

Performance Evaluation Report
Health Net Community Solutions, Inc.
July 1, 2012–June 30, 2013

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

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 PERFORMANCE EVALUATION REPORT B-1**

Performance Evaluation Report – Health Net Community Solutions, Inc.

July 1, 2012 – June 30, 2013

1. INTRODUCTION

Purpose of Report

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

The Code of Federal Regulations (CFR) at 42 CFR §438.364² 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 provided by the states’ Medicaid MCPs. The EQRO’s performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

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

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

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

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

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

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

This report is specific to DHCS’s contracted MCP, Health Net Community Solutions, Inc. (“Health Net” or “the MCP”) for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

Health Net is a full-scope MCP delivering services to MCMC members as a “commercial plan” (CP) MCP under the Two-Plan Model (TPM) and as a Geographic Managed Care (GMC) Model.

In most TPM counties, there is a “Local Initiative” LI and a CP. DHCS contracts with both plans. The LI is designed—with the input of local government, community groups, and health care providers—to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. MCMC beneficiaries may enroll in Health Net, the CP MCP, or in the alternative LI.

MCMC beneficiaries in Kern, Los Angeles, San Joaquin, Stanislaus, and Tulare counties may enroll in Health Net, the CP MCP, or in the alternative LI. Following are the LI MCPs and the county in which they are available:

- ◆ Kern Family Health Care in Kern County
- ◆ L.A. Care Health Plan in Los Angeles County
- ◆ Health Plan of San Joaquin in San Joaquin and Stanislaus counties
- ◆ Anthem Blue Cross Partnership Plan in Tulare County

In the GMC model, DHCS allows MCMC beneficiaries to select from several commercial MCPs within a specified geographic area. Health Net serves MCMC beneficiaries as a GMC model in Sacramento and San Diego counties.

Health Net became operational in Sacramento County to provide MCMC services effective 1994 and then expanded into its additional contracted counties, with the most recent being San Joaquin County in January 2013. As of June 30, 2013, Health Net had 51,997 MCMC members in Kern

County, 569,574 in Los Angeles County, 83,435 in Sacramento County, 43,691 in San Diego County, 8,354 in San Joaquin County, 53,161 in Stanislaus County, and 60,512 in Tulare County—for a total of 870,724 MCMC members.³

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

2. MANAGED CARE PLAN STRUCTURE AND OPERATIONS

for Health Net Community Solutions, Inc.

Conducting the EQRO Review

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

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

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

Assessing the State's Compliance Review Activities

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

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

Readiness Reviews

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

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

Medical Performance Audits and Member Rights Reviews

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

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

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

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

DHCS did not conduct any audits or reviews with Health Net during the review period for this report. In the MCP's 2011–12 MCP-specific evaluation report, HSAG noted that the MCP had one outstanding deficiency from the DMHC May 2008 medical performance review related to access to dermatologists in Stanislaus County. In the report, HSAG recommended that Health Net provide documentation to DHCS showing that the MCP had secured access to a dermatologist specialist

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

group in Stanislaus County to fully resolve the deficiency. As part of the process for producing Health Net's 2012–13 MCP-specific evaluation report, Health Net was asked to document actions the MCP had taken in response to each recommendation from the 2011–12 MCP-specific evaluation report. Health Net submitted a spreadsheet with names of six dermatologists in Stanislaus County, which provides evidence that the MCP has addressed the specialty access issues in Stanislaus County. The list was submitted to HSAG, and Health Net did not indicate whether the MCP had submitted the information to DHCS.

Strengths

Health Net provided evidence that the MCP has addressed the specialty access issues in Stanislaus County, which was the one outstanding deficiency from the DMHC 2008 medical performance review.

Opportunities for Improvement

Since it appears that Health Net has fully addressed the specialty access issues in Stanislaus County, HSAG does not have any recommendations for opportunities for improvement in the area of compliance.

Conducting the EQRO Review

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

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

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

Validating Performance Measures and Assessing Results

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

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

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

Performance Measure Validation

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

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

Performance Measure Validation Findings

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

- ◆ Health Net established and documented a three-tier verification cycle for both its claims and encounter data processes. This verification cycle ensured accurate and complete data.
- ◆ Health Net used a new vendor for data integration and HEDIS reporting. The vendor provided the MCP with comprehensive documentation, reference manuals, and needed support, and held weekly meeting with Health Net HEDIS staff members. The conversion to a new vendor resulted in staff much more knowledgeable of the file preparation, transfer, and verification processes.

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

⁷ NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

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

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

Performance Measure Abbreviation	Full Name of 2013 Reporting Year[†] Performance Measure
AAB	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
ACR	<i>All-Cause Readmissions[‡]</i>
AMB–ED	<i>Ambulatory Care—Emergency Department (ED) Visits</i>
AMB–OP	<i>Ambulatory Care—Outpatient 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>
CBP	<i>Controlling High Blood Pressure</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>
MMA–50	<i>Medication Management for People with Asthma—Medication Compliance 50% Total</i>
MMA–75	<i>Medication Management for People with Asthma—Medication Compliance 75% Total</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>
[†] The reporting year represents the year the measure rate is reported and generally represents the previous calendar year’s data. [‡] The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.	

Tables 3.2 through 3.7 present a summary of Health Net’s 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Tables 3.2 through 3.7 show the MCP’s 2013 performance compared to the DHCS-established MPLs and HPLs.

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

**Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
Health Net—Kern County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS’s Minimum Performance Level ⁶	DHCS’s High Performance Level (Goal) ⁷
AAB	Q	17.23%	26.00%	★★	↑	18.98%	33.33%
ACR	Q, A	--	10.40%	--	Not Comparable	--	--
AMB–ED	‡	47.52	53.28	‡	Not Comparable	‡	‡
AMB–OP	‡	269.41	200.09	‡	Not Comparable	‡	‡
CAP–1224	A	93.78%	89.78%	★	↓	95.56%	98.39%
CAP–256	A	80.79%	70.48%	★	↓	86.62%	92.63%
CAP–711	A	78.17%	68.16%	★	↓	87.56%	94.51%
CAP–1219	A	81.18%	76.57%	★	↓	86.04%	93.01%
CBP	Q	--	51.34%	--	Not Comparable	--	--
CCS	Q,A	67.16%	46.99%	★	↓	61.81%	78.51%
CDC–BP	Q	65.82%	50.12%	★	↓	54.48%	75.44%
CDC–E	Q,A	54.04%	44.28%	★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	40.88%	38.20%	★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	50.58%	52.80%	★	↔	50.31%	28.95%
CDC–HT	Q,A	78.52%	73.24%	★	↔	78.54%	91.13%
CDC–LC (<100)	Q	35.57%	38.93%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	73.21%	72.75%	★★	↔	70.34%	83.45%
CDC–N	Q,A	83.14%	80.78%	★★	↔	73.48%	86.93%

**Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
Health Net—Kern County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
CIS-3	Q,A,T	71.35%	68.71%	★★	↔	64.72%	82.48%
IMA-1	Q,A,T	60.58%	71.90%	★★	↑	50.36%	80.91%
LBP	Q	75.26%	73.53%	★★	↔	72.04%	82.04%
MMA-50	Q	--	69.12%	--	Not Comparable	--	--
MMA-75	Q	--	51.47%	--	Not Comparable	--	--
MPM-ACE	Q	77.67%	75.85%	★	↔	83.72%	91.33%
MPM-DIG	Q	NA	83.33%	★	Not Comparable	87.93%	95.56%
MPM-DIU	Q	79.57%	76.59%	★	↔	83.19%	91.30%
PPC-Pre	Q,A,T	89.47%	78.87%	★	↓	80.54%	93.33%
PPC-Pst	Q,A,T	62.41%	53.09%	★	↓	58.70%	74.73%
W-34	Q,A,T	69.21%	65.54%	★★	↔	65.51%	83.04%
WCC-BMI	Q	55.28%	72.02%	★★	↑	29.20%	77.13%
WCC-N	Q	71.24%	81.02%	★★★	↑	42.82%	77.61%
WCC-PA	Q	51.24%	63.99%	★★	↑	31.63%	64.87%

