2012 Healthy Families Program Healthcare Effectiveness Data and Information Set (HEDIS) Report

California Managed Risk Medical Insurance Board

December 2013

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Managed Risk Medical Insurance Board
Healthy Families Program

MRMIB provides and promotes access to affordable coverage for comprehensive, high quality, cost-effective health care services to improve the health of Californians.

Janette Casillas
Executive Director
Managed Risk Medical Insurance Board

Ellen Badley
Deputy Director
Benefits & Quality Monitoring Division

Juanita Vaca
Research Analyst II
Benefits & Quality Monitoring Division

David Bruglia
Associate Governmental Program Analyst
Benefits & Quality Monitoring Division

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EXECUTIVE SUMMARY

Introduction

The 2012 Healthcare Effectiveness Data and Information Set (HEDIS®) Report for the Healthy Families Program (HFP) presents information on the quality of care provided by 21 participating health plans to HFP subscribers. Each year, health plans are required to report to the Managed Risk Medical Insurance Board (MRMIB) on a selection of HEDIS measures. HEDIS is a national, standardized set of measures developed by the National Committee for Quality Assurance (NCQA). For additional information on HEDIS visit NCQA's website at http://www.ncqa.org.

For more than a decade, MRMIB has used HEDIS results to monitor plan performance and to inform decision-making regarding quality improvement activities and health plan participation in HFP. In addition, HEDIS results have been provided to subscribers in enrollment materials, including the program handbook, so that families could compare health plan performance in areas important to them. HFP results are also displayed on the State of California's Office of the Patient Advocate website at http://www.opa.ca.gov/reportcard.

HFP HEDIS Measures for 2012

MRMIB selects specific measures for monitoring the performance of health plans participating in the HFP. For 2012, MRMIB collected the same measures as in 2011.

For most of these measures, a child or adolescent must be enrolled continuously throughout the year, with a single gap of not more than 45 days.

For 2012, the HFP HEDIS measures were:

Children's and Adolescents' Access to Primary Care Practitioners:

- *12 -24 Months*
- *25 Months- 6 Years*
- *7 – 11 Years*
- *12 – 18 Years*

Childhood Immunization Status, Combination 3
Childhood Immunization Status, Combination 10
Well-Child Visits in the First 15 Months of Life
Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life
Immunizations for Adolescents
Adolescent Well-Care Visits
Chlamydia Screening in Women
Mental Health Utilization
Identification of Alcohol and Other Drug Services
Use of Appropriate Medications for People with Asthma
Appropriate Testing for Children with Pharyngitis
Appropriate Treatment for Children with Upper Respiratory Infection
Lead Screening in Children

Key Findings:

- 98 percent of infants 12 to 24 months old had at least one primary care visit in 2012.
- Almost three-quarters of eligible HFP subscribers received the Combination 1 vaccination for adolescents.
- Nearly 90 percent of HFP subscribers with asthma were prescribed appropriate medication.
- 90 percent of HFP subscribers were appropriately treated for the common cold.
- The overall HFP rate for *Childhood Immunization Status, Combination 3* dropped from 79.3 to 54.6 percent. The significant drop and the large number of plans with rates below the national commercial 10th percentile this year may be explained in part by the change in methodology for most plans in 2012 from a hybrid to an administrative method of measurement.

- The overall HFP rate for *Well-Child Visits in the First 15 Months of Life* also dropped from 62.1 to 46.5 percent. Like *Childhood Immunization Status, Combination 3*, the significant drop this year and the increased number of plans with rates below the national commercial 10th percentile may be explained in part by the change in measurement methodology for most plans in 2012.

- The greatest increase in access to PCP's over the last three years was observed for Korean speaking families.

- *Appropriate Pharyngitis Testing* shows improvement for each of the last two years for every language group except Vietnamese.

- English speaking teens received mental health treatment at much higher rates than any other language group, followed by Spanish speaking teens.

- White subscribers received *Appropriate Testing for Children with Pharyngitis* at the highest rate of 64.2 percent, followed by Black/African American subscribers at a rate of 61.9 percent, while only a third of Asian/Pacific Islander subscribers received appropriate treatment for pharyngitis.

- Asian/Pacific Islander subscribers had the lowest rate of mental health services at 1.4 percent, well below that of all other ethnic groups.

- Access for subscribers for both the 0-6 and 7-19 age groups was over 90 percent in every region but Los Angeles.

- Almost 60 percent of teens in the South Coast region received appropriate testing for Chlamydia, while only 25 percent of teens in the Northern Region were tested.

- The rate of *Appropriate Testing for Children with Pharyngitis* has increased in every region in both of the last two years.

Conclusions and Lessons Learned

Overall, the 2012 HEDIS results indicate that the HFP performed well in access to care for all four age groups. HFP made incremental improvements in *Chlamydia Screening in Women*, *Appropriate Testing for Children with Pharyngitis* and *Appropriate Treatment for Children with Upper Respiratory Infection*. In addition, for six measures not a single plan performed below the national commercial 10th percentile.

Over the life of HFP, MRMIB placed significant effort and focus on measuring and improving the quality of health care provided to HFP subscribers by its' contracting plans. These efforts were guided by an advisory group of quality experts, external stakeholders, MRMIB staff, health plan partners and members of the HFP Advisory Panel. MRMIB found that the contributions of external quality experts, plan partners and subscribers were essential to the development of sound quality improvement strategies. These groups set a high bar of expectations, and worked tirelessly to ensure that HFP was a high quality, responsive public program. For that reason, MRMIB recommends that other public programs utilize similar expertise in the development of their quality strategies.

HEDIS measures enabled MRMIB to assess health plan performance based on practice guidelines and recommendations from the Agency for Healthcare Research and Quality, the American Academy of Pediatrics, and the Centers for Disease Control and Prevention. In addition, public reporting of these measures was an important tool to enable policymakers to evaluate the quality of healthcare provided by HFP health plans. HFP used this information to identify areas where plans were performing well and where more effort was needed and to inform quality improvement initiatives. MRMIB recommends that the Department of Health Care Services use these same measures to measure the delivery of care of the transitioned population and to assess and publicly report on the effectiveness of the HFP transition for quality and access to care.

With the transition of HFP subscribers to the Medi-Cal program in 2013, this is the final HEDIS report MRMIB will publish. While submission of HEDIS data was an HFP contract requirement, plan's

had discretion in determining the methodology for measuring and reporting the data within the guidelines required by NCQA. As a result of this transition, most plans used a less costly and rigorous methodology for measuring and reporting a number of measures in 2012. Consequently, HFP averages for some measures show large decreases and care should be taken in drawing any conclusions about these program results. A more detailed explanation of data collection and reporting is provided later in this report. In addition, Appendix B denotes the plans and measures that used a different methodology in 2012 as compared to the 2011 report.

In conclusion, MRMIB would like to recognize the commitment and partnership shown by its health plans to the families served by HFP over the life of the program.

BACKGROUND

Members Included in the Measures

For several measures, a member must be enrolled continuously throughout the year, with a single gap of not more than 45 days. Measures requiring two years' continuous enrollment are the *Children's and Adolescents' Access to Primary Care Practitioners* for 7-11 year-olds and 12-18 year-olds, and the *Use of Appropriate Medications for People with Asthma*. The measures *Appropriate Testing for Children with Pharyngitis and Appropriate Treatment for Children with Upper Respiratory Infection* require 30 days of enrollment prior to the episode. Measures that count every member who received a service are *Mental Health Utilization* and *Identification of Alcohol and Other Drug Services*.

Measurement Methods

There are two methods for determining the number of members who receive a service under HEDIS. The administrative method measures billing data. The hybrid method uses a statistically valid random sample of members and determines the measure using administrative data and a review of services recorded in the medical chart. Some HFP plans use the hybrid method for measures of immunizations and well-care visits because requirements to count as a "yes" are very detailed and the resulting measurement is more accurate. This methodology is more fully described in the Data Collection and Reporting Methodology section found on page 26.

As a result of the transition of HFP subscribers to the Medi-Cal program in 2013, a large number of plans that utilized the hybrid method of measurement in 2011, switched to the administrative method for 2012. The hybrid method is more resource intensive, time consuming and costly. However, this change resulted in some striking performance changes for some plans and the reported results this year should be considered in that context.

Trends in HFP Performance from 2009-2012

Table 1 on the next page provides the HFP averages by measure for each of the past four years and shows that the HFP improved for two consecutive years for:

- *Childhood Immunization Status, Combination 10*
- *Immunization for Adolescents, Combination 1*
- *Chlamydia Screening in Women*
- *Appropriate Testing for Children with Pharyngitis*
- *Mental Health Utilization, 13-17 Years*

HFP's overall average decreased more than five percentage points from 2009 to 2012 for the following measures:

- *Childhood Immunization Status, Combination 3*
- *Well Child Visits in the First 15 Months of Life, 6 + Visits*
- *Well Child Visits in the 3rd to 6th Years of Life*

However, as previously discussed, the significant drop this year in these measures may be explained in part by the change in methodology for most plans in 2012 from a hybrid to an administrative method of measurement.

Table 1. Rates of the HEDIS Measures 2009, 2010, 2011 and 2012

HEDIS Measure	HEDIS Abbre-viation	Rates			
		2009	2010	2011	2012
Children's Access to Primary Care Practitioners: 12 - 24 Months	CAP_1	97.9%	97.4%	98.1%	98.0%
Children's Access to Primary Care Practitioners: 25 Months - 6 Years	CAP_2	91.0%	90.2%	90.4%	89.5%
Children's Access to Primary Care: 7 - 11 Years	CAP_3	90.8%	90.4%	91.2%	90.6%
Adolescents' Access to Primary Care: 12 - 18 Years	CAP_4	89.3%	87.5%	91.8%	91.8%
Childhood Immunization Status, Combination 3	CIS3*	77.7%	74.5%	79.3%	54.6%
Childhood Immunization Status, Combination 10	CIS10*	ND	18.1%	23.8%	28.8%
Immunizations for Adolescents, Combination 1	IMA*	ND	54.4%	69.5%	71.9%
Well-Child Visits in the First 15 Months of Life, 6+ Visits	W15_6*	58.1%	60.9%	62.1%	46.5%
Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	W34*	76.8%	74.0%	74.3%	70.0%
Adolescent Well-Care Visits	AWC*	46.3%	47.3%	58.4%	46.7%
Chlamydia Screening in Women	CHL	44.4%	47.7%	47.8%	49.4%
Use of Appropriate Medications for People with Asthma	ASM	93.6%	92.6%	89.0%	89.1%
Appropriate Testing for Children with Pharyngitis	CWP	34.8%	38.5%	46.0%	49.7%
Appropriate Treatment for Children with Upper Respiratory Infection	URI	87.2%	88.8%	87.8%	89.8%
Mental Health Utilization, 13-17 Years	MPT*	3.7%	3.9%	4.3%	4.4%
Identification of Alcohol and Other Drug Services, 13-17 Years	IAD*	0.8%	0.9%	0.9%	1.0%
Lead Screening in Children	LSC*	61.7%	56.6%	56.4%	56.4%

*Some overall results are weighted averages and are denoted with an asterisk. Weighted averages are calculated for some measures because it considers variations in enrollment across HFP plans. The performance measures by health plan is given in Appendix B, and significant changes in performance by each health plan are highlighted with up/down arrows in Appendix C.

Comparison to National Averages

To assess HFP performance relative to other types of health insurance coverage, HFP averages for 2012 are compared with national commercial and national Medicaid HMOs in Table 2. Four HFP HEDIS rates are above both the commercial and Medicaid averages, and six rates are below both averages.

Table 2: HFP Rates Compared to National Averages

HEDIS Measure	2012 HEDIS Averages*		
	Healthy Families Program	National Commercial HMOs	National Medicaid HMOs
Childhood Immunization Status, Combination 3	54.6%	77.1%	71.9%
Childhood Immunization Status, Combination 10	28.8%	21.3%	16.5%
Immunizations for Adolescents, Combination 1	71.9%	59.9%	62.3%
Well-Child Visits, First 15 Months of Life, 6+ Visits	46.5%	80.6%	63.0%
Well-Child Visits, 3rd, 4th, 5th, & 6th Years of Life	70.0%	74.6%	72.3%
Adolescent Well-Care Visits	46.7%	41.3%	49.7%
Mental Health Utilization, 13 - 17 Years of Age	4.4%	8.9%	12.4%
Identification of Alcohol and Other Drug Services, 13 - 17 Years	1.0%	1.0%	1.9%
Use of Appropriate Medications for People with Asthma	89.1%	92.3%	85.9%
Appropriate Treatment for Upper Respiratory Infection	89.8%	85.3%	85.3%
Appropriate Testing for Children with Pharyngitis	49.4%	82.0%	70.0%
Lead Screening in Children	56.4%		71.4%
Chlamydia Screening in Women	49.7%	43.9%	58.4%
Access to Primary Care: 12 - 24 Months	98.0%	98.5%	97.0%
Access to Primary Care: 25 Months - 6 Years	89.5%	92.8%	89.2%
Access to Primary Care: 7 - 11 Years	90.6%	92.5%	90.6%
Access to Primary Care: 12 - 18 Years	91.8%	89.7%	89.2%

*These averages released by the National Committee for Quality Assurance (NCQA) in 2012 are derived from data collected in calendar year 2011; data for calendar year 2012 will be published in Spring 2014.

Health Plan Performance

High and low performing plans were determined by comparing the number of HEDIS rates at or above the commercial 90th percentile (high rates) and at or below the 10th percentile (low rates).

High Performers

For 2012, there are five health plans that had four or more HEDIS rates above the national commercial 90th percentile rate:

Kaiser Foundation Health Plan-North	11 rates
Kaiser Foundation Health Plan-South	9 rates
CalOptima	4 rates
Health Plan of San Mateo	4 rates
San Francisco Health Plan	4 rates

Low Performers

For 2012, three health plans had eight or more HEDIS rates at or below the national commercial 10th percentile rate:

Care1st Health Plan	10 rates
Anthem Blue Cross HMO	8 rates
LA Care Health Plan	8 rates

Demographic Findings

MRMIB monitors its health plans to ensure that access to quality healthcare is shared by all of its subscribers. Statistical analysis of HEDIS data tells where a particular demographic stands out among the others. Three demographic variables were evaluated in this report home language, subscriber ethnicity and region. Three years of data for selected measures are presented in Appendices D, E and F with key findings.

CHILDREN'S AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS

Measure Definition

Children's Access to Primary Care Practitioners measures children who visited a primary care practitioner (PCP) at least once during 2012 (ages 12 to 24 months and ages 25 months to 6 years), or at least once in *either* 2009 *or* 2010 (ages 7 to 11 years and 12 to 18 years). There are four separate rates reported for the four age groups:

- 12 to 24 months if born on or between December 31, 20011 and December 1, 2010
- 25 months to 6 years if born on or between November 30, 2010 and January 1, 2006
- 7 to 11 years as of December 31, 2012
- 12 to 18 years as of December 31, 2012

Importance of this Measure

Having a primary care provider serve as the point of first contact serves two main functions. First, the patient benefits from obtaining care from the most appropriate source of care; second, to the extent that the gatekeeper either provides care him/herself or refers the patient to non-specialist providers, this practice is likely to result in lower cost of treatment. The benefit of first contact care consists of: fewer visits to specialist, fewer emergency room visits, and lower hospitalization rates.[1]

Children's and Adolescents' Access to Primary Care Practitioners (CAP) – Summary for All Age Groups

Plans whose subscribers visited a primary care practitioner at a high rate in all four age groups were:

- Kaiser Foundation Health Plan-South
- Health Plan of San Mateo

Plans whose subscribers visited a primary care practitioner at a rate below the commercial 10th percentile in three of four age groups were:

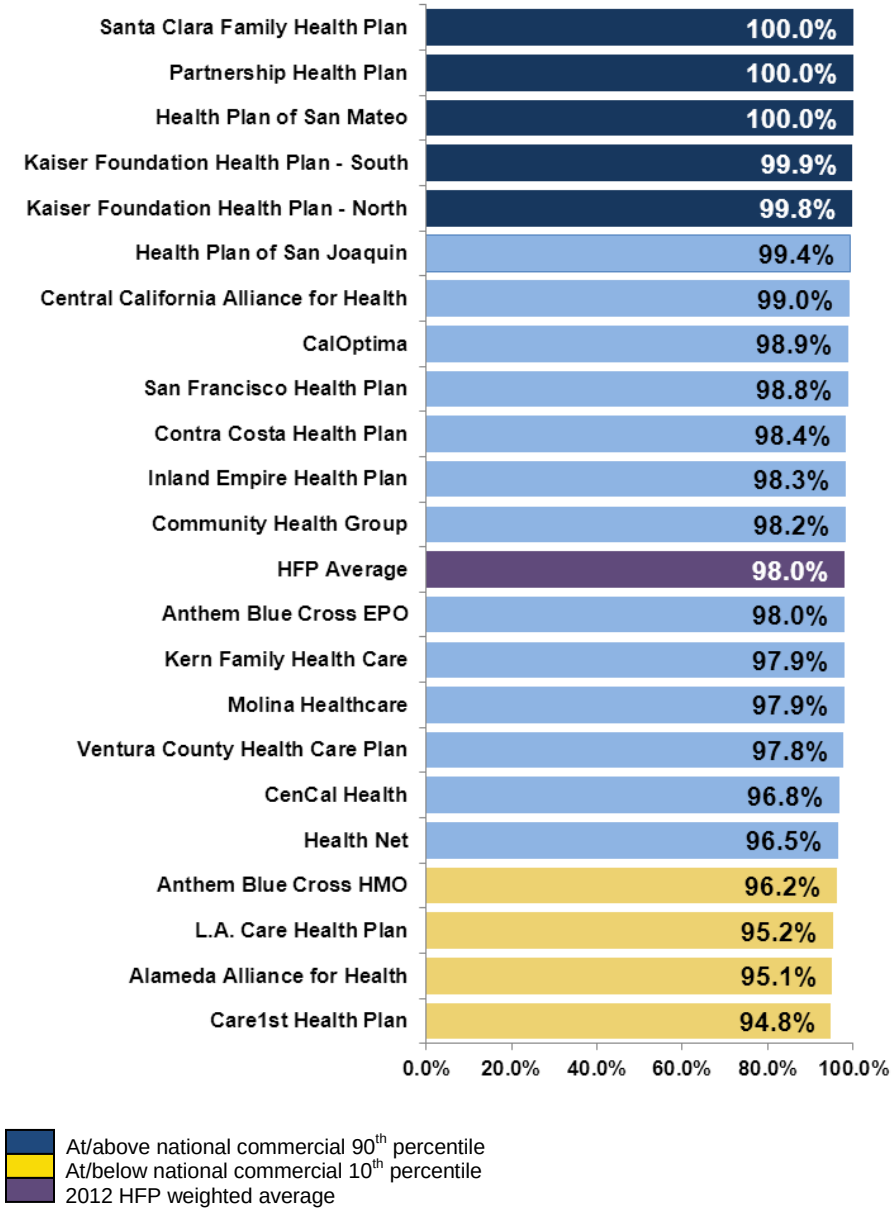
- Anthem Blue Cross HMO
- Care1st Health Plan

Demographic Analysis

Demographic analysis was done on this measure by home language, ethnicity and region. This information can be found in Appendices D, E and F.

[1] Analysis of Attributes of Care: First Contact Care. (1992) Child and Adolescent Health Policy Center. The John Hopkins University School of Hygiene and Public Health. Department of Maternal and Child Health for the Maternal and Child Health Bureau.

Figure 1. 2012 Individual Plan Rates



Plans Above the National Commercial HMO 90th Percentile

- Santa Clara Family Health Plan
- Partnership Health Plan
- Health Plan of San Mateo
- Kaiser Foundation Health Plan, South
- Kaiser Foundation Health Plan, North

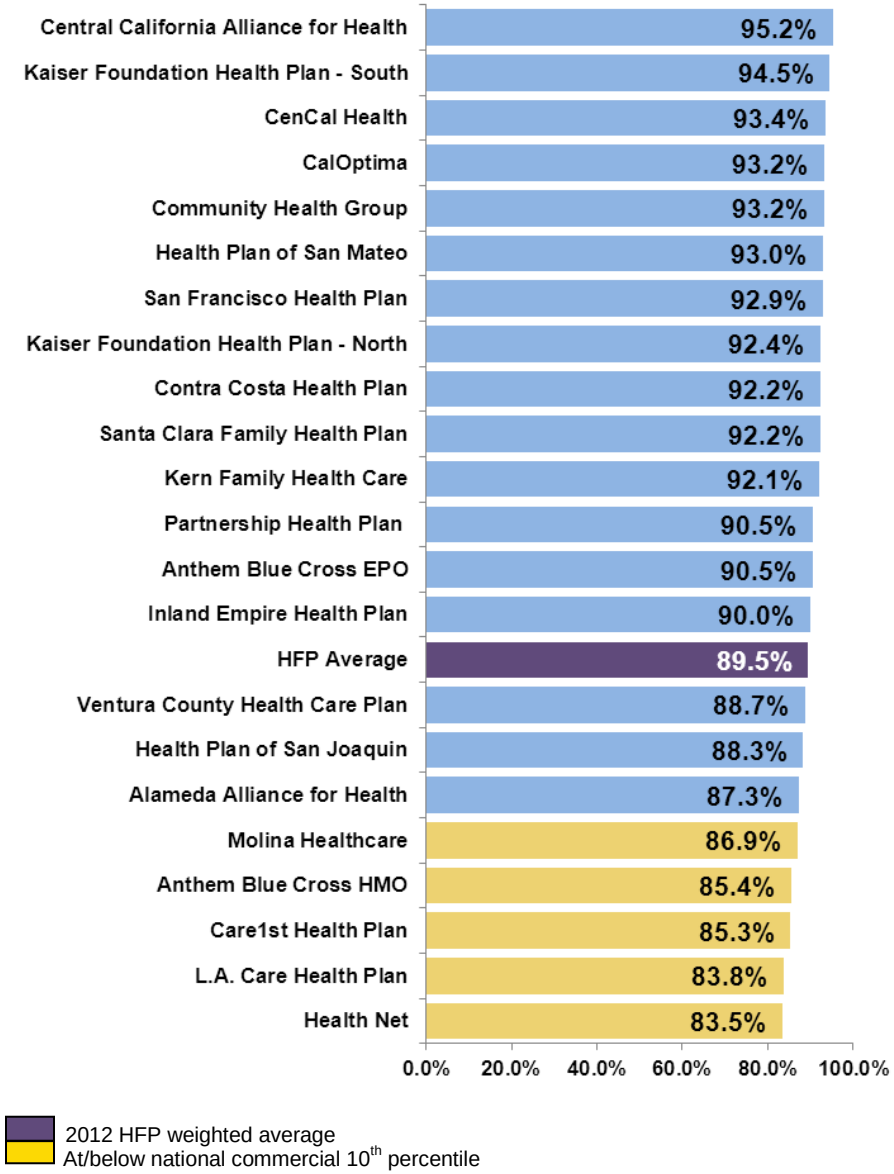
Overall Results

HFP plans performed very well, as they have for the past three years, resulting in nearly 98 percent of infants 12 to 24 months old having at least one primary care visit in 2012. Five HFP health plans performed above the national commercial 90th percentile of 99.6 percent. Four plans performed at or below the 10th percentile of 96.2 percent.

