%	78.6%	★★	↔	73.9%	86.9%
CIS-3	Q,A,T	69.8%	77.3%	★★	↑	64.4%	82.6%
IMA-1	Q,A,T	--	65.3%	--	Not Comparable	--	--
LBP	Q	74.1%	77.4%	★★	↔	72.3%	82.3%
MPM-ACE	Q	--	78.1%	--	Not Comparable	--	--
MPM-DIG	Q	--	NA	--	Not Comparable	--	--
MPM-DIU	Q	--	77.6%	--	Not Comparable	--	--
PPC-Pre	Q,A,T	88.8%	83.4%	★★	↓	80.3%	93.2%
PPC-Pst	Q,A,T	62.5%	54.8%	★	↓	59.6%	75.2%
W-34	Q,A,T	72.8%	70.0%	★★	↔	66.1%	82.9%
WCC-BMI	Q	51.3%	67.6%	★★	↑	19.7%	69.8%
WCC-N	Q	61.3%	67.8%	★★	↑	39.0%	72.0%
WCC-PA	Q	43.1%	49.6%	★★	↔	28.5%	60.6%

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

Table 3.6—Comparison of 2011 and 2012 Performance Measure Results for Health Net Community Solutions, Inc.—Stanislaus County

Performance Measure ¹	Domain of Care ²	2011 HEDIS Rates ³	2012 HEDIS Rates ⁴	Performance Level for 2012	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	26.5%	29.6%	★★	↔	18.8%	31.6%
AMB-ED	‡	--	49.4	--	Not Comparable	--	--
AMB-OP	‡	--	349.9	--	Not Comparable	--	--
AWC	Q,A,T	32.9%	42.6%	★★	↑	39.6%	64.1%
CAP-1224	A	--	97.2%	--	Not Comparable	--	--
CAP-256	A	--	88.9%	--	Not Comparable	--	--
CAP-711	A	--	87.9%	--	Not Comparable	--	--
CAP-1219	A	--	85.9%	--	Not Comparable	--	--
CCS	Q,A	64.0%	77.3%	★★	↑	64.0%	78.7%
CDC-BP	Q	67.8%	67.3%	★★	↔	54.3%	76.0%
CDC-E	Q,A	48.7%	50.0%	★★	↔	43.8%	70.6%
CDC-H8 (<8.0%)	Q	52.8%	53.1%	★★	↔	39.9%	59.1%
CDC-H9 (>9.0%)	Q	37.1%	36.5%	★★	↔	52.1%	29.1%
CDC-HT	Q,A	82.0%	84.6%	★★	↔	77.6%	90.9%
CDC-LC (<100)	Q	37.4%	39.3%	★★	↔	27.3%	45.9%
CDC-LS	Q,A	75.4%	76.1%	★★	↔	70.4%	84.2%
CDC-N	Q,A	82.0%	77.0%	★★	↔	73.9%	86.9%
CIS-3	Q,A,T	67.8%	68.5%	★★	↔	64.4%	82.6%
IMA-1	Q,A,T	--	54.2%	--	Not Comparable	--	--
LBP	Q	77.6%	83.8%	★★★	↔	72.3%	82.3%
MPM-ACE	Q	--	75.9%	--	Not Comparable	--	--
MPM-DIG	Q	--	NA	--	Not Comparable	--	--
MPM-DIU	Q	--	79.8%	--	Not Comparable	--	--
PPC-Pre	Q,A,T	93.2%	91.5%	★★	↔	80.3%	93.2%
PPC-Pst	Q,A,T	62.3%	60.1%	★★	↔	59.6%	75.2%
W-34	Q,A,T	75.6%	71.1%	★★	↔	66.1%	82.9%
WCC-BMI	Q	55.2%	58.7%	★★	↔	19.7%	69.8%
WCC-N	Q	63.3%	65.8%	★★	↔	39.0%	72.0%
WCC-PA	Q	41.1%	40.2%	★★	↔	28.5%	60.6%

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

Table 3.7—Comparison of 2011 and 2012 Performance Measure Results for Health Net Community Solutions, Inc.—Tulare County