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

**Table 3.3—Comparison of 2012 and 2013 Performance Measure Results
Health Net—Los Angeles County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	21.40%	40.16%	★★★	↑	18.98%	33.33%
ACR	Q, A	--	11.93%	--	Not Comparable	--	--
AMB-ED	‡	33.03	36.51	‡	Not Comparable	‡	‡
AMB-OP	‡	241.22	251.36	‡	Not Comparable	‡	‡
CAP-1224	A	96.13%	94.29%	★	↓	95.56%	98.39%
CAP-256	A	88.17%	81.11%	★	↓	86.62%	92.63%
CAP-711	A	87.98%	83.12%	★	↓	87.56%	94.51%
CAP-1219	A	85.90%	82.82%	★	↓	86.04%	93.01%
CBP	Q	--	57.91%	--	Not Comparable	--	--
CCS	Q,A	68.41%	63.06%	★★	↔	61.81%	78.51%
CDC-BP	Q	67.53%	50.12%	★	↓	54.48%	75.44%
CDC-E	Q,A	58.82%	47.69%	★★	↓	45.03%	69.72%
CDC-H8 (<8.0%)	Q	48.47%	39.90%	★	↓	42.09%	59.37%
CDC-H9 (>9.0%)	Q	39.76%	48.42%	★★	▼	50.31%	28.95%
CDC-HT	Q,A	83.53%	78.10%	★	↓	78.54%	91.13%
CDC-LC (<100)	Q	37.41%	35.52%	★★	↔	28.47%	46.44%
CDC-LS	Q,A	76.47%	75.43%	★★	↔	70.34%	83.45%
CDC-N	Q,A	82.35%	82.97%	★★	↔	73.48%	86.93%
CIS-3	Q,A,T	87.62%	81.63%	★★	↔	64.72%	82.48%
IMA-1	Q,A,T	65.02%	73.67%	★★	↑	50.36%	80.91%
LBP	Q	81.09%	78.01%	★★	↓	72.04%	82.04%
MMA-50	Q	--	72.65%	--	Not Comparable	--	--
MMA-75	Q	--	49.52%	--	Not Comparable	--	--
MPM-ACE	Q	74.03%	76.09%	★	↑	83.72%	91.33%
MPM-DIG	Q	76.99%	85.92%	★	↑	87.93%	95.56%
MPM-DIU	Q	74.07%	76.27%	★	↑	83.19%	91.30%
PPC-Pre	Q,A,T	83.64%	73.41%	★	↓	80.54%	93.33%
PPC-Pst	Q,A,T	52.34%	48.05%	★	↔	58.70%	74.73%
W-34	Q,A,T	83.10%	77.08%	★★	↔	65.51%	83.04%

**Table 3.3—Comparison of 2012 and 2013 Performance Measure Results
Health Net—Los Angeles County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
WCC–BMI	Q	71.53%	75.78%	★★	↔	29.20%	77.13%
WCC–N	Q	79.86%	80.73%	★★★	↔	42.82%	77.61%
WCC–PA	Q	63.66%	66.41%	★★★	↔	31.63%	64.87%

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

**Table 3.4—Comparison of 2012 and 2013 Performance Measure Results
Health Net—Sacramento County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	20.21%	51.66%	★★★	↑	18.98%	33.33%
ACR	Q, A	--	12.15%	--	Not Comparable	--	--
AMB-ED	‡	38.10	45.02	‡	Not Comparable	‡	‡
AMB-OP	‡	241.00	300.55	‡	Not Comparable	‡	‡
CAP-1224	A	95.41%	92.53%	★	↓	95.56%	98.39%
CAP-256	A	84.73%	80.19%	★	↓	86.62%	92.63%
CAP-711	A	84.22%	80.69%	★	↓	87.56%	94.51%
CAP-1219	A	83.57%	81.64%	★	↓	86.04%	93.01%
CBP	Q	--	54.50%	--	Not Comparable	--	--
CCS	Q,A	69.34%	53.95%	★	↓	61.81%	78.51%
CDC-BP	Q	62.91%	48.91%	★	↓	54.48%	75.44%
CDC-E	Q,A	48.36%	40.63%	★	↓	45.03%	69.72%
CDC-H8 (<8.0%)	Q	52.82%	43.55%	★★	↓	42.09%	59.37%
CDC-H9 (>9.0%)	Q	35.92%	45.26%	★★	▼	50.31%	28.95%
CDC-HT	Q,A	83.57%	77.86%	★	↓	78.54%	91.13%
CDC-LC (<100)	Q	33.57%	35.77%	★★	↔	28.47%	46.44%
CDC-LS	Q,A	73.94%	67.40%	★	↓	70.34%	83.45%
CDC-N	Q,A	82.63%	83.45%	★★	↔	73.48%	86.93%
CIS-3	Q,A,T	69.55%	66.67%	★★	↔	64.72%	82.48%
IMA-1	Q,A,T	54.61%	63.08%	★★	↑	50.36%	80.91%
LBP	Q	87.52%	87.00%	★★★	↔	72.04%	82.04%
MMA-50	Q	--	78.74%	--	Not Comparable	--	--
MMA-75	Q	--	55.94%	--	Not Comparable	--	--
MPM-ACE	Q	59.33%	67.16%	★	↑	83.72%	91.33%
MPM-DIG	Q	NA	82.46%	★	Not Comparable	87.93%	95.56%
MPM-DIU	Q	55.59%	67.40%	★	↑	83.19%	91.30%
PPC-Pre	Q,A,T	83.58%	81.77%	★★	↔	80.54%	93.33%
PPC-Pst	Q,A,T	60.78%	53.16%	★	↓	58.70%	74.73%
W-34	Q,A,T	78.20%	71.18%	★★	↔	65.51%	83.04%

**Table 3.4—Comparison of 2012 and 2013 Performance Measure Results
Health Net—Sacramento County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
WCC–BMI	Q	69.51%	77.32%	★★★	↑	29.20%	77.13%
WCC–N	Q	77.58%	76.34%	★★	↔	42.82%	77.61%
WCC–PA	Q	52.69%	57.07%	★★	↔	31.63%	64.87%

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

**Table 3.5—Comparison of 2012 and 2013 Performance Measure Results
Health Net—San Diego County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	18.46%	44.85%	★★★	↑	18.98%	33.33%
ACR	Q, A	--	15.96%	--	Not Comparable	--	--
AMB-ED	‡	44.10	50.92	‡	Not Comparable	‡	‡
AMB-OP	‡	258.60	317.66	‡	Not Comparable	‡	‡
CAP-1224	A	94.01%	93.98%	★	↔	95.56%	98.39%
CAP-256	A	85.83%	85.27%	★	↔	86.62%	92.63%
CAP-711	A	85.38%	84.91%	★	↔	87.56%	94.51%
CAP-1219	A	82.99%	82.51%	★	↔	86.04%	93.01%
CBP	Q	--	55.23%	--	Not Comparable	--	--
CCS	Q,A	66.28%	51.75%	★	↓	61.81%	78.51%
CDC-BP	Q	64.38%	52.07%	★	↓	54.48%	75.44%
CDC-E	Q,A	51.91%	45.99%	★★	↔	45.03%	69.72%
CDC-H8 (<8.0%)	Q	48.35%	50.85%	★★	↔	42.09%	59.37%
CDC-H9 (>9.0%)	Q	41.48%	41.61%	★★	↔	50.31%	28.95%
CDC-HT	Q,A	84.48%	85.40%	★★	↔	78.54%	91.13%
CDC-LC (<100)	Q	35.62%	41.12%	★★	↔	28.47%	46.44%
CDC-LS	Q,A	76.34%	79.08%	★★	↔	70.34%	83.45%
CDC-N	Q,A	78.63%	82.24%	★★	↔	73.48%	86.93%
CIS-3	Q,A,T	77.30%	72.30%	★★	↔	64.72%	82.48%
IMA-1	Q,A,T	65.29%	76.86%	★★	↑	50.36%	80.91%
LBP	Q	77.40%	76.04%	★★	↔	72.04%	82.04%
MMA-50	Q	--	75.28%	--	Not Comparable	--	--
MMA-75	Q	--	55.06%	--	Not Comparable	--	--
MPM-ACE	Q	78.12%	83.68%	★	↑	83.72%	91.33%
MPM-DIG	Q	NA	100.0%	★★★	Not Comparable	87.93%	95.56%
MPM-DIU	Q	77.56%	83.82%	★★	↑	83.19%	91.30%
PPC-Pre	Q,A,T	83.38%	76.67%	★	↓	80.54%	93.33%
PPC-Pst	Q,A,T	54.77%	53.75%	★	↔	58.70%	74.73%
W-34	Q,A,T	70.00%	74.43%	★★	↔	65.51%	83.04%

**Table 3.5—Comparison of 2012 and 2013 Performance Measure Results
Health Net—San Diego County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
WCC–BMI	Q	67.56%	72.99%	★★	↔	29.20%	77.13%
WCC–N	Q	67.78%	74.70%	★★	↑	42.82%	77.61%
WCC–PA	Q	49.56%	67.15%	★★★	↑	31.63%	64.87%

