2012 HEDIS Aggregate Report for the Medi-Cal Managed Care Program

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

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1. EXECUTIVE SUMMARY

During the 2011 calendar year, the Department of Health Care Services (DHCS) held contracts with 22 full-scope health plans and three specialty plans to provide health care services to approximately 4.9 million members enrolled in the Medi-Cal Managed Care (MCMC) Program.[1]

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with managed care plans, measure and report on performance to assess the quality and appropriateness of care and services provided to members. In response, the DHCS implemented a monitoring system to provide an objective, comparative review of health plan quality-of-care outcomes and performance measures called the External Accountability Set (EAS). The DHCS designates performance measures on an annual basis and requires plans to report on them.

The DHCS 2012 EAS consisted of 14 performance measures with 30 distinct indicators providing information on access to care for women, adolescents, and children; use of imaging studies for low back pain; screening for diseases such as cervical cancer; weight assessment and counseling for nutrition and physical activity for children and adolescents; care provided to members with chronic diseases such as diabetes; hospital readmissions rates; and utilization of outpatient and emergency department care.

The DHCS based all selected performance measures on the Healthcare Effectiveness Data and Information Set (HEDIS®[2]) developed by the National Committee for Quality Assurance (NCQA) with the exception of an internally developed measure, *All-Cause Readmissions*, used for the statewide collaborative quality improvement project. This HEDIS data set is a nationally recognized and standardized set of performance measures used by consumers, employers, government agencies, legislators, advocates, and potential purchasers to assess the quality of care provided within a health plan's Medicare, Medicaid, and commercial lines of business.

As part of the EAS, the DHCS requires plans to undergo an NCQA HEDIS Compliance Audit™[3] conducted by an external quality review organization (EQRO). The EQRO assesses the plans' information systems (IS) capabilities and compliance with HEDIS specifications to ensure standardized reporting of performance measure results. The DHCS contracted with Health Services Advisory Group, Inc. (HSAG) to perform these on-site compliance audits in 2012,

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1 Medi-Cal Managed Care Enrollment Report, January 2012. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: April 30, 2012.

2 HEDIS® is a registered trademark of the National Committee for Quality Assurance.

3 NCQA HEDIS Compliance Audit™ is a trademark of NCQA.

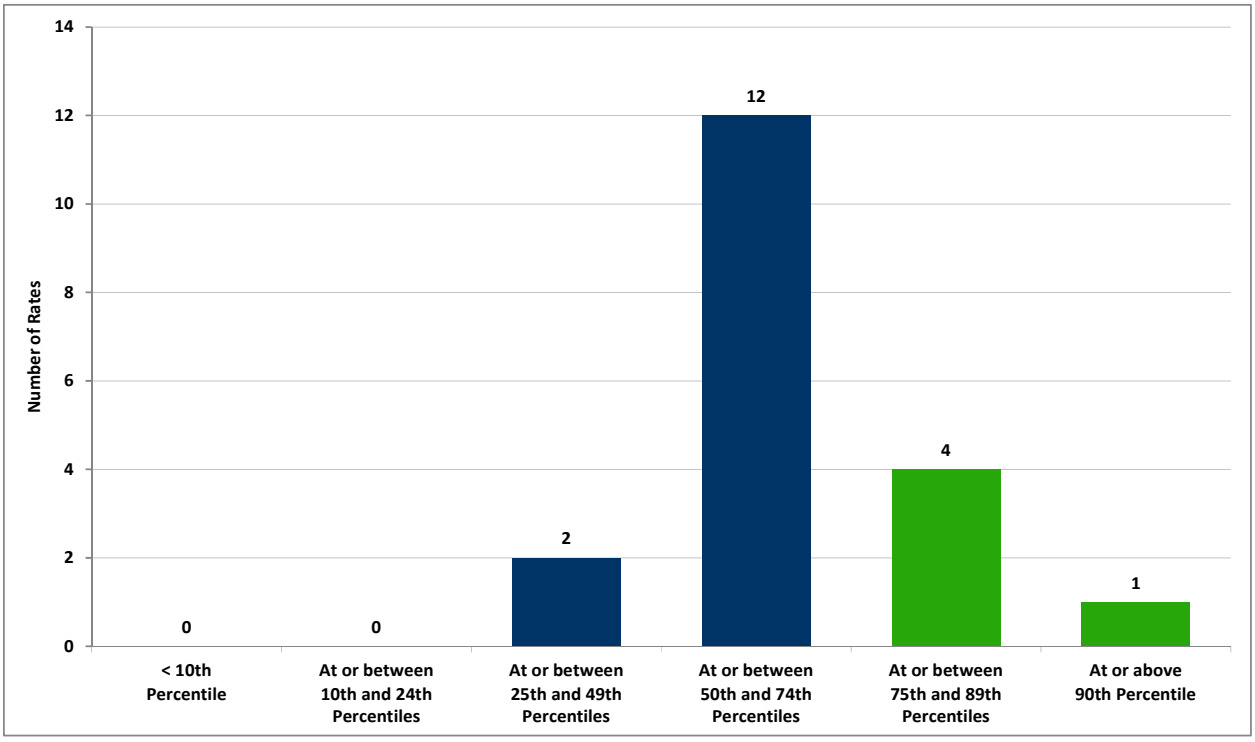
analyze MCMC HEDIS rates objectively, and evaluate each plan's current performance level relative to local and national thresholds and benchmarks.

This report presents MCMC HEDIS 2012 results for the 2011 measurement period of January 1, 2011, through December 31, 2011. The DHCS did not require two plans that were contracted during the 2011 calendar year, CalViva and Gold Coast Health Plan, to report rates for this time frame. These two plans will begin reporting HEDIS data as part of the HEDIS 2013 measure set.

Key Findings

The MCMC's 2012 results were very similar to 2011. The MCMC Program as a whole demonstrated average performance for most measures, noting some strengths as well as areas that need improvement. As shown in Figure1.1, the majority of the MCMC Program's 2012 performance results were between the 50th and 74th national Medicaid percentiles with 12 weighted averages falling into this category.The MCMC Program performed at or above the 90th national percentile for one of the HEDIS measures (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling*). The MCMC had four measures that scored between the 75th and 89th national Medicaid percentiles and two measures ranked between the 25th and 49th national Medicaid percentiles. The MCMC Program performed better on 17 performance measures and worse on two performance measures in 2012 compared to 2011.

Figure 1.1—Medi-Cal Managed Care Program Performance Compared to National Medicaid Benchmarks—2012 National Medicaid Percentile Range



Eleven performance measures were not measured against the HPLs and MPLs in 2012. Eight were new measures for the 2012 reporting year, two were utilization measures, and one was an internally developed measure for the statewide collaborative quality improvement project. These measures were:

- *Ambulatory Care*
  - *Outpatient Visits*
  - *Emergency Department Visits*
- *Annual Monitoring for Patients on Persistent Medications*
  - *ACE Inhibitors or ARBs*
  - *Digoxin*
  - *Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners*
  - *Children 12 to 24 months who had a visit with a PCP during the measurement year*
  - *Children 25 months to 6 years who had a visit with a PCP during the measurement year*
  - *Children 7 to 11 years who had a visit with a PCP during the measurement year or the year prior to the measurement year*
  - *Adolescent 12 to 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year*
- *Immunizations for Adolescents—Combination 1*
- *All-Cause Readmissions*

The top four performance measure rates, those with the smallest differences between the MCMC weighted averages and the HPLs, were *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling,* with a -0.1 percentage point difference; *Use of Imaging Studies for Low Back Pain,* with a 1.3 percentage point difference; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment,* with a 1.5 percentage point difference; and *Childhood Immunizations Status, Combination 3,* with a 4.4 percentage point difference. The MCMC weighted average outperformed the HPL for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling.*

The four lowest-scoring performance measure rates, those with the largest differences between the MCMC weighted averages and the HPLs, were *Comprehensive Diabetes Care Eye Exam (Retinal) Performed,* with a 15.1 percentage point difference; *Prenatal and Postpartum Care—Postpartum Care,* with a 13.5 percentage point difference; *Prenatal and Postpartum Care—Prenatal Care,* with a 9.4 percentage point difference; and *Adolescent Well-Care Visits,* with a 9.3 percentage point difference.

High and Low Performance

Four full-scope plans demonstrated high performance across the EAS, exceeding 14 or more of the DHCS's established high performance levels (HPLs), which represent the national Medicaid 90th percentiles; and none of these plans performed below the MPLs for any single measure. HSAG also identified these plans as the top performers in 2011. San Francisco Health Plan—San Francisco County exceeded the HPLs on 16 measures, Kaiser Permanente—Sacramento County exceeded the HPLs on 15 measures, and both Kaiser Permanente—San Diego County and Central CA Alliance for Health—Monterey/Santa Cruz counties exceeded the HPLs on 14 measures.