Performance Measure ¹	Domain of Care ²	2011 HEDIS Rates ³	2012 HEDIS Rates ⁴	Performance Level for 2012	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	17.5%	22.8%	★★	↔	18.8%	31.6%
AMB-ED	‡	--	39.3	--	Not Comparable	--	--
AMB-OP	‡	--	386.7	--	Not Comparable	--	--
AWC	Q,A,T	42.9%	58.5%	★★	↑	39.6%	64.1%
CAP-1224	A	--	97.3%	--	Not Comparable	--	--
CAP-256	A	--	92.2%	--	Not Comparable	--	--
CAP-711	A	--	92.8%	--	Not Comparable	--	--
CAP-1219	A	--	91.5%	--	Not Comparable	--	--
CCS	Q,A	77.7%	78.8%	★★★	↔	64.0%	78.7%
CDC-BP	Q	71.3%	67.5%	★★	↔	54.3%	76.0%
CDC-E	Q,A	56.4%	56.8%	★★	↔	43.8%	70.6%
CDC-H8 (<8.0%)	Q	48.6%	47.9%	★★	↔	39.9%	59.1%
CDC-H9 (>9.0%)	Q	41.7%	43.4%	★★	↔	52.1%	29.1%
CDC-HT	Q,A	86.5%	83.0%	★★	↔	77.6%	90.9%
CDC-LC (<100)	Q	32.2%	36.6%	★★	↔	27.3%	45.9%
CDC-LS	Q,A	77.5%	76.2%	★★	↔	70.4%	84.2%
CDC-N	Q,A	82.9%	82.8%	★★	↔	73.9%	86.9%
CIS-3	Q,A,T	76.3%	78.9%	★★	↔	64.4%	82.6%
IMA-1	Q,A,T	--	61.8%	--	Not Comparable	--	--
LBP	Q	73.1%	82.7%	★★★	↑	72.3%	82.3%
MPM-ACE	Q	--	83.6%	--	Not Comparable	--	--
MPM-DIG	Q	--	NA	--	Not Comparable	--	--
MPM-DIU	Q	--	79.7%	--	Not Comparable	--	--
PPC-Pre	Q,A,T	93.2%	93.8%	★★★	↔	80.3%	93.2%
PPC-Pst	Q,A,T	68.4%	67.9%	★★	↔	59.6%	75.2%
W-34	Q,A,T	81.3%	77.3%	★★	↔	66.1%	82.9%
WCC-BMI	Q	73.4%	77.6%	★★★	↔	19.7%	69.8%
WCC-N	Q	66.7%	66.4%	★★	↔	39.0%	72.0%
WCC-PA	Q	49.2%	45.3%	★★	↔	28.5%	60.6%

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

Performance Measure Result Findings

Overall, Health Net demonstrated average performance across all six counties for 2012 reported performance measures. Across all counties, 12 measures performed above the HPLs, and 4 measures performed below the MPLs. All counties combined had 21 measures with statistically significant improvement in performance from 2011 to 2012 and 2 measures with statistically significant decline in performance. Los Angeles and Tulare counties had the strongest performance among Health Net's counties with the following performance measure results:

- ◆ Los Angeles County had five measures perform above the HPLs and one measure perform below the MPL. This county also had five measures with statistically significant improvement from 2011 to 2012.
- ◆ Tulare County had four measures perform above the HPLs and no measures perform below the MPLs. Two measures in this county had statistically significant improvement from 2011 to 2012.

As in 2011, San Diego County was the lowest-performing county. In 2012 this county had no measures above the HPLs and two measures below the MPLs. Although the lowest performer in terms of measure rates, San Diego County had the most measures (six) with statistically significant improvement from 2011 to 2012. Despite the noted improvement, this county was the only county that had measures with statistically significant decline in performance from 2011 to 2012.

Three counties (Sacramento, Stanislaus, and Tulare) performed above the HPLs on the *Use of Imaging Studies for Low Back Pain* measure. Los Angeles and San Diego counties performed below the MPLs on the *Prenatal and Postpartum Care—Postpartum Care* measure, and Kern and San Diego counties performed below the MPLs on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*.

HEDIS Improvement Plans

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

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

Health Net had six 2011 IPs in progress. Below is a summary of each IP and HSAG's analysis of the progress the plan made on improving performance on the measures.

Adolescent Well-Care Visits

Health Net was required to continue an IP for the *Adolescent Well-Care Visits* measure for three counties (Kern, San Diego, and Stanislaus). The plan identified several barriers and challenges that contributed to this measure performing below the MPLs, including:

- ◆ Adolescents tending to be healthy; therefore, parents and/or adolescents do not feel they need an annual well-care visit with their provider. Additionally, adolescents wanting privacy regarding their health conditions and not wanting to go to the provider with their parents also presented challenges.
- ◆ Physicians having limited resources to conduct member outreach for adolescent well-care visits.
- ◆ Difficulty collecting medical records in some physician groups' offices, especially in San Diego County in 2011.

To address the barriers and challenges, Health Net continued several strategies from the previous reporting period, including:

- ◆ Making reminder calls and sending postcard reminders to adolescents regarding scheduling their well-care visit.
- ◆ Including an article in the member newsletter on the importance of yearly adolescent well-care visits.