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

**Table 3.6—Comparison of 2012 and 2013 Performance Measure Results
Health Net—Stanislaus County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	29.55%	32.31%	★★	↔	18.98%	33.33%
ACR	Q, A	--	8.71%	--	Not Comparable	--	--
AMB-ED	‡	49.38	55.13	‡	Not Comparable	‡	‡
AMB-OP	‡	349.91	369.94	‡	Not Comparable	‡	‡
CAP-1224	A	97.18%	97.04%	★★	↔	95.56%	98.39%
CAP-256	A	88.90%	87.15%	★★	↓	86.62%	92.63%
CAP-711	A	87.88%	85.24%	★	↓	87.56%	94.51%
CAP-1219	A	85.93%	86.00%	★	↔	86.04%	93.01%
CBP	Q	--	56.20%	--	Not Comparable	--	--
CCS	Q,A	77.28%	59.12%	★	↓	61.81%	78.51%
CDC-BP	Q	67.30%	58.39%	★★	↓	54.48%	75.44%
CDC-E	Q,A	50.00%	41.61%	★	↓	45.03%	69.72%
CDC-H8 (<8.0%)	Q	53.08%	56.93%	★★	↔	42.09%	59.37%
CDC-H9 (>9.0%)	Q	36.49%	31.87%	★★	↔	50.31%	28.95%
CDC-HT	Q,A	84.60%	88.32%	★★	↔	78.54%	91.13%
CDC-LC (<100)	Q	39.34%	34.55%	★★	↔	28.47%	46.44%
CDC-LS	Q,A	76.07%	78.59%	★★	↔	70.34%	83.45%
CDC-N	Q,A	77.01%	78.59%	★★	↔	73.48%	86.93%
CIS-3	Q,A,T	68.52%	71.67%	★★	↔	64.72%	82.48%
IMA-1	Q,A,T	54.18%	65.77%	★★	↑	50.36%	80.91%
LBP	Q	83.83%	83.22%	★★★	↔	72.04%	82.04%
MMA-50	Q	--	77.04%	--	Not Comparable	--	--
MMA-75	Q	--	52.55%	--	Not Comparable	--	--
MPM-ACE	Q	75.91%	83.73%	★★	↑	83.72%	91.33%
MPM-DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM-DIU	Q	79.78%	84.46%	★★	↔	83.19%	91.30%
PPC-Pre	Q,A,T	91.52%	91.90%	★★	↔	80.54%	93.33%
PPC-Pst	Q,A,T	60.10%	58.73%	★★	↔	58.70%	74.73%
W-34	Q,A,T	71.11%	70.47%	★★	↔	65.51%	83.04%

**Table 3.6—Comparison of 2012 and 2013 Performance Measure Results
Health Net—Stanislaus County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
WCC–BMI	Q	58.68%	70.56%	★★	↑	29.20%	77.13%
WCC–N	Q	65.75%	65.69%	★★	↔	42.82%	77.61%
WCC–PA	Q	40.18%	58.15%	★★	↑	31.63%	64.87%

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

**Table 3.7—Comparison of 2012 and 2013 Performance Measure Results
Health Net—Tulare County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
AAB	Q	22.85%	26.14%	★★	↔	18.98%	33.33%
ACR	Q, A	--	11.86%	--	Not Comparable	--	--
AMB-ED	‡	39.30	41.73	‡	Not Comparable	‡	‡
AMB-OP	‡	386.74	467.09	‡	Not Comparable	‡	‡
CAP-1224	A	97.32%	97.76%	★★	↔	95.56%	98.39%
CAP-256	A	92.25%	92.37%	★★	↔	86.62%	92.63%
CAP-711	A	92.76%	91.72%	★★	↔	87.56%	94.51%
CAP-1219	A	91.48%	93.05%	★★★	↑	86.04%	93.01%
CBP	Q	--	54.01%	--	Not Comparable	--	--
CCS	Q,A	78.83%	63.54%	★★	↓	61.81%	78.51%
CDC-BP	Q	67.45%	54.26%	★	↓	54.48%	75.44%
CDC-E	Q,A	56.84%	41.85%	★	↓	45.03%	69.72%
CDC-H8 (<8.0%)	Q	47.88%	49.64%	★★	↔	42.09%	59.37%
CDC-H9 (>9.0%)	Q	43.40%	43.55%	★★	↔	50.31%	28.95%
CDC-HT	Q,A	83.02%	86.62%	★★	↔	78.54%	91.13%
CDC-LC (<100)	Q	36.56%	36.50%	★★	↔	28.47%	46.44%
CDC-LS	Q,A	76.18%	77.86%	★★	↔	70.34%	83.45%
CDC-N	Q,A	82.78%	82.00%	★★	↔	73.48%	86.93%
CIS-3	Q,A,T	78.93%	78.47%	★★	↔	64.72%	82.48%
IMA-1	Q,A,T	61.80%	78.32%	★★	↑	50.36%	80.91%
LBP	Q	82.72%	80.00%	★★	↔	72.04%	82.04%
MMA-50	Q	--	72.85%	--	Not Comparable	--	--
MMA-75	Q	--	47.68%	--	Not Comparable	--	--
MPM-ACE	Q	83.59%	83.50%	★	↔	83.72%	91.33%
MPM-DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM-DIU	Q	79.73%	84.60%	★★	↔	83.19%	91.30%
PPC-Pre	Q,A,T	93.75%	90.16%	★★	↔	80.54%	93.33%
PPC-Pst	Q,A,T	67.93%	65.57%	★★	↔	58.70%	74.73%
W-34	Q,A,T	77.32%	73.31%	★★	↔	65.51%	83.04%

**Table 3.7—Comparison of 2012 and 2013 Performance Measure Results
Health Net—Tulare County**

Performance Measure ¹	Domain of Care ²	2012 Rates ³	2013 Rates ⁴	Performance Level for 2013	Performance Comparison ⁵	DHCS's Minimum Performance Level ⁶	DHCS's High Performance Level (Goal) ⁷
WCC–BMI	Q	77.57%	76.64%	★★	↔	29.20%	77.13%
WCC–N	Q	66.36%	66.42%	★★	↔	42.82%	77.61%
WCC–PA	Q	45.33%	49.15%	★★	↔	31.63%	64.87%

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

Seniors and Persons with Disabilities Performance Measure Results

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

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in

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

measures such as *All-Cause Readmissions*, *Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Tables 3.8 through 3.19, which present a summary of Health Net's 2013 SPD measure results. Tables 3.8, 3.10, 3.12, 3.14, 3.16, and 3.18 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,⁹ and the total combined rate for all measures except the *Ambulatory Care* measures. Tables 3.9, 3.11, 3.13, 3.15, 3.17, and 3.19 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- ◆ *All-Cause Readmissions—Statewide Collaborative QIP*
- ◆ *Ambulatory Care—Outpatient Visits*
- ◆ *Ambulatory Care—Emergency Department (ED) Visits*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- ◆ *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- ◆ *Comprehensive Diabetes Care—LDL-C Screening*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

⁹ HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD Compared to Non-SPD” column in Tables 3.8, 3.10, 3.12, 3.14, 3.16, and 3.18.

**Table 3.8—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Net—Kern County**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.36%	11.72%	▼	10.40%
CAP-1224	89.99%	NA	Not Comparable	89.78%
CAP-256	70.52%	68.83%	↔	70.48%
CAP-711	68.00%	72.27%	↔	68.16%
CAP-1219	76.72%	73.89%	↔	76.57%
CDC-BP	49.14%	48.66%	↔	50.12%
CDC-E	49.88%	43.55%	↔	44.28%
CDC-H8 (<8.0%)	32.84%	40.15%	↑	38.20%
CDC-H9 (>9.0%)	59.01%	49.15%	▲	52.80%
CDC-HT	68.64%	73.24%	↔	73.24%
CDC-LC (<100)	28.89%	40.88%	↑	38.93%
CDC-LS	64.20%	75.91%	↑	72.75%
CDC-N	75.56%	83.21%	↑	80.78%
MPM-ACE	70.82%	78.34%	↑	75.85%
MPM-DIG	NA	NA	Not Comparable	83.33%
MPM-DIU	70.73%	78.90%	↑	76.59%

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

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

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

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

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

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

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

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

**Table 3.9—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net—Kern County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
196.35	47.99	219.48	80.74