Demographic Analysis

Demographic analysis was done on this measure by home language, ethnicity and region. This information can be found in Appendices D, E and F.

Figure 2. 2012 Individual Plan Rates



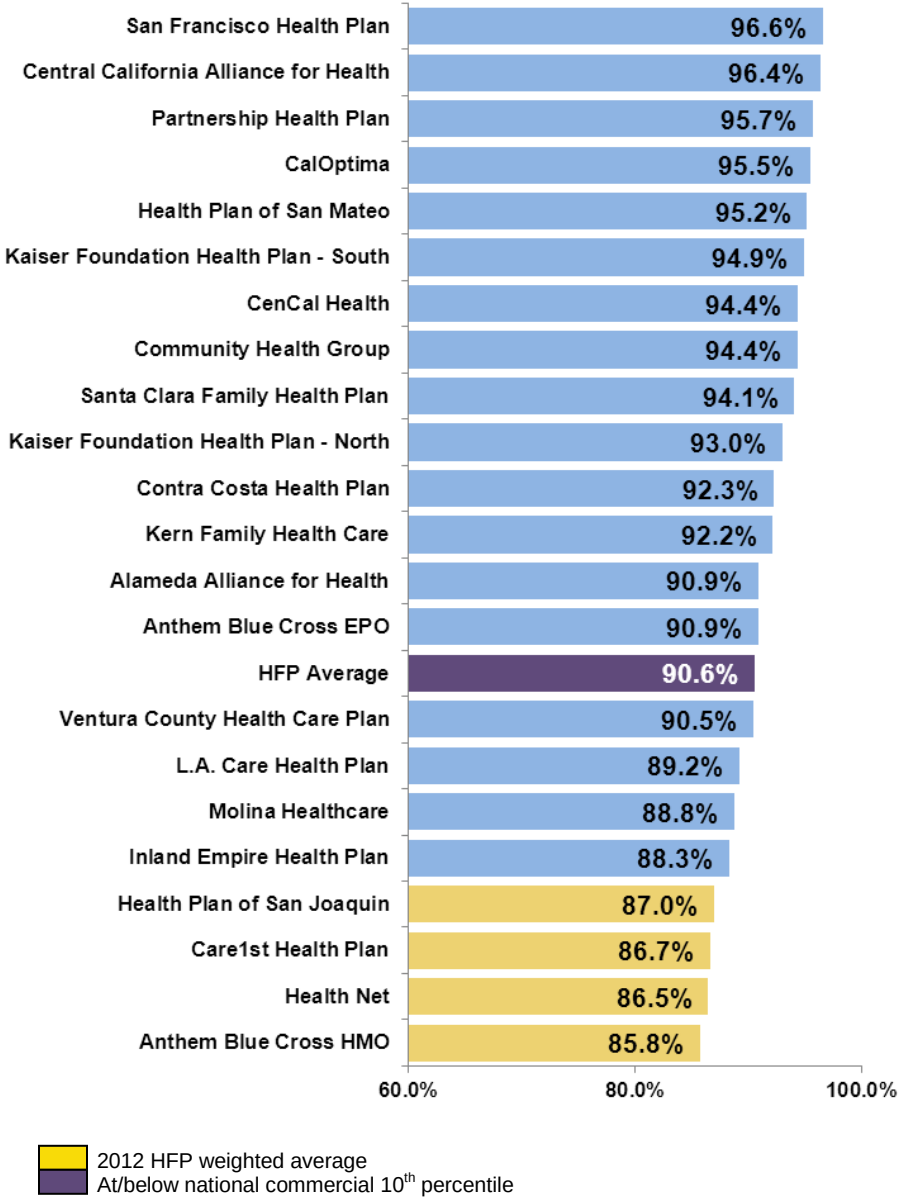
Overall Results

Ninety percent of HFP children ages 25 months to 6 years old saw a primary care practitioner in 2012. No health plans achieved the national commercial 90th percentile of 96.3 percent for this measure. Five plans performed at or below the 10th percentile of 86.9 percent.

Demographic Analysis

Demographic analysis was done on this measure by home language, ethnicity and region. This information can be found in Appendices D, E and F.

Figure 3. 2012 Individual Plan Rates



Overall Results

In 2012, individual health plan rates varied from 85.8 percent to 96.6 percent with HFP's average at 90.6 percent. None of the 22 health plans had rates at or above the national commercial 90th percentile rate of 97.3 percent. Four health plans had rates at or below the national commercial 10th percentile of 87.1 percent.

Demographic Analysis

Demographic analysis was done on this measure by home language, ethnicity and region. This information can be found in Appendices D, E and F.

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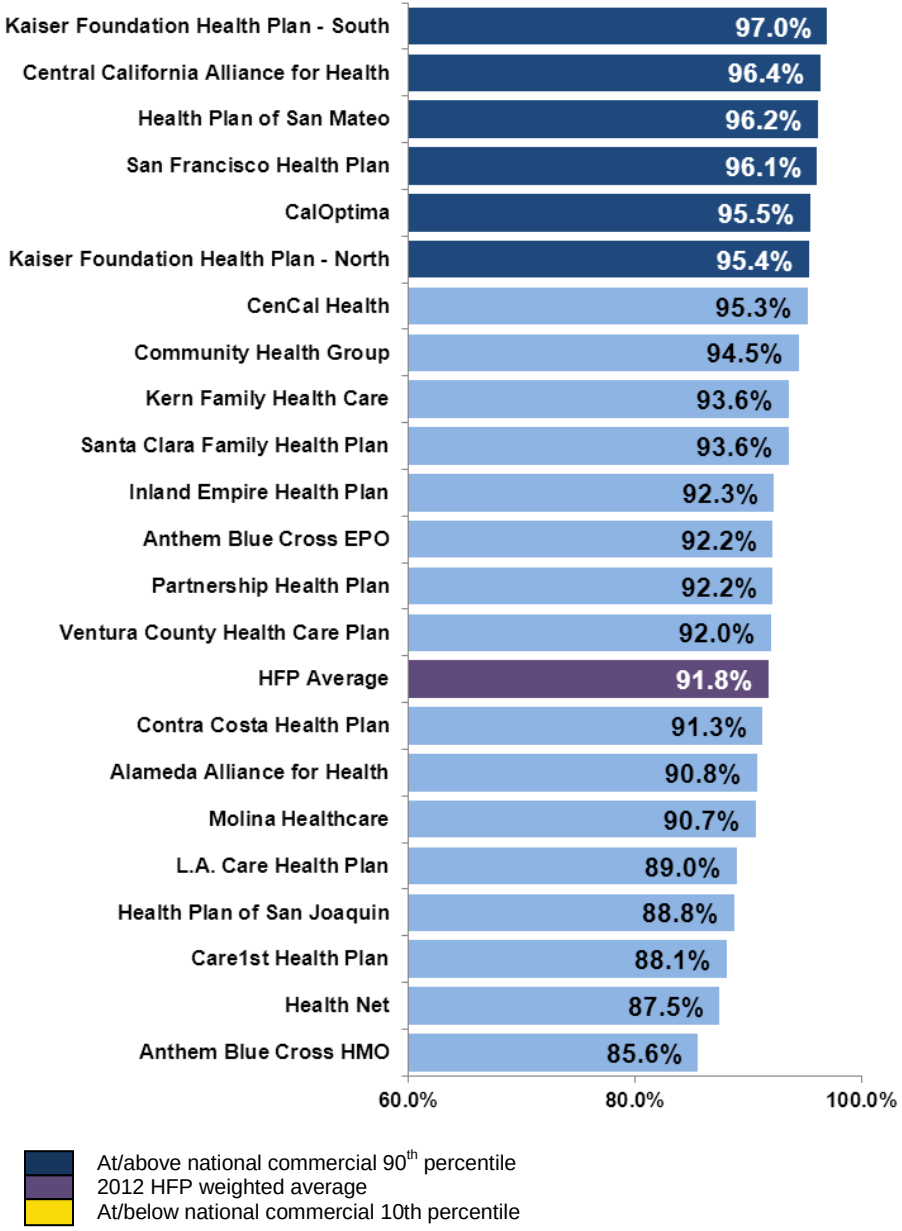
Figure 4. 2012 Individual Plan Rates



Plans Above the National Commercial HMO 90th Percentile

- Kaiser Foundation Health Plan-South
- Central California Alliance for Health
- Health Plan of San Mateo
- San Francisco Health Plan
- CalOptima
- Kaiser Foundation Health Plan-North

Overall Results

The 2012 HFP average for 12 to 18 year olds was at 91.8 percent. Six of the 22 health plans achieved rates at or above the national commercial 90th percentile rate of 95.4 percent. None of the health plans provided primary care visits at a rate below the national commercial 10th percentile of 84.4 percent.

Demographic Analysis

Demographic analysis was done on this measure by home language, ethnicity and region. This information can be found in Appendices D, E and F.

CHILDHOOD IMMUNIZATION STATUS

Measure Definition

Childhood Immunization Status measures how many children, who by their second birthday, received vaccines recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics.

Combination 3 is the first of two immunization combinations monitored by MRMIB and includes:

- Diphtheria, tetanus, and pertussis (DTaP)
- Polio (IPV)
- Measles, mumps, and rubella (MMR)
- Hepatitis B (HepB)
- Chicken Pox (VZV)
- H influenza type B (HiB)
- Pneumonia (PCV)

Combination 10 comprises all of the immunizations of *Combination 3* above, and in addition includes immunizations for:

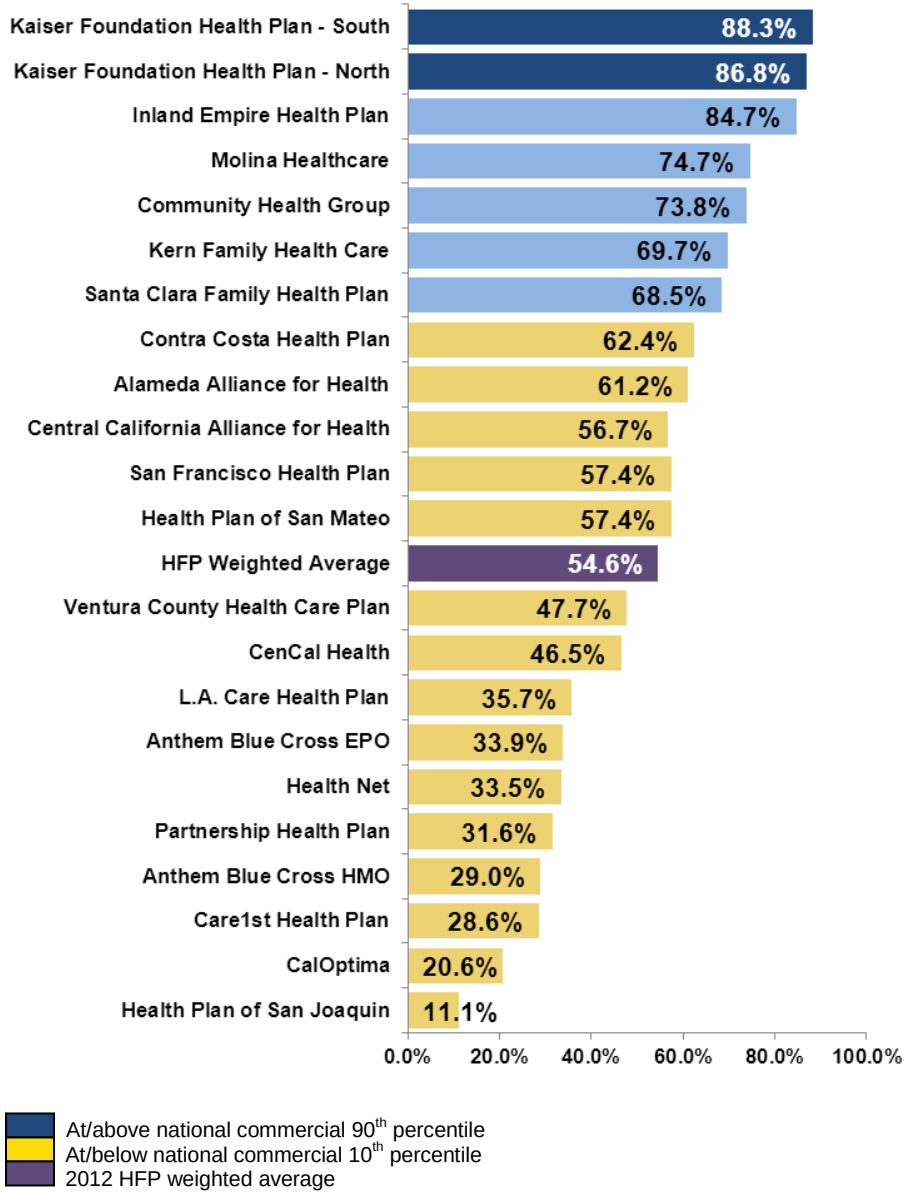
- Hepatitis A (HepA)
- Rotavirus (RV)
- Influenza

Although *Combination 10* was new to HFP measures in 2010, these vaccines have been recommended by the CDC since 2007.

Importance of the Measure

Vaccinations are very important for a variety of reasons. For children, vaccines are particularly important because younger children are vulnerable to disease germs and their bodies may not yet have the strength to fight diseases. Secondly, vaccinations protect the health of the entire community - if many are immunized, those who cannot be vaccinated will be exposed to less disease. For instance, infants cannot be vaccinated for certain diseases such as measles, but are still susceptible to contracting measles. If older children have been vaccinated, infants will be less likely to be exposed to measles. Finally, vaccinations are critical to slowing or stopping the spread of diseases and preventing outbreaks. For these reasons, children's health is protected through immunization.

Figure 5. 2012 Individual Plan Rates



Plans Above the National Commercial HMO 90th Percentile

- Kaiser Foundation Health Plan-South
- Kaiser Foundation Health Plan-North

Overall Results

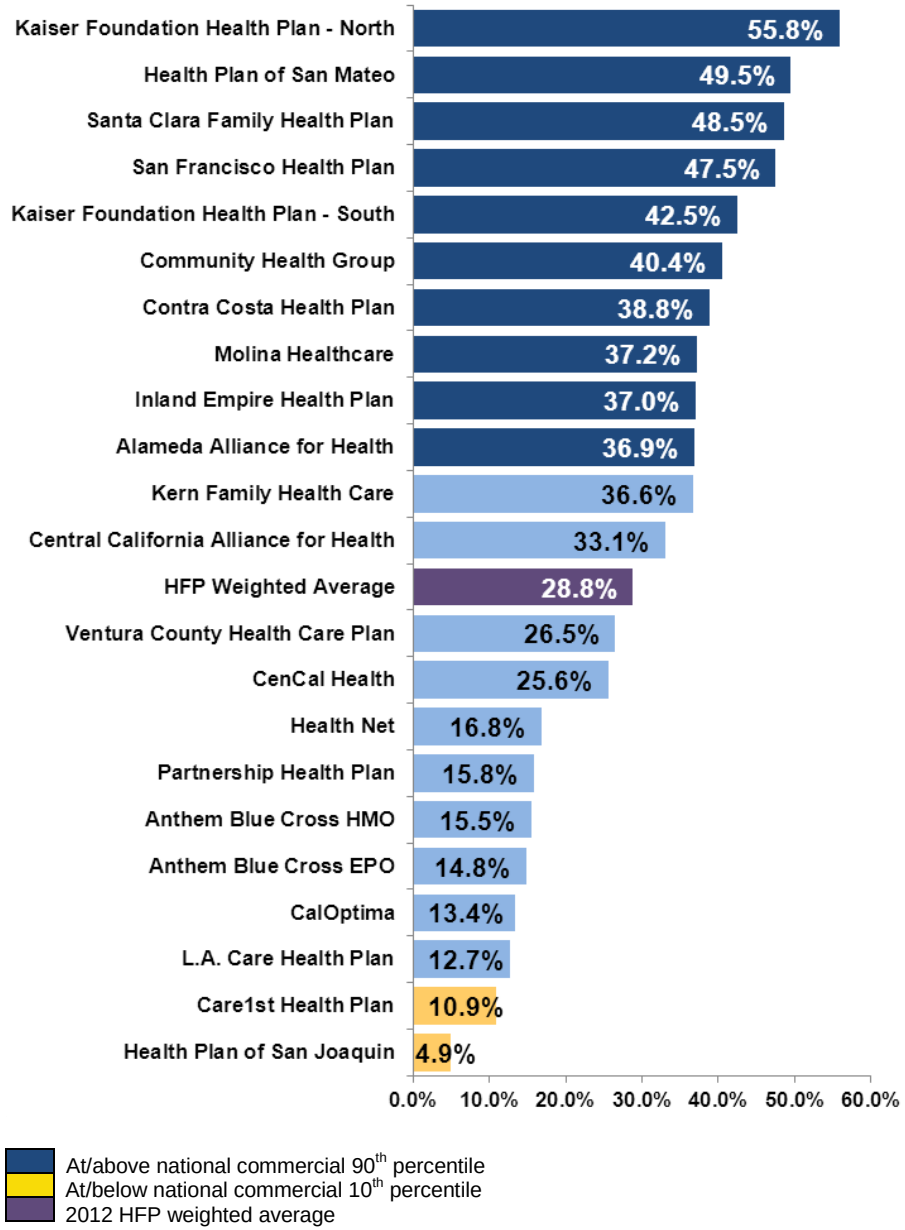
In 2012, 54.6 percent of HFP subscribers under two years old received the combination 3 vaccination. Two plans had rates above the national commercial 90th percentile rate of 84.9 percent, and 15 health plans had rates below the national commercial 10th percentile rate of 65.6 percent.

In 2011, the HFP weighted average for this measure was 79.3 percent. The significant drop this year and the large number of plans with rates below the national commercial 10th percentile this year may be explained in part by the change in methodology for most plans in 2012 from a hybrid to an administrative method of measurement. There were three plans in 2011 with rates below the 10th commercial percentile.

Although Kaiser Health Plans also used the administrative method this year and in previous years, it is likely that their integrated system of electronic medical records provides more accurate data than can be achieved by health plans with contracted provider networks.

Appendix B provides a table of the rates by plan. In this table, bold numbers indicate plans that used the administrative method this year, and shaded boxes denote measures that previously used the hybrid method.