The plan also implemented new interventions, including:

- ◆ Offering an incentive to adolescents who attend their well-care appointment.
- ◆ Distributing tip sheets on preventive care to all providers that included information about the importance of adolescent well-care visits.
- ◆ Providing high-volume providers with monthly eligible/encounter reports that detailed which members were in need of their annual adolescent well-care visit.
- ◆ Providing incentives for providers in Kern and Stanislaus counties that submitted completed confidential screening/billing report (PM 160) forms, which include information on adolescent well-care visits.

The implemented interventions resulted in all three counties having statistically significant improvement on the *Adolescent Well-Care Visits* measure from 2011 to 2012 and rates above the MPL. Health Net will not have to continue this IP in 2013.

Appropriate Treatment for Children with Upper Respiratory Infection

Health Net was required to submit an IP for the *Appropriate Treatment for Children with Upper Respiratory Infection* measure for Los Angeles County, which was the only county that performed

below the MPL on this measure in 2011. The plan identified several barriers and challenges that contributed to this measure performing below the MPL, including:

- ◆ Patients pressuring providers to prescribe an antibiotic because they do not want to leave the provider's office empty-handed.
- ◆ Providers making the assumption that the upper respiratory infection is bacterial.
- ◆ Providers lacking effective ways to educate patients about viral versus bacterial infections.

To address the barriers and challenges, Health Net implemented the following interventions:

- ◆ Provider education including distribution of a provider toolkit that included clinical practice guidelines for acute bronchitis and upper respiratory infection care and appropriate antibiotic use.
- ◆ Distribution of Health Net prescription pads to providers that can be used to prescribe over-the-counter medications and instructions for home care of upper respiratory infections.
- ◆ Member education including an article in the member newsletter on appropriate treatment for children with upper respiratory infection.
- ◆ Quarterly mailings to providers that included a list of patients diagnosed with upper respiratory infection who were inappropriately prescribed antibiotics. Also included was the provider's rate of inappropriate antibiotic prescriptions compared to peers in their participating physician group and Health Net providers statewide.

Since this measure was not included in DHCS's EAS for calendar year 2011 reporting (HEDIS 2012), HSAG was unable to determine if the plan's efforts resulted in improved performance on this measure.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Health Net was required to continue an IP for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure for Kern, San Diego, and Tulare counties in 2012. The plan identified the following barriers and challenges that contributed to this measure performing below the MPLs:

- ◆ Patients pressuring providers to prescribe an antibiotic because they do not want to leave the provider's office empty-handed.
- ◆ Providers needing more effective ways to educate patients about viral versus bacterial infections.

To address the barriers and challenges, Health Net continued several strategies from the previous reporting period, including:

- ◆ Participating in the Alliance Working for Antibiotic Resistance Education (AWARE) collaborative that sends providers toolkits about appropriate antibiotic use. Health Net also

collaborated with AWARE to revise the clinical practice guidelines included in the toolkit to update the antibiotic treatment recommendations.

- ◆ Supplying physicians with member educational materials to assist with educating members about appropriate antibiotic use and treatment for bronchitis.
- ◆ Distributing an over-the-counter prescription pad to providers to use to inform members how to treat bronchitis at home without antibiotics.

The plan also implemented the following new intervention:

- ◆ Quarterly mailings to providers that included a list of patients diagnosed with bronchitis who were inappropriately prescribed antibiotics. Also included was a comparison of prescribing practices among all providers.

Review of the 2012 HEDIS rates revealed that Tulare County was able to improve its rate for this measure to above the MPL; however, the rates in Kern and San Diego counties remained below the MPL. Health Net will be required to continue the IP for this measure in Kern and San Diego counties in 2013.

Breast Cancer Screening

Although 2011 was the last year Medi-Cal plans were required to report *Breast Cancer Screening* HEDIS results, plans that performed below the MPLs on this measure in 2011 were still required to conduct an IP for the measure. Health Net was required to implement an IP for this measure in Kern, Sacramento, San Diego, and Tulare counties.

Health Net identified several barriers and challenges to performing above the MPLs on this measure, including:

- ◆ Members not realizing the importance of being screened for breast cancer or not being motivated to get screened.
- ◆ Physicians having limited resources for member education and outreach.
- ◆ Members being confused by conflicting breast cancer screening recommendations that are publicized through mass media outlets.
- ◆ Members not being aware that a mammogram is a free Health Net benefit.

To address the barriers and challenges, Health Net continued previously implemented interventions and added a new strategy in 2012. Continued interventions included conducting reminder calls and educating members and providers on the importance of breast cancer screening. Beginning in 2012, Health Net began sending a letter to women who were due for their mammogram informing them of an incentive program that entered them in a raffle if they had a mammogram performed in 2012.