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

**Table 3.10—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Net—Los Angeles County**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.58%	14.16%	▼	11.93%
CAP-1224	94.35%	86.07%	↓	94.29%
CAP-256	81.21%	76.93%	↓	81.11%
CAP-711	83.10%	83.57%	↔	83.12%
CAP-1219	83.01%	78.40%	↓	82.82%
CDC-BP	53.04%	50.36%	↔	50.12%
CDC-E	51.09%	43.55%	↓	47.69%
CDC-H8 (<8.0%)	35.04%	45.50%	↑	39.90%
CDC-H9 (>9.0%)	51.34%	44.28%	▲	48.42%
CDC-HT	78.83%	78.83%	↔	78.10%
CDC-LC (<100)	31.63%	38.20%	↑	35.52%
CDC-LS	75.91%	78.10%	↔	75.43%
CDC-N	81.27%	84.43%	↔	82.97%
MPM-ACE	74.64%	77.01%	↑	76.09%
MPM-DIG	83.33%	86.48%	↔	85.92%
MPM-DIU	72.64%	78.39%	↑	76.27%

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

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.
 ↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.
 ↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.
 (▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.
 ▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.
 ▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.
 Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.11—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net—Los Angeles County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
248.68	33.35	267.73	55.77

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

**Table 3.12—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Net—Sacramento County**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	6.02%	14.03%	▼	12.15%
CAP-1224	92.71%	NA	Not Comparable	92.53%
CAP-256	80.23%	78.66%	↔	80.19%
CAP-711	80.41%	86.48%	↑	80.69%
CAP-1219	81.67%	81.16%	↔	81.64%
CDC-BP	50.12%	48.91%	↔	48.91%
CDC-E	36.98%	37.71%	↔	40.63%
CDC-H8 (<8.0%)	39.66%	49.64%	↑	43.55%
CDC-H9 (>9.0%)	51.34%	39.42%	▲	45.26%
CDC-HT	72.51%	80.78%	↑	77.86%
CDC-LC (<100)	23.60%	37.96%	↑	35.77%
CDC-LS	59.61%	71.78%	↑	67.40%
CDC-N	72.51%	85.64%	↑	83.45%
MPM-ACE	61.52%	69.20%	↑	67.16%
MPM-DIG	NA	83.93%	Not Comparable	82.46%
MPM-DIU	56.74%	71.03%	↑	67.40%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.
 ↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.
 ↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.
 ↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.
 (▲ ▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.
 ▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.
 ▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.
 Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.13—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net—Sacramento County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
274.99	39.84	399.51	65.06

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

Table 3.14—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population Health Net—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.38%	17.88%	▼	15.96%
CAP-1224	94.45%	NA	Not Comparable	93.98%
CAP-256	85.41%	81.31%	↔	85.27%
CAP-711	84.87%	85.96%	↔	84.91%
CAP-1219	82.60%	80.42%	↔	82.51%
CDC-BP	50.18%	53.28%	↔	52.07%
CDC-E	47.67%	43.31%	↔	45.99%
CDC-H8 (<8.0%)	43.01%	51.82%	↑	50.85%
CDC-H9 (>9.0%)	48.75%	37.71%	▲	41.61%
CDC-HT	78.49%	86.37%	↑	85.40%
CDC-LC (<100)	28.32%	43.80%	↑	41.12%
CDC-LS	68.82%	81.75%	↑	79.08%
CDC-N	70.97%	87.59%	↑	82.24%
MPM-ACE	76.98%	86.17%	↑	83.68%
MPM-DIG	NA	NA	Not Comparable	100.00%
MPM-DIU	75.42%	86.79%	↑	83.82%

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

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

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

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

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

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

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

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

Table 3.15—2013 Non-SPD and SPD Rates for Ambulatory Care Measures Health Net—San Diego County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
296.72	46.14	406.58	71.22

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

Table 3.16—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population Health Net—Stanislaus County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	5.66%	10.12%	↔	8.71%
CAP-1224	97.12%	NA	Not Comparable	97.04%
CAP-256	87.18%	86.27%	↔	87.15%
CAP-711	84.96%	90.98%	↔	85.24%
CAP-1219	85.74%	94.25%	↑	86.00%
CDC-BP	58.30%	60.58%	↔	58.39%
CDC-E	45.56%	41.12%	↔	41.61%
CDC-H8 (<8.0%)	50.19%	60.10%	↑	56.93%
CDC-H9 (>9.0%)	36.29%	30.17%	↔	31.87%
CDC-HT	85.33%	89.78%	↔	88.32%
CDC-LC (<100)	29.34%	42.82%	↑	34.55%
CDC-LS	76.83%	81.27%	↔	78.59%
CDC-N	74.13%	82.97%	↑	78.59%
MPM-ACE	84.65%	83.26%	↔	83.73%
MPM-DIG	NA	NA	Not Comparable	NA
MPM-DIU	80.25%	86.47%	↔	84.46%

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

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

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

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

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

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

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

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

Table 3.17—2013 Non-SPD and SPD Rates for Ambulatory Care Measures Health Net—Stanislaus County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
350.80	50.77	491.16	82.73

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

**Table 3.18—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Net—Tulare County**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	5.79%	15.86%	▼	11.86%
CAP-1224	97.78%	NA	Not Comparable	97.76%
CAP-256	92.30%	94.74%	↔	92.37%
CAP-711	91.58%	94.50%	↔	91.72%
CAP-1219	93.09%	92.00%	↔	93.05%
CDC-BP	58.64%	49.39%	↓	54.26%
CDC-E	43.55%	45.01%	↔	41.85%
CDC-H8 (<8.0%)	44.53%	53.77%	↑	49.64%
CDC-H9 (>9.0%)	45.50%	38.93%	↔	43.55%
CDC-HT	84.43%	87.59%	↔	86.62%
CDC-LC (<100)	30.90%	38.20%	↑	36.50%
CDC-LS	73.97%	76.64%	↔	77.86%
CDC-N	79.81%	82.73%	↔	82.00%
MPM-ACE	83.16%	83.74%	↔	83.50%
MPM-DIG	NA	NA	Not Comparable	NA
MPM-DIU	79.55%	87.50%	↑	84.60%

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

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

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

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

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

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

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

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

**Table 3.19—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net—Tulare County**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
449.45	37.86	602.84	71.55

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

Performance Measure Result Findings

Note: Although Health Net began serving MCMC beneficiaries in San Joaquin County in January 2013, which is during the review period for this report, no performance measure results for San Joaquin County are included in this report. In order for an MCP to report rates for a specific county, the members in that county must first meet continuous enrollment requirements for each measure being reported, which typically means members need to be enrolled in the MCP for 11 of 12 months during the measurement year. Since the measurement year for this report is 2012 and Health Net did not begin serving MCMC beneficiaries in San Joaquin County until January 2013, the MCP has no performance measure results to report for San Joaquin County. Health Net is required to submit performance measure results for San Joaquin County in 2014 for the 2013 measurement period. HSAG will include the 2014 results in the MCP's 2013–14 MCP-specific evaluation report.

Overall, Health Net demonstrated below-average performance across all six counties for performance measures reported in 2013, impacting the quality, access, and timeliness domains of care. Across all counties, 12 measures had rates above the HPLs, which is the same number with rates above the HPLs in 2012, and 56 measures had rates below the MPLs, compared to 4 measures with rates below the MPLs in 2012. All counties combined had 27 measures with rates that improved significantly from 2012 to 2013 and 42 measures with rates that were significantly worse in 2013 when compared to 2012. In 2012, 2 measures had rates with significant improvement from 2011, and 2 measures had rates that declined significantly from 2011.

In 2012, Los Angeles and Tulare counties had the strongest performance. In 2013, the counties with the most number of measures with rates above the HPLs were Los Angeles, Sacramento, and San Diego; however, each of these counties had a significant number of measures with rates below the MPLs—12, 13, and 9, respectively. Kern County had 15 measures with rates below the MPLs, which was the most of any county. Stanislaus and Tulare counties had the least number of measures with rates below the MPLs—4 and 3, respectively. The rates for the *Immunizations for Adolescents—Combination 1* measure improved significantly in all counties from 2012 to 2013.

The following measures had rates above the HPLs in 2013:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Los Angeles, Sacramento, and San Diego counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* in Tulare County
- ◆ *Use of Imaging Studies for Low Back Pain* in Sacramento and Stanislaus counties
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin* in San Diego County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in Sacramento County

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total* in Kern and Los Angeles counties
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total* in Los Angeles and San Diego counties

The following measures had rates below the MPLs in at least four counties:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- ◆ *Cervical Cancer Screening*
- ◆ *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*

Seniors and Persons with Disabilities Findings

The SPD rates were significantly better than the non-SPD rates in all six counties for the following measures:

- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)*

The SPD rates for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure in all counties except Stanislaus County were significantly better than the non-SPD rates.

The SPD rates for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* and *Annual Monitoring for Patients on Persistent Medications—ACE* measures were significantly better than the non-SPD rates in Kern, Los Angeles, Sacramento, and San Diego counties. The SPD rates for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure were significantly better than the non-SPD rates in Kern, Sacramento, San Diego, and Stanislaus counties.