Four plans showed the greatest opportunity for improvement, with seven or more performance measures below the DHCS-established minimum performance levels (MPLs), which represents the national Medicaid 25th percentiles. Anthem Blue Cross—Alameda and Contra Costa counties each had 12 measures below the MPLs, followed by Anthem Blue Cross—Sacramento County with 10 measures, and Anthem Blue Cross—San Joaquin County with seven measures below the MPLs.

Model Type Performance

The County-Operated Health System (COHS) model type outperformed the Geographic Managed Care (GMC) and Two-Plan model types on 23 of the 27 performance measures (*Ambulatory Care—Outpatient Visits* and *Ambulatory Care—ED Visits* were not considered because they are utilization measures). The Two Plan model outperformed the other model types for *Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis, Cervical Cancer Screening, and Comprehensive Diabetes Care—HbA1c Poor Control.* The GMC model type outperformed the other model types on the *Immunizations for Adolescents—Combination.*

Because the COHS model type is the only option the MCMC Program provides in certain counties, this structure may have an advantage over other model types on performance measures. With fewer members shifting between plans and a relatively stable provider network, the COHS structure may provide a better opportunity for continuity and coordination of care for members.

Performance Measure Compliance Audit—Key Findings

HSAG conducted performance measure validation of all MCMC plans. All plans were able to report valid rates for their DHCS-required measures, and all plans were compliant with the information system standards.

Conclusions and Recommendations

The MCMC Program demonstrates a commitment to monitor and improve the quality of care delivered to its enrollees through its development of an EAS that supports the MCMC Program's overall quality strategy. Each plan's performance contributes to the MCMC Program's overall weighted averages, which were at or above the national Medicaid average for most measures.

The DHCS continued a variety of mechanisms that support the improvement efforts of plans. The auto-assignment program offers an increased incentive for plans in the GMC and Two-Plan model types to perform well by rewarding higher-performing plans with increased default membership. During 2011, the DHCS met with its contracted plans to obtain input on potential measure changes to the 2013 EAS, including changes that may impact auto-assignment. The DHCS may make modifications to the auto-assignment measures in 2013 to continue to emphasize improved performance across the measure set. Additionally, the DHCS has supported plans in selecting performance measures as formal quality improvement projects (QIPs) to help structure improvement efforts to increase the likelihood of achieving statistically significant improvement and sustained improvement. The DHCS has taken a more active role in reviewing plan QIP proposals to ensure that plans are selecting areas that are actionable and need improvement rather than selecting topics of consistent or high performance. The DHCS evaluates its EAS and auto-assignment program measures annually to rotate out measures that show consistent, high performance among plans. For the 2012 EAS, the DHCS retired the *Appropriate Treatment for Children With Upper Respiratory Infection* and *Breast Cancer Screening* measures to focus on five new measures. This process allows the DHCS to identify and select new measures as opportunities for improvement. Finally, the DHCS has improved its oversight process of the plans' performance over time and has begun to work with plans that have demonstrated poor performance over several years on multiple measures.

Based on the review of the 2012 HEDIS results, HSAG provides the following recommendations for continued improvement to the plans:

- Plans need to place a greater emphasis on moving from documentation compliance of low HEDIS rates and HEDIS improvement plans to efforts that actually address improved health outcomes.
- Plans need to critically evaluate intervention effectiveness to identify those interventions that have been successful and should be continued and those that were not successful and can be discontinued or modified.
- Plans should consider selecting performance measures with poor rates as the focus for formal QIPs as this strategy has been effective for many plans across a wide number of performance measures.
- Plans need to consider evidence-based strategies when selecting interventions.

- Plans should consider working with the EQRO to provide more intensive technical assistance for measures that remain low over consecutive years.
- Plans should scrutinize the claims process to ensure that the rendering provider detail is accurately submitted and captured from all sources, especially multispecialty and group practices.

Medi-Cal Managed Care Program Overview

The DHCS administers the Medi-Cal Managed Care (MCMC) Program, California's managed care program for Medicaid recipients. The program serves about 62 percent of the Medi-Cal population, with 38 percent enrolled in fee-for-service Medi-Cal.

During the 2011 measurement year, the DHCS contracted with 22 full-scope plans and three specialty plans operating throughout California in 24 of California's 58 counties, to provide health care services to approximately 4.9 million members enrolled in managed care plans.

Medi-Cal Managed Care Program Delivery System

The DHCS operates the MCMC Program through a service delivery system that encompasses three different plan model types for its full-scope services: the County-Organized Health System (COHS), Geographic Managed Care (GMC), and Two-Plan model types. The DHCS monitors plan performance across model types. Table 2.1 shows participating MCMC plans by model type.

County-Organized Health System

In a COHS model, the DHCS contracts with one county-organized and operated plan in a county to provide managed care services to all Medi-Cal beneficiaries in that county with very few exceptions. Beneficiaries can choose from a wide network of managed care providers. Beneficiaries in COHS plan counties do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the DHCS.

Geographic Managed Care

In the GMC model, enrollees choose from three or more commercial plans offered in a county. Beneficiaries with designated mandatory aid codes must enroll in a managed plan. Seniors and individuals with disabilities who are eligible for Medi-Cal benefits under the Supplemental Security Income (SSI) program and a small number of beneficiaries in several other aid codes are not required to enroll in a plan but may choose to do so. These voluntary beneficiaries may either enroll in a managed care plan or receive services through the Medi-Cal fee-for-service (FFS) program. The GMC model type currently operates in San Diego and Sacramento counties.

Two-Plan

In the Two-Plan model, the DHCS contracts with two managed care plans in each county to provide health care services to beneficiaries. Most Two-Plan model counties offer a locally operated, local initiative (LI) plan and a non-governmental commercial plan (CP). As with the GMC model type, the DHCS requires beneficiaries with designated mandatory aid codes to enroll in a plan, while seniors and individuals with disabilities who are eligible for Medi-Cal benefits under the SSI program and a small number of beneficiaries in several other aid codes can voluntarily choose either to enroll in a plan or remain in the FFS program. As in the GMC model, these voluntary beneficiaries may either enroll in a managed care plan or receive services through the Medi-Cal FFS program.

Specialty and Prepaid Health Plans

In addition to the full-scope plans, the DHCS contracts with several plans to provide health care services to specialized populations. During the 2012 measurement period, the DHCS held contracts with three specialty plans. The DHCS requires each specialty and prepaid health plan (PHP) to report annually on two DHCS-approved performance measures chosen specifically for each plan.

Note: As of June 1, 2011, enrollment in Two-Plan and GMC Medi-Cal managed care plans became mandatory for seniors and individuals with disabilities who do not have other health coverage (Medi-Cal only). For more information about this change, see the "Seniors and Persons with Disabilities" page on the DHCS Web site at http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDEnrollment.aspx

Table 2.1—Medi-Cal Managed Care Program Plans by Model Type as of December 31, 2011

Model Type		Plan Name	County
County-Organized Health System		CalOptima	Orange
		CenCal Health	Santa Barbara, San Luis Obispo
		Central CA Alliance for Health	Monterey, Santa Cruz, Merced
		Health Plan of San Mateo	San Mateo
		Partnership Health Plan[1]	Napa, Solano, Sonoma, Yolo
Geographic Managed Care		Anthem Blue Cross	Sacramento
		Care1st Health Plan	San Diego
		Community Health Group	San Diego
		Health Net	Sacramento
		Health Net	San Diego
		Kaiser Permanente—North	Sacramento
		Kaiser Permanente—South	San Diego
		Molina Health Care	Sacramento
		Molina Health Care	San Diego
Two-Plan	Commercial	Anthem Blue Cross	Alameda
		Anthem Blue Cross	Contra Costa
		Anthem Blue Cross	San Francisco
		Anthem Blue Cross	San Joaquin
		Anthem Blue Cross	Santa Clara
		Health Net	Kern
		Health Net	Los Angeles
		Health Net	Stanislaus
		Health Net	Tulare
		Molina Health Care	Riverside, San Bernardino
	Local Initiative	Alameda Alliance for Health	Alameda
		Anthem Blue Cross	Stanislaus
		Anthem Blue Cross	Tulare
		Contra Costa Health Plan	Contra Costa
		Health Plan of San Joaquin	San Joaquin
		Inland Empire Health Plan	Riverside, San Bernardino
		Kern Family Health Care	Kern
		L.A. Care Health Plan	Los Angeles
		San Francisco Health Plan	San Francisco
		Santa Clara Family Health	Santa Clara
Specialty and Prepaid Health Plans		AHF Healthcare Centers	Los Angeles
		Family Mosaic Project	San Francisco
		Senior Care Action Network (SCAN) Health Plan	Los Angeles

Note: The DHCS did not require two plans that were contracted during the 2011 calendar year, CalViva and Gold Coast Health Plan, to report rates for this time frame.

[1] Partnership Health Plan expanded into Marin and Mendocino counties effective July 1, 2011.