Since this measure was not included in DHCS's EAS for calendar year 2011 reporting (HEDIS 2012), HSAG was unable to determine if the plan's efforts resulted in improved performance on this measure.

Cervical Cancer Screening

Sacramento and San Diego counties performed below the MPLs for the *Cervical Cancer Screening* measure in 2011, which resulted in Health Net being required to submit an IP for this measure in 2012. The plan identified several barriers and challenges that prevented Sacramento and San Diego counties from performing above the MPLs on this measure, including:

- ◆ Members not realizing the importance of being screened for cervical cancer or not being motivated to get screened.
- ◆ Physicians having limited resources for member outreach.
- ◆ Providers not being aware of which members are due for their Pap smear.
- ◆ Members not being aware that a Pap smear is a free Health Net benefit.

To address the barriers and challenges, Health Net implemented several strategies, including:

- ◆ Establishing a system to identify members due for Pap smears and using an automated Interactive Voice Response (IVR) call system to make reminder calls, and sending primary care providers (PCPs) the names of their patients who are due for Pap smears so appointments could be initiated by the PCPs.
- ◆ Educating members and providers on the importance of cervical cancer screening.
- ◆ Beginning in 2012, sending a letter to women who were due for their Pap smear informing them of an incentive program that entered them in a raffle if they had a Pap smear performed in 2012.

Health Net's improvement strategies were successful in bringing the rate for the *Cervical Cancer Screening* measure above the MPLs in Sacramento and San Diego counties in 2012. Health Net will not be required to submit an improvement plan for this measure in 2013.

Prenatal and Postpartum Care—Postpartum Care

Based on 2011 performance, Health Net had to submit an IP in Los Angeles County for the *Prenatal and Postpartum Care—Postpartum Care* measure. The plan identified several barriers and challenges that prevented Los Angeles County from performing above the MPL on this measure, including:

- ◆ Members feeling well after delivery and not feeling that follow-up is needed.
- ◆ Members who have had more than one baby thinking that they know how to take care of themselves and their baby.

- ◆ Lack of understanding of the importance of follow-up after delivery.
- ◆ Members who have had C-sections scheduling their incision site evaluation appointment within 10 days of delivery, which is outside of the postpartum care HEDIS specifications time frame for the *Postpartum Care* measure.

To address the barriers and challenges, Health Net implemented several interventions, including:

- ◆ Women confirmed to have given birth were sent a pregnancy packet. The packet included information on postpartum visits and breastfeeding.
- ◆ A Well Woman Pad was distributed to providers to disseminate to women aged 18 years and older. The note pad outlines the recommendations for diagnostic screenings, including postpartum care.
- ◆ An IVR call system was implemented that automatically contacted new mothers to remind them about scheduling their postpartum care visit.
- ◆ Information about the importance of postpartum care was included in the member newsletter.

The interventions did not have the desired effect. Although not statistically significant, Los Angeles County's rate for this measure declined in 2012 and performance remained below the MPL. Health Net will be required to continue the IP for this measure in Los Angeles County in 2013. Additionally, San Diego County had statistically significant decline in performance on the *Prenatal and Postpartum Care—Postpartum Care* measure, which moved the rate from performing above the MPL to below the MPL. Health Net will be required to include San Diego County in the plan's IP for this measure in 2013.

Strengths

Across all counties, 12 measures performed above the HPLs; and 21 measures had statistically significant improvement in performance from 2011 to 2012. Los Angeles and Tulare counties had the strongest performance among Health Net's counties. Los Angeles County had five measures perform above the HPLs and only one measure perform below the MPL. This county also had five measures with statistically significant improvement from 2011 to 2012. Tulare County had four measures perform above the HPLs and no measures perform below the MPLs. Two measures in this county had statistically significant improvement from 2011 to 2012. Although San Diego County was the lowest-performing county, it had the most measures (six) with statistically significant improvement from 2011 to 2012.

The IP for the *Adolescent Well-Care Visits* measure in Kern, San Diego, and Stanislaus counties resulted in all three counties having statistically significant improvement on the measure from 2011 to 2012 and rates above the MPLs in 2012. Additionally, the IP in Kern, San Diego, and

Tulare counties for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure resulted in improvement in Tulare County's rate to above the MPL in 2012. Finally, the IP for the *Cervical Cancer Screening* measure in Sacramento and San Diego counties resulted in both counties performing above the MPLs for this measure in 2012.

As in 2010 and 2011, Health Net performed above the MPLs for all diabetes-related measures across its counties in 2012, which showed the plan's continued ability to effectively manage a chronic disease such as diabetes, and provided evidence of 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 has the following opportunities for improvement:

- ◆ The plan should assess the factors that are impacting continued poor performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Prenatal and Postpartum Care—Postpartum Care* measures and modify IP interventions as appropriate to move performance to above the MPLs for the counties that continue to have poor performance.
- ◆ Health Net should assess the factors that led to San Diego County experiencing a statistically significant decline in performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and develop and implement strategies to prevent the rate on this measure from declining to below the MPL.