The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The SPD rates for the *All-Cause Readmissions* measure in all counties except Stanislaus County were significantly higher than the non-SPD rates, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population in these counties.

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

Improvement Plans

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

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

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

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 in Kern and San Diego counties. The MCP identified several new barriers and challenges that contributed to the rates for this measure being below the MPLs in Kern and San Diego counties, including:

- ◆ Members being unaware that antibiotics do not kill viruses.
- ◆ Providers giving in to pressure from patients to prescribe antibiotics for acute bronchitis.

- ◆ Primary care physicians being unaware that their patients are being prescribed antibiotics for acute bronchitis through emergency departments.
- ◆ Providers being unaware of the clinical practice guidelines related to use of antibiotics for patients with respiratory conditions such as bronchitis.

Health Net continued existing interventions with some modifications based on lessons learned, including:

- ◆ Expanded member education efforts to include use of Promotores to educate members on appropriate treatment for acute bronchitis. (Promotores are volunteer community members who generally share the ethnicity, language, socio-economic status, and life experiences of the community members they serve.)
- ◆ Targeted distribution of the over-the-counter prescription pad to prescribing physicians, not just the primary care providers, if the prescribing physician was contracted with Health Net.
- ◆ Distributed an updated Alliance Working for Antibiotic Resistance Education toolkit to providers and members.
- ◆ Distributed the quarterly provider profile report to providers who inappropriately prescribed antibiotics to members diagnosed with acute bronchitis.

Health Net’s interventions were successful at bringing the rates for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure above the MPLs in Kern and San Diego counties in 2013. The rates for this measure improved significantly in both counties, and the rate improved so much in San Diego County that it moved from below the MPL in 2012 to above the HPL in 2013. The MCP will not be required to continue this IP.

Prenatal and Postpartum Care—Postpartum Care

Health Net was required to continue an IP for the *Prenatal and Postpartum Care—Postpartum Care* measure in Los Angeles County and add San Diego County to the IP. The MCP identified several barriers and challenges that contributed to the rates for this measure being below the MPLs in Los Angeles and San Diego counties, including:

- ◆ Women who are 26 years of age or younger who have lower education levels being less likely to get postpartum care.
- ◆ Women feeling that the postpartum care visit is not a priority.
- ◆ Some women having transportation challenges.
- ◆ Having a limited number of providers.
- ◆ Providers having inconvenient or lack of appointment times.

To address the barriers and challenges, Health Net continued to implement the same interventions as the prior year, making some modifications. Health Net modified its approach to sending out the pregnancy packets. Rather than only sending the packets to women who requested them, the packets were also mailed to members known to have had prenatal visits and who had not yet requested/received the packet. The MCP also enhanced the interactive voice response reminder call program, calling members in need of postpartum care every other week to remind them of their postpartum care visits.

The MCP's efforts were not successful at bringing the rates for this measure above the MPLs in Los Angeles and San Diego counties. Additionally, the rates for the *Prenatal and Postpartum Care—Postpartum Care* measure in Kern and Sacramento counties declined significantly from 2012 to 2013, resulting in the rates moving from above the MPLs in 2012 to below the MPLs in 2013. Due to the high concern that the rate in Los Angeles County for this measure has been below the MPL for three consecutive years, DHCS made a decision to have Health Net discontinue the IP for this HEDIS measure and is requiring that the MCP conduct a *Postpartum Care* QIP that includes all the counties with postpartum care rates below the MPLs.

In addition to conducting a *Postpartum Care* QIP, Health Net will be required to submit IPs for the following measures with rates below the MPLs in 2013:

- ◆ *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* in Kern, Los Angeles, Sacramento, San Diego, and Tulare counties
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Kern, Sacramento, Stanislaus, and Tulare counties
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)* in Kern and Los Angeles counties
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (<9.0 Percent)* in Kern County
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* in Kern, Los Angeles, and Sacramento counties
- ◆ *Comprehensive Diabetes Care—LDL-C Screening* in Sacramento County
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE* in Kern, Los Angeles, Sacramento, San Diego, and Tulare counties
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin* in Kern, Los Angeles, and Sacramento counties
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Kern, Los Angeles, and Sacramento counties
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Kern, Los Angeles, and San Diego counties

Although Health Net's rates for the *Cervical Cancer Screening* measure were below the MPLs in 2013 in Kern, Sacramento, San Diego, and Stanislaus counties, the MCP will not be required to submit an IP for this measure. In August 2013, it was learned that significant changes were made to the specifications for the *Cervical Cancer Screening* measure. NCQA will therefore not publically report this measure for HEDIS 2014, and DHCS made a decision that the MCPs with *Cervical Cancer Screening* rates below the MPLs in 2013 would not be required to submit an IP for the measure. Although this decision was made after the review period for this report, since the decision was made prior to the report being finalized, the information is included.

Although Health Net's rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures in Kern, Los Angeles, Sacramento, and San Diego counties were below the MPLs in 2013 and the rates for two of the *Children and Adolescents' Access to Primary Care Practitioners* measures in Stanislaus County—*7–11 Years* and *12–19 Years*—were below the MPLs, the MCP will not be required to submit an IP for this measure. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact.

Strengths

Across all counties, 12 measures had rates above the HPLs and 27 measures had rates that improved significantly from 2012 to 2013. Additionally, the MCP's IP for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was successful at bringing the rates for this measure above the MPLs in Kern and San Diego counties in 2013. The rates for this measure improved significantly in both counties, and the rate improved so much in San Diego County that it moved from below the MPL in 2012 to above the HPL in 2013.

Opportunities for Improvement

Health Net has the opportunity to make improvements on many measures to impact the quality and timeliness of and access to care for the MCP's MCMC members. Since the MCP is performing poorly on a significant number of measures, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than trying to make improvements on all measures at once. In instances where Health Net has some counties with rates on a particular measure below the MPLs and some counties with rates above the MPLs, the MCP has the opportunity to apply successful strategies from the counties with rates above the MPLs to the poorer-performing counties, as applicable.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol¹⁰ to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

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

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

Validating Quality Improvement Projects and Assessing Results

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

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

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

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

Quality Improvement Project Objectives

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

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

Note: San Joaquin County is not included in any of the QIPs. Health Net will be required to initiate a QIP in San Joaquin County in 2014. If the QIP is initiated prior to June 30, 2014, information about it will be included in Health Net’s 2013–14 MCP-specific evaluation report.

**Table 4.1—Quality Improvement Projects for Health Net
July 1, 2012, through June 30, 2013**

QIP	Counties	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare	Clinical	Q, A
<i>Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities</i>	Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare	Clinical	Q, A

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

Prior to initiation of the statewide collaborative QIP, Health Net had an overall 30-day readmission rate of 9.05 percent among Medi-Cal beneficiaries. Health Net did not specify the readmission rates for the SPD and non-SPD populations.

The *Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities* QIP 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 SPD eligible population for all counties was 7,981 members.¹¹ 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.

¹¹ This QIP initially included Fresno County; however, the MCP stopped providing services in Fresno County starting March 1, 2011.

Quality Improvement Project Validation Findings

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

**Table 4.2—Quality Improvement Project Validation Activity
Health Net—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties
July 1, 2012, through June 30, 2013**

Name of Project/Study	Counties	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>All-Cause Readmissions</i>	Counties received the same score—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare	Study Design Submission	89%	100%	<i>Met</i>
Internal QIPs					
<i>Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities</i>	Kern	Annual Submission	89%	100%	<i>Met</i>
	Los Angeles	Annual Submission	85%	100%	<i>Met</i>
	Sacramento	Annual Submission	89%	100%	<i>Met</i>
	San Diego	Annual Submission	85%	100%	<i>Met</i>
	Stanislaus	Annual Submission	88%	100%	<i>Met</i>
	Tulare	Annual Submission	88%	100%	<i>Met</i>
¹ Type of Review —Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG’s validation criteria to receive an overall <i>Met</i> validation status. ² Percentage 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>). ³ Percentage 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> . ⁴ Overall 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> .					

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by Health Net of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 89 percent of evaluation elements met. Health Net received an overall validation status of *Met* for its *Improving Cervical*

Cancer Screening Among Seniors and Persons with Disabilities annual submission with 100 percent of critical elements and between 85 and 89 percent of evaluation elements met across all counties.

Table 4.3 summarizes the aggregated validation results for Health Net’s QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
Health Net—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	86%	14%	0%
Design Total		95%	5%	0%
Implementation	VII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	VIII: Appropriate Improvement Strategies	80%	10%	10%
Implementation Total		94%	3%	3%
Outcomes	IX: Real Improvement Achieved	33%	0%	67%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		33%	0%	67%
*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.				