Figure 6. 2012 Individual Plan Rates



Plans Above the National Commercial HMO 90th Percentile

- Kaiser Foundation Health Plan-North
- Health Plan of San Mateo
- Santa Clara Family Health Plan
- San Francisco Health Plan
- Kaiser Foundation Health Plan-South
- Community Health Group
- Contra Costa Health Plan
- Molina Healthcare
- Inland Empire Health Plan
- Alameda Alliance for Health

Overall Results

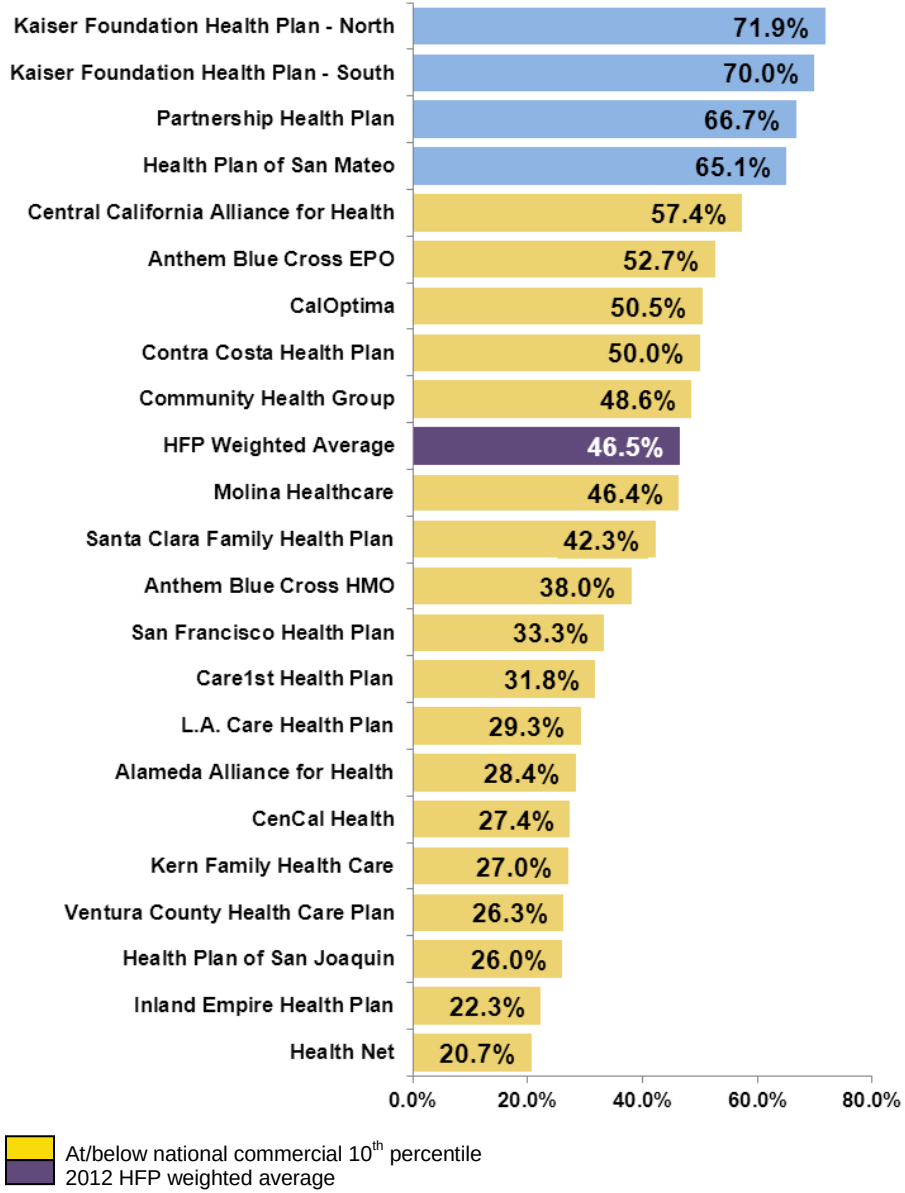
28 percent of HFP subscribers under two years old received three additional vaccines in *Childhood Immunization Status, Combination 10*. Ten plans had rates above the national commercial 90th percentile of 36.7 percent. Two plans had rates below the 10th percentile of 12.4 percent.

In 2011, the HFP weighted average for this measure was 23.8 percent. There were no plans in 2011 with rates below the 10th commercial percentile. Most plans also changed from a hybrid to an administrative method of measurement in 2012. While the overall weighted average increased this year and more plans achieved the 90th percentile, it is unknown if the performance would have been even better if plans used the same methodology in both years.

Appendix B provides a table of the rates by plan. In this table, bold numbers indicate plans that used the administrative method this year, and shaded boxes denote measures that previously used the hybrid method.

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE, 6 OR MORE

Figure 7. 2012 Individual Plan Rates



Measure Definition

Well-Child Visits in the First 15 Months of Life, 6 or More Visits is used to track the percentage of subscribers who turned 15 months old during 2012, and who had six or more well-child visits.

Importance of this Measure

Well-child visits are important during the early months of a child's life to assess growth and development and identify any problems early. This measure is based on the CMS and American Academy of Pediatrics (AAP) guidelines for at least six well-child visits from birth to 15 months of age.

Overall Results

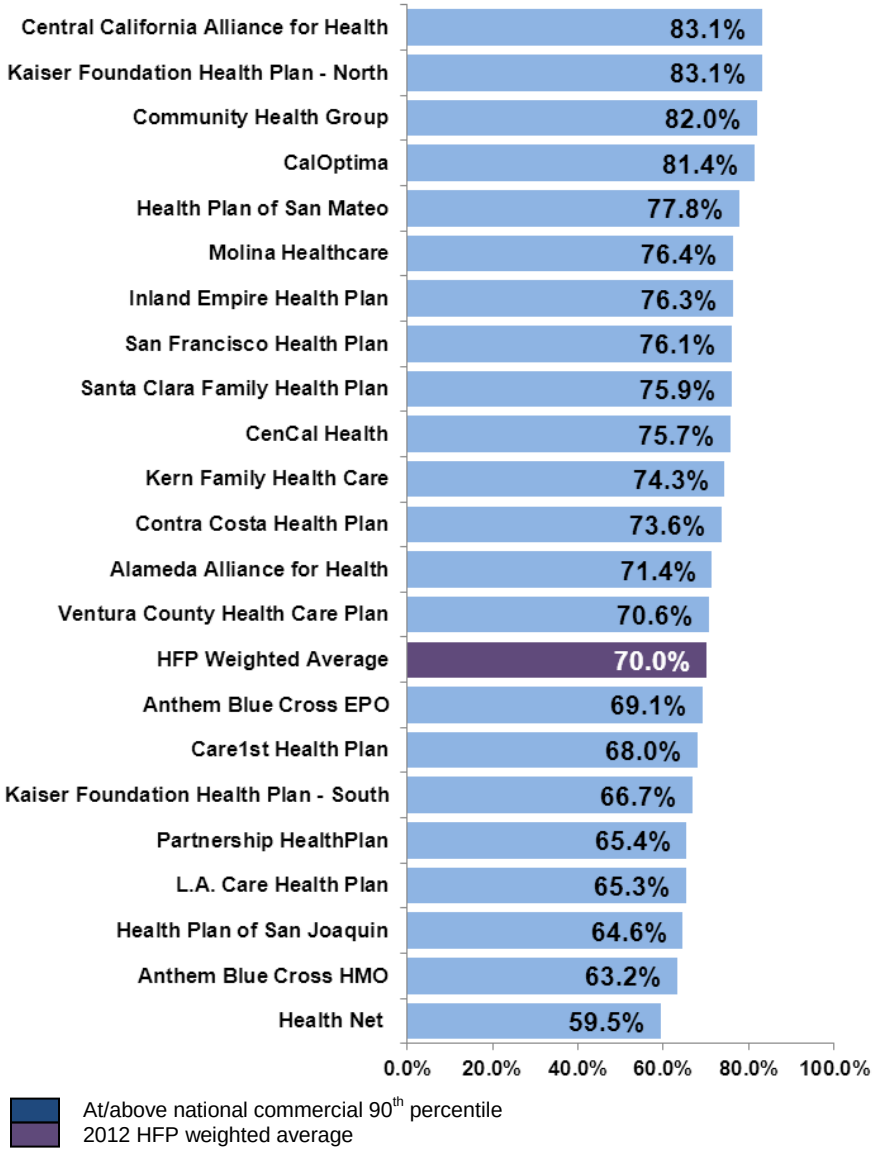
During 2012, less than 50 percent of eligible HFP infants received the recommended number of well child visits. Eighteen plans had rates below the national commercial 10th percentile rate of 64.5 percent. No plans achieved the 90th percentile of 90.6 percent.

In 2011, the HFP weighted average for this measure was 62.1 percent. The significant drop this year and the increased number of plans with rates below the national commercial 10th percentile may be explained in part by the change in methodology for most plans in 2012 from a hybrid to an administrative method of measurement. There were 14 plans in 2011 with rates below the 10th commercial percentile, two of which did not report this year because they exited HFP during 2012.

Appendix B provides a table of the rates by plan. In this table, bold numbers indicate plans that used the administrative method this year, and shaded boxes denote measures that previously used the hybrid method.

WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEARS OF LIFE

Figure 8. 2012 Individual Plan Rates



Measure Definition

Well-Child Visits in the Three to Six,Years of Life measures the percentage of subscribers' ages three to six years, who had one or more well child visits with a primary care practitioner in 2012.

Importance of this Measure

Well child visits are important during early and middle childhood to assess growth and development and identify any problems early. The American Academy of Pediatrics (AAP) recommends that children receive annual well-child visits.[2]

Overall Results

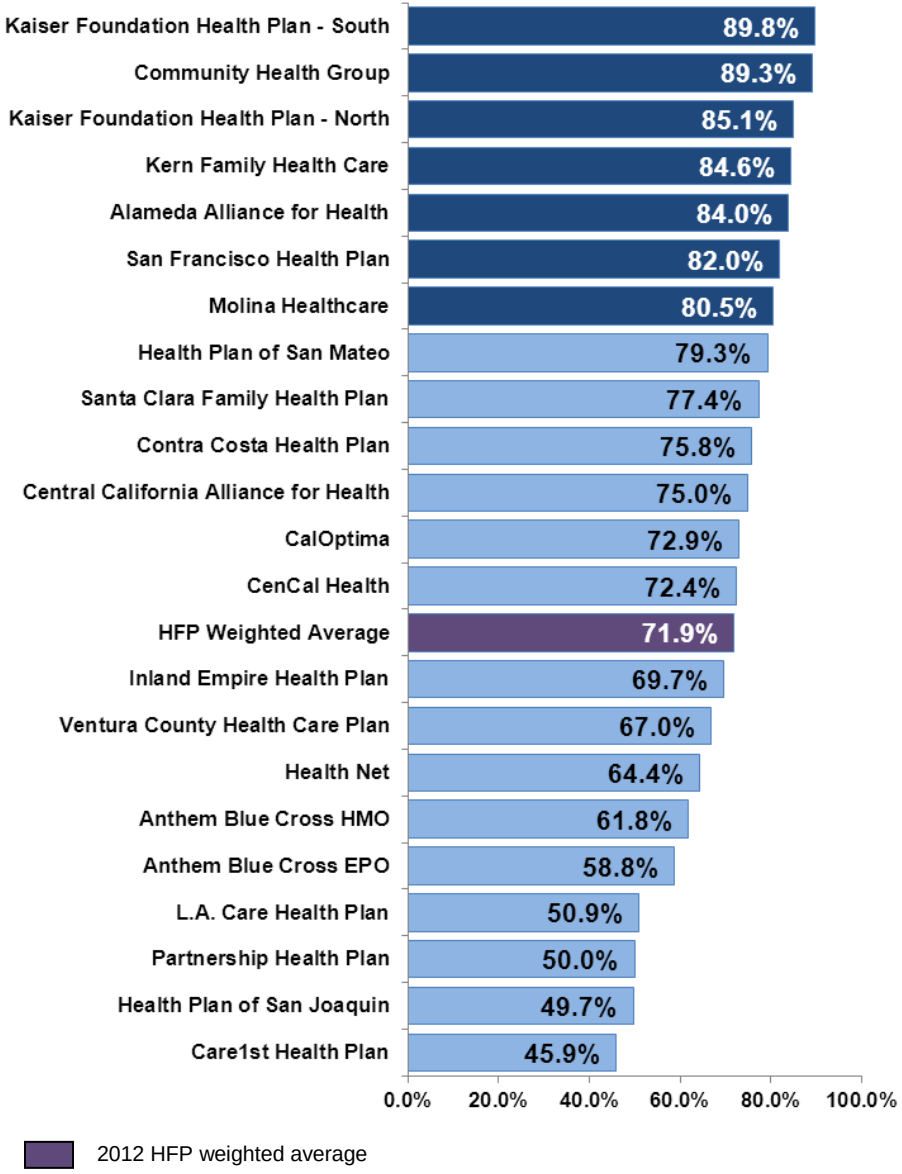
In 2012, 70 percent of eligible HFP subscribers received the recommended well child visits. No health plans had rates above the 90th percentile of 86.2 percent, nor did any health plans have rates below the commercial 10th percentile of 57.9 percent.

In 2011, the HFP weighted average for this measure was 74.3 percent. The drop this year may be explained in part by the change in methodology for most plans in 2012 from a hybrid to an administrative method of measurement. There were four plans in 2011 with rates above the 90th commercial percentile.

Appendix B provides a table of the rates by plan. In this table, bold numbers indicate plans that used the administrative method this year, and shaded boxes denote measures that previously used the hybrid method.

[2] American Academy of Pediatrics. (2010.) Recommendations for Preventive Pediatric Health Care. http://practice.aap.org/content.aspx?aid=1599&nodeID=4043

Figure 9. 2012 Individual Plan Rates



Measure Definition

Immunizations in Adolescents is collected for meningococcal vaccine on or between the 11th and 13th birthdays, and for a Tdap booster (tetanus, diphtheria, and acellular pertussis) on or between the 10th and 13th birthdays, for adolescents who turned 13 years old in 2012.

Importance of this Measure

There are several reasons why it is important to immunize adolescents. Immunizations can save lives, it's easy and effective, it protects others, can save time and money, and it protects future generations.[3]

Plans above the National Commercial HMO 90th Percentile

- Kaiser Foundation Health Plan-South
- Community Health Group
- Kaiser Foundation Health Plan-North
- Kern Family Health Care
- Alameda Alliance for Health
- San Francisco Health Plan
- Molina Healthcare

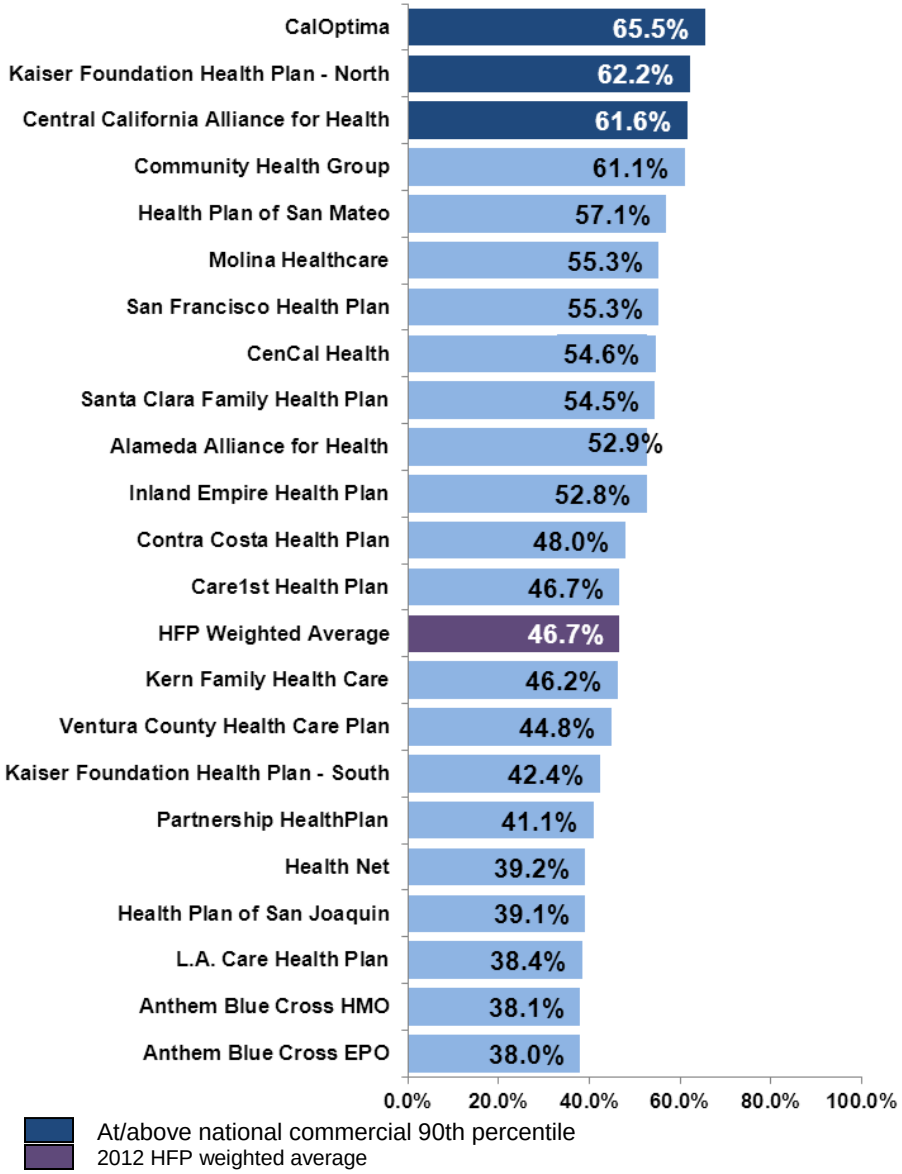
Overall Results

In 2012, almost three-quarters or 71.9 percent of eligible HFP subscribers received the Combination 1 vaccination for adolescents. Seven health plans had rates at or above the national commercial 90th percentile of 79.9 percent and no health plans had rates below the 10th percentile of 39.4 percent. Most plans changed from a hybrid to an administrative method of measurement in 2012 and while the overall rate increased this year, it is unknown if it would have been better if plans used the same methodology in both years.

[3] Five Important Reasons to Immunize Your Child. http://www.cdc.gov/vaccines

ADOLESCENT WELL-CARE VISITS

Figure 10. 2012 Individual Plan Rates



Measure Definition

Adolescent Well-Care Visits measures the percentage of subscribers who were 12 to 18 years old on or before December 31, 2012, who had at least one well-care visit with a primary care or OB/GYN practitioner in 2012 that included *all* of the following:

- A health and developmental history;
- A physical exam; and,
- Health education/anticipatory guidance.

Importance of this Measure

Adolescents face a variety of health risks and health problems including unintended pregnancies, sexually transmitted diseases, substance use disorders, and depression, among others.

Plans Above the National Commercial HMO 90th Percentile

- CalOptima
- Kaiser Foundation Health Plan-North
- Central California Alliance for Health

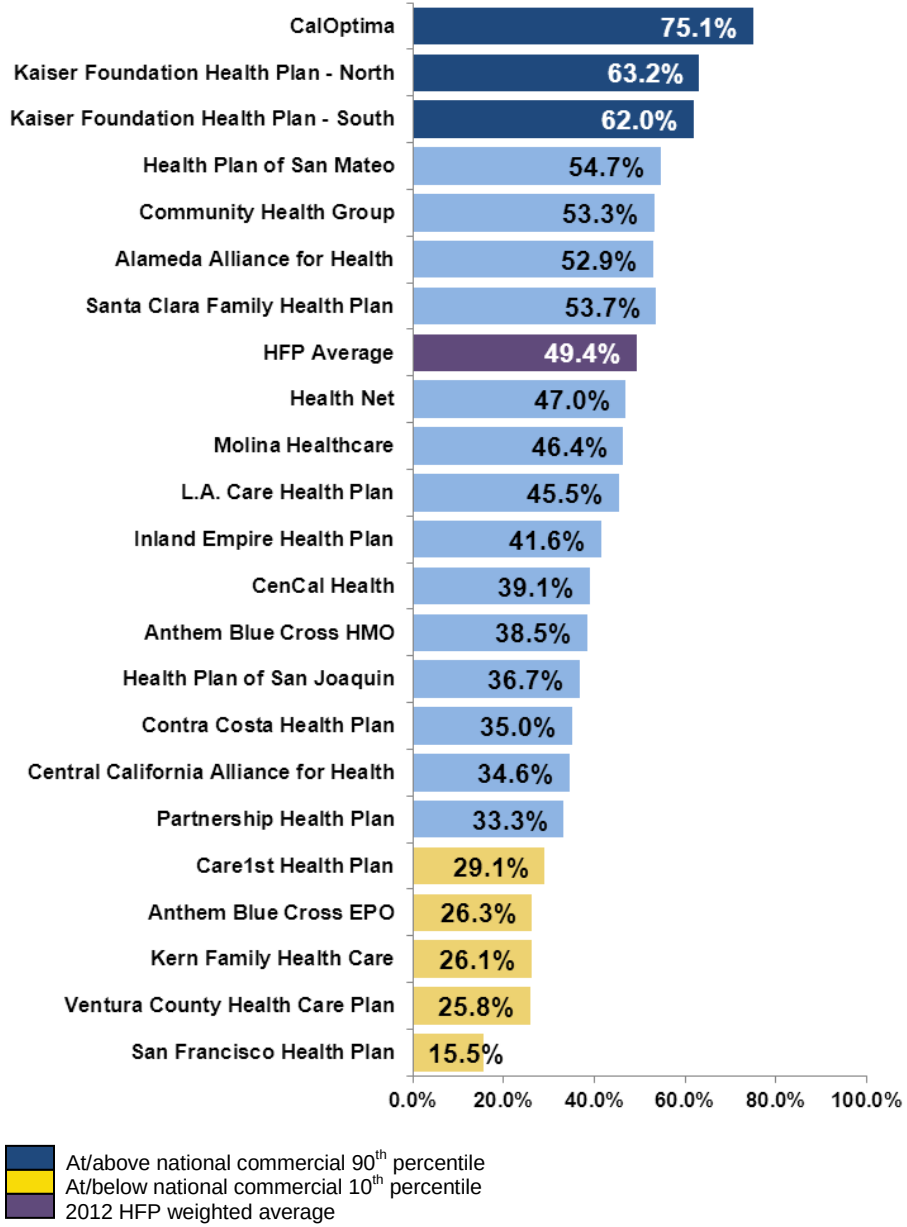
Overall Results

Less than half of eligible HFP adolescents had a well-care visit in the last two years. Three plans achieved rates above the national commercial 90th percentile of 61.5 percent and no plans had rates below the 10th percentile of 29.7 percent.

In 2011, the HFP weighted average for this measure was 58.4 percent. The drop this year may be explained in part by the change in methodology for most plans in 2012 from a hybrid to an administrative method of measurement. There were 13 plans in 2011 with rates above the 90th commercial percentile.

Appendix B provides a table of the rates by plan indicating plans that used the administrative method this year with shaded boxes to show measures that previously used the hybrid method.

Figure 11. 2012 Individual Plan Rates



Measure Definition

This measure monitors the percentage of teens 16 or over, identified as sexually active and received a test for Chlamydia.