Conducting the Review

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

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

Validating Quality Improvement Projects and Assessing Results

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

Quality Improvement Project Objectives

Health Net had two clinical QIPs and one clinical QIP proposal in progress during the review period of July 1, 2011–June 30, 2012. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS's statewide collaborative QIP. The second QIP focused on improving the cervical cancer screening rates among seniors and persons with disabilities. Additionally, the plan participated in the new statewide *All-Cause Readmissions* collaborative which focused on reducing readmissions for members aged 21 years and older. All three QIPs fell under the quality and access domains of care.

The 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. At the initiation of the QIP, Health Net had identified 30,170 ER room visits that were avoidable, which was 21.9 percent of the plan's ER visits. Health Net's objective was to reduce this rate by using member,

provider, and system improvement strategies. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

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

For 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. Before the initiation of the QIP, the combined Seniors and Persons with Disabilities (SPD) eligible population for all seven counties was 7,981 members. The rate of cervical cancer screening for the eligible population ranged between 30.6 percent in Sacramento County to 40.4 percent in Los Angeles County. 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 QIP validation results and status across CMS protocol activities during the review period. 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 *Improve Cervical Cancer Screening among Seniors and Persons with Disabilities* QIP. For the current submission, each county received the same score for the *All-Cause Readmissions* QIP.

Table 4.1—Quality Improvement Project Validation Activity for Health Net Community Solutions, Inc.—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties July 1, 2011, through June 30, 2012

Name of Project/Study	County	Type of Review ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Overall Validation Status ⁴
Statewide Collaborative QIP					
<i>Reducing Avoidable Emergency Room Visits</i>	All counties combined	Annual Submission	97%	100%	<i>Met</i>
<i>All-Cause Readmissions*</i>	All counties received the same score	Proposal	Not Applicable	Not Applicable	<i>Pass</i>
Internal QIPs					
<i>Improve Cervical Cancer Screening among Seniors and Persons with Disabilities</i>	Fresno	Annual Submission	97%	100%	<i>Met</i>
	Kern	Annual Submission	95%	100%	<i>Met</i>
	Los Angeles	Annual Submission	89%	100%	<i>Met</i>
	Sacramento	Annual Submission	89%	100%	<i>Met</i>
	San Diego	Annual Submission	95%	100%	<i>Met</i>
	Stanislaus	Annual Submission	95%	100%	<i>Met</i>
	Tulare	Annual Submission	95%	100%	<i>Met</i>
<p>¹Type 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 <i>Met</i> validation status.</p> <p>²Percentage Score of Evaluation Elements <i>Met</i>—The percentage score is calculated by dividing the total elements <i>Met</i> (critical and noncritical) by the sum of the total elements of all categories (<i>Met</i>, <i>Partially Met</i>, and <i>Not Met</i>).</p> <p>³Percentage Score of Critical Elements <i>Met</i>—The percentage score of critical elements <i>Met</i> is calculated by dividing the total critical elements <i>Met</i> by the sum of the critical elements <i>Met</i>, <i>Partially Met</i>, and <i>Not Met</i>.</p> <p>⁴Overall Validation Status—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were <i>Met</i>, <i>Partially Met</i>, or <i>Not Met</i>.</p> <p>*During the review period, the <i>All-Cause Readmissions</i> QIP was reviewed as a <i>Pass/Fail</i> only, since the project was in its study design phase.</p>					

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 *Improve Cervical Cancer Screening among Seniors and Persons with Disabilities* QIP for each of the seven counties all received an overall validation status of *Met*. Based on the validation feedback, the plan was not required to resubmit these QIPs. For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

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

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

Table 4.2—Quality Improvement Project Average Rates* for Health Net Community Solutions, Inc.—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties (Number = 8 QIP Submissions, 2 QIP Topics) July 1, 2011, through June 30, 2012

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total		100%	0%	0%
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		100%	0%	0%
Outcomes	VIII: Sufficient Data Analysis and Interpretation	89%	11%	0%
	IX: Real Improvement Achieved	69%	0%	31%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total**		81%	7%	11%
*The activity average rate represents the average percentage of applicable elements with a <i>Met</i> , <i>Partially Met</i> , or <i>Not Met</i> finding across all the evaluation elements for a particular activity.				
**The stage and/or activity totals may not equal 100 percent due to rounding.				