HSAG validated Activities I through VI for Health Net’s *All-Cause Readmissions* study design submission and Activities I through X for the MCP’s *Improving Cervical Cancer Screening Among Seniors and Persons with Disabilities* QIP annual submission.

Health Net demonstrated a strong application of the Design stage, meeting 95 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. The MCP did not fully describe the data analysis plan for the *All-Cause Readmissions* QIP, which resulted in a lower score for Activity VI. Health Net met 100 percent of the requirements for all applicable evaluation elements for the Design stage for all counties for the *Improving Cervical Cancer Screening Among Seniors and Persons with Disabilities* QIP.

Only the *Improving Cervical Cancer Screening Among Seniors and Persons with Disabilities* QIP progressed to the Implementation and Outcomes stages. Health Net demonstrated a strong application of the

Implementation stage, meeting 94 percent of the requirements for all applicable evaluation elements within this stage. For Los Angeles and San Diego counties, the MCP failed to revise the interventions to address the poor outcomes in these counties, resulting in a lower score for Activity VIII. Additionally, Activity VIII's score was lowered because Health Net did not identify successful interventions or provide specific documentation about standardizing successful interventions for Kern and Sacramento counties.

The *Improving Cervical Cancer Screening Among Seniors and Persons with Disabilities* QIP did not achieve statistically significant improvement on the study indicator in any of the counties, which resulted in only 33 percent of the requirements for all applicable elements being met for Activity IX. Activity X was not assessed since sustained improvement cannot be assessed until statistically significant improvement over baseline is achieved.

Quality Improvement Project Outcomes and Interventions

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

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

**Table 4.4—Quality Improvement Project Outcomes for Health Net—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties
July 1, 2012, through June 30, 2013**

QIP #1—Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities (SPD)				
Study Indicator: The percentage of SPD women who received one or more Pap tests during the measurement year or the two prior years				
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[‡]
Kern	40.9%	41.5%	42.0%	‡
Los Angeles	50.8%	50.5%	49.8%	‡
Sacramento	39.6%	37.4%	39.8%	‡
San Diego	42.1%	43.4%	41.1%	‡
Stanislaus	44.7%	47.9%	45.6%	‡
Tulare	40.6%	46.5%	45.6%	‡

[‡] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.
[‡] The QIP did not progress to this phase during the review period and therefore could not be assessed.

Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities QIP

Health Net continued to see no significant improvement in any county for the *Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities* QIP. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- ◆ For Kern and Sacramento counties, Health Net indicated that the interventions were ongoing, did not identify successful interventions, or provide specific documentation about standardizing successful interventions. The MCP should regularly monitor interventions to determine if implemented interventions are having a positive impact. Health Net should also document how interventions will be standardized, revised, or discontinued based on remeasurement results. If current interventions are unsuccessful, the MCP should use its drill-down analysis information to develop county-specific interventions.
- ◆ Health Net did not revise existing interventions to address the outcomes reported in Los Angeles, San Diego, and Stanislaus counties. HSAG recommends that the MCP use its drill-down analysis information to identify county-specific problem areas and revise existing interventions or implement new interventions designed to positively impact the indicator rates.
- ◆ For Tulare County, HSAG recommends that the MCP target interventions to low-performing providers.
- ◆ As was done in previous years, Health Net identified county-specific barriers; however, the MCP implemented the same interventions for all counties. Health Net indicated that its decision to implement similar interventions in all counties was based on the large influx of SPD members in the eligible population who may not have been familiar with the Medi-Cal benefits or the importance of being screened for cervical cancer.

Note: As indicated in the Performance Measures section of this report, in August 2013, it was learned that significant changes were made to the specifications for the *Cervical Cancer Screening* measure. NCQA will therefore not publically report this measure for HEDIS 2014. As a result of the changes in the measure specifications, in October 2013, DHCS determined, with input from HSAG, that Health Net should close the *Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities* QIP and identify a new QIP topic. Although this decision was made after the review period for this report, since the decision was made prior to the report being finalized, the information is included.

Strengths

Health Net demonstrated a strong application of the Design and Implementation stages. The MCP was able to achieve a *Met* validation status for both QIPs on the first submission.

Opportunities for Improvement

Although Health Net understands the QIP design process, the MCP has opportunities to improve the documentation for each QIP since not all required information was included in the MCP's most recent QIP submissions. Since the *Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities* QIP will be closed, HSAG does not provide opportunities for improvement specifically related to this QIP; however, HSAG identifies the following opportunities for improvement in Health Net's approach to designing and implementing QIPs:

- ◆ Ensure that the planned interventions target county-specific barriers.
- ◆ Ensure that the MCP conducts ongoing evaluation of each county-specific intervention and modifies or discontinues existing interventions, or implements new ones, based on the evaluation results.
- ◆ Target low-performing, high-volume providers for interventions and duplicate successful interventions across all providers.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)¹² survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

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

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

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

Findings

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

¹² CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CAHPS Global Rating Measures:

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

CAHPS Composite Measures:

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

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

Table 5.1—CAHPS Measures Domains of Care

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

National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.¹³ Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).¹⁴

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)¹⁵ using the following percentile distributions in Table 5.2.

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

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

Tables 5.3 through 5.6 present the star ratings for the global ratings and composite measures for Health Net’s adult and child Medicaid populations.¹⁶

**Table 5.3—Medi-Cal Managed Care Adult County-Level Global Ratings
Health Net—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties**

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

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

¹³ National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.

¹⁴ NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.

¹⁵ Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.

¹⁶ Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

Table 5.4—Medi-Cal Managed Care Child County-Level Global Ratings
Health Net—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties

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

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

Table 5.5—Medi-Cal Managed Care Adult County-Level Composite Measures
Health Net—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties

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

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

Table 5.6—Medi-Cal Managed Care Child County-Level Composite Measures
Health Net—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties

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

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

Strengths

Across all counties, Health Net received the highest ratings for the child *Rating of Specialist Seen Most Often* measure. The MCP received an *Excellent* rating in Los Angeles, San Diego, Stanislaus, and Tulare counties and a *Very Good* rating in Kern County. Please note that Kern, Sacramento, San Diego, and Stanislaus counties had fewer than 100 respondents for all measures; Tulare County had fewer than 100 respondents for all but one measure, and Los Angeles County had fewer than 100 respondents for three measures, so caution should be exercised when evaluating these results.

Health Net improved its ratings on the following measures in Kern County from 2010 to 2013:

- ◆ *Rating of Personal Doctor*—child population
- ◆ *Rating of Specialist Seen Most Often*—adult and child populations
- ◆ *Customer Service*—adult population

Health Net improved its rating on the child *Rating of Specialist Seen Most Often* measure in Los Angeles County from 2010 to 2013.

Health Net improved its rating on the child *Rating of Specialist Seen Most Often* measure in Sacramento County from 2010 to 2013.

Health Net improved its rating on the adult and child *Rating of Specialist Seen Most Often* measures in San Diego County from 2010 to 2013.

Health Net improved its ratings on the following measures in Stanislaus County from 2010 to 2013:

- ◆ *Rating of Personal Doctor*—adult population
- ◆ *Rating of Specialist Seen Most Often*—adult and child populations
- ◆ *Getting Needed Care*—child population
- ◆ *Getting Care Quickly*—child population
- ◆ *Customer Service*—child population

Health Net improved its ratings on the following measures Tulare County from 2010 to 2013:

- ◆ *Rating of Health Plan*—adult and child populations
- ◆ *Rating of All Health Care*—adult population
- ◆ *Getting Needed Care*—child population

Opportunities for Improvement

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

Conducting the EQRO Review

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

Methodology

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

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)¹⁷ completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

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

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

¹⁷ The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

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

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

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

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

Encounter Data Validation Findings

Review of Encounter Systems and Processes

Overall, the information provided in Health Net's Roadmap and supplemental questionnaire consistently demonstrated that the MCP had sound operational policies and practices for the creation, validation, correction, and ongoing monitoring of encounter data submission. Health Net has implemented a Web-based encounter correction/resubmission system for its providers. Also, provider submission time frame requirements vary from daily for the pharmacy benefit manager (PBM), to monthly for the vision service plan, to 90 days for contracted providers. Health Net provides monthly submissions to DHCS, and if encounters are rejected by DHCS, Health Net staff members manually research the issue and update the database with corrected information and the latest adjudicated status. The record is sent to DHCS in a separate submission from the monthly file.