How the DHCS Uses Performance Measures

The overall goal of the DHCS is to preserve and improve the health status of all Californians. The MCMC Program provides comprehensive health care services to a large population of low-income children and families, as well as to an expanding population of seniors and persons with disabilities. Since the Medi-Cal program serves some of California's most vulnerable populations, the need to evaluate and monitor the quality of health care has remained a key objective for the DHCS in meeting its overall goal.

One mechanism established to monitor accountability for quality health care is the DHCS's implementation of the EAS. The DHCS selects performance measures annually and requires its contracted plans to report rates at the county level unless otherwise specified.

The DHCS expects its plans to implement effective quality improvement systems to monitor, evaluate, and improve performance. These systems include health care claims systems, membership and provider files, and hardware/software management tools that facilitate accurate and reliable reporting of HEDIS measures.

Federal requirements mandate the validation of performance measures. The DHCS satisfies this federal requirement by contracting with an EQRO to conduct performance measure validation. HSAG follows the CMS protocol for validating performance measures by conducting NCQA HEDIS Compliance Audits™ for HEDIS measures or using the CMS protocol for validating performance measures for non-HEDIS measures, ensuring that plans report accurate and complete information.

The DHCS shares plan-specific and aggregate HEDIS results with the plans and CMS and releases the results publicly. The DHCS also incorporates these results into its consumer guides for new enrollees and uses the data as part of its annual performance assessment of plans and the MCMC Program as a whole.

In addition, the DHCS gives annual quality awards to plans in recognition of their accomplishments. The criteria for these awards are based on plans' HEDIS results for exceptional performance or marked improvement. HEDIS awards were presented to plans at the 2012 Annual Quality Conference, *Reducing Readmissions Through Safe Transitions of Care,* held in Sacramento, CA, on April 11, 2012. These awards were based on HEDIS 2011 performance results. The awards were presented as follows:

- Gold Award—San Francisco Health Plan (San Francisco County)
- Silver Award—Central CA Alliance for Health (Monterey/Santa Cruz counties)
- Bronze Award—Kaiser Permanente–North—Sacramento County
- Honorable Mention—CalOptima (Orange County)
- Most Improved—Community Health Group (San Diego County)

Minimum Performance Levels and High Performance Levels

The DHCS establishes both MPLs and HPLs for each required performance measure annually. Using NCQA's most recent percentiles available, which reflect the previous year's benchmarks, the DHCS used the *HEDIS 2011 Audit Means, Percentiles, and Ratios* (reflecting the CY 2010 measurement period) to base its MPLs for the 2012 rates on the Medicaid national 25th percentiles. Plans are contractually required to perform at or above the established MPLs. Plans that have rates below the MPLs must submit an improvement plan to the DHCS outlining the steps they will take to improve care. The DHCS established HPLs for the 2012 rates based on the national Medicaid 90th percentiles. Plan performance regarding the MPL and HPL for each measure becomes public record with the release of this report.

It is important to note that for the *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)* measure, where a lower rate represents higher performance, HSAG rotated the percentiles to align with the performance. If the *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)* rate was at or between the 10th and 24th percentiles, it was inverted at or between the 75th and 89th percentiles to represent the level of performance.

Auto-Assignment Program

Currently, six performance measures selected from the EAS are part of the DHCS's auto-assignment program, along with two measures related to plan use of safety net providers. The department awards more default enrollment to Two-Plan and GMC model plans that score high on these measures and that achieve improvement over time. The auto-assignment program encourages plans to improve and/or maintain quality of care and services provided to their members.

Medi-Cal Managed Care Program's 2012 HEDIS Measures

The DHCS's 2012 EAS for full-scope plans, which uses 2011 measurement year data, includes the following measures:

- *Adolescent Well-Care Visits*
- *Ambulatory Care*
  - *Emergency Department Visits*
  - *Outpatient Visits*
- *Annual Monitoring for Patients on Persistent Medications*
  - *ACE Inhibitors or ARBs*
  - *Digoxin*
  - *Diuretics*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Children and Adolescents' Access to Primary Care Practitioners*
  - *Children 12 to 24 months who had a visit with a PCP during the measurement year*
  - *Children 25 months to 6 years who had a visit with a PCP during the measurement year*
  - *Children 7 to 11 years who had a visit with a PCP during the measurement year or the year prior to the measurement year*
  - *Adolescent 12 to 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year*
- *Comprehensive Diabetes Care*
  - *Hemoglobin A1c (HbA1c) Testing*
  - *Poor HbA1c Control (>9.0 Percent)*
  - *HbA1c Control (<8.0 Percent)*
  - *LDL-C Screening*
  - *LDL-C Control (<100 mg/dL)*
  - *Eye Exam (Retinal) Performed*
  - *Medical Attention for Nephropathy*
  - *Blood Pressure Control (< 140/90 mm Hg)*
- *Immunizations for Adolescents —Combination 1*
- *All-Cause Readmissions* (developed as statewide collaborative QIP measure)
- *Prenatal and Postpartum Care*
  - *Timeliness of Prenatal Care*
  - *Postpartum Care*

- *Use of Imaging Studies for Low Back Pain*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
  - *BMI Assessment: Total*
  - *Nutrition Counseling: Total*
  - *Physical Activity Counseling: Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

About HEDIS

HEDIS, developed by NCQA, is a standardized set of performance measures used to provide health care purchasers, consumers, and others with a reliable comparison among health plans. HEDIS data are often used to produce health plan "report cards," analyze quality improvement activities, and benchmark performance. NCQA classifies the broad range of HEDIS measures across eight domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction With the Experience of Care
- Use of Services
- Cost of Care
- Health Plan Descriptive Information
- Health Plan Stability
- Informed Health Care Choices

Performance measures within these domains provide information about a plan's performance in such areas as providing timely access to preventive services, management of members with chronic disease, and appropriate treatment for members with select conditions.

While HEDIS data provide an opportunity to compare plans based on some aspects of health care delivered to members, the intent of the data is not to provide an overall, comprehensive assessment of health care quality for a plan.

Rather, the DHCS uses HEDIS data as one component of its overall quality monitoring strategy. Both the DHCS and plans use plan-specific data, aggregate data, and comparisons to state and national benchmarks to identify opportunities for improvement, analyze performance, and assess whether previously implemented interventions were effective.

How HEDIS Results Are Calculated and Displayed

NCQA developed specific HEDIS methodology to ensure that plans collect data and calculate and report results consistently to allow for plan comparison.

Methodology

To assist plans in standardized reporting, NCQA develops and makes available technical specifications that provide information on how to collect data for each measure, with general guidelines for sampling and calculating rates. The DHCS's EAS requirements for 2012 indicate that plans are responsible for adhering to the *HEDIS 2012 Technical Specifications, Volume 2*.

To ensure that plans calculate and report performance measures consistent with HEDIS specifications and that the results can be compared to other plans' HEDIS results, the plans must undergo an independent audit. NCQA publishes *HEDIS Compliance Audit™: Standards, Policies, and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an information systems (IS) capabilities assessment and an evaluation of compliance with HEDIS specifications for a plan. The DHCS requires that plans undergo an annual compliance audit conducted by its contracted EQRO.

The HEDIS process begins well in advance of plans reporting their rates. Plans calculated their 2012 HEDIS rates with measurement data from January 1, 2011, to December 31, 2011. Performance measure calculation and reporting typically involves three phases: Pre-on-site, On-site, and Post-on-site.[4]

Pre-on-site Activity (October through December)

- Plans prepare for data collection and the on-site audit.
- Plans complete the HEDIS Record of Administration, Data Management, and Processes (Roadmap), a tool used by plans to communicate information to the auditor about the plans' systems for collecting and processing data for HEDIS.

On-site Activity (January through April)

- Plans conduct data capture and data collection.
- The EQRO conducts on-site audits to assess the plans' capabilities to collect and integrate data from internal and external sources.
- The EQRO provides preliminary audit findings to the plans.

[4] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Calculating Performance Measures: A Protocol for use in Conducting Medicaid External Quality Review Activities*. Final Protocol, Version 1.0. May 1, 2002.

Post-on-site Activity (May through October)

- The EQRO provides final audit reports to plans.
- Plans submit final audited rates to the DHCS (June).
- The EQRO analyzes data and generates the HEDIS aggregate report in coordination with the DHCS.

Data Collection Methodology

NCQA specifies two methods for data capture: the administrative method and the hybrid method.

Administrative Method

The administrative method requires plans to identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims and encounters. In addition, plans derive the numerator(s), or services provided to members in the eligible population, solely from administrative data sources. Plans cannot use medical records to retrieve information. When using the administrative method, the entire eligible population becomes the denominator because NCQA does not allow sampling.

The DHCS selected EAS measures for which NCQA methodology requires the administrative method to derive rates:

- *All-Cause Readmissions* (statewide collaborative QIP measure)
- *Ambulatory Care*
- *Annual Monitoring for Patients on Persistent Medications*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Breast Cancer Screening**
- *Children and Adolescents' Access to Primary Care Practitioners*
- *Osteoporosis Management in Women Who Had a Fracture**
- *Use of Imaging Studies for Low Back Pain*

*A specialty or PHP plan measure

The administrative method is cost-efficient, but it can produce lower rates due to incomplete data submission by capitated providers.