Health Net submitted Remeasurement 3 data for the *Reducing Avoidable Emergency Room Visits* QIP; therefore, HSAG validated Activity I through Activity X. For the *Improve Cervical Cancer Screening among Seniors and Persons with Disabilities* QIP, the plan submitted Remeasurement 1 data; so HSAG assessed Activities I through IX.

Health Net demonstrated an excellent application of the design and implementation stages, scoring 100 percent on all applicable evaluation elements for all six applicable activities. For the outcomes stage, Health Net correctly analyzed and interpreted the results for the two QIP topics. Additionally, the plan demonstrated statistically significant improvement for its *Reducing Avoidable Emergency Room Visits* QIP outcome. However, the plan was scored lower in Activity IX for its *Improve Cervical Cancer Screening among Seniors and Persons with Disabilities* QIP, since the plan only reported statistically significant improvement for Fresno County. 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 and Interventions

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

Table 4.3—Quality Improvement Project Outcomes for Health Net Community Solutions, Inc.—Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties July 1, 2011, through June 30, 2012

QIP #1—Reducing Avoidable Emergency Room Visits					
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Remeasurement 2 1/1/09–12/31/09	Remeasurement 3 1/1/10–12/31/10	Sustained Improvement*
Percentage of avoidable ER visits^ (combined rate for all counties)	15.8%	21.6%*	21.2%*	19.9%*	No
QIP #2—Improve Cervical Cancer Screening among Seniors and Persons with Disabilities (SPD)					
QIP Study Indicator	County	Baseline Period 1/1/09–12/31/09	Remeasurement 1 1/1/10–12/31/10	Remeasurement 2 1/1/11–12/31/11	Sustained Improvement*
The percentage of SPD women who received one or more Pap tests during the measurement year or the two prior years	Fresno	40.2%	45.5%*	‡	‡
	Kern	40.9%	41.5%	‡	‡
	Los Angeles	50.8%	50.5%	‡	‡
	Sacramento	39.6%	37.4%	‡	‡
	San Diego	42.1%	43.4%	‡	‡
	Stanislaus	44.7%	47.9%	‡	‡
	Tulare	40.6%	46.5%	‡	‡
^A lower rate indicates better performance. ‡ Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period’s results must reflect improvement when compared to the baseline results. * A statistically significant difference between the measurement period and prior measurement period (<i>p</i> value < 0.05). ‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.					

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, Health Net set an overall objective to achieve a 10 percent reduction in ER visits designated as avoidable. For this project outcome, a lower rate demonstrates improved performance. While the plan did not meet its overall objective, it was able

to reduce the percentage of avoidable ER visits for two measurement periods. The plan's avoidable ER visit rate demonstrated a statistically significant decrease from the first to the second remeasurement period and from the second to the third remeasurement period (0.4 and 1.3 percentage points, respectively). The plan did not achieve overall improvement; rather, it demonstrated a decline in performance over the course of the project as evidenced by the increased rate of avoidable ER visits at the final remeasurement period compared to the baseline rate. A critical analysis of the plan's improvement strategy led to the following observations:

- ◆ Collaborative interventions were initiated in early 2009, continued through 2010, and correspond to Health Net's statistically significant decrease in avoidable ER visits for these two measurement periods. Specifically, for the plan-hospital data collaborative intervention, the plan reported that the participating hospital reported 77.6 percent of the ER data to the plan within 10 days. Similarly, Health Net reported that it contacted between 89.5 and 93.6 percent of the members within 14 days of receiving notice of their first ER visit. Further evaluation of this intervention showed that the avoidable ER visit rates were lower at the participating hospital compared to the non-participating hospitals (14.6 percent versus 21.1 percent), although, the rates may not be accurate.
- ◆ The plan attributed the lack of improvement from baseline to the final remeasurement period to the high number of new members who had not yet established a primary care provider; however, the plan did not implement any interventions to address this barrier.
- ◆ The plan conducted appropriate county-specific and subgroup analysis; however, the plan did not use the information to develop improvement strategies targeted to any county or subgroup.

Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.

Improve Cervical Cancer Screening among Seniors and Persons with Disabilities QIP

For the *Improve Cervical Cancer Screening among Seniors and Persons with Disabilities* QIP, Health Net had established a goal of increasing the cervical cancer screening by 1 percent per measurement period. The plan should raise this goal since a 1 percent increase does not represent a statistically significant increase for any of the counties. By the first remeasurement period, Health Net only documented a statistically significant increase in cervical cancer screening for Fresno County. Health Net had not progressed to the point of reporting second remeasurement data, so HSAG could not assess for sustained improvement. A critical analysis of the plan's improvement strategy identified some weaknesses, which may have led to the lack of improvement in outcomes:

- ◆ The plan identified county-specific barriers; however, it chose to implement the same interventions for all counties.