Importance of this Measure

Chlamydia is the leading preventable cause of infertility in the U.S. The National Commission on Prevention Priorities ranks chlamydia screening as one of the ten high value clinical preventative services.[4]

Plans Above the National Commercial HMO 90th Percentile

- CalOptima
- Kaiser Foundation Health Plan-North
- Kaiser Foundation Health Plan-South

Overall Results

Less than half of eligible teens received this recommended screening in 2012. Three health plans exceeded the national commercial 90th percentile of 60.3 percent. Five health plans had rates below the national commercial 10th percentile of 32 percent. In 2011, the HFP weighted average for this measure was 47.8 percent. Most plans changed from a hybrid to an administrative method of measurement in 2012 and while the overall rate increased this year, it is unknown if it would have been better if plans used the same methodology in both years.

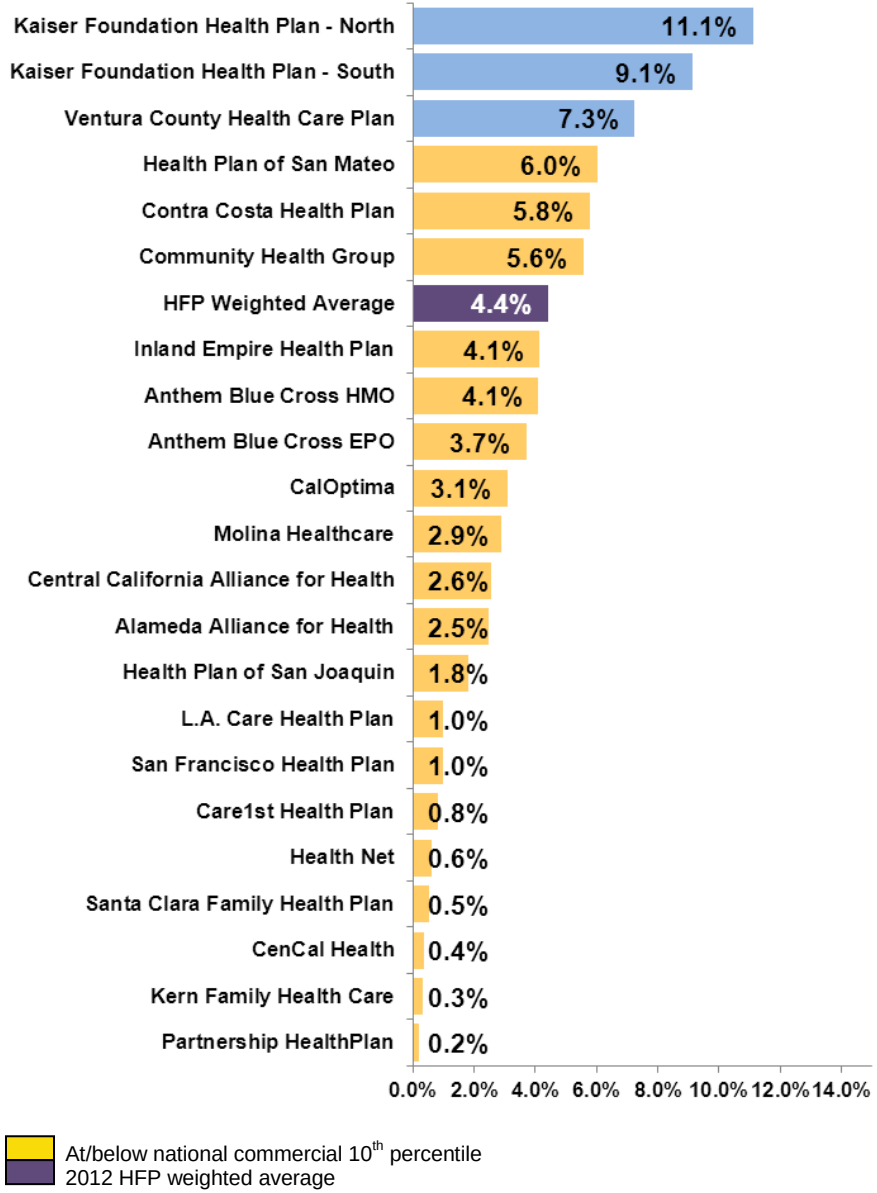
Demographic Analysis

Demographic analysis was done on this measure by home language, ethnicity and region. This information can be found in Appendices D, E and F.

[4] Why Screen for Chlamydia? (2008) Chlamydia Screening. http://prevent.org/data/files/ncc/

MENTAL HEALTH UTILIZATION FOR AGES 13 TO 17 Years

Figure 12. 2012 Individual Plan Rates



Measure Definition

Mental Health Utilization evaluates the percentage of subscribers who received one of the following mental health services: inpatient treatment, intensive outpatient treatment or outpatient treatment, including emergency department visits. This report displays the utilization percentages for the 13 to 17 year old age group.

Importance of this Measure

Many research studies have shown that when people receive appropriate mental health care, their use of medical services declines. Mental health strengthens and supports the ability to have healthy relationships, make good life choices, maintain physical health and well-being, handle the natural ups and downs of life and discover and grow toward their potential.[5]

Overall Results

In California, children who meet certain criteria qualify for services from County Mental Health Departments. As a result, the 2012 HFP weighted average is low because not all care is provided by health plans. Only Kaiser North and South and Ventura County performed above the 10th percentile of national commercial plans at 6.1 percent. However, Kaiser has an integrated delivery system and did not refer subscribers outside their plan for treatment.

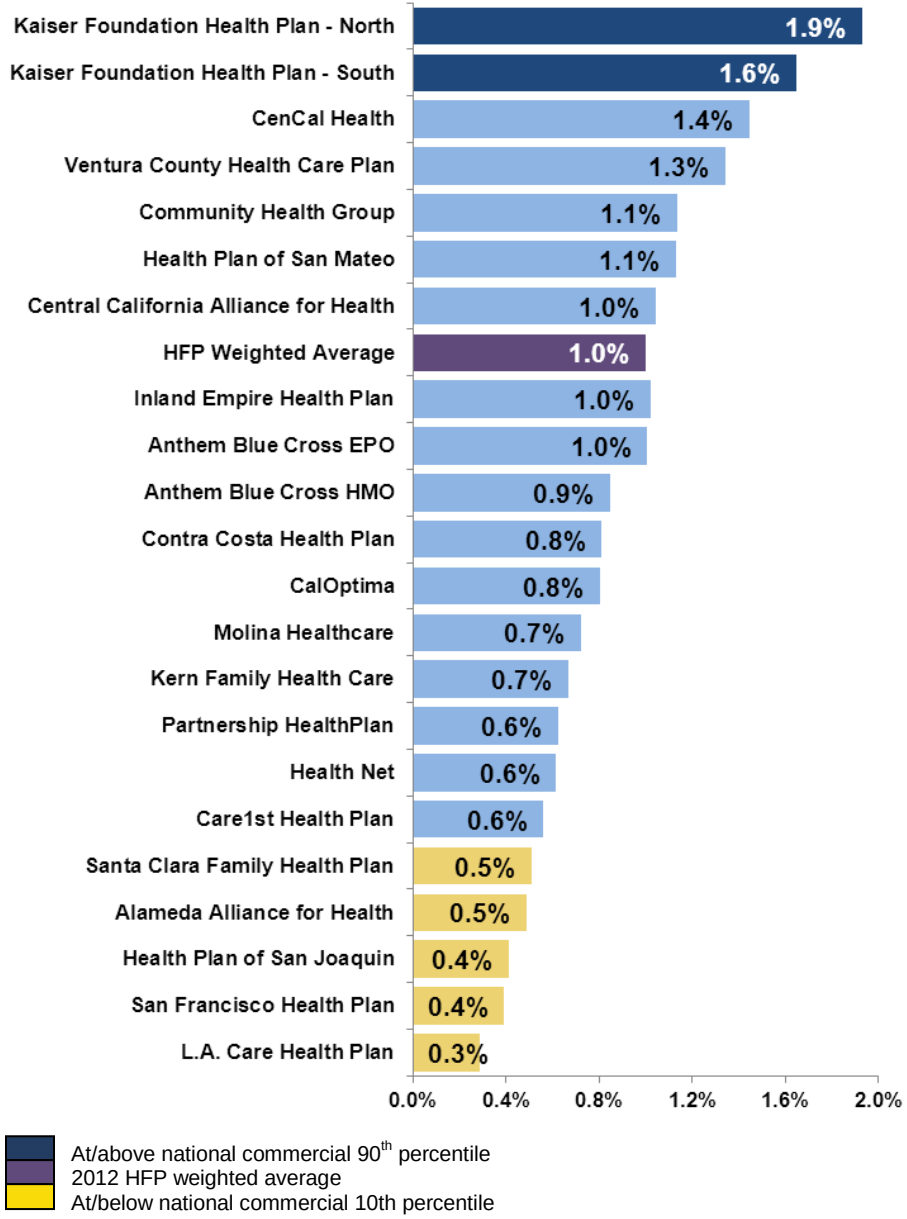
Demographic Analysis

Demographic analysis was done on this measure by home language, ethnicity and region. This information can be found in Appendices D, E and F.

[5] Useful Psychology Information: Importance of Mental Health. http://www.ripsych.org/importance-of-mental-health

IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES

Figure 13. 2012 HFP Plan Rates



Measure Definition

Identification of Alcohol and Other Drug Services tracks the percentage of subscribers who received alcohol and other drug (AOD) services. This measure includes subscribers who had inpatient treatment or intensive outpatient treatment or outpatient treatment, including emergency department visits. This report displays the utilization percentages for the 13 to 17 year old age group.

Importance of this Measure

According to estimates from the National Survey on Drug Use and Health[6], 11 percent of adolescents in California ages 12 to 17 reported use of an illicit drug in the month prior to the 2008-09 survey, while 4.75 percent of these children said they needed but did not receive treatment for illicit drug use. Past month alcohol use in this age group for California is 14 percent, and 8.5 percent of children ages 12 to 17 report binge drinking in the month prior to the survey. Nearly 5 percent of 12 to 17 year olds report needing, but not receiving, treatment for alcohol use.

Overall Results

Two plans reached the national commercial 90th percentile rate of 1.5 percent and five plans were at or below than the national commercial 10th percentile rate of 0.5 percent.

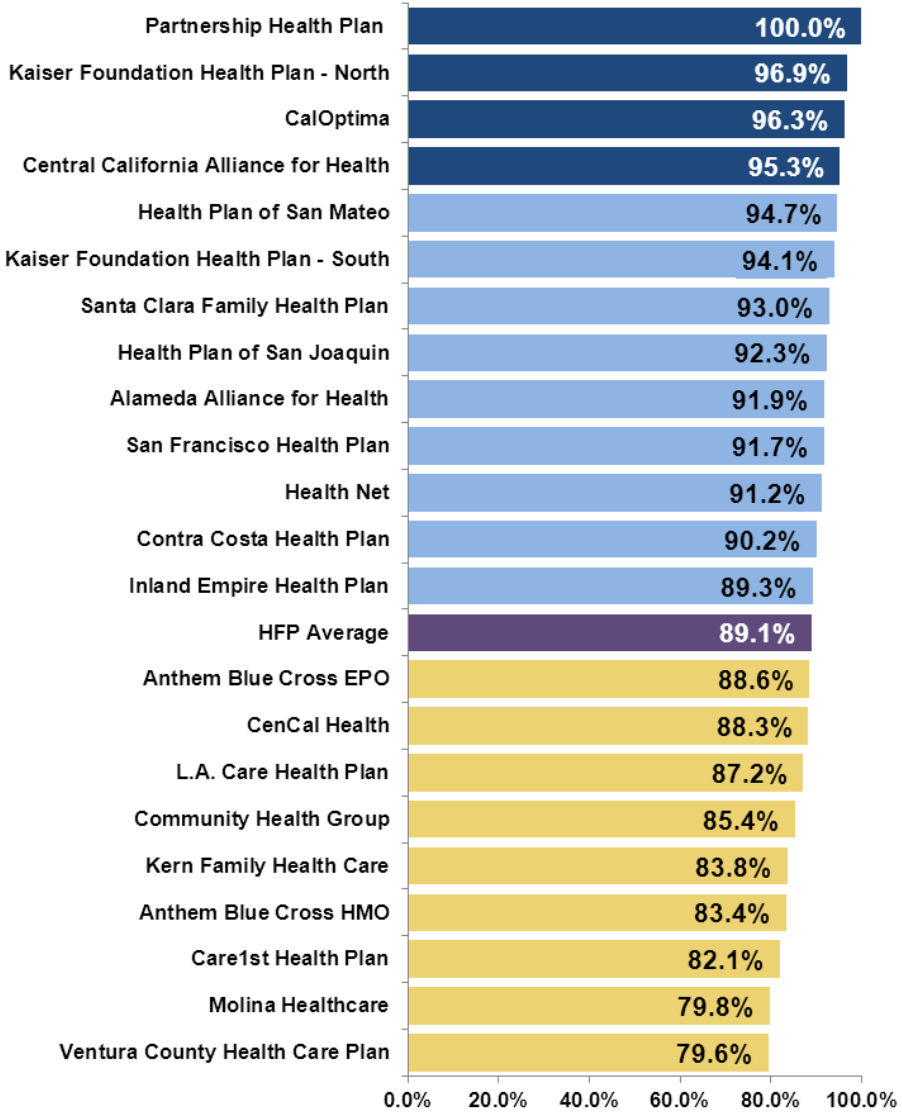
Demographic Analysis

Demographic analysis was done on this measure by home language, ethnicity and region. This information can be found in Appendices D, E and F.

[6] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008 and 2009, Table 20 in http://oas.samhsa.gov/2k9State/WebOnlyTables/CA.pdf

USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA

Figure 14. 2012 Individual Plan Rates



At/above national commercial 90th percentile
At/below national commercial 10th percentile
2012 HFP weighted average

Measure Definition

Use of Appropriate Medication for People with Asthma tracks the percentage of subscribers 5 to 18 years old who were identified as having asthma and appropriately prescribed medication.

Importance of the Measure

Asthma is a chronic condition that disproportionately affects low income Californians. Current asthma prevalence varies in California from 6 percent in San Francisco County to 12.9 percent in Fresno County.[7] It is important that children with asthma are diagnosed and treated early and given necessary education to manage their condition.

Overall Results

During 2012, nearly 90 percent of HFP subscribers with asthma were prescribed appropriate medication. Four plans' rates were above the national commercial 90th percentile of 95.2 percent and nine plans' rates were below the national 10th percentile of 88.9 percent. Most plans changed from a hybrid to an administrative method of measurement in 2012 and while the overall rate increased slightly this year, it is unknown if it would have been better if plans used the same methodology in both years.

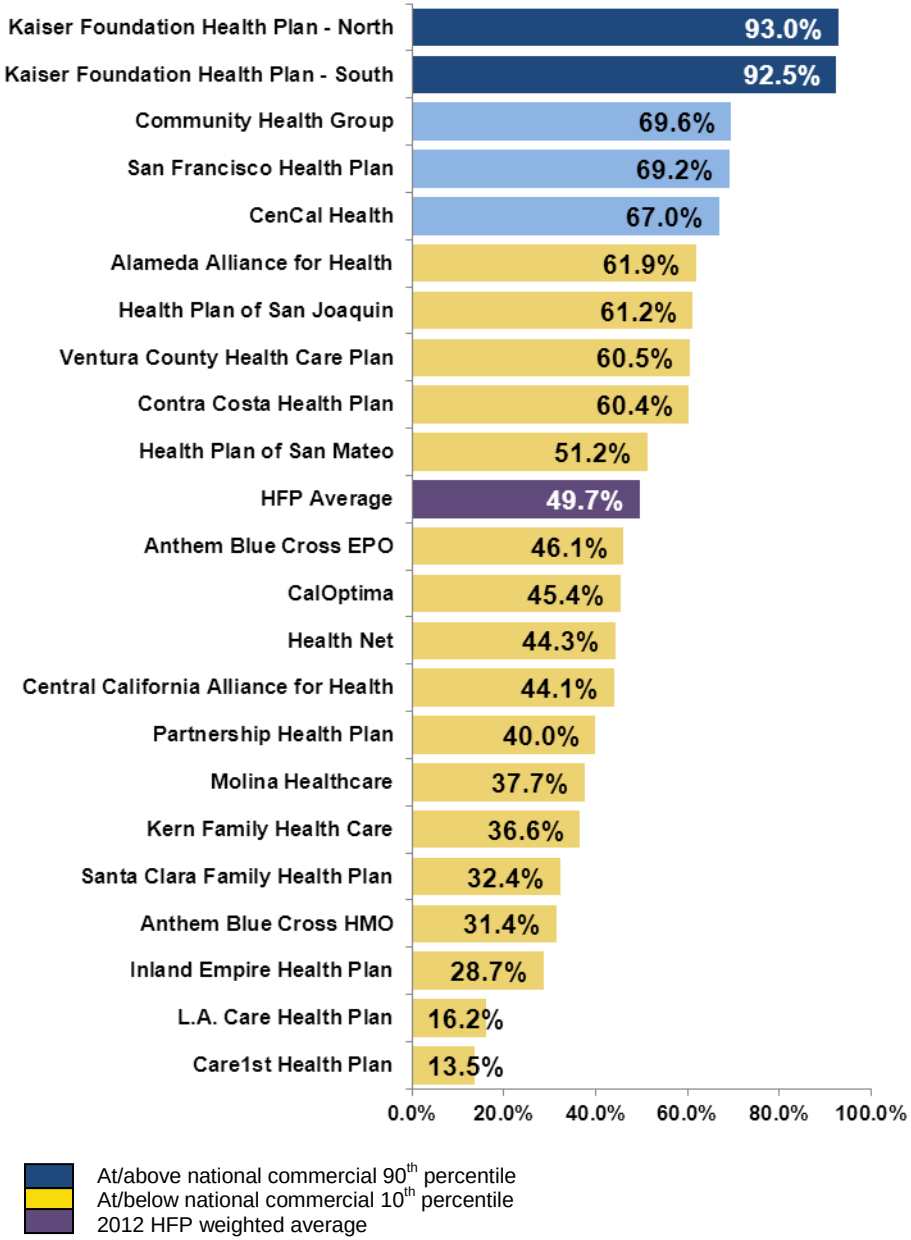
Demographic Analysis

Demographic analysis was done on this measure by home language, ethnicity and region. This information can be found in Appendices D, E and F.

[7] Income Disparities in Asthma Burden and Care in California, UCLA Center for Health Policy and Research, December 2010, http://www.healthpolicy.ucla.edu/pubs/files/asthma-burden-report-1210.pdf

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Figure 15. 2012 Individual Plan Rates



Measure Definition

Appropriate Testing for Children with Pharyngitis measures children 2½ years of age or older who were diagnosed with pharyngitis, dispensed an antibiotic, and given a group A streptococcus (strep) test. A higher rate represents better performance i.e., appropriate testing.

Importance of this Measure

The Centers for Disease Control (CDC) encourages careful antibiotic use because of the rising resistance to antibiotics, appropriate use of antibiotics is an important measure of quality of care.[8]

Plans Above the National Commercial HMO 90th Percentile

- Kaiser Foundation Health Plan-North
- Kaiser Foundation Health Plan-South

Overall Results

In 2012, about half of HFP subscribers were prescribed antibiotics without having recommended testing. Two health plans provided this service above the national commercial 90th percentile of 92.1 percent and 17 plans fell below the national commercial 10th percentile of 67.3 percent. Most plans changed from a hybrid to an administrative method of measurement in 2012 and while the overall rate increased this year, it is unknown if it would have been better if plans used the same methodology in both years.

Demographic Analysis

Demographic analysis was done on this measure by home language, ethnicity and region. This information can be found in Appendices D, E and F.

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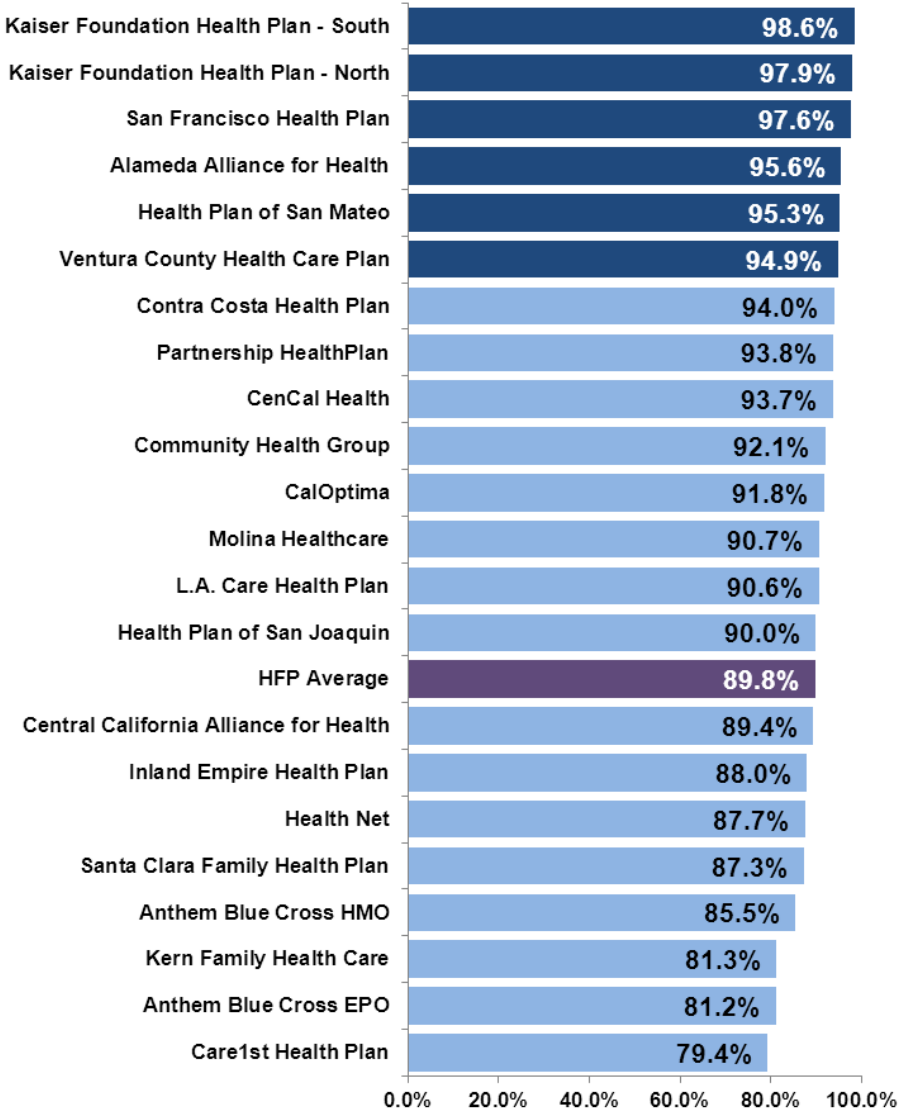
[8] Improving diagnostic testing and reducing overuse of antibiotics for children with pharyngitis: a useful role for the electronic record. http://www.ncbi.nlm.nih.gov/pubmed/14688562

APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION

Figure 16. 2012 Individual Plan Rates



Measure Definition

Appropriate Treatment for Children with Upper Respiratory Infection measures continuously enrolled children, identified as having upper respiratory infection and not dispensed an antibiotic prescription.