Hybrid Method

The hybrid method requires plans to identify the eligible population using administrative data and then extract a systematic sample of members from the eligible population, which becomes the denominator. Plans use administrative data to identify services provided to those members. When administrative data do not show evidence that a service was provided, plans then review medical records for those members.

The hybrid method generally produces higher rates but is considerably more labor-intensive. For example, a plan that has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure may perform the hybrid method. After randomly selecting 411 eligible members, the plan finds that 161 members have evidence of a postpartum visit using administrative data. The plan then obtains and reviews medical records for the 250 members who do not have evidence of a postpartum visit using administrative data. Of those 250 members, the plan finds 54 additional members who have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would be (161 + 54)/411, or 52 percent.

In contrast, using the administrative method, if the plan finds that 4,000 members out of the 10,000 had evidence of a postpartum visit using only administrative data, the final rate for this measure would be 4,000/10,000, or 40 percent.

The DHCS-selected EAS measures for which NCQA methodology allows hybrid data collection:

- *Adolescent Well-Care Visits*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Colorectal Cancer Screening**
- *Comprehensive Diabetes Care*
- *Controlling High Blood Pressure**
- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

* A specialty or PHP measure

Plans that have complete and robust administrative data may choose to report measures using only the administrative method and avoid labor-intensive medical record review; however, currently only two of the Medi-Cal Managed Care (MCMC) contracted plans report rates in this manner, Kaiser Permanente—Sacramento County and Kaiser Permanente—San Diego County. The Kaiser plans have IS capabilities, primarily due to their closed-system model and electronic medical

records that support administrative-only reporting because medical record review does not generally yield additional data beyond what the plan had already captured administratively.

HEDIS Aggregate Report Data Displays

This report displays 2012 HEDIS results relative to both local and national performance thresholds and benchmarks to compare the quality of services provided to MCMC members. A comparison of performance gives both the DHCS and plans a framework to identify opportunities to improve care.

National benchmarks displayed in this report include the national Medicaid averages and the national commercial averages as reported by NCQA. The objectives and goals of the federal *Healthy People 2010* program provide another source of national benchmarks for comparison within this report, as available.[5] Local benchmarks include prior-year MCMC weighted averages. Plans' submission of HEDIS data provides rates calculated to the sixth decimal place. Results in this report are rounded to the first decimal place to be consistent with the display of comparative local and national benchmarks. Some rounded rates may appear the same; however, the more precise rates are not identical.

Medi-Cal Managed Care Program Weighted Averages

The principal measure of overall MCMC performance on a given measure is the weighted average rate. This use of a weighted average, based on each plan's eligible population for that measure, provides the most representative rate for the overall MCMC population. Weighting the MCMC average by each plan's eligible population size ensures that the rate for a health plan with 125,000 members, for example, has a greater impact on the overall MCMC weighted average than the rate for a plan with only 10,000 members.

HSAG computed the 2012 MCMC Program weighted average for each measure using plan-reported rates and weighted these by each plan's reported eligible population size for the measure. Rates that were given an audit result of *Not Reportable* were not included in the calculation of these averages. This is a better estimate of care for all MCMC enrollees than a straight average of MCMC plans' performance.

[5] *Healthy People 2010* is managed by the U.S. Department of Health and Human Services' Office of Prevention and Health Promotion. *Healthy People 2010* provides a framework for prevention for the nation by establishing national health objectives and setting national goals to reduce threats. Available at: www.healthypeople.gov.

Significance Testing

HSAG used a Chi-square test to determine if plan-specific differences between 2012 and 2011 rates were statistically significant. The Chi-square test was used to judge how likely it is that the difference is real and not the result of chance.

To determine significance for this report, HSAG selected a risk level of 0.05. This risk level, or alpha level, means that five times out of 100, a statistically significant difference will be found between the mean values even if none actually existed (i.e., it happened by chance).

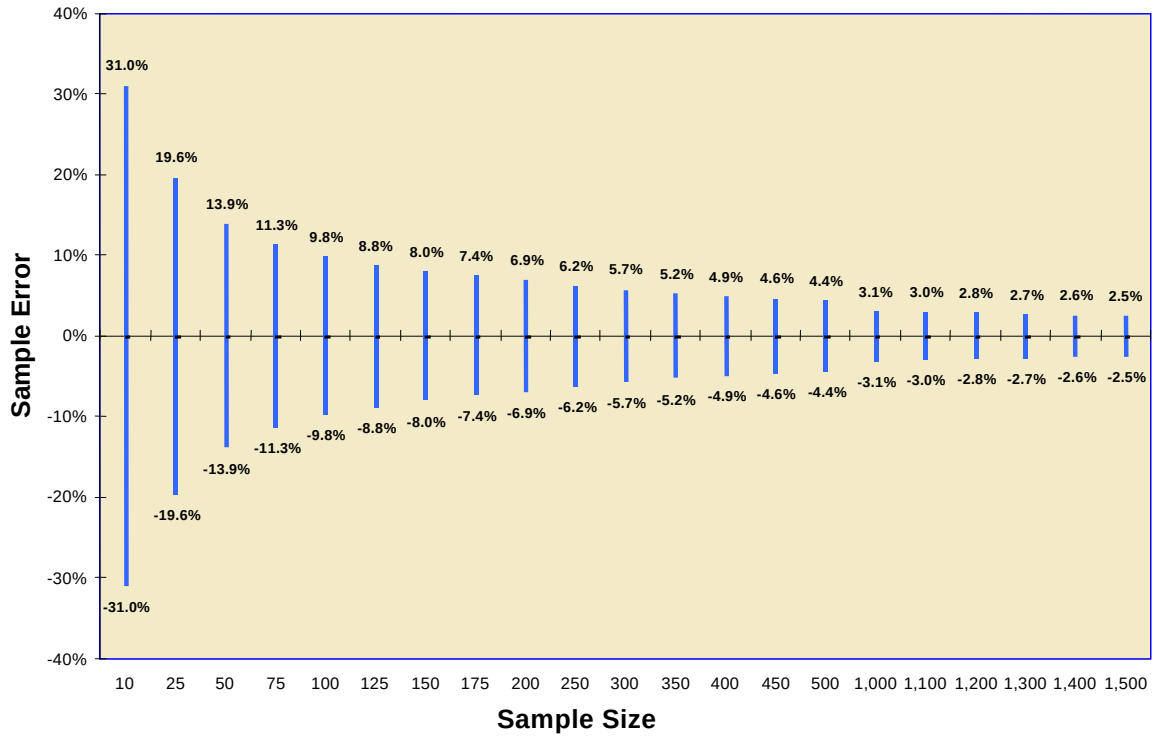
Understanding Sampling Error and Effect Size

Correct interpretation of results for measures collected using the HEDIS hybrid methodology requires an understanding of sampling error. It is rarely possible, logistically or financially, to conduct medical record reviews of the entire eligible population for a given measure. Measures collected using the HEDIS hybrid method include only a sample from the eligible population, and statistical techniques are used to maximize the probability that the sample results reflect the experience of the entire eligible population.

For results to be generalized to the entire eligible population, the process of sample selection must be such that everyone in the eligible population has an equal chance of being selected. The HEDIS hybrid method prescribes a systematic sampling process of selecting at least 411 members from the eligible population. Health plans may use a 5 percent, 10 percent, 15 percent, or 20 percent oversample to replace invalid cases (e.g., a male selected for *Postpartum Care*).

Figure 3.1 shows that if 411 health plan members are included in a measure, the margin of error is approximately ± 4.9 percentage points. Note that the data in this figure are based on the assumption that the size of the eligible population is greater than 2,000. The smaller the sample included in the measure, the larger the sampling error.

Figure 3.1—Relationship of Sample Size to Sample Error



Effect Size

The difference between two measured rates may not be statistically significant, but may, nevertheless, be important. The judgment of the reviewer is always a requisite for meaningful data interpretation. As Figure 3.1 shows, sample error gets smaller as the sample size gets larger. Consequently, when sample sizes are very large and sampling errors are very small, almost any difference is statistically significant. This does not mean that all such differences are important.

Effect sizes can be somewhat arbitrary and controversial, but are often used to determine the sample size needed to detect the difference that is desired.

The general guidelines to determine effect size are:

- A "small" difference between means is equal to one fifth the standard deviation.
- A "medium" effect size is equal to one half the standard deviation.
- A "large" effect is equal to 0.8 times the standard deviation.

The HEDIS sample sizes have already considered the effect size. The sampling formula used by HEDIS is sufficient to detect a difference of 10 percentage points. According to the *HEDIS 2012 Technical Specifications*, *Volume 2*, "This was chosen because it is a big enough difference to be actionable, it is not unduly burdensome for data collection, and it is not so small as to be

'swamped' by nonsampling error." Sample size is calculated using a two-tailed test of significance between two proportions (alpha =.5, 80 percent power) and a normal approximation to the binomial with a continuity correction factor also employed.