- ◆ While the plan distributed a list to the call center of providers that could provide access and accommodation to the SPD members, it did not notify the SPD members directly. Instead, an SPD member would have to reach out to the call center to obtain this information.
- ◆ Health Net did not identify any other SPD-specific barriers besides the providers' access and accommodations.
- ◆ The plan supplied lists to the providers of SPD members due for a Pap test and encouraged the providers to reach out to the members. The plan did not follow up with the providers as to whether (1) they reached the members, and (2) of those members contacted, whether any of the members subsequently received a Pap test. The plan acknowledged sending follow-up letters and conducting calls with providers who expressed concerns or had comments regarding the supplied member lists; however, the plan did not identify common barriers or if the process would be changed in any way.
- ◆ Similarly, the plan contacted the members using an automated voice system. The plan reported that 43.4 percent of the members were contacted, yet the plan did not provide an evaluation of whether the calls resulted in the members receiving a Pap test.

The plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine whether to modify or discontinue existing interventions, or implement new ones, thereby reducing the likelihood of achieving project objectives and improving performance.

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 *Improve Cervical Cancer Screening among Seniors and Persons with Disabilities* 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, for its *Reducing Avoidable Emergency Room Visits* QIP, the plan was able to reduce the percentage of avoidable ER visits for the combined counties over the last two measurement periods.

Opportunities for Improvement

Health Net should improve the documentation of the barrier analyses by providing the supporting data analyses results, identifying the targeted population, and documenting the rationale for the prioritization of the barriers.

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

Health Net may find that targeting high-volume providers with low cervical cancer screening rates within each county, specifically related to the SPD members, may provide measureable improvement in the *Improve Cervical Cancer Screening among Seniors and Persons with Disabilities* QIP outcome.

5. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

for Health Net Community Solutions, Inc.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

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

Quality

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

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

Overall, Health Net demonstrated average performance for the quality domain of care. Across all counties, 12 measures falling into the quality domain of care performed above the HPLs; and four quality measures performed below the MPLs.

Health Net had six IPs in place in 2012. Two of the IPs were for measures that were not included in DHCS's EAS for calendar year 2012. The remaining four IPs were for measures that fall into the quality domain of care, including the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure. The IP was implemented in Kern, San Diego, and Tulare counties. Health Net

saw mixed results from the plan's interventions to improve the rate for this measure. Tulare County's rate improved to above the MPL; however, the rates in Kern and San Diego counties remained below the MPLs in 2012.

Based on Health Net's self-report, it appears the plan has addressed the finding identified during the most recent MR/PIU review related to including all required information in the plan's grievance resolution letters and ensuring confidentiality of members' medical information.

The plan was successful at sufficiently documenting required information for the *Reducing Avoidable Emergency Room Visits* and *Improve Cervical Cancer Screening among Seniors and Persons with Disabilities* QIPs. Health Net received an overall *Met* validation status for both QIPs, and no resubmissions were required. Although Health Net was able to reduce the percentage of avoidable ER visits for two measurement periods, the plan did not achieve overall improvement on the *Reducing Avoidable Emergency Room Visits* QIP.

HSAG reviewed the plan's 2012 quality improvement program description. It appears that Health Net has structures in place to ensure that quality health care services are provided to members.

Access

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

Overall, Health Net demonstrated above-average performance for the access domain of care. Across all counties, four measures falling into the access domain of care performed above the HPLs; and two measures performed below the MPLs. Health Net had three IPs for measures that fell into the access domain of care, including the *Cervical Cancer Screening* measure. The IP for this measure was implemented in Sacramento and San Diego counties. The plan's efforts were successful, resulting in the rate on this measure improving to above the MPL in both counties.

In addition to falling into the quality domain of care, the plan's QIPs fell into the access domain of care. As indicated above, Health Net had some success at reducing the number of avoidable ER visits; however, one of the barriers identified that contributed to a lack of improvement from

baseline to the final remeasurement period was the high number of new members who had not yet established a primary care provider. This suggests that the plan may need to assess the process by which new members are connected with a primary care provider to ensure access to needed health care services.

Timeliness

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

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

Overall, Health Net demonstrated average performance in the timeliness domain of care. Across all counties, three measures falling into the timeliness domain of care performed above the HPLs; and two measures performed below the MPLs. Health Net had two IPs for measures that fell into the timeliness domain of care: *Prenatal and Postpartum Care—Postpartum Care* and *Adolescent Well-Care Visits* measures. The IP for the *Postpartum Care* measure was implemented in Los Angeles County. The plan's efforts were not successful in bringing the rate for this measure above the MPL. Additionally, San Diego County had statistically significant decline on performance on this measure, which moved the rate in this county from above the MPL to below the MPL.

The MR/PIU review results showed that Health Net was fully compliant in standards pertaining to timeliness.