Importance of the Measure

Upper respiratory infection, known as the common cold, is caused by a virus and is not affected by antibiotics. Overuse and improper use of antibiotics has led to several strains of antibiotic resistant bacteria, reducing the arsenal of effective antibiotics.

Plans Above the National Commercial HMO 90th Percentile

- Kaiser Foundation Health Plan-South
- Kaiser Foundation Health Plan-North
- San Francisco Health Plan
- Alameda Alliance for Health
- Health Plan of San Mateo
- Ventura County Health Plan

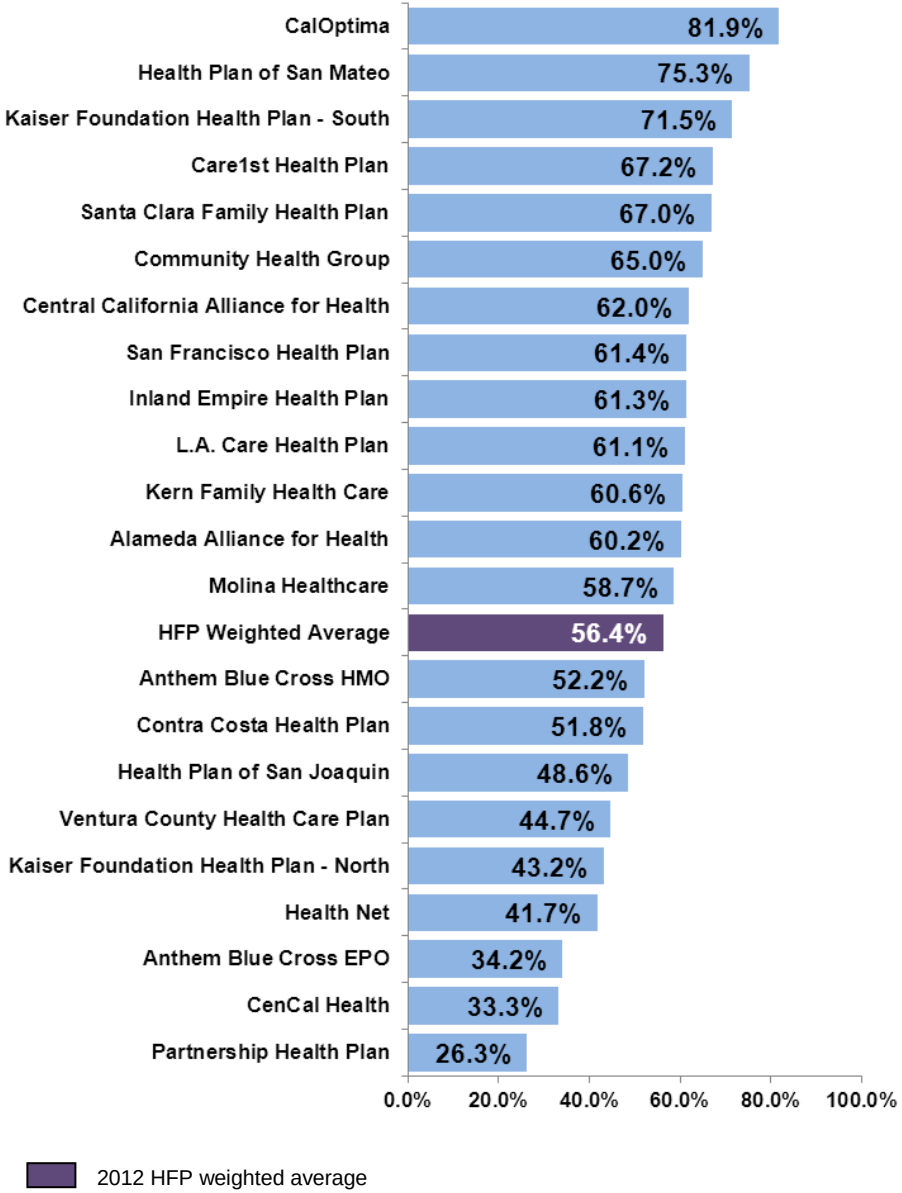
Overall Results

Nearly 90 percent of HFP subscribers were appropriately treated for the common cold. Six health plans performed at or above the national commercial 90th percentile of 94.2 percent and no plans fell below the national commercial 10th percentile of 72 percent. Most plans changed from a hybrid to an administrative method of measurement in 2012 and while the overall rate increased this year, it is unknown if it would have been better if plans used the same methodology in both years.

Demographic Analysis

Demographic analysis was done on this measure by home language, ethnicity and region. This information can be found in Appendices D, E and F.

Figure 17. 2010 Individual Plan Rates



Measure Definition

Lead Screening in Children assesses the percentage of subscribers who received one or more capillary or venous blood tests for lead toxicity by their second birthday.

Importance of this Measure

Lead poisoning occurs when small amounts of lead builds up in the body and cause lifelong learning and behavior problems. It is the most common environmental illness in California children.[9] Children under six years old are at greatest risk of harmful health effects from lead poisoning because their brains and nervous systems are still forming, and they frequently crawl or play on floors or furniture contaminated with lead dust and put their hands or other objects in their mouths. Paint manufactured before 1978 contained lead, and soil on sites near busy roadways and factories are common sources of lead.

Overall Results

In 2012, 56.4 percent of HFP subscribers under two years old were screened for elevated blood lead levels. There are no commercial benchmarks for this measure.

[9] http://www.cdph.ca.gov/programs/CLPPB/Pages?FAQ-CLPPB.aspx

Health Plan Data Collection

The information in this report is based on HEDIS data collected by 22 HFP health plans for subscribers continuously enrolled from January 1, 2012 through December 31, 2012. Two methods are used to collect data:

1. Administrative, which involves querying administrative databases for eligible subscribers who received the service; and

2. Hybrid, where a statistically valid random sample of eligible subscribers are drawn and used to query administrative databases or patient charts for subscribers who received the services.

The hybrid method of data collection is much more labor intensive and costly compared to the administrative method, but provides more accurate results for some measures. In previous years, most HFP plans used the hybrid method for measures of immunizations, well visits and measurements of appropriate treatment. However, due to the transition of HFP subscribers to Medi-Cal in 2013, most plans did not conduct hybrid data collection for the 2012 year, and instead reported only administrative measures. Consequently, the reported plan results for many measures are not comparable to prior years. Appendix B provides a table of the rates by plan. In this table, bold numbers indicate plans that used the administrative method, and shaded boxes denote measures that previously used the hybrid method.

Data Processing and Quality Review

Each year HFP health plans are required to undergo a HEDIS compliance audit. Health plans' information systems are checked against HEDIS technical specifications to ensure standardized reporting. Upon completion of this audit, HFP health plans submit a raw data file and a data matrix with their HEDIS rates to MRMIB.

Each health plan's raw data files are processed using SAS, which is software used for statistical analysis. MRMIB uses SAS to perform data quality checks, standardize data for reporting, produce frequencies and rates, and perform statistical analyses. Discrepancies between frequencies and rates generated using SAS and those reported in the health plan's matrix are identified, communicated to the health plan, and resolved.

After all health plans' data have been processed, the data are then merged with enrollment data from the same year. HFP subscriber records from health plans are merged with corresponding subscriber records in the enrollment file using a unique client identification number. Records submitted by the plan for which there is not a corresponding match in the enrollment file are not included in the final data set used for demographic analysis and to determine final enrollment.

MRMIB performs data quality checks and corrects demographic reporting errors such as miscoded data or missing values for demographic data.

If for a particular measure, a health plan reports a sample size of 30 or fewer subscribers, the health plan's rates are not reported and the reported HFP weighted averages include data only from plans with sample sizes of 31 or more.

HFP Average

For the measures where all eligible subscribers are counted, the HFP average is simply the number of enrollees who received a particular service divided by the number of eligible enrollees, expressed as a percent.

For hybrid measures performed by sampling and chart review, *Childhood Immunization Status, Immunizations for Adolescents, Well-Child Visits, Adolescent Well Care Visits* and *Lead Screening in Children,* the following weighted average calculation is performed:

1) Each plan's calculated rate is multiplied by the number of subscribers eligible for a given service in the plan, generating the predicted number of subscribers who received the service.

2) The predicted number of service recipients from each plan is summed, generating the total number of predicted service recipients.
3) The total number of predicted service recipients is divided by the sum of all plan subscribers eligible, generating the HFP weighted average.

The weighted average is preferred for hybrid measures because it considers the variations in enrollment across HFP plans which a simple average of plan rates would not. Therefore, it is a better estimate of the true proportion of HFP subscribers that receive a given service.

Benchmarks

This report includes comparisons of the HFP average or weighted average and each health plan's HEDIS rate against national benchmarks. The primary national benchmark used to indicate high performance for a given measure is the national commercial 90th percentile. Conversely, the national commercial 10th percentile is used as the lower performance benchmark.

National 90th and 10th percentiles for Medicaid are also considered in comparing HFP performance for a given measure. The national averages for commercial and Medicaid plans are based on the most recent available data from NCQA. The 2012 national percentile rates and averages from NCQA are used for comparison throughout this report.

Testing for Statistical Differences

The Chi-Square Test was used to determine whether the changes in measures during the past two years are statistically significant at $p<0.05$.

Demographic Analysis

In assessing HFP performance, MRMIB also examines demographic data. There are several demographic data elements used for this purpose.

Primary Home Language:

- English
- Spanish
- Chinese
- Korean
- Vietnamese
- Other: includes Arabic, Armenian, Cambodian, Farsi, French, Hebrew, Hmong, Ilocano, Italian, Japanese, Lao, Mien, Polish, Portuguese, Russian, Samoan, Tagalog, Thai and Turkish.

Child's Ethnicity:

- African American
- Asian/Pacific Islander
- Hispanic/Latino
- Other
- White

Family Federal Poverty Level (FPL):

- 100% - 150% FPL (lowest income category)
- 151% - 200% FPL (middle income category)
- 201% - 250% FPL (highest income category)

Gender:

- Female
- Male

Region:

- Bay Area
- Los Angeles
- Northern
- South Coast
- Southern
- Central Valley

Age and Age Groups:

For HEDIS measures that cover all ages, differences in age groups analyzed were:

- 0 – 4
- 5 – 9
- 10 – 14
- 15 – 19

Appendices D, E and F provide charts displaying three years of data for selected measures by ethnicity, language and region.

HFP subscribers are disenrolled from the program at the end of the month in which they turn 19. The anchor date for inclusion of subscribers in HEDIS measures is December 31 of the measurement year. Therefore, some measures include 19 year olds.
Each of the demographic data elements is used to estimate the percentage of children in each demographic that received the recommended service, for example, rates of subscribers for each primary language that received the service.

It is important to note that demographics are estimates derived from two sources of data: plan submitted HEDIS data, which does not contain demographic information, and MRMIB internal enrollment data, which does contain demographic information. These two data sources were merged to create one data set containing both HEDIS and demographic information.

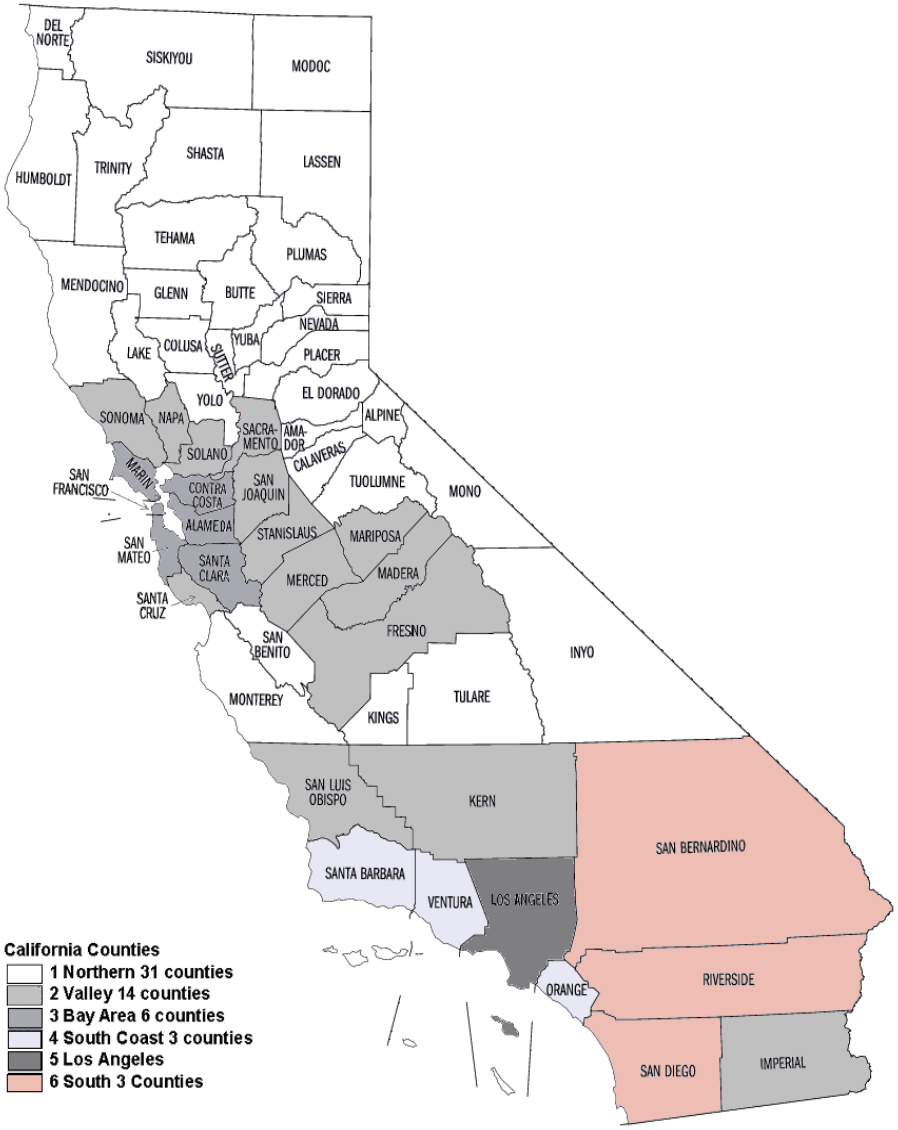
Demographic data are self reported and therefore are subject to some error and missing data. When possible, reporting errors are corrected. Records with missing or unknown values were not included in the final data set used for analysis.

Significance testing was not conducted for health plan rates for *Identification of Alcohol and Other Drug Services* (IAD) or *Mental Health Utilization* (MPT) because the plan rates for these measures are based on subscriber months not the number of subscribers eligible.

Historically MRMIB has reported the percent of subscribers for each demographic level for IAD and MPT using the total number of subscribers who received these services as a denominator. For 2012, rates were calculated for demographic variables for IAD and MPT in the same manner used for other HEDIS measures, reporting percent of service recipients for each level within a demographic variable.

APPENDIX A. CALIFORNIA REGIONS

Map of California Regions



California's 6 Regions

Region	Counties	HFP Continuous Enrollment for 2012	Percentage* of Total Enrollment
Bay Area	Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara	71,310	11.4
Los Angeles	Los Angeles	149,119	23.9
Northern	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba	56,031	9.0
South Coast	Orange, Santa Barbara, Ventura	75,461	12.1
Southern	Riverside, San Bernardino, San Diego	146,763	23.5
Central Valley	Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus	124,846	20.0

APPENDIX B. 2012 HEDIS RATES BY HEALTH PLAN

Health Plan	CAP1	CAP2	CAP3	CAP4	CIS3	CIS10	IMA	W15	W34	AWC	CHL	MPT	IAD	ASM	CWP	URI	LSC
Alameda Alliance for Health	95.1	87.3	90.9	90.8	**61.2**	**36.9**	**84.0**	**28.4**	**71.4**	**52.9**	52.9	2.5	0.5	**91.9**	**61.9**	**95.6**	60.2
Anthem Blue Cross EPO	98.0	90.5	90.9	92.2	**33.9**	**14.8**	**58.8**	**52.7**	**69.1**	**38.0**	26.3	3.7	1.0	**88.6**	**46.1**	**81.2**	34.2
Anthem Blue Cross HMO	96.2	85.4	85.8	85.6	**29.0**	**15.5**	**61.8**	**38.0**	**63.2**	**38.1**	38.5	4.1	0.9	**83.4**	**31.4**	**85.5**	52.2
CalOptima	98.9	93.2	95.5	95.5	**20.6**	**13.4**	**72.9**	**50.5**	**81.4**	**65.5**	75.1	3.1	0.8	**96.3**	**45.4**	**91.8**	81.9
Care1st Health Plan	94.8	85.3	86.7	88.1	**28.6**	**10.9**	**45.9**	**31.8**	**68.0**	**46.6**	29.1	0.8	0.6	**82.1**	**13.5**	**79.4**	67.2
CenCal Health	96.8	93.4	94.4	95.3	**46.5**	**25.6**	**72.4**	**27.4**	**75.7**	54.6	39.1	0.4	1.4	**88.3**	**67.0**	**93.7**	**33.3**
Central California Alliance for Health	99.0	95.2	96.4	96.4	**56.7**	**33.1**	**75.0**	**57.4**	**83.1**	**61.6**	34.6	2.6	1.0	**95.3**	**44.1**	**89.4**	62.0
Community Health Group	98.2	93.2	94.4	94.5	73.8	40.4	89.3	48.6	82.0	61.1	53.3	5.6	1.1	85.4	69.6	92.1	**65.0**
Contra Costa Health Plan	98.4	92.2	92.3	91.3	**62.4**	**38.8**	**75.8**	**50.0**	**73.6**	**48.0**	35.0	5.8	0.8	**90.2**	**60.4**	**94.0**	**51.8**
Health Net of California	96.5	83.5	86.5	87.5	**33.5**	**16.8**	**64.4**	**20.7**	**59.5**	**39.2**	47.0	0.6	0.6	**91.2**	**44.3**	**87.7**	41.7
Health Plan of San Joaquin	99.4	88.3	87.0	88.8	**11.1**	**4.9**	**49.7**	**26.0**	**64.6**	**39.1**	36.7	1.8	0.4	**92.3**	**61.2**	**90.0**	48.6
Health Plan of San Mateo	100.0	93.0	95.2	96.2	**57.4**	**49.5**	**79.3**	**65.1**	**77.8**	**57.1**	54.7	6.0	1.1	**94.7**	**51.2**	**95.3**	75.3
Inland Empire Health Plan	98.3	90.0	88.3	92.3	84.7	37.0	**69.7**	**22.3**	**76.3**	**52.8**	41.6	4.1	1.0	**89.3**	**28.7**	**88.0**	61.3
Kaiser Foundation Health Plan - North	99.8	92.4	93.0	95.4	**86.8**	**55.8**	**85.1**	**71.9**	**83.1**	**62.2**	63.2	11.1	1.9	96.9	93.0	97.9	43.2
Kaiser Foundation Health Plan - South	99.9	94.5	94.9	97.0	**88.3**	**42.5**	**89.8**	**70.0**	**66.7**	**42.4**	62.0	9.1	1.6	94.1	92.5	98.6	71.5
Kern Family Health Care	97.9	92.1	92.2	93.6	**69.7**	**36.6**	**84.6**	**27.0**	**74.3**	**46.2**	26.1	0.3	0.7	**83.8**	**36.6**	**81.3**	60.6
L.A. Care Health Plan	95.2	83.8	89.2	89.0	**35.7**	**12.7**	**50.9**	**29.3**	**65.3**	**38.4**	45.5	1.0	0.3	**87.2**	**16.2**	**90.6**	61.1
Molina Healthcare	97.9	86.9	88.8	90.7	74.7	37.2	80.5	46.4	76.4	55.3	46.4	2.9	0.7	79.8	37.7	90.7	58.7
Partnership HealthPlan of California	100.0	90.5	95.7	92.2	**31.6**	**15.8**	**50.0**	**66.7**	**65.4**	**41.1**	33.3	0.2	0.6	**100.0**	**40.0**	**93.8**	26.3
San Francisco Health Plan	98.8	92.9	96.6	96.1	**57.4**	**47.5**	**82.0**	**33.3**	**76.1**	**55.3**	15.5	1.0	0.4	**91.7**	**69.2**	**97.6**	61.4
Santa Clara Family Health Plan	100.0	92.2	94.1	93.6	68.5	48.5	77.4	42.3	75.9	54.5	53.7	0.5	0.5	93.0	32.4	87.3	67.0
Ventura County Healthcare Plan	97.8	88.7	90.5	92.0	**47.7**	**26.5**	**67.0**	26.3	70.6	44.8	25.8	7.3	1.3	79.6	60.5	94.9	**44.7**
2012 HFP Average Rate	98.0	89.5	90.6	91.8							49.4			89.1	49.7	89.8	
2012 HFP Weighted Average Rate					54.6	28.8	71.9	46.5	70.0	46.7		4.4	1.0				56.4