Record Completeness

Health Net had very low record omission and record surplus rates for the Pharmacy claim type, indicating relatively complete Pharmacy data when comparing DHCS's data and the encounter data extracted from Health Net's data system for this study. The Hospital/Inpatient and long-term care (LTC) claim types had worse record omission rates than the statewide record omission rates by 3.1 and 23.1 percentage points, respectively. Although the record omission rate for LTC encounters (24.2 percent) was high, there were only 314 LTC records omitted from the DHCS data warehouse. The main cause for the Hospital/Inpatient omissions was duplicated records

(based on *CCN* and *CCN Line Number*) in the data Health Net submitted to HSAG. The highest record surplus rate was 13.2 percent for the Medical/Outpatient data, which was worse than the statewide rate of 10.6 percent. The surplus Medical/Outpatient records appeared to have a pattern in the DHCS processing date and adjudication date. There were variations at the county level for the record omission and record surplus rates. Some of the highlighted rates included the record omission rate for the Hospital/Inpatient data for which all counties had rates less than 10 percent except Los Angeles County (18.1 percent). In addition, for the Hospital/Inpatient claim type, San Diego County had a record surplus rate of 28.7 percent, while all other counties had rates below 5 percent.

Data Element Completeness

Overall, Health Net had excellent data completeness, with data element omission and element surplus rates of 0.0 or 0.1 percent for all key data elements. All of Health Net's element omission and element surplus rates met or exceeded the statewide rates across all four claim types. At the county level, there was minimal variation for each key data element.

Data Element Accuracy

Health Net had high data element accuracy with accuracy rates greater than 99.5 percent for all key data elements except the *Billing/Reporting Provider Number* in the Medical/Outpatient claim type and *Billing/Reporting Provider Number* and *Revenue Code* in the Hospital/Inpatient claim type. The *Billing/Reporting Provider Number* had slightly lower data element accuracy rates of 98.4 percent and 96.5 percent for the Medical/Outpatient and Hospital/Inpatient encounters, respectively, due to truncation of the provider ID number in the DHCS data warehouse. The data element *Revenue Code* for Hospital/Inpatient encounters had a lower accuracy rate of 82.5 percent because the two data sources displayed the revenue codes in a different order on the claim lines for some of the encounters. The *Billing/Reporting Provider Number* data element had a rate variation of 4.7 percentage points in the Medical/Outpatient claim type and a 29.8 percentage point variation in the Hospital/Inpatient claim type on the county level.

The all-element accuracy rates were very high, ranging from 80.2 percent for the Hospital/Inpatient data to 100.0 percent for the Pharmacy and LTC data. All claim types exceeded the statewide all-element accuracy rates by more than 15 percentage points, and the LTC claim type had an exceptionally high accuracy rate that exceeded the statewide rate by 67.6 percentage points. Overall, all the counties performed well and had consistent performance, except San Diego County, which had a low all-element accuracy rate of 60.0 percent for the Hospital/Inpatient data due to the inaccuracy on the data element *Billing/Reporting Provider Number*.

Recommendations

Based on its review, HSAG recommends the following:

- ◆ Although there were numerous adjustment records in the DHCS data warehouse, all of the records were submitted to correct a data error. Based on Health Net's responses to the questionnaire, if retrospective adjustments were applied after the records were submitted to DHCS, the modified records were not submitted to DHCS. To ensure the data in the DHCS data warehouse are complete and accurate, Health Net should modify its processes so that it can submit the subsequent claims adjustments to DHCS after the original submission.
- ◆ Although the high rate for LTC record omission (24.2 percent) only indicated that 314 records were missing from the DHCS data warehouse, Health Net should investigate why its data system had more LTC records compared to the records stored in the DHCS data warehouse.
- ◆ The high record omission rate for the Hospital/Inpatient claim type was mainly caused by the duplicated records in the data Health Net submitted to HSAG. In addition, the duplicated records had submission dates of August 22, 2011, and September 19, 2011. This issue was likely related to how Health Net extracted/prepared data for this EDV study. However, Health Net should investigate the reason(s) to ensure potential issues related to the data submissions to DHCS are addressed earlier.
- ◆ Health Net should investigate the reason(s) for the high record surplus rate for the Medical/Outpatient claim type and create strategies for future improvement on this indicator. The MCP could begin the investigation by determining why two-thirds of the surplus records in the DHCS data warehouse were processed by DHCS in July 2012 and one-third of these records were processed in August 2011.
- ◆ For the data element *Billing/Reporting Provider Number*, the field length is 12 characters based on the Encounter Data Element Dictionary. However, this data element was stored as a 10-character field in the DHCS data warehouse. Since DHCS stores the data element as a 10-character field, Health Net should try to submit the provider's 10-digit National Provider Identifier (NPI) whenever possible.
- ◆ For the low accuracy rate from the *Revenue Code* data element for Hospital/Inpatient encounters, Health Net should investigate why the revenue codes were populated in a different order for some of the encounters that existed in both sources. Health Net needs to populate the revenue code in a consistent way for future data submissions to DHCS.

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

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.¹⁸

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

¹⁸ This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

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

HSAG reviewed the quality documents Health Net submitted as part of the process for producing this MCP-specific evaluation report. Health Net's quality improvement program structure supports the provision of quality care to the MCP's members and includes continuous quality improvement goals and processes.

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

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Los Angeles, Sacramento, and San Diego counties
- ◆ *Use of Imaging Studies for Low Back Pain* in Sacramento and Stanislaus counties
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin* in San Diego County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in Sacramento County
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* in Kern and Los Angeles counties
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* in Los Angeles and San Diego counties

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

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Kern, Los Angeles, Sacramento, and San Diego counties
- ◆ *Immunizations for Adolescents—Combination 1* in all counties
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE* in Los Angeles, Sacramento, San Diego, and Stanislaus counties
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin* in Los Angeles County
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Los Angeles, Sacramento, and San Diego counties
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* in Kern, Sacramento, and Stanislaus counties
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* in Kern and San Diego counties

- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total* in Kern, San Diego, and Stanislaus counties.

Across all counties, the rates for 29 measures falling into the quality domain of care were significantly worse in 2013 when compared to 2012. Additionally, the following quality measures had rates below the MPLs in 2013:

- ◆ *Cervical Cancer Screening* in Kern, Sacramento, San Diego, and Stanislaus counties
- ◆ *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* in Kern, Los Angeles, Sacramento, San Diego, and Tulare counties
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Kern, Sacramento, Stanislaus, and Tulare counties
- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)* in Kern and Los Angeles counties
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (<9.0 Percent)* in Kern County
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* in Kern, Los Angeles, and Sacramento counties
- ◆ *Comprehensive Diabetes Care—LDL-C Screening* in Sacramento County
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE* in Kern, Los Angeles, Sacramento, San Diego, and Tulare counties
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin and Diuretics* in Kern, Los Angeles, and Sacramento counties
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Kern, Los Angeles, and San Diego counties
- ◆ *Prenatal and Postpartum Care—Postpartum Care* in Kern, Los Angeles, Sacramento, and San Diego counties

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care. The SPD rates were significantly better than the non-SPD rates in all six counties for the following quality measures:

- ◆ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)*

The SPD rates for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure, which falls into the quality domain of care, were significantly better than the non-SPD rates in all counties except Stanislaus County.

The SPD rates for the following quality measures were significantly better than the non-SPD rates in Kern, Los Angeles, Sacramento, and San Diego counties:

- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE*

The SPD rates for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure, which falls into the quality domain of care, were significantly better than the non-SPD rates in Kern, Sacramento, San Diego, and Stanislaus counties.

The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The SPD rates for the *All-Cause Readmissions* measure, which falls into the quality domain of care, were significantly higher than the non-SPD rates in all counties except Stanislaus County, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population in these counties.

All CAHPS measures fall into the quality domain of care. Across all counties, most of the measures had a *Poor* rating for both the adult and child populations. Since the MCP had fewer than 100 respondents for most measures, caution should be exercised when interpreting these results.

Both of Health Net’s QIPs fall into the quality domain of care. Since the *All-Cause Readmissions* QIP did not progress to the Outcomes stage, HSAG was not able to assess the QIP’s success at improving the quality of care delivered to the MCP’s members. The *Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities* QIP reached the Outcomes stage and was not successful at increasing the cervical cancer screening rates in the SPD population.

Overall, Health Net showed below-average performance related to the quality domain of care.

Access

The access domain of care relates to an MCP’s standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP’s compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care. Measures such as

well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

When reviewing the quality improvement documents Health Net submitted as part of the process for producing this MCP-specific evaluation report, HSAG found activities and goals with a focus on ensuring members' access to needed care.