Follow-Up on Prior Year Recommendations

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

Recommendations

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

- ◆ Ensure all deficiencies identified during the May 2008 medical performance review are fully resolved. Specifically:
 - Provide documentation to DHCS showing that Health Net has secured access to a dermatology specialist group in Stanislaus County.
- ◆ Assess the factors that are impacting continued poor performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Prenatal and Postpartum Care—Postpartum Care* measures and modify IP interventions as appropriate to move performance to above the MPLs for the counties that continue to perform below the MPLs.
- ◆ Assess the factors that led to San Diego County experiencing a statistically significant decline in performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and develop and implement strategies to prevent the rate on this measure from declining to below the MPL.
- ◆ Improve the documentation of the QIP barrier analyses by providing the supporting data analyses results, identifying the targeted population, and documenting the rationale for the prioritization of the barriers.
- ◆ Ensure that QIP interventions address the high-priority barriers. The plan should document a method to evaluate the effectiveness of each intervention as well as provide the results of the intervention’s evaluation for each measurement period.
- ◆ Target high-volume providers with low cervical cancer screening rates within each county, specifically related to the SPD members, which may provide measureable improvement in the *Improve Cervical Cancer Screening among Seniors and Persons with Disabilities* QIP outcome.

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

Quality, Access, and Timeliness

<p>Scale 2.5–3.0 = Above Average 1.5–2.4 = Average 1.0–1.4 = Below Average</p>
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HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Tables 3.2 through 3.7)

Quality Domain

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

Access Domain

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

Timeliness Domain

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

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

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

◆ **Sustained Improvement** (*Table 4.3*): Activity X—**Achieved Sustained Improvement**

- **Above Average** = All study indicators achieved sustained improvement.
- **Average** = Not all study indicators achieved sustained improvement.
- **Below Average** = No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

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

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

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

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

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

for **Health Net Community Solutions, Inc.**

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

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

2010–2011 EQR Recommendation	Health Net’s Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Update policies and procedures in the area of grievances for the MR/PIU audit.	<p>Health Net made the required revisions to our policies and procedures to ensure the grievance resolution letters contain a clear and concise explanation of the plan's decision. Health Net's revised Medi-Cal member grievance P&P GA 201-ML was approved by Nathan Nau at DHCS in March 2010.</p> <p>Another copy of the P&P is attached for your review. See Attachment #1. The revised language can be found on pages 11 and 14, sections A.11 and B.15, respectively.</p>
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.	<p>The following factors may have affected the decline between 2010/2011 rates: difficulty in collecting medical records with some providers in some counties, and implementing multiple interventions with negligible or no improvement outcome. Since then, Health Net had worked with specific providers in collecting medical records. Similarly, Health Net had evaluated effectiveness of some interventions to determine their effectiveness for continued implementation. An example of an intervention that showed improvement is the implementation of provider incentive for completion of the PM 160 that addresses HEDIS measures, i.e., ABA, WCC, AWC.</p>
Enhance the quality and effectiveness of its HEDIS improvement plans to avoid having repeat measures on improvement plans.	<p>Met with the Quality Improvement team, reviewed HEDIS results, barriers identified and made intervention recommendations based on resources and evaluation of interventions’ effectiveness. An example of an intervention that showed improvement is the provider incentive for completion of PM 160 showing improved HEDIS measures, i.e., ABA, WCC, AWC.</p>
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.	<p>Conducted all county-specific barrier analyses, statistical testing between measurements and initiated interventions based on the barriers identified and analysis of results per measurement period for the SPD-CCS QIP.</p>
Implement interventions that would address the barriers associated with new members’ use of the ER for the <i>Reducing avoidable Emergency Room Visits</i> QIP.	<p>Health Net’s <i>Reducing Avoidable Emergency Room Visits</i> QIP was closed in 2011 with a validation score of 97%. The SWC QIP was replaced by the <i>All Cause Readmission</i> QIP. However, Health Net continues to implement interventions for this measure by distributing the SWC developed educational materials for members and providers at provider offices, and the provider and member newsletter continues to discuss what to do if not sure if it’s an emergency. In addition, information about accessing the Nurse Advice Line is included in all new member packets. The flyer advises members what to do if they are not sure if they need care and to call the Nurse Advice Line which is available 24/7.</p>
Evaluate the efficacy of its interventions and revise or implement new interventions as needed to sustain improvement in the area of ER utilization reduction.	<p>Health Net’s <i>Reducing Avoidable Emergency Room Visits</i> QIP was closed in 2011 with a validation score of 97%. The SWC QIP was replaced by the <i>All Cause Readmission</i> QIP. However, effective interventions to reduce avoidable ED visits are continuing.</p>