CAP1 = Children's Access to Primary Care: 12-24 Months
CAP2 = Children's Access to Primary Care: 25 Months - 6 Years
CAP3 = Children's Access to Primary Care: 7 - 11 Years
CAP4 = Children's Access to Primary Care: 12 - 18 Years
CIS3 = Childhood Immunization Status, Combo 3
CIS10 = Childhood Immunization Status, Combo 10

IMA = Immunizations in Adolescents
W15_6 = Well Child Visits, 1st 15 Months, 6 or More
W34 = Well Child Visits in the 3rd - 6th Years
AWC = Adolescent Well Care Visits
CHL = Chlamydia Screening in Women

MPT = Mental Health Utilization
IAD = Identification of Alcohol and Other Drugs
ASM = Appropriate Medication for People with Asthma
CWP = Appropriate Testing for Children with Pharyngitis
URI = Appropriate Treatment for Upper Respiratory Infection
LSC = Lead Screening in Children

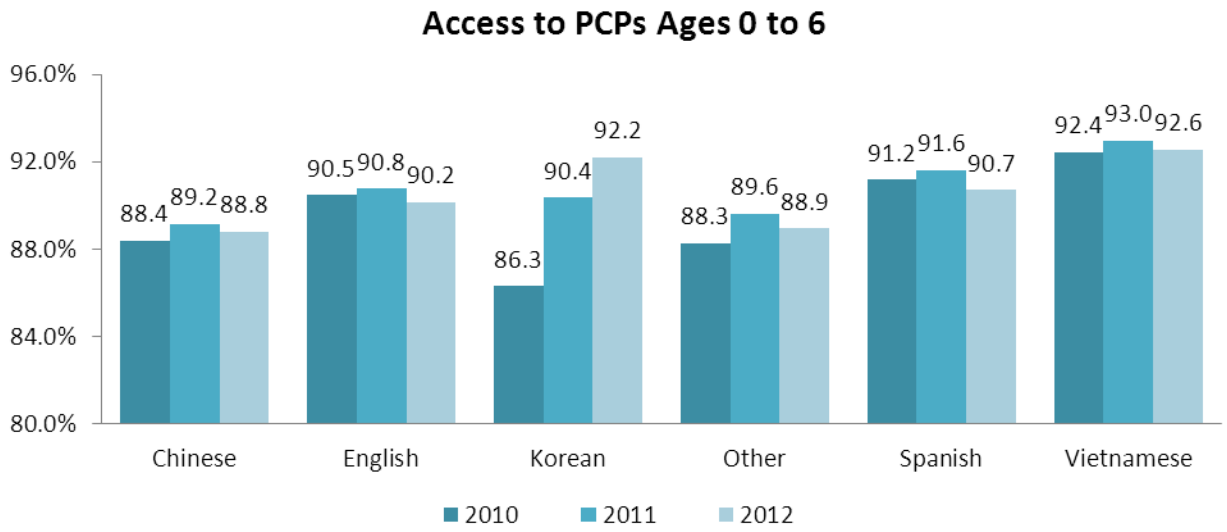
Note: Bold numbers indicate administrative measure methodology.
Shaded boxes denote measures that were reported in 2011 using the hybrid methodology.

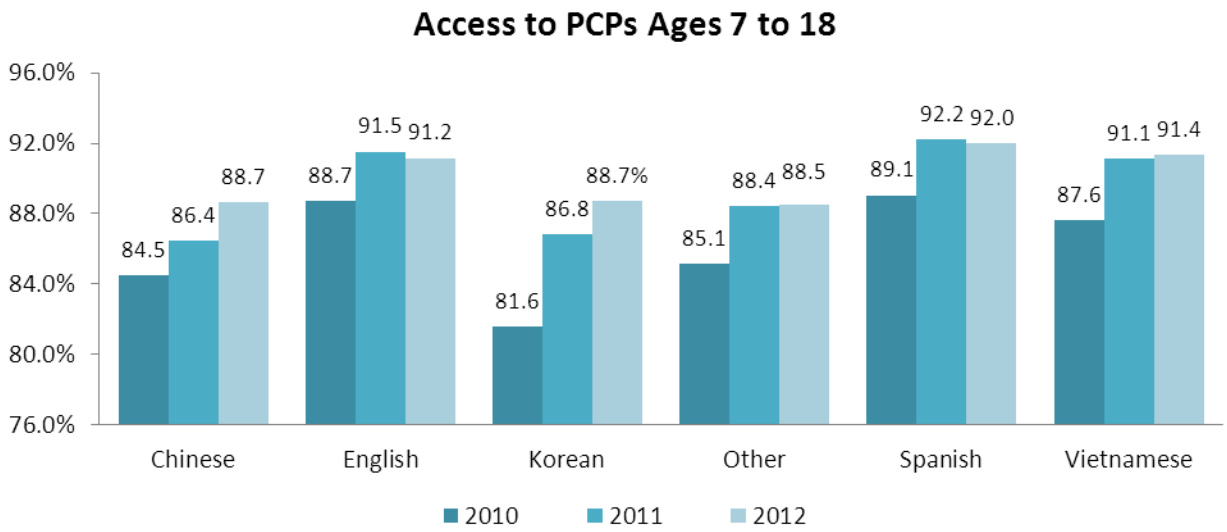
APPENDIX C. 2012 COMPARISON OF THE HEDIS MEASURES DURING 2011-2012 BY HFP PLANS

Healthy Families Program	▼	▲	▼	▼	▼	▼	▼		▼	▼	▼		▲	▲	
MEASURE	**CIS3**	**CIS10**	**IMA**	**LSC**	**W15_6**	**W34**	**AWC**	**CAP_1**	**CAP_2**	**CAP_3**	**CAP_4**	**ASM**	**URI**	**CWP**	**CHL**
Alameda Alliance for Health					▼	▼	▼		▼	▼	▼			▲	
Anthem Blue Cross EPO	▼		▲				▼		▼		▲			▲	▲
Anthem Blue Cross HMO	▼		▼		▼	▼	▼		▼	▲	▲	▼	▲	▲	
CalOptima	▼	▼	▼		▼	▼	▼		▼			▼			
Care 1st Health Plan	▼		▼			▼	▼		▼						▼
CenCal Health	▼				▼		▼								▲
Central CA Alliance for Health	▼				▼		▼								
Community Health Group	▼	▲	▲	▲	▼	▼	▼		▼		▼	▼			
Contra Costa Health Plan	▼						▼							▲	▼
Health Net	▼	▼		▼	▼	▼	▼		▼	▼	▼	▲	▲		
Health Plan of San Joaquin	▼	▼	▼		▼	▼	▼		▲	▼	▼				
Health Plan of San Mateo	▼						▼							▲	
Inland Empire Health Plan		▲	▲		▼		▼								
Kaiser Foundation HP - North	▼	▲	▲		▼	▲	▲		▼				▲		
Kaiser Foundation HP - South		▲	▲	▼		▲	▼	▲	▼	▼		▼	▲	▼	
Kern Family Health Care	▼	▲	▲	▼		▲	▼								
L.A. Care Health Plan	▼	▼	▼	▼		▼	▼		▼				▲		
Molina Healthcare		▲	▲			▼	▼		▼				▲		▲
Partnership Health Plan	▼						▼								
San Francisco Health Plan	▼				▼	▼	▼			▲	▲		▲	▲	
Santa Clara Family Health Plan	▼	▲	▲		▼		▼				▲				
Ventura County Healthcare Plan	▼						▼						▲	▲	

Chi-Square Test significance for p<0.05		
	▲	an increase that is statistically significant
	▼	a decrease that is statistically significant
		change is not statistically significant

APPENDIX D. 2012 DEMOGRAPHIC HEDIS MEASURES COMPARISON BY LANGUAGE





Overview

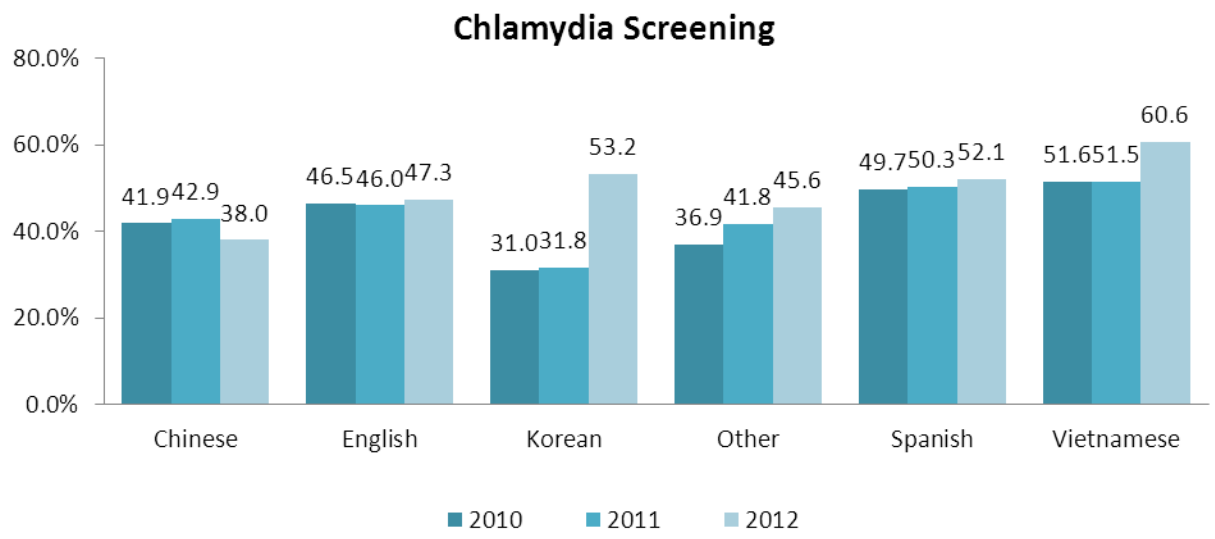
The charts on this page provide three years of demographic comparison by home language for the Access to Primary Care Practitioners HEDIS measures.

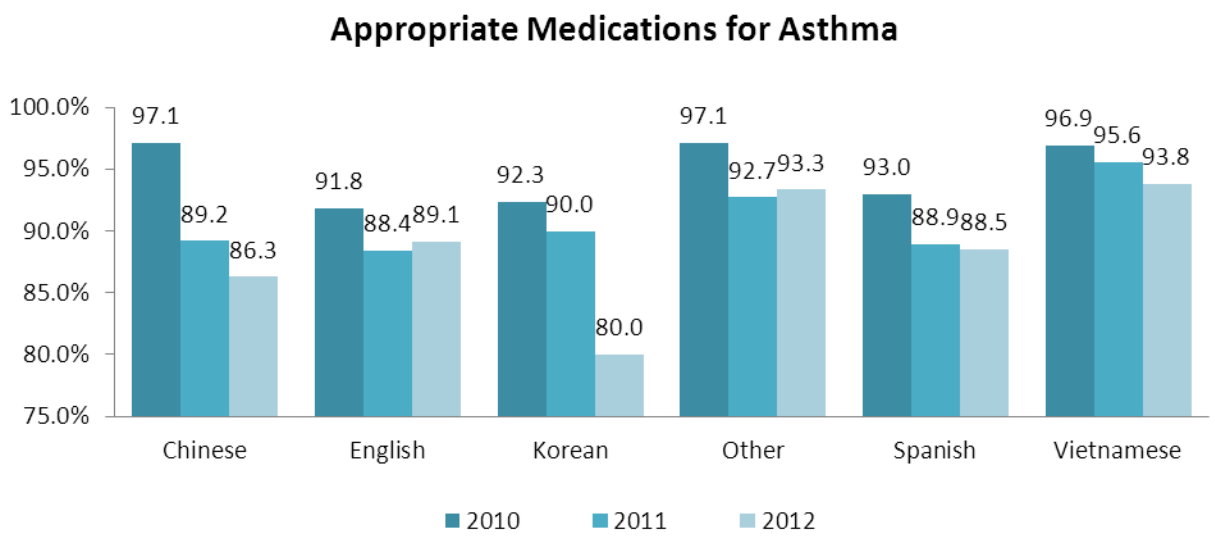
Key Findings

- The greatest increase in access to PCP's over the last three years was for Korean speaking families in both age categories.
- Korean and Vietnamese speaking families had the highest rates for access to PCPs in the 0-6 age category, while Vietnamese, Spanish and English Speaking families had the highest rates for the 7-19 age category.

Note: The term "Other" language includes Arabic, Armenian, Cambodian, Farsi, French, Hebrew, Hmong, Ilocano, Italian, Japanese, Lao, Mien, Polish, Portuguese, Russian, Samoan, Tagalog, Thai and Turkish.

APPENDIX D. 2012 DEMOGRAPHIC HEDIS MEASURES COMPARISON BY LANGUAGE





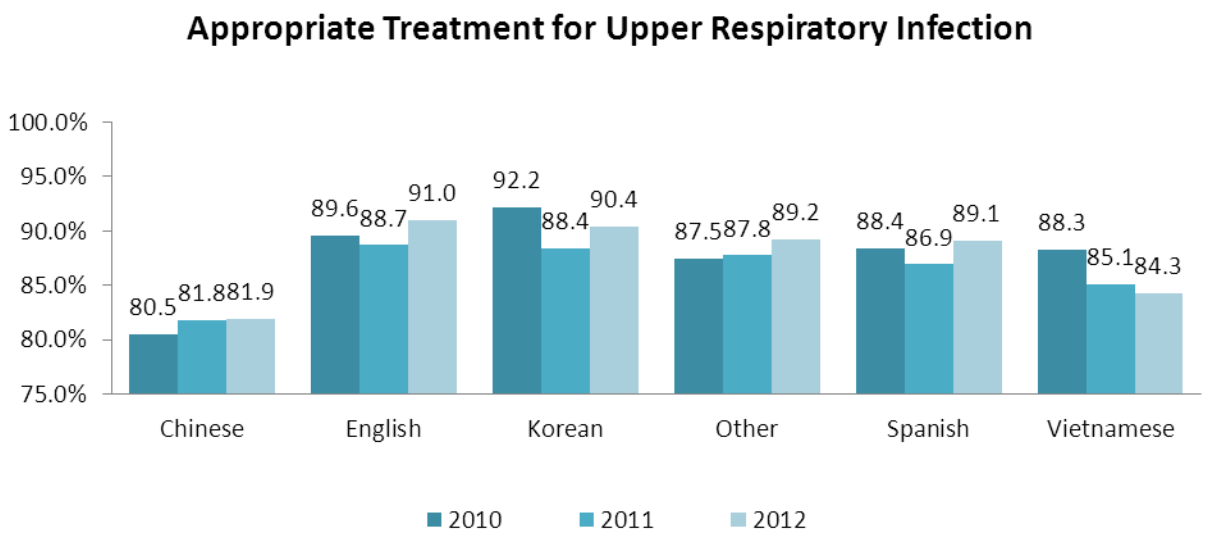
Overview

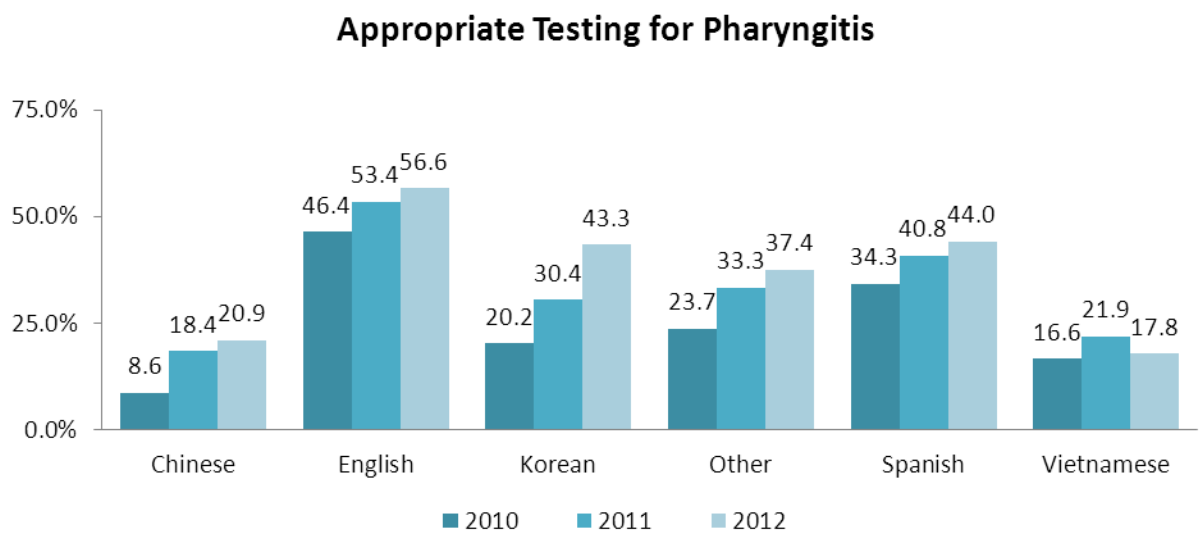
The charts on this page provide three years of demographic comparison by home language for the *Chlamydia Screening* and *Appropriate Medications for Asthma* measures.

Key Findings

- Vietnamese speaking teens had the highest rate of *Chlamydia Screening* at 60.6 percent.
- Korean speaking teens showed the greatest improvement in *Chlamydia Screening* over the last three years, from a rate of 31 percent in 2010 to 53.2 percent in 2012.
- Vietnamese speaking families also had the highest rate of *Appropriate Medications for Asthma*.
- Vietnamese, Spanish, Korean and Chinese speaking families showed a decline in medication for asthma measure from the prior year, with the greatest decline observed in Korean speaking families. However, this result may be explained in part by the change in methodology for most plans in 2012 from a hybrid to an administrative measurement.

APPENDIX D. 2012 DEMOGRAPHIC HEDIS MEASURES COMPARISON BY LANGUAGE





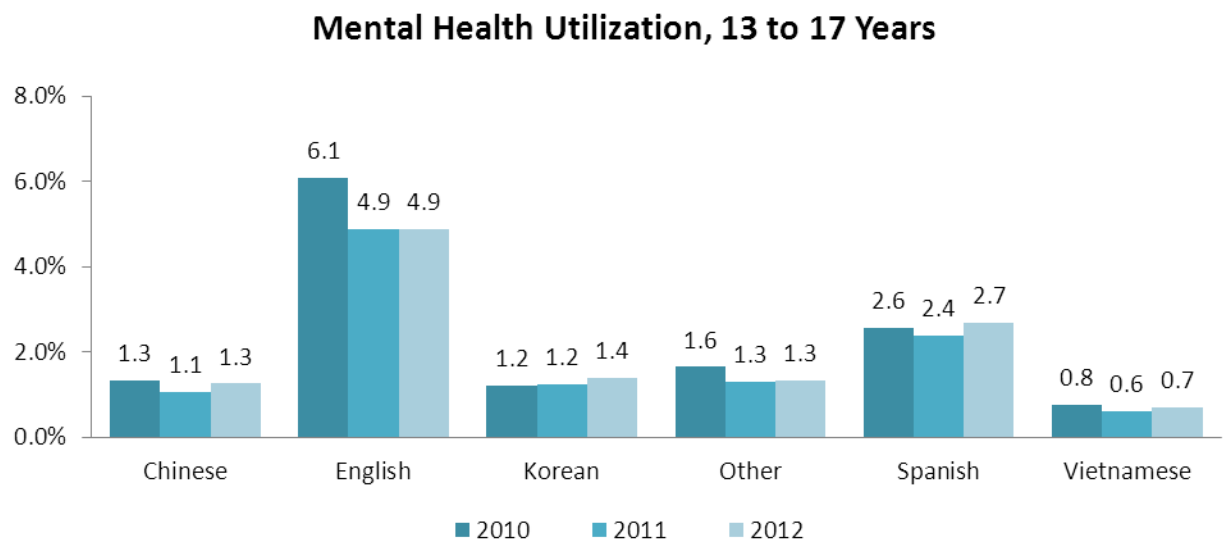
Overview

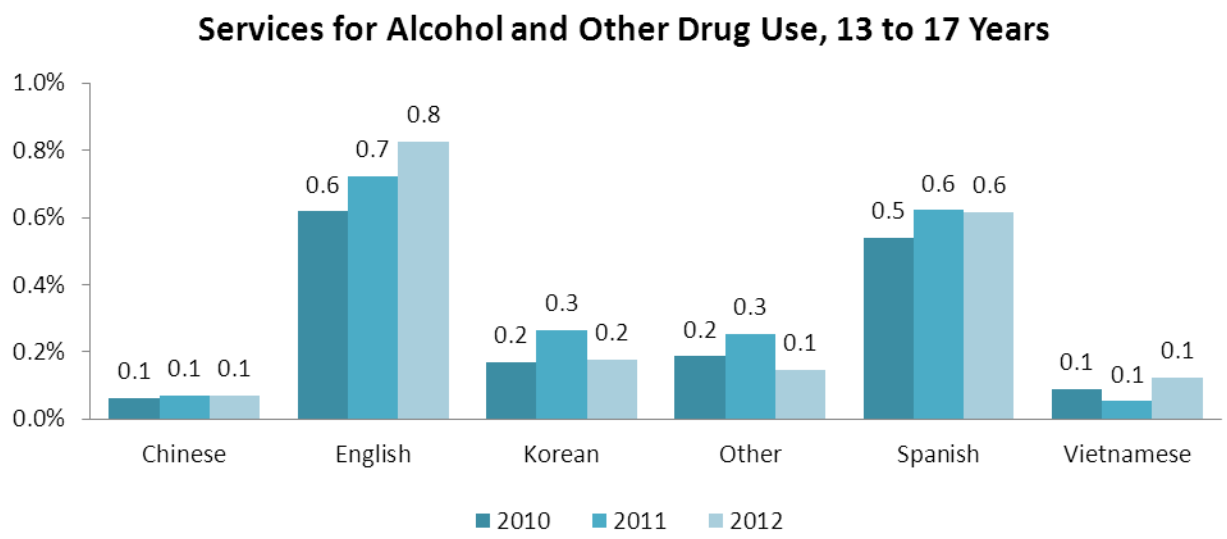
The charts on this page provide three years of demographic comparison by home language for the *Appropriate Treatment for Upper Respiratory Infection* and *Appropriate Testing for Pharyngitis* measures.

Key Findings

- *Appropriate Treatment for an Upper Respiratory Infection* improved for every language group in 2012 with the exception of Vietnamese.
- Pharyngitis testing shows improvement for each of the last two years for every language group except Vietnamese.
- English speaking families showed the highest rate of *Appropriate Testing for Pharyngitis* at 56.6 percent.
- The *Pharyngitis Testing* rate for Korean speaking families was more than double the rate for Vietnamese or Chinese speaking families.

APPENDIX D. 2012 DEMOGRAPHIC HEDIS MEASURES COMPARISON BY LANGUAGE





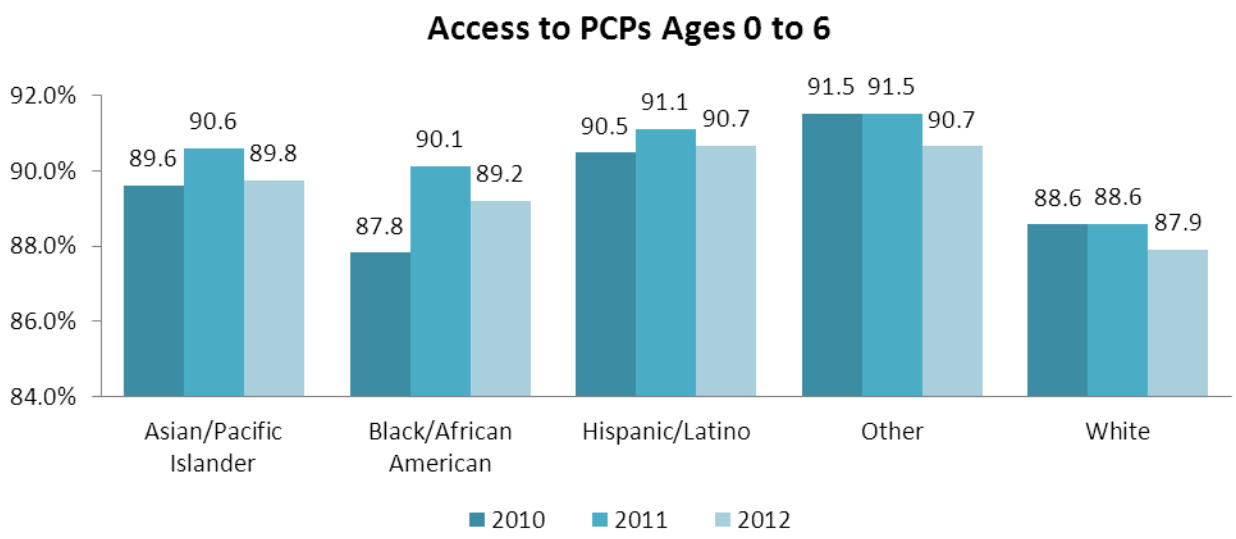
Overview

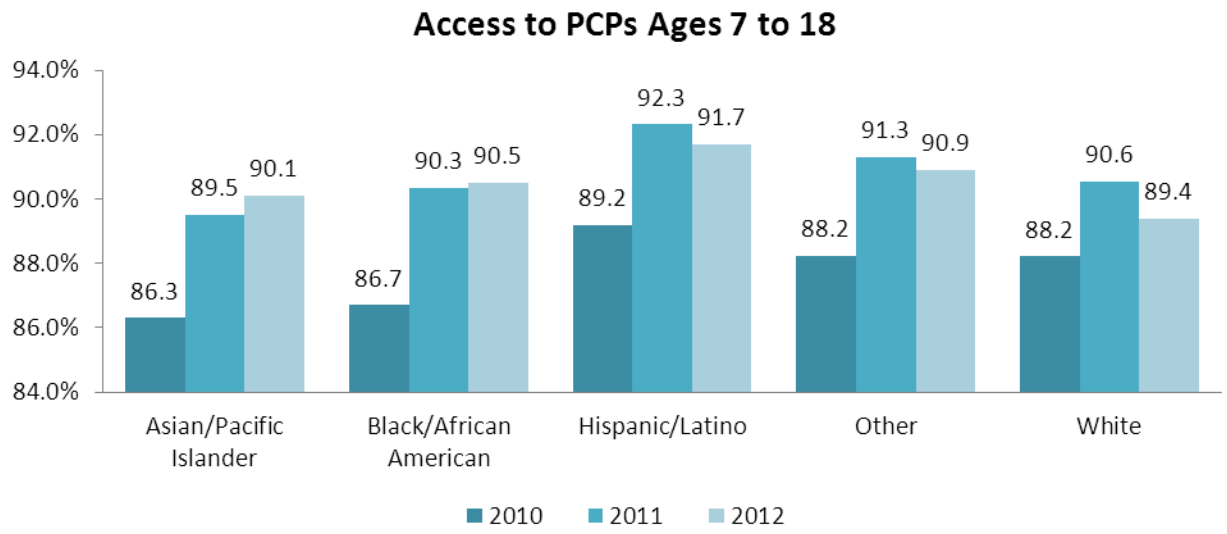
The charts on this page provide three years of demographic comparison by home language for the *Mental Health Utilization* and *Services for Alcohol and Other Drug Use* measures.

Key Findings

- English speaking teens received mental health treatment at much higher rates than any other language group, followed by Spanish speaking teens.
- Asian language teens and those in the Other category had the lowest rates of mental health treatment at about half the rate for Spanish speaking teens and a quarter of the rate of English speaking teens.
- English speaking teens received services for alcohol and drug use at the highest rate, followed by Spanish speaking teens.
- Asian language teens and those in the Other category received treatment for alcohol and drug use at much lower rates than other language groups.
- Rates in both areas clearly demonstrate a need for early identification and treatment.

APPENDIX E. 2012 DEMOGRAPHIC HEDIS MEASURES COMPARISON BY ETHNICITY





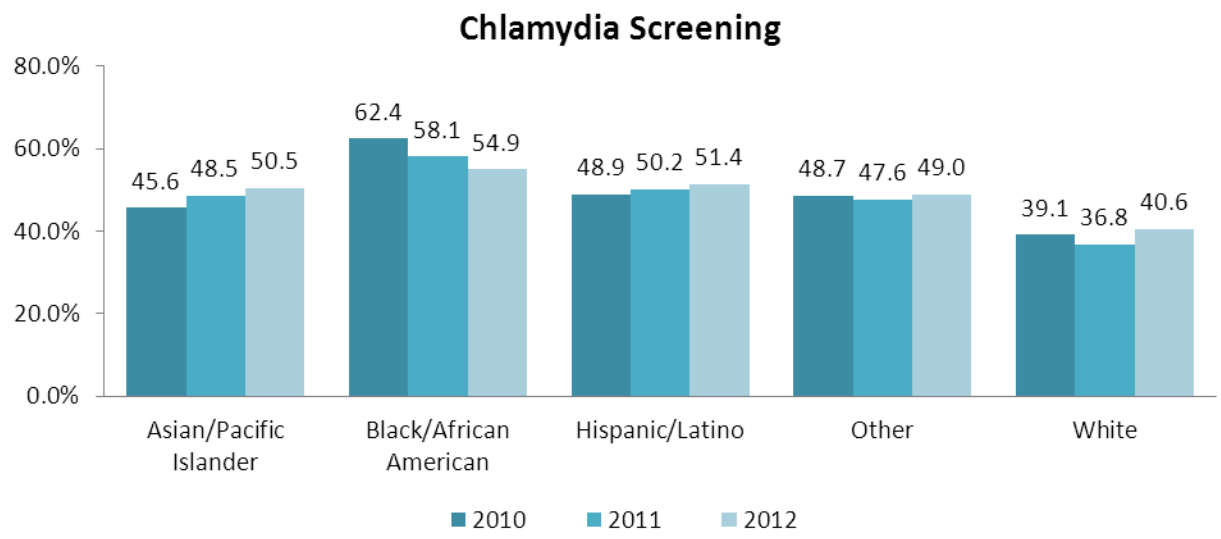
Overview

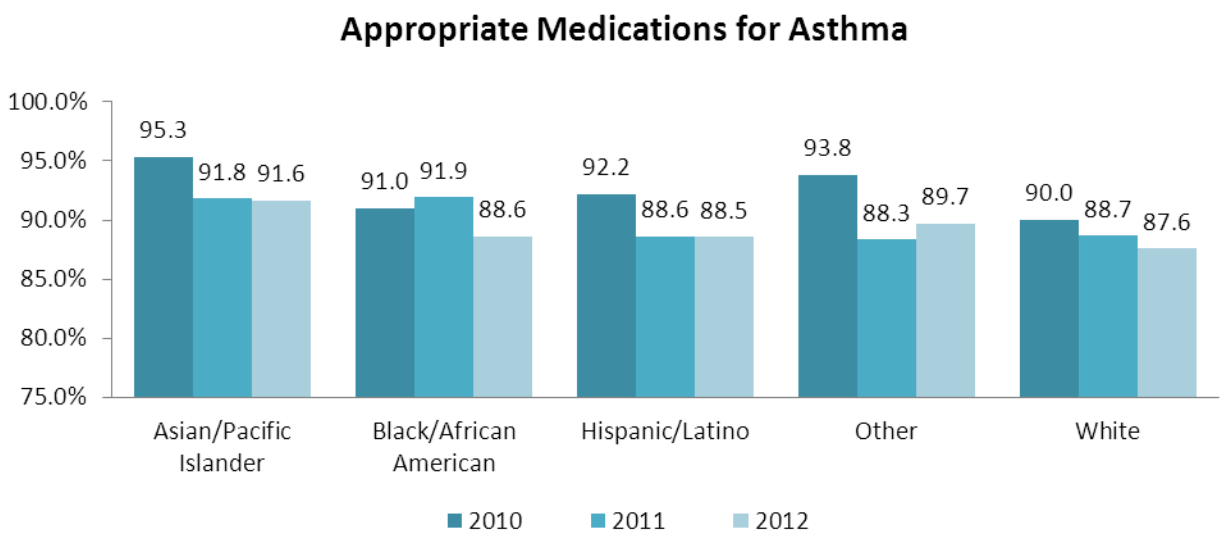
The charts on this page provide three years of demographic comparison by ethnicity for the Access to Primary Care Practitioners HEDIS measures.

Findings

- Access to PCPs for subscribers under age 7 decreased for every ethnic group in 2012 as compared to 2011.
- Access to PCP's for subscribers aged 7-18 decreased for every ethnic group in 2012 as compared to 2011, except for Black/African American subscribers. However, rates in 2012 for every ethnic group show an increase since 2010.
- The highest rates for Access to PCP's for both the 0-6 and 7-18 age groups was among Hispanic/Latino and Other ethnicities.
- Whites had the lowest rate of access to PCP's for both the 0-6 and 7-18 age groups.

APPENDIX E. 2012 DEMOGRAPHIC HEDIS MEASURES COMPARISON BY ETHNICITY





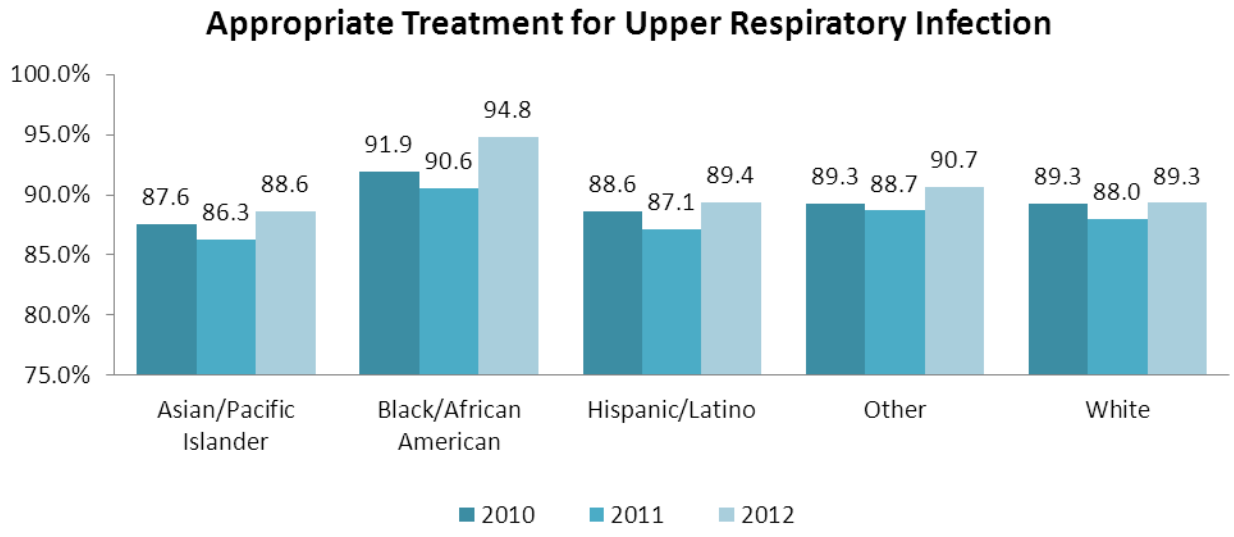
Overview

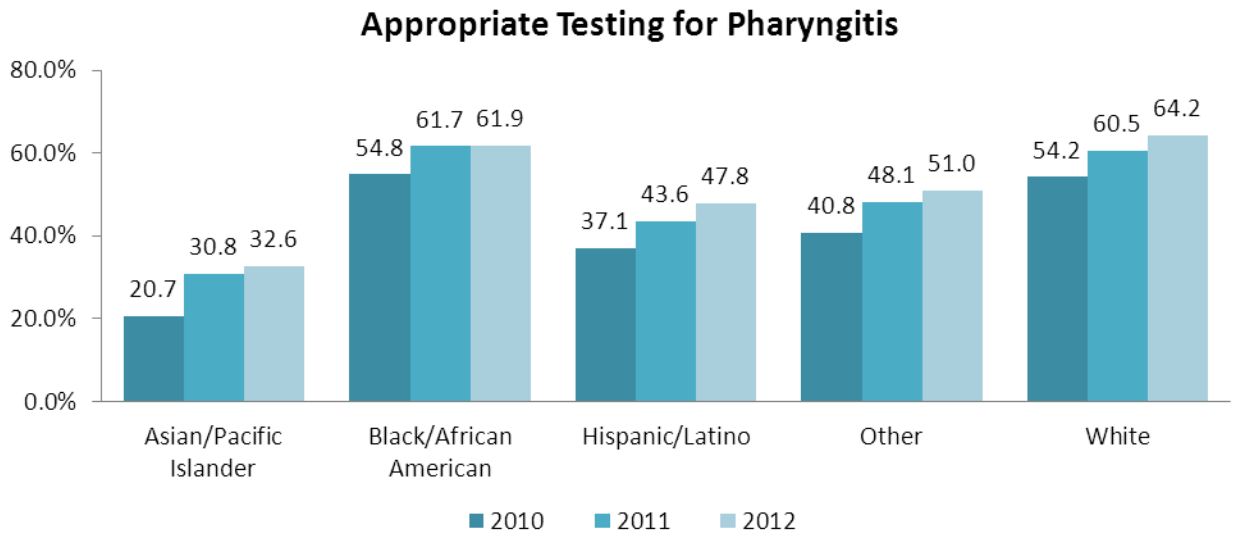
The charts on this page provide three years of demographic comparison by ethnicity for the *Chlamydia Screening* and *Appropriate Medications for Asthma* measures.

Key Findings

- Black/African American teens received *Chlamydia Screening* at the highest rate of 54.9 percent, followed by Hispanic/Latino teens with a rate of 51.4 percent.
- White teens received *Chlamydia Screening* at the lowest rate of 40.6 percent.
- *Chlamydia Screening* increased for every ethnic group in 2012 as compared to 2011, except for Black/African American teens.
- *Appropriate Medications for Asthma* decreased in 2012 compared to 2011 for all ethnic groups, except Other. However, this result may be explained in part by the change in methodology for most plans in 2012 from a hybrid to an administrative measurement.
- Asian/Pacific Islander subscribers received appropriate asthma treatment at the highest rate of 91.6 percent, while White subscribers at the lowest rate of 87.6 percent.

APPENDIX E. 2012 DEMOGRAPHIC HEDIS MEASURES COMPARISON BY ETHNICITY





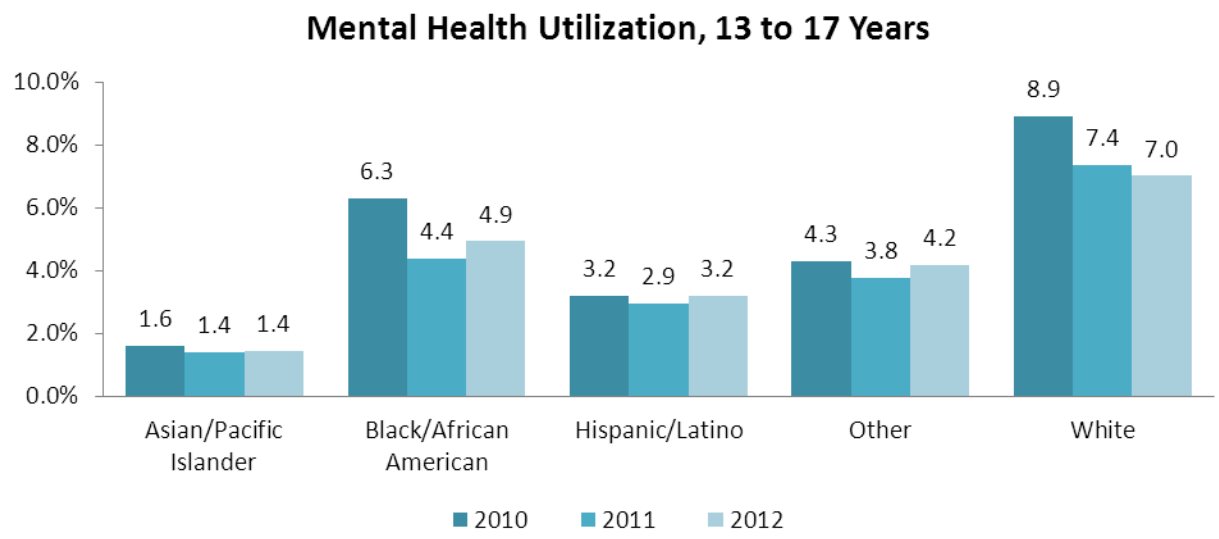
Overview

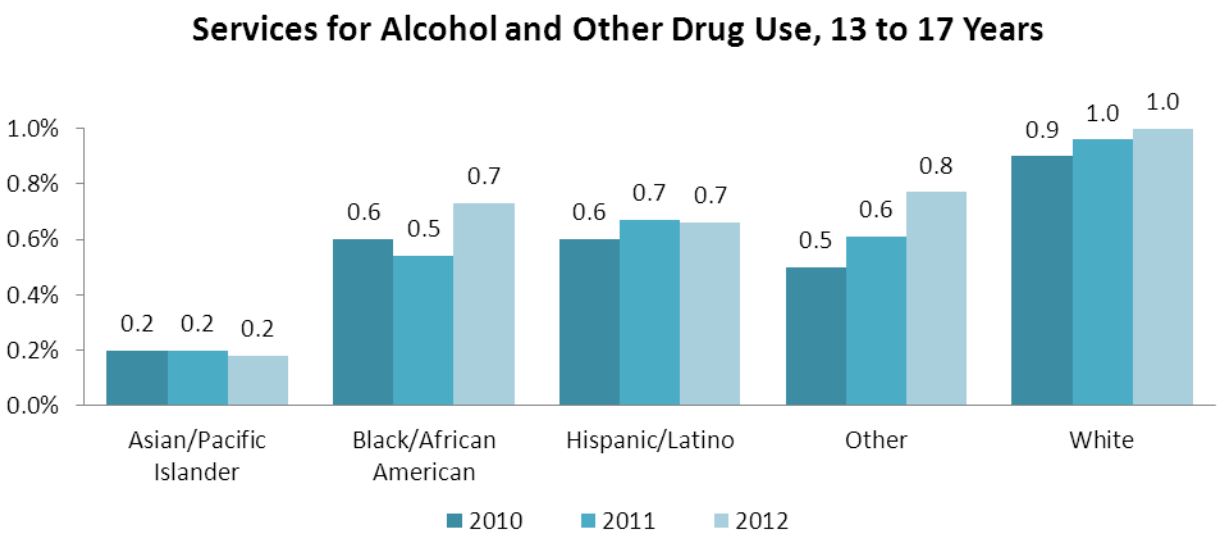
The charts on this page provide three years of demographic comparison by ethnicity for the *Appropriate Treatment for Upper Respiratory Infection* and *Appropriate Testing for Pharyngitis* measures.

Key Findings

- The *Appropriate Treatment of Upper Respiratory Infection* measure improved for every ethnic group in 2012 in comparison to 2011 and 2010.
- Almost 95 percent of Black/African American subscribers received *Appropriate Treatment for Upper Respiratory Infection*, while Asian/Pacific Islander subscribers received appropriate treatment at the lowest rate - 88.6 percent.
- *Appropriate Testing for Pharyngitis* has improved for every ethnic group in each of the last two years.
- White subscribers received *Appropriate Testing for Pharyngitis* at the highest rate of 64.2 percent, followed by Black/African American subscribers at a rate of 61.9 percent.
- Only a third of Asian/Pacific Islander subscribers received *Appropriate Testing for Pharyngitis*.

APPENDIX E. 2012 DEMOGRAPHIC HEDIS MEASURES COMPARISON BY ETHNICITY





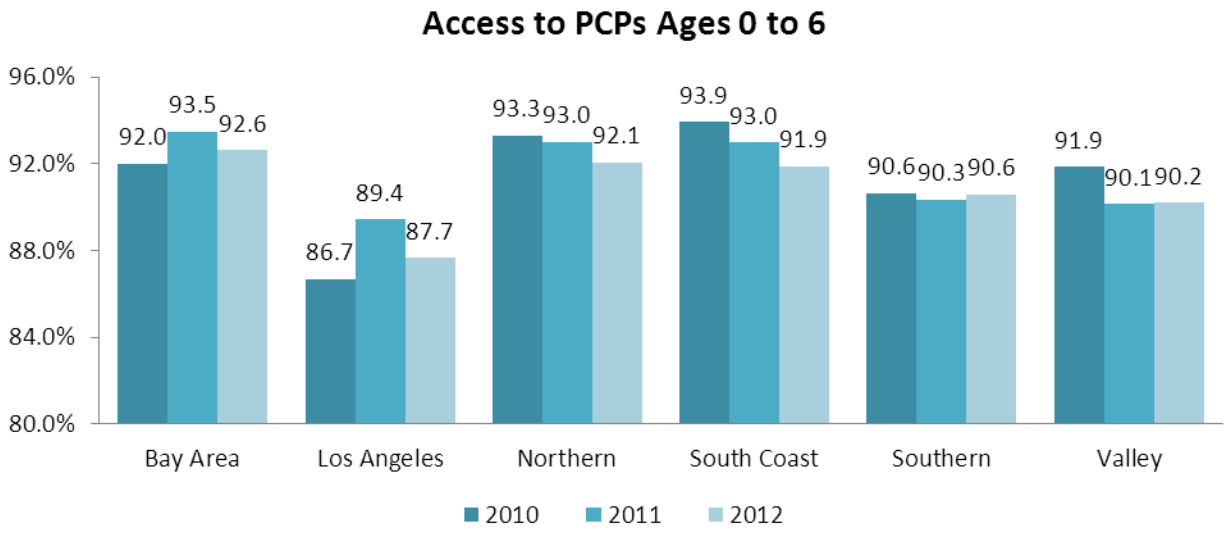
Overview

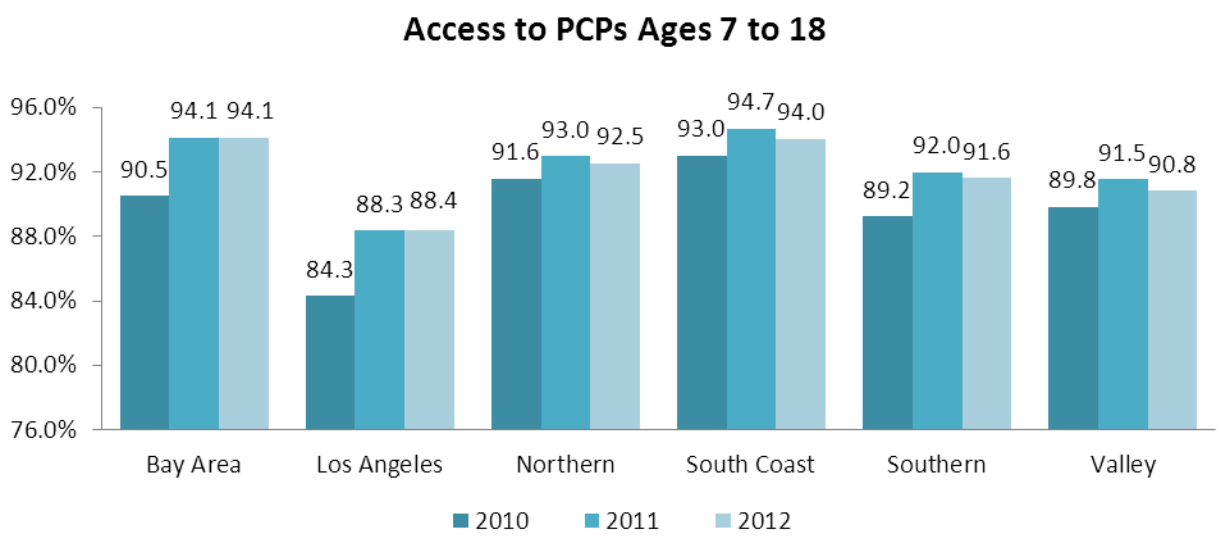
The charts on this page provide three years of demographic comparison by ethnicity for the *Mental Health Utilization* and *Services for Alcohol and Other Drug Use* measures.

Key Findings

- The *Utilization of Mental Health Services* has dropped for both White and Black/Americans since 2010, with Asian/Pacific Islander and Hispanic/Latino showing very little change in the last two years.
- White subscribers had the highest rate of *Mental Health Utilization* at 7 percent, followed by Black/African Americans at 4.9 percent.
- Asian/Pacific Islander subscribers had the lowest rate of *Mental Health Utilization* at 1.4 percent, well below that of all other ethnic groups.
- *Services for Alcohol and Other Drug Use* has increased for every ethnic group in the past two years except for Asian/Pacific Islanders.
- About one percent of White subscribers received treatment for *Alcohol and Other Drug Use* in 2012, while Asian/Pacific Islanders received treatment at the lowest rate, one-fifth that of Whites.

APPENDIX F. 2012 DEMOGRAPHIC HEDIS MEASURES COMPARISON BY REGION





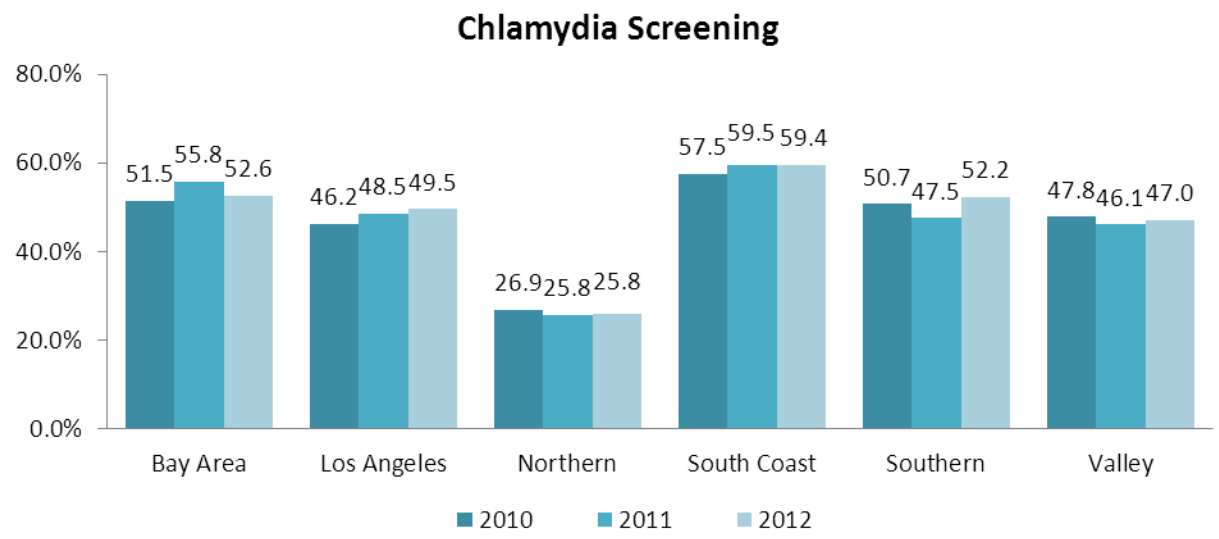
Overview

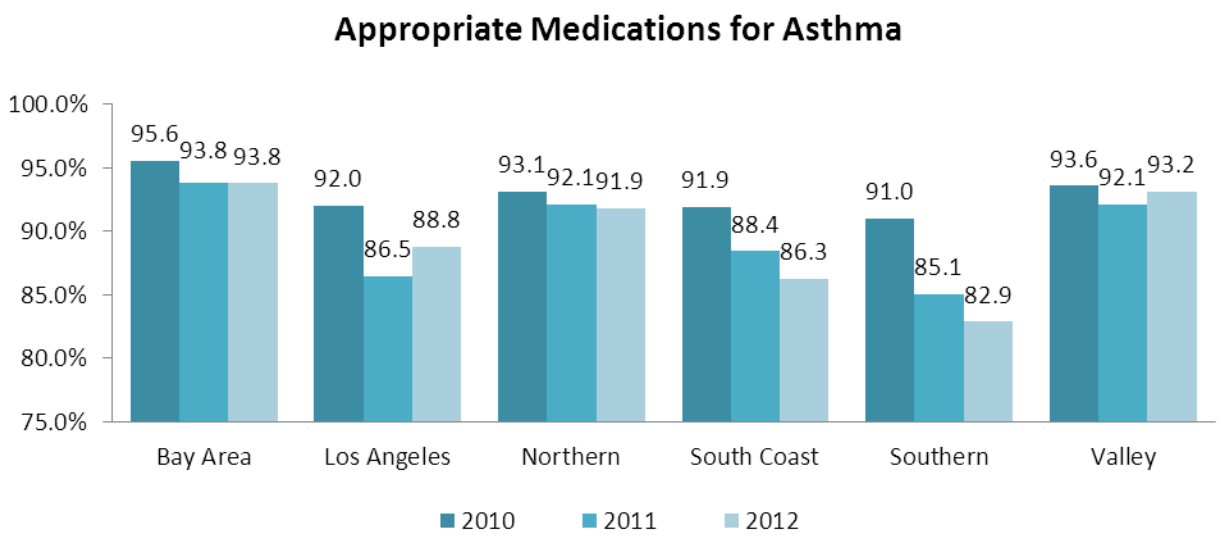
The charts on this page provide three years of demographic comparison by region for the Access to Primary Care Practitioners HEDIS measures.

Findings

- Access for subscribers for both the 0-6 and 7-18 age groups was over 90 percent in every region but Los Angeles.
- The Bay Area region had the highest Access to PCPs for both age groups.
- Access to PCP's increased slightly for the 0-6 age group in 2012 in the Southern and Valley regions, while the Bay Area, Los Angeles, Northern and South Coast regions showed decreases.
- Access to PCP's increased slightly for the 7-18 age group in 2012 in the Los Angeles region, while the Northern, South Coast, Southern and Valley regions showed decreases. The Bay Area region was unchanged at 94.1 percent.

APPENDIX F. 2012 DEMOGRAPHIC HEDIS MEASURES COMPARISON BY REGION





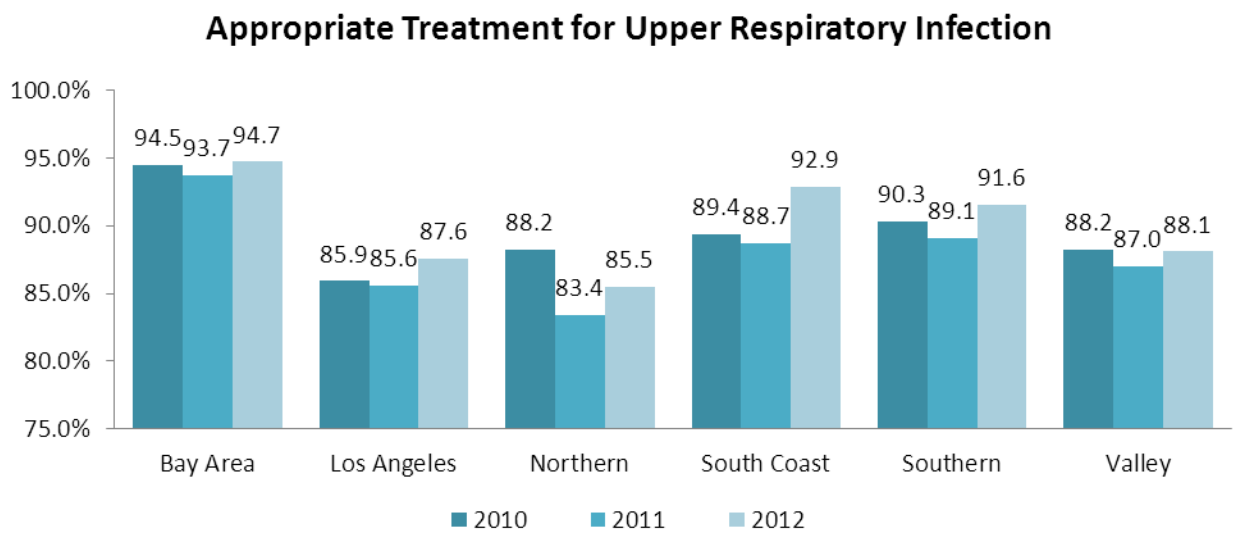
Overview

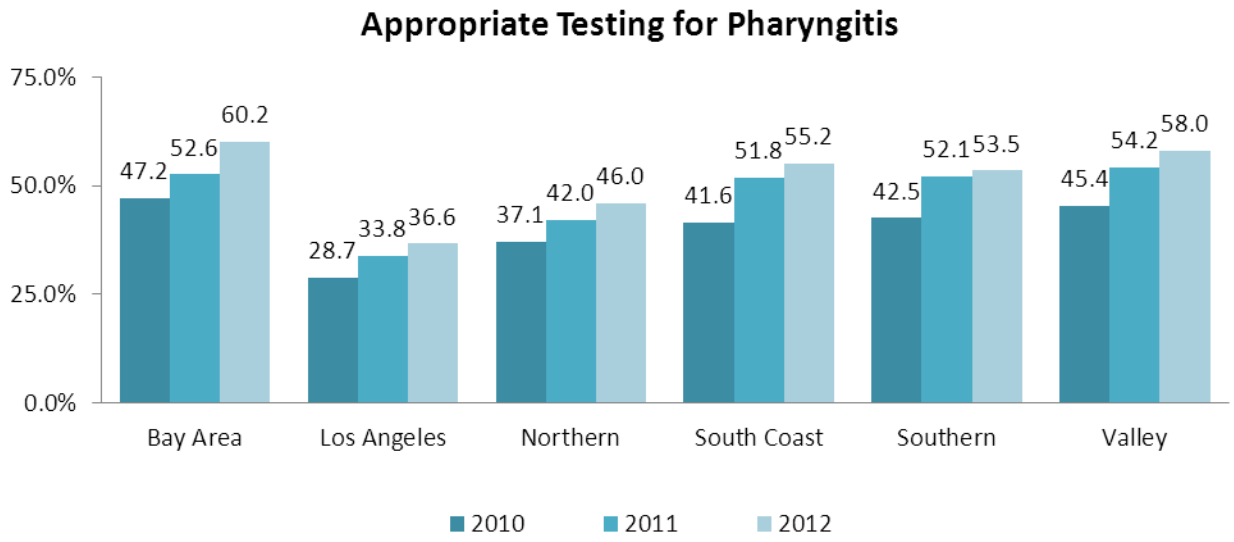
The charts on this page provide three years of demographic comparison by region for the *Chlamydia Screening* and *Appropriate Medications for Asthma* measures.

Key Findings

- Almost 60 percent of teens in the South Coast region received appropriate testing for *Chlamydia Screening*, while only 26 percent of teens in the Northern Region were tested.
- The rates in each region have been relatively flat, with little increase or decrease in the last two years.
- Over 90 percent of subscribers with asthma received appropriate medications in the Bay Area, Northern and Valley regions.
- However, since 2010, *Appropriate Medication for Asthma* has dropped in every region, with the largest decrease observed in the Southern region.

APPENDIX F. 2012 DEMOGRAPHIC HEDIS MEASURES COMPARISON BY REGION





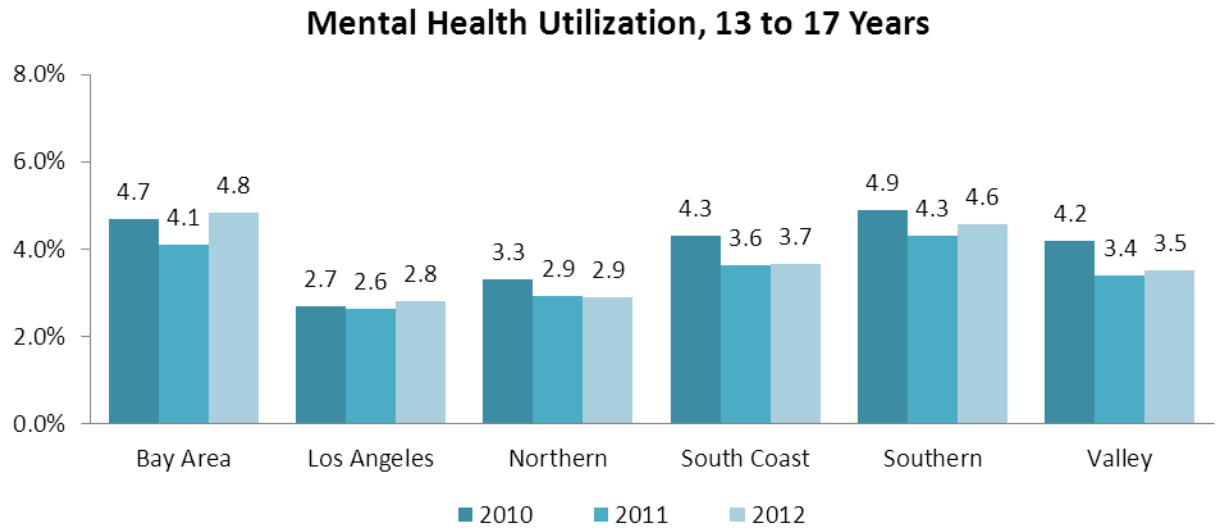
Overview

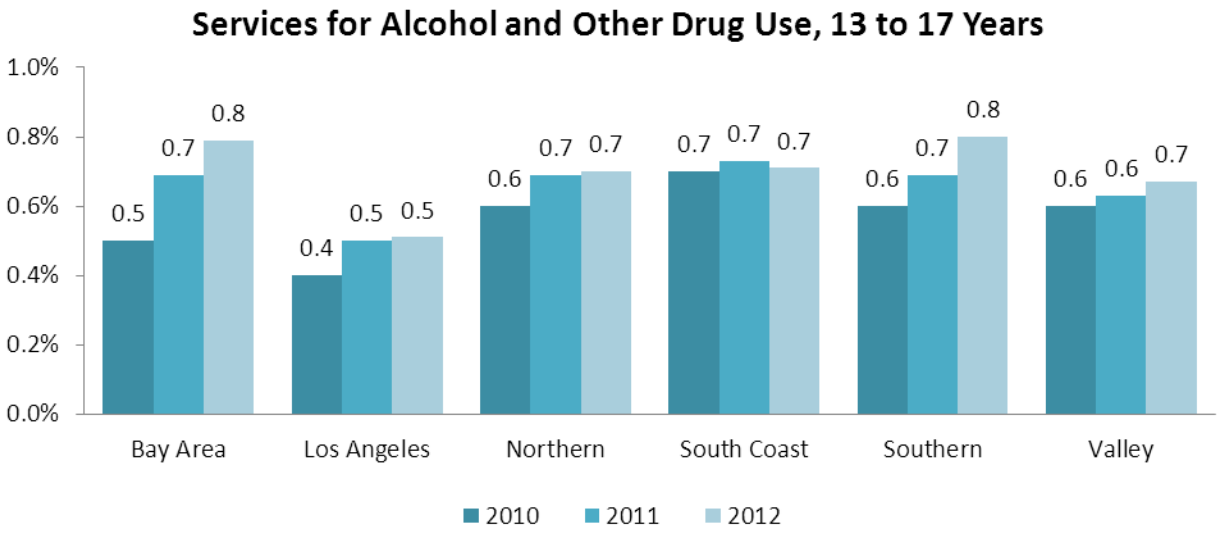
The charts on this page provide three years of demographic comparison by region for the *Appropriate Treatment for Upper Respiratory Infection* and *Appropriate Testing for Pharyngitis* measures.

Key Findings

- More than 90 percent of subscribers in the Bay Area, South Coast and Southern regions received *Appropriate Treatment for Upper Respiratory Infection*. These regions also increased their rate from 2010.
- The lowest rate of *Appropriate Treatment for Upper Respiratory Infection* was in the Northern region at 85.5 percent.
- While 60 percent of subscribers in the Bay Area received *Appropriate Testing for Pharyngitis*, less than 40 percent of subscribers in the Los Angeles region did.
- The rate of *Appropriate Testing for Pharyngitis* has increased in every region in both of the last two years.

APPENDIX F. 2012 DEMOGRAPHIC HEDIS MEASURES COMPARISON BY REGION





Overview

The charts on this page provide three years of demographic comparison by region for the *Mental Health Utilization* and *Services for Alcohol and Other Drug Use* measures.

Key Findings

- The Bay Area and Southern regions provided mental health treatment to over 4 percent of their subscribers, while the Los Angeles and Northern regions were below 3 percent.
- The rate of mental health services increased in every region in 2012 as compared to 2011, with the exception of the Northern region which was unchanged.
- *Services for Alcohol and Other Drug Use* increased in the Bay Area, Southern and Valley regions in 2012 compared to 2011. The largest increases were observed in the Bay Area and Southern regions
- Rates are significantly low and demonstrate a need for more outreach and education on this topic.