HEDIS results are intended to be used for decision making based on expected future performance. In this manner, the results of the sample are generalized to the population, and the plan's entire population is considered a "sample" of future populations. When there is no interest in generalizing the results to the population (e.g., there is only interest in the results for the sample), there is no need for significance testing. In these situations, effect sizes are sufficient and suitable.

How to Interpret Results

HEDIS results can differ among plans and even across measures for the same plan. The following questions generally arise when examining these data:

Considerations for Data Interpretation

1. How accurate are the results?

2. How do MCMC rates compare to national percentiles?

3. How are MCMC plans performing overall?

Results Accuracy

The DHCS requires all MCMC plans to have their HEDIS results confirmed by an NCQA HEDIS Compliance Audit™. As a result, HSAG verified all rates in this report as an unbiased estimate of the measure. NCQA designed the HEDIS protocol with its hybrid method, which produces results with a sampling error of ± 5 percent at a 95 percent confidence level.

Sampling error can affect the accuracy of results. Suppose a plan uses the hybrid method to derive a *Prenatal and Postpartum Care* rate of 52 percent. Because of sampling error, the true rate is actually ± 5 percent of this rate—somewhere between 47 percent and 57 percent at a 95 percent confidence level. If the target is a rate of 55 percent, it is uncertain whether the true rate, which is between 47 percent and 57 percent, meets the target level.

To prevent such ambiguity, this report uses a standardized methodology that requires the reported rate to be at or above the threshold level to be considered as meeting the target. For internal purposes, plans should understand and consider the issue of sampling error when implementing interventions.

Comparing Medi-Cal Managed Care Program Rates to National Percentiles

This report displays the MCMC Program weighted average and compares it to the following local and national benchmarks:

- 2011 National Medicaid Average—The most current available mean rate of all Medicaid plans nationwide that reported rates to NCQA in 2011.
- 2011 National Commercial Average—The most current available mean rate of all commercial plans nationwide that reported rates to NCQA in 2011.
- Healthy People 2010—The available, established, and relevant goals similar to the MCMC Program's EAS.

Medi-Cal Managed Care Plans' Overall Performance

The DHCS establishes performance thresholds annually for minimum performance and high performance. This report displays each plan's rate relative to the established MPL and HPL for each measure, with the highest threshold or rate at the top of the chart, continuing in descending order to the lowest threshold or rate. Using NCQA's *HEDIS 2011 Audit Means, Percentiles, and Ratios,* the DHCS established its MPLs and HPLs for its HEDIS 2012 EAS. The DHCS based the MPLs on the 2011 Medicaid national 25th percentile and the HPLs on the 2011 Medicaid national 90th percentile, which represent the most recent data available from NCQA at the time this report was prepared. Appendix A includes all the HEDIS 2011 national Medicaid percentiles.

For most measures in this report, the 90th percentile indicates the HPL and the 25th percentile represents the MPL. This means that MCMC plans with reported rates above the 90th percentile rank in the top 10 percent of all Medicaid plans nationwide. Similarly, plans reporting rates below the 25th percentile (MPL) rank in the bottom 25 percent nationwide for that measure.

This differs for one measure, *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)*, where lower rates of poor control indicate better care. For this measure, the 10th percentile (rather than the 90th percentile) shows excellent performance, and the 75th percentile (rather than the 25th percentile) shows below-average performance. For this measure only, a *lower* rate indicates better performance.

For one specialty plan, *Colorectal Cancer Screening* does not have established national percentiles for the Medicaid population. For this measure, HSAG and the DHCS use the established commercial 25th and 90th percentiles for comparison.

Performance Trend Analysis

In Appendix B, the column, "2011–2012 Rate Difference," shows, by measure, a comparison between the HEDIS 2011 results and the HEDIS 2012 results for each plan. HSAG used a Chi-square test to calculate the statistical significance between plan rates in 2011 and 2012. The table shows the rate difference between 2011 and 2012 graphically using the key below:

↑	Rates in 2012 were significantly higher than they were in 2011.
↓	Rates in 2012 were significantly lower than they were in 2011.
↔	Rates in 2012 were not significantly different than they were in 2011.
Not comparable	A 2011–2012 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Different symbols (▲▼) are used to indicate a performance change for *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)*, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant *increase* in the 2012 rate from the 2011 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2012 rate from the 2011 rate.

About Performance Measure Validation

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 this requirement, the DHCS contracted with HSAG to conduct validation of the selected EAS performance measures. All but one (*All-Cause Readmissions*) of the selected EAS measures for 2012 for regular, full-scope plans are also HEDIS measures; therefore, HSAG conducted audits in accordance with the 2012 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that plans must meet, including the criteria for any manual processes used to report HEDIS information. When a plan did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. Plans not fully compliant with all of the IS standards may still report all measures as long as the final reported rate is not significantly biased.

The IS standards include:

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry.
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry.
- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry.
- IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight.
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry.
- IS 6.0—Member Call Center Data—Capture, Transfer, and Entry (Note: This standard is not covered under the scope of the MCMC Care Program audit).
- IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity.

Audit Results

Through the audit process HSAG assigns each measure an audit result. Audit results include a valid rate, "R" *Reportable*, (indicated by a numeric result), "NA" *Not Applicable*, "NR" *Not Reportable*, and "NB" *No Benefit*.

A numeric result indicates that the plan complied with all HEDIS specifications to produce an unbiased, reportable rate or rates that can be released for public reporting. Although a plan may have complied with all applicable specifications, if the plan's denominator is too small to report (less than 30), the audit result is *NA*. An audit result of *NR* indicates that the rate should not be publicly reported because the measure deviated from HEDIS specifications enough to bias the reported rate significantly or that the plan chose not to report the measure. An *NB* audit result indicates that the plan did not offer the benefit required to report the measure.

HEDIS Reporting Capabilities

Key Findings

Twenty-three contracted plans underwent performance measure validation. Twenty-two of those plans had a HEDIS Compliance Audit. Family Mosaic Project (FMP), a specialty plan, reported non-HEDIS measures; therefore, the plan underwent a performance measure validation audit consistent with the CMS protocol for conducting performance measure validation.

Either HSAG's NCQA-certified compliance auditors or HSAG's subcontracted NCQA-certified compliance auditors performed all 23 plan audits for the 2012 reporting year.

Of the 23 audited plans, 20 used an NCQA-certified software vendor to produce rates. All of these software vendors achieved full certification status for the reported HEDIS measures. For the three plans that did not use a certified software vendor, HSAG reviewed and approved the source code. HSAG also reviewed and approved 20 health plans' 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.

Strengths

All plans were able to report valid rates for their DHCS-required measures. The plans had sufficient transactional systems that captured the required data elements for producing valid rates.

With a few exceptions, HSAG found plans fully compliant with the overall IS standards. For the few plans that did not achieve full compliance with all IS standards, the auditor determined that the deficiencies did not bias any reported rates.

Challenges

Most of the challenges and opportunities were health plan specific, and there were few challenges that were applicable to all or most of the plans. However, HSAG did identify that the plans with highly capitated payment models run a risk of incomplete encounter data. To determine if this is an opportunity for improvement at the individual plan level, the plans may consider conducting analysis of medical record numerator compliant hits gained from hybrid pursuit and determine if there are patterns among providers that do not submit service data.

Recommendations

Based on the results of the audit findings, HSAG provides the following recommendation for improved reporting capabilities by the plans:

- Ensure that the rendering provider type is included on all submitted claims, specifically for services performed at a multispecialty clinic.
- Explore the use of supplemental data to enhance HEDIS reporting.
- Work with providers to encourage the submission of LOINC and CPT Level II codes that include results values that will minimize the burden of medical record review.
- Closely monitor timelines, milestones, and deliverables of contracted providers. Health plans should consider implementing sanctions for vendors that do not meet contract requirements.
- Work to increase electronic data submission.

Adolescent Well-Care Visits

Measure Definition

The *Adolescent Well-Care Visits* measure reports the percentage of adolescents 12 to 21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician or gynecologist (OB/GYN) during the measurement year.

Importance

The healthy transition from childhood to adolescence is critical to the well-being of children and United States society. Understanding this transitional period is difficult; and physicians can play a critical role in helping parents and guardians with physical, emotional, and social adolescent problems. The death rate increases for adolescents aged 15 to 24 years due to the large number of accidents, homicides, and suicides—three preventable causes of death.[6] Physicians can help parents and guardians understand the root cause of many mental and physical disorders—including sexually transmitted diseases, substance abuse, pregnancy, and antisocial behavior—and work with the parents, guardians, or other medical professionals to counsel young people about their behaviors and risks to their health.

Annual visits with a physician can reinforce health promotion messages, identify at-risk adolescents, and build relationships that foster open disclosure of future health information.[7] Furthermore, regular health care visits aid in the prevention, early diagnosis, and treatment of health care conditions so that the transition from youth to adulthood is a healthy one. The American Medical Association's *Guidelines for Adolescent Preventive Services* recommend that all adolescents 11 to 21 years of age have an annual preventive services visit that focuses on both the biomedical and psychosocial aspects of health.[8] Adolescents, however, commonly underutilize health care services and have unique barriers to access. They tend to have greater difficulty obtaining appropriate health care services on their own due to developmental characteristics and

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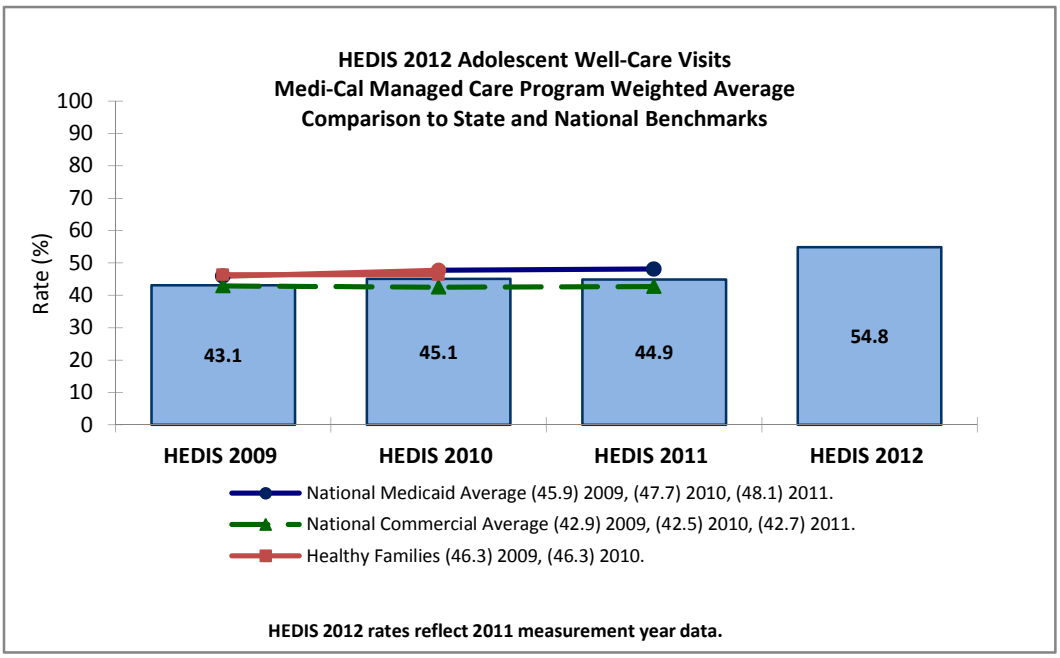
[6] U.S. Department of Health and Human Services. National Institutes of Health. MedlinePlus. *Death among children and adolescents*. Updated 7/26/2010. Available at: http://www.nlm.nih.gov/medlineplus/ency/article/001915.htm. Accessed on: August 23, 2012.

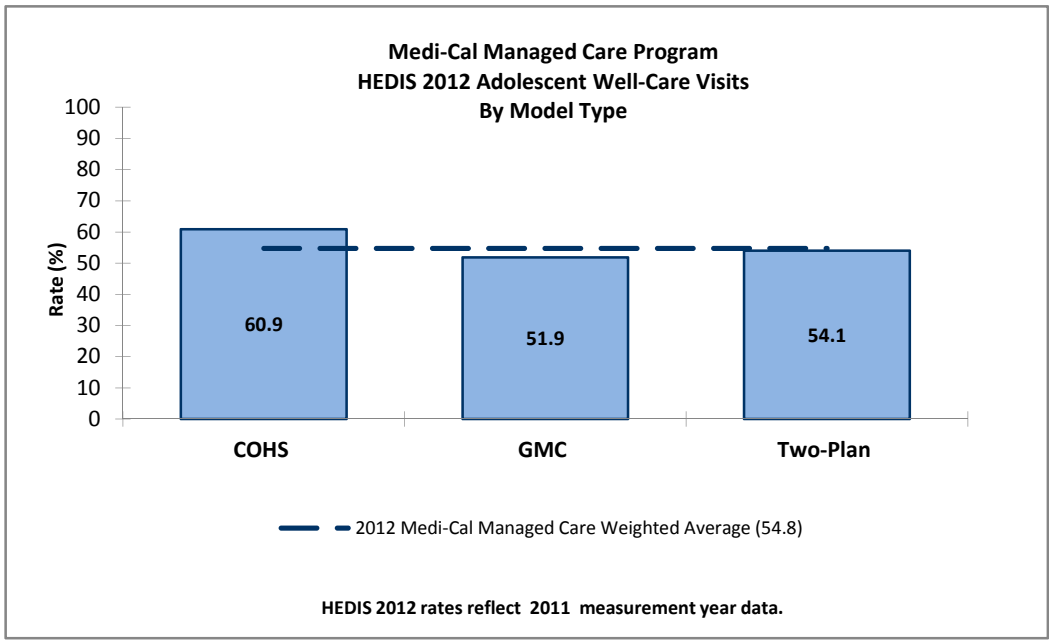
[7] American Medical Association. *Guidelines for Adolescent Preventive Services (GAPS)*. 1997. Available at: http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf. Accessed on: August 23, 2012.

[8] Ibid.

lack of experience negotiating medical systems. Adolescents often need specialized planning to respond to their needs for confidentiality, quality service, and coordination of care.[9]

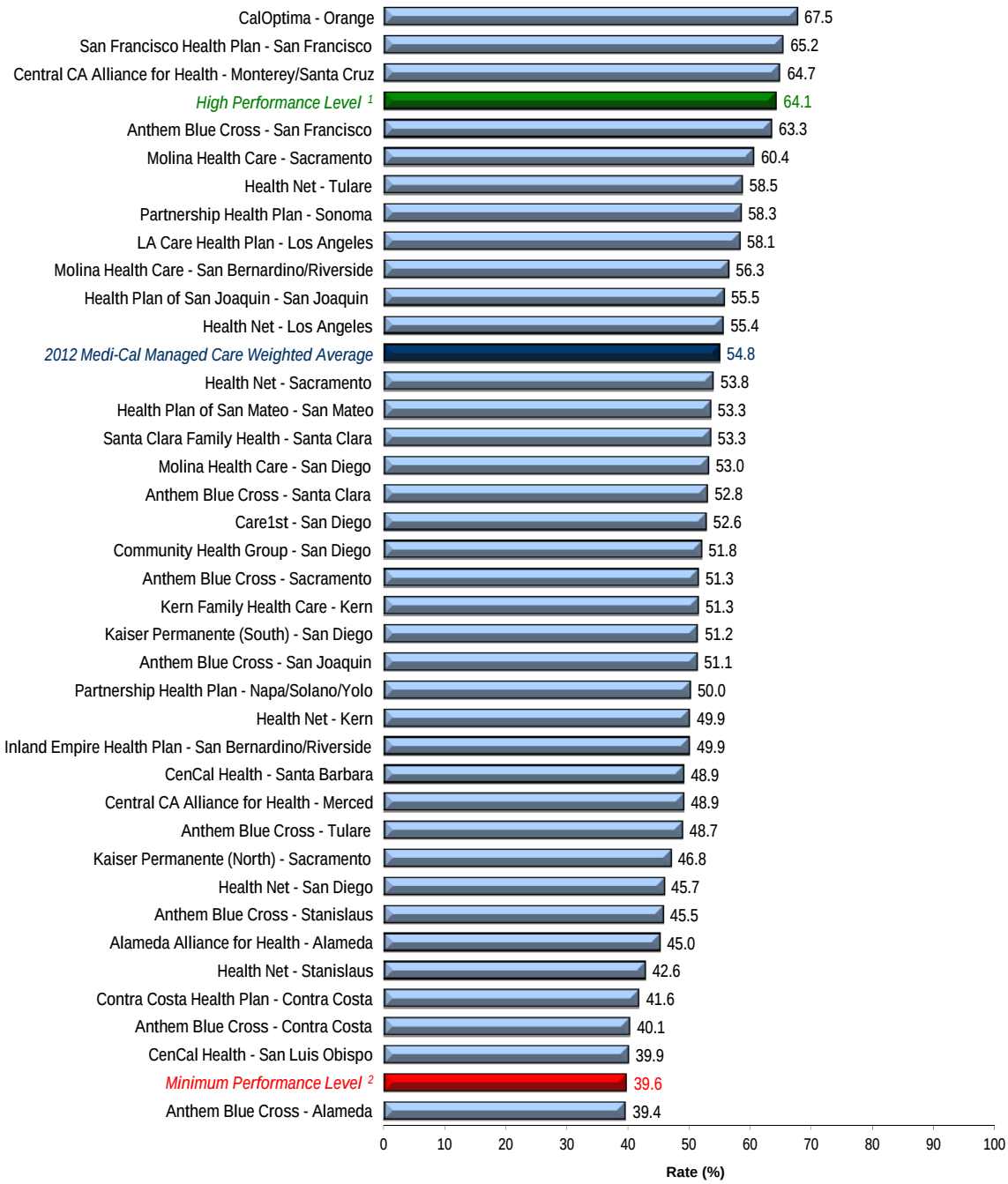
Performance Results





[9] National Adolescent Health Information Center. *Assuring the Health of Adolescents in Managed Care: A Quality Checklist for Planning and Evaluating Components of Adolescent Health Care.* 2002. Available at: http://nahic.ucsf.edu/downloads/Assuring_Hlth_Checklist.pdf. Accessed on: August 23, 2012.

Medi-Cal Managed Care
HEDIS 2012 Adolescent Well-Care Visits



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's 2012 weighted average experienced an approximate 10 percentage point increase from 2011 for the *Adolescent Well-Care Visits* measure; this was the largest increase in the last three years.

The COHS model type outperformed both the GMC and Two-Plan model in 2012. Three plans exceeded the HPL, while one plan fell below the MPL. Eleven plans met or exceeded the weighted average.

High and Low Performers

Three rates reported by Cal Optima—Orange County, San Francisco Health Plan—San Francisco County, and Central CA Alliance for Health—Monterey/Santa Cruz counties scored above the HPL in 2012. Anthem Blue Cross—Alameda County was the only rate that came in below the MPL. The range of rates for this measure (the difference between the highest performing rate and the lowest) was wide, indicating quite a bit of variability in performance across the program.

Thirty-two rates showed statistically significant improvement in 2012 compared with their 2011 rates, a sign of much improved focus on this measure (refer to Appendix B).

Best and Emerging Practices

Improve Access

Open-access appointments can increase compliance by expanding provider availability.[10] Providers offering evening or weekend clinic hours can help accommodate parents who cannot take time off from work or adolescents with extracurricular activities. For example, one Saturday a month could be set aside for children and adolescents, with clinicians designated to perform well-visits on that day. Visits on certain days could be made available on a walk-in, first-come, first-served basis. Additionally, providers should encourage parents to schedule their next visit before leaving the clinic. Plans also may consider improved access to transportation as a strategy to increase well-visit compliance. Another approach is to deliver preventive services to adolescents at alternate settings, such as schools. School-based clinics have been successful in improving immunization rates among this age group.[11]

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[10] O'Connor ME, Matthews BS, Gao D. Effect of Open Access Scheduling on Missed Appointments, Immunizations, and Continuity of Care for Infant Well-Child Care Visits. *Archives of Pediatrics & Adolescent Medicine.* 2006; 160: 889-893.

[11] Middleman, A.B. Coordinating delivery of vaccinations and other preventive health care recommendations for adolescents. *Preventive Medicine.* 2011. 53:522-528.
Available at: http://ac.els-cdn.com/S0091743511003057/1-s2.0-S0091743511003057main pdf?_tid=79bed26b9e3b786a8e5d9bab9758b851&acdnat=1345747824_b3e26f66640d39dbab97f742e458f57c.
Accessed on: August 23, 2012.

Reminder Systems

Postcards are an easy and effective tool for increasing well visits. They can be sent to parents as a reminder to schedule their adolescent's well visit. To be most effective, postcards should include contact information for either doctors' offices near the member's address or the member's assigned PCP. In addition, age-specific forms detailing which services should be provided and why they are important to the well-being of the child can help educate parents. To increase effectiveness, follow-up telephone calls should be conducted with members who have not scheduled visits after the initial postcard mailing.

Physician Education

Quarterly provider reports that highlight adolescents in need of well-visits are useful for promoting visit reminders and helping providers track their performance. Members who saw a doctor but did not have a well visit can be flagged as missed opportunities. To make this information pertinent to providers, their performance may be tied to a recognition program for providers who display outstanding performance. Another practice that can improve well-visit compliance is for plans to educate providers on proper billing codes for well-child visits, which can improve accurate reporting of well-care visits provided. Additionally, electronic tracking tools and provider prompts are associated with greater provider satisfaction rates as well as increased well-care visit rates.

Confidentiality is a concern for adolescents within this age group and is associated with decreased well care visits. Plans should assess providers' practices related to confidentiality and increase providers' awareness concerning how often they discuss confidentiality policies with adolescent patients and their parents.

Annual Monitoring for Patients on Persistent Medications (MPM)

Measure Definition[12]

The *Annual Monitoring for Patients on Persistent Medications (MPM)* measure assesses the percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. For each product line, rates are reported separately.

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).
- Annual monitoring for members on digoxin.
- Annual monitoring for members on diuretics.

Importance

Patient safety is highly important, especially for patients at increased risk of adverse medication events from long-term medication use. Persistent use of these medications warrants monitoring and follow-up by the prescribing provider to assess for side-effects and adjust medication dosage accordingly. The medications included in this measure also have more detrimental effects in the elderly.[12]

The costs of annual monitoring are offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications. According to the Agency for Healthcare Research and Quality, the total costs of medication-related problems due to misuse of medications in the ambulatory setting has been estimated to exceed $76 billion annually.[13]

Appropriate monitoring of medication therapy remains a significant issue to guide therapeutic decision making and provides largely unmet opportunities for improvement in care for patients on persistent medications.[14]

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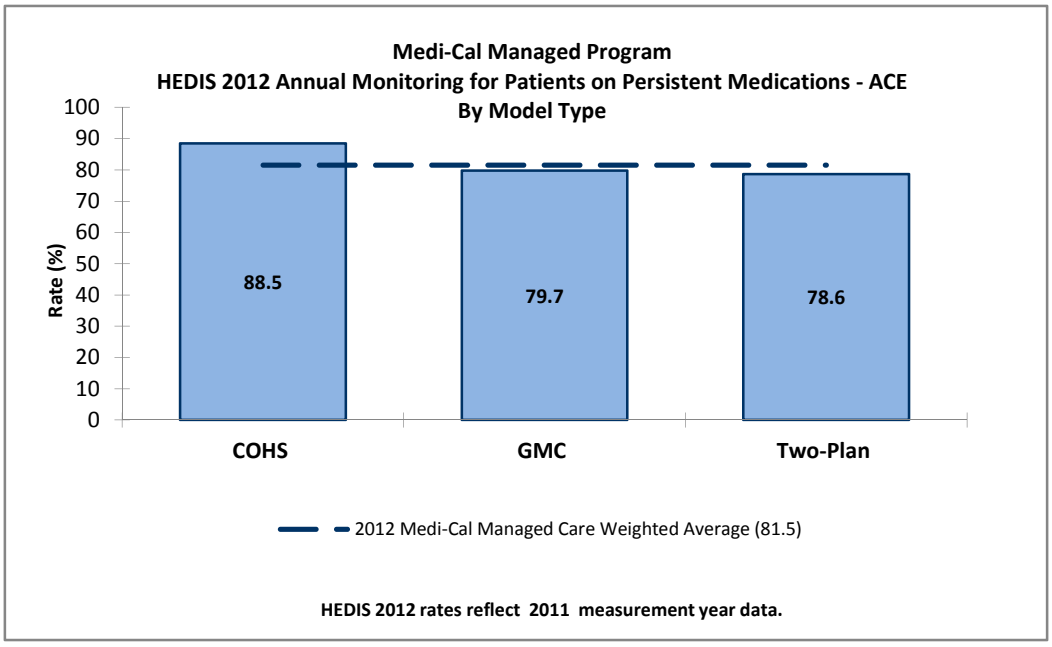
[12] Agency for Healthcare Research and Quality. *National Quality Measures Clearinghouse.* Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=34030. Accessed on: August 27, 2012.

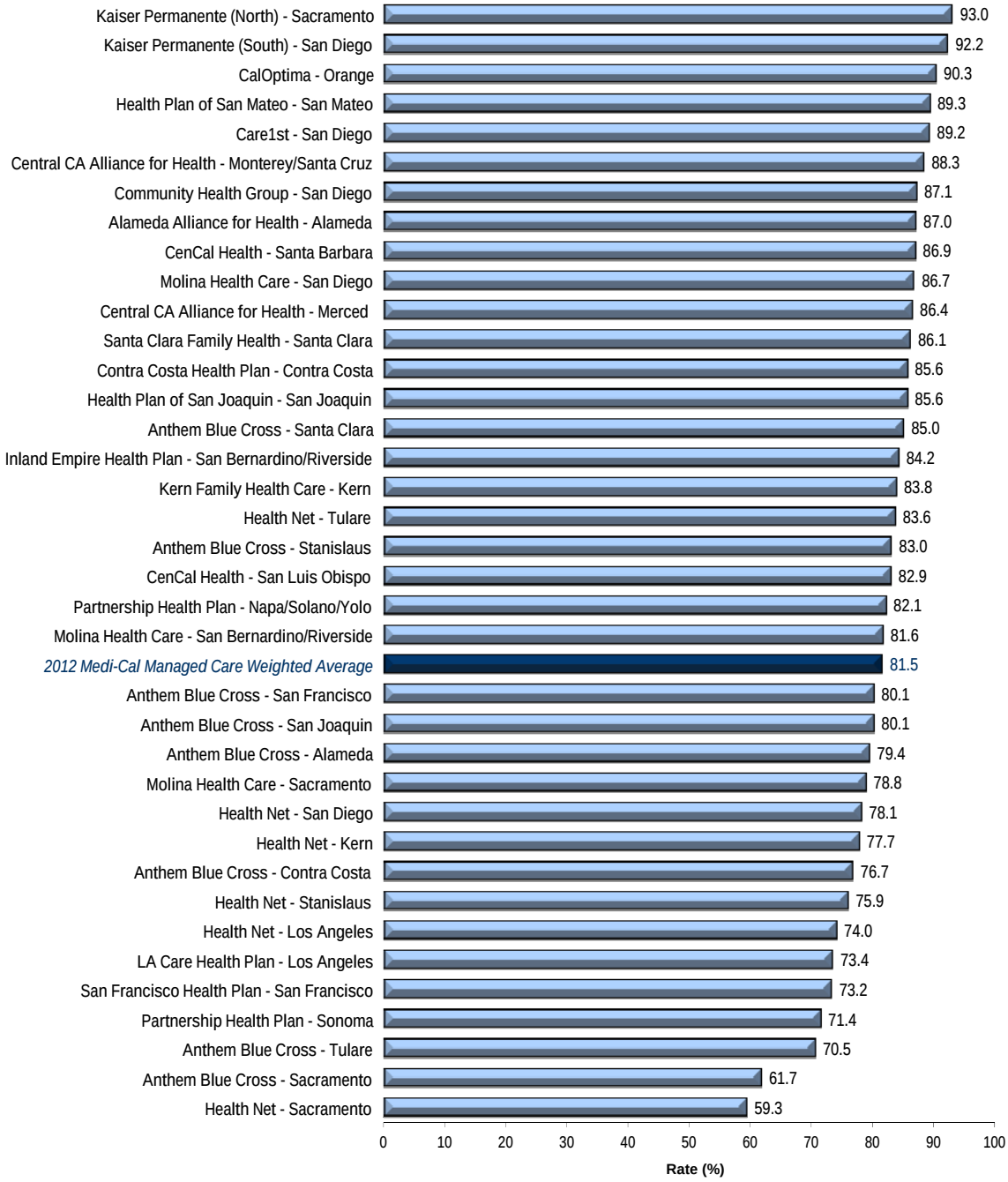
[13] Agency for Healthcare Research and Quality. *National Quality Measures Clearinghouse.* Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=34677. Accessed on August 27, 2012.

[14] Ibid.

Performance Results—Annual Monitoring for Members on Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB)



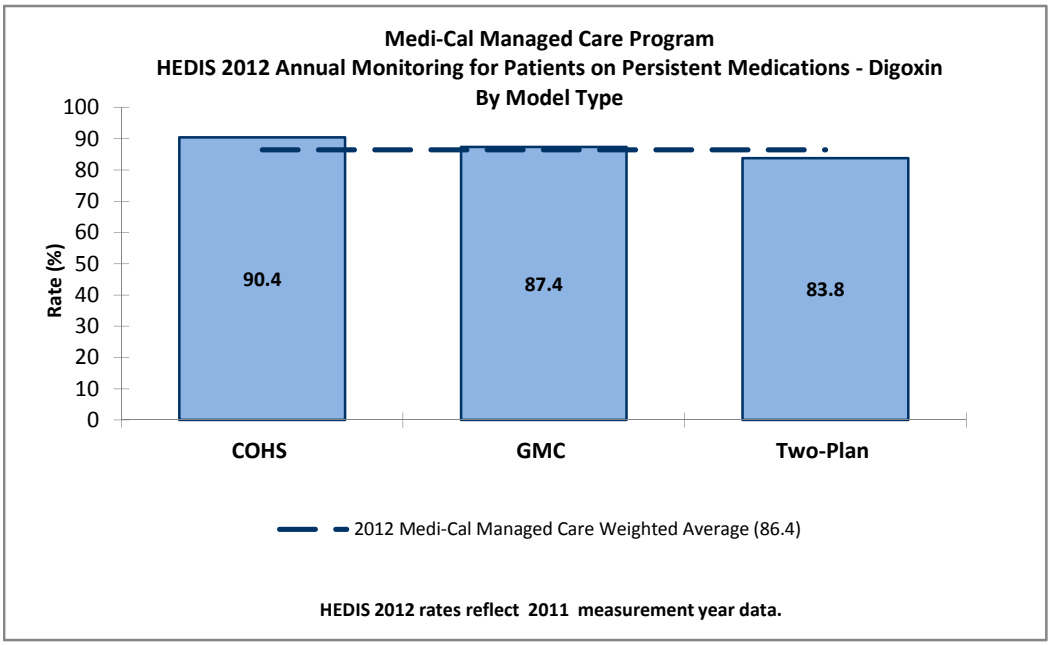
Medi-Cal Managed Care
HEDIS 2012 Annual Monitoring for Members on Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB)



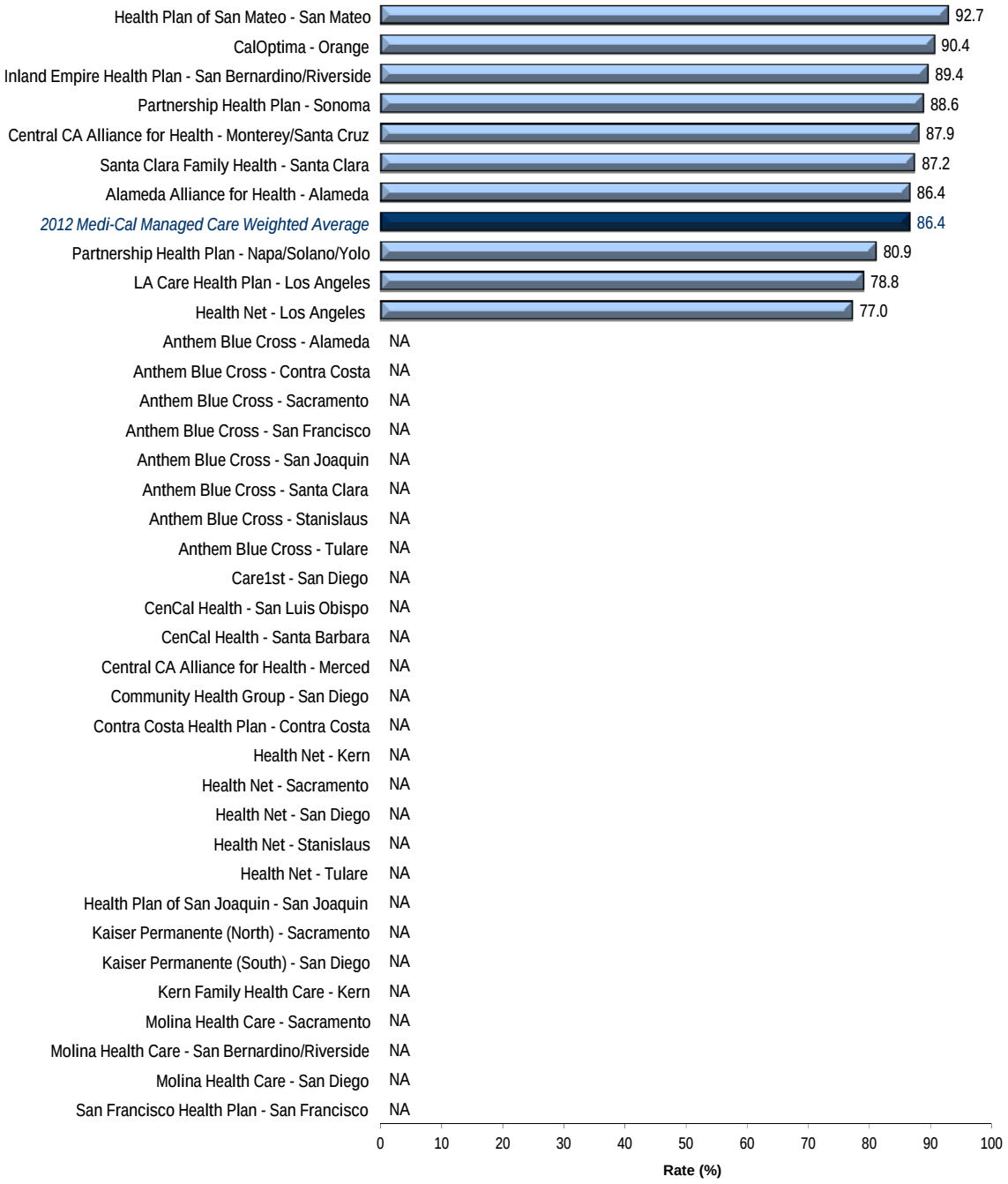
The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS required the measure.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Performance Results—Annual Monitoring for Members on Digoxin