The rate for one access measure, *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*, was above the HPL in Tulare County, and the following access measures had rates that improved significantly from 2012 to 2013:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* in Tulare County
- ◆ *Immunizations for Adolescents—Combination 1* in all counties

Across all counties, 32 access measures had rates that were significantly worse in 2013 when compared to 2012, and the following access measures had rates below the MPLs in 2013:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)* in Kern, Los Angeles, Sacramento, and San Diego counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)* in Kern, Los Angeles, Sacramento, and San Diego counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* in Kern, Los Angeles, Sacramento, San Diego, and Stanislaus counties
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* in Kern, Los Angeles, Sacramento, San Diego, and Stanislaus counties
- ◆ *Cervical Cancer Screening* in Kern, Sacramento, San Diego, and Stanislaus counties
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Kern, Sacramento, Stanislaus, and Tulare counties
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* in Kern, Los Angeles, and Sacramento counties
- ◆ *Comprehensive Diabetes Care—LDL-C Screening* in Sacramento County
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Kern, Los Angeles, and San Diego counties
- ◆ *Prenatal and Postpartum Care—Postpartum Care* in Kern, Los Angeles, Sacramento, and San Diego counties

Nine of the performance measures stratified for the SPD population fall into the access domain of care, and the SPD rates for the following access measures were significantly better than the non-SPD rates:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)* in Sacramento County
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* in Stanislaus County
- ◆ *Comprehensive Diabetes Care—HbA1c Testing* in Sacramento and San Diego counties
- ◆ *Comprehensive Diabetes Care—LDL-C Screening* in Kern, Sacramento, and San Diego counties
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Kern, Sacramento, San Diego, and Stanislaus counties

The *All-Cause Readmissions* measure falls into the access domain of care. As indicated above, the SPD rates were significantly higher than the non-SPD rates in all counties except Stanislaus County, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population in these counties. Additionally, the SPD rates for the following access measures were significantly worse than the non-SPD rates in Los Angeles County:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

The *Getting Needed Care* CAHPS measure falls into the access domain of care. Health Net received a *Poor* rating on this measure for the adult and child populations in all counties except Stanislaus and Tulare counties, which received *Very Good* ratings. Los Angeles County was the only county with more than 100 respondents for this measure, so caution should be exercised when interpreting these results.

Both of Health Net's QIPs fall into the access domain of care. As indicated above, the *All-Cause Readmissions* QIP did not progress to the Outcomes stage; therefore, HSAG was not able to assess the QIP's success at improving access to needed health care services. Also as indicated above, the *Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities* QIP reached the Outcomes stage and was not successful at increasing the cervical cancer screening rates in the SPD population.

Overall, Health Net showed below-average performance related to the access domain of care.

Timeliness

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

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

Health Net's quality improvement program description provides details about the MCP's activities related to grievances, continuity and coordination of care, and utilization management, which all impact the timeliness of care delivered to members.

No timeliness measures had rates above the HPLs in 2013, and the following timeliness measures had rates below the MPLs:

- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Kern, Los Angeles, and San Diego counties
- ◆ *Prenatal and Postpartum Care—Postpartum Care* in Kern, Los Angeles, Sacramento, and San Diego counties

The rate for the *Immunizations for Adolescents—Combination 1* measure, which falls into the timeliness domain of care, improved significantly in all counties from 2012 to 2013, and the rates for the following measures declined significantly from 2012 to 2013:

- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Kern, Los Angeles, and San Diego counties
- ◆ *Prenatal and Postpartum Care—Postpartum Care* in Kern and Sacramento counties

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. Health Net received a *Poor* rating on this measure for the adult and child populations in all counties except Stanislaus County, which received a *Very Good* rating for the child population. Los Angeles County was the only county with more than 100 respondents for this measure, so caution should be exercised when interpreting these results.

Overall, Health Net showed below-average performance related to the timeliness domain of care.

Follow-Up on Prior Year Recommendations

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

- ◆ Since the MCP is performing poorly on a significant number of measures, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than trying to make improvements on all measures at once. In instances where Health Net has some counties with rates on a particular measure below the MPLs and some counties with rates above the MPLs, the MCP has the opportunity to apply successful strategies from the counties with rates above the MPLs to the poorer-performing counties, as applicable.
- ◆ Engage in the following efforts to improve performance on QIPs:
 - Reference the QIP Completion Instructions to ensure all required documentation is included in the QIP Summary Form.
 - Ensure that the planned interventions target county-specific barriers.
 - Conduct ongoing evaluation of each county-specific intervention and modify or discontinue existing interventions, or implement new ones, based on the evaluation results.
 - Target low-performing, high-volume providers for interventions and duplicate successful interventions across all providers.
- ◆ Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Getting Needed Care*, *How Well Doctors Communicate*, and *Rating of All Health Care* priority areas.
- ◆ Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

Quality, Access, and Timeliness Scoring Process

Scale

2.5–3.0 = Above Average

1.5–2.4 = Average

1.0–1.4 = Below Average

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.¹⁹ This process allows HSAG to evaluate each MCP’s performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Tables 3.2 through 3.7)

Quality Domain

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

¹⁹ The CMS protocols specify that the EQRO must include an assessment of each MCP’s strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

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

Access and Timeliness Domains

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

CAHPS Survey Measures

(Refer to Tables 5.3 through 5.6)

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

Quality Domain

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

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

Access Domain

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

Timeliness Domain

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

Quality Improvement Projects (QIPs)

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

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

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

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

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

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

Calculating Final Quality, Access, and Timeliness Scores

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

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

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

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

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

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

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

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

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

2011–12 External Quality Review Recommendation	Health Net’s Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. Ensure all deficiencies identified during the May 2008 medical performance review are fully resolved. Specifically:	
a. Provide documentation to DHCS showing that Health Net has secured access to a dermatology specialist group in Stanislaus County.	<p>Health Net currently has six contracted dermatology specialists in Stanislaus County. A spreadsheet containing the physician’s names and office locations is attached within the e-mail.</p> <p>NOTE: HSAG reviewed the spreadsheet and confirmed the list includes dermatologists in Stanislaus County. HSAG could not confirm that Health Net has submitted the information to DHCS.</p>
2. Assess the factors that are impacting continued poor performance on the <i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis and Prenatal and Postpartum Care—Postpartum Care</i> measures and modify IP interventions as appropriate to move performance to above the MPLs for the counties that continue to perform below the MPLs.	<p>AAB—Health Net’s barrier analysis identified providers who have been prescribing antibiotics inappropriately and sent quarterly member profile lists with their patients who had been prescribed inappropriate antibiotics. Health Net participates in the Statewide AWARE collaborative developing educational materials for members and providers</p> <p>Postpartum care—Bimonthly, Health Net identified members who have delivered and used the data to make IVR reminder calls with live connection to member services reminding members to have their postpartum visit within the recommended time frame. In addition, Health Net initiated an incentive program of a \$100 gift card weekly raffle for those who have postpartum visits within the recommended time frame. The letters regarding the member incentive information are sent to members bimonthly with the form to complete confirming their postpartum visits. Health Net provider’s front office staff are given talking points as well as the access 1 page reminder schedule for prenatal and postpartum visits. We continue to participate in the T4t that reminds moms when to schedule for prenatal and postpartum visits.</p>

2011–12 External Quality Review Recommendation	Health Net's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
<p>3. Assess the factors that led to San Diego County experiencing a statistically significant decline in performance for the <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> measure and develop and implement strategies to prevent the rate on this measure from declining to below the MPL.</p>	<p>There were providers who refused to share medical records with Health Net. This was resolved with involvement of the provider network management assistance, HEDIS team, and medical director.</p> <p>Health Net continued to initiate postpartum and prenatal initiatives noted above.</p>
<p>4. 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.</p>	<p>QIP barriers had been prioritized and interventions had been implemented dependent on the prioritized barriers with documentation supporting the barrier and intervention prioritization.</p> <p>For SPD-CCS QIP, conflicting recommendations from NCQA and United States Preventive Services Task Force (USPSTF) caused annoyance from providers and noncompliance from both providers and members.</p>
<p>5. 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.</p>	<p>Interventions that are quantitatively measured had been evaluated for their effectiveness and had been reported for the measurement periods when interventions were implemented.</p>
<p>6. 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 <i>Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities</i> QIP outcome.</p>	<p>Providers who had high-volume CCS numerator negative members were sent a list of their members due for testing. Providers were advised to make appointments for testing. Several providers contacted Health Net and complained that Health Net's request is inappropriate and wasteful. This has been a problematic measure since NCQA and USPSTF recommendations have not been congruent with each other resulting in providers' and members' noncompliance.</p> <p>In addition, this measure is recommended by NCQA as not reportable in reporting year 2014 since the HEDIS specs have changed to conform to the USPSTF recommendation.</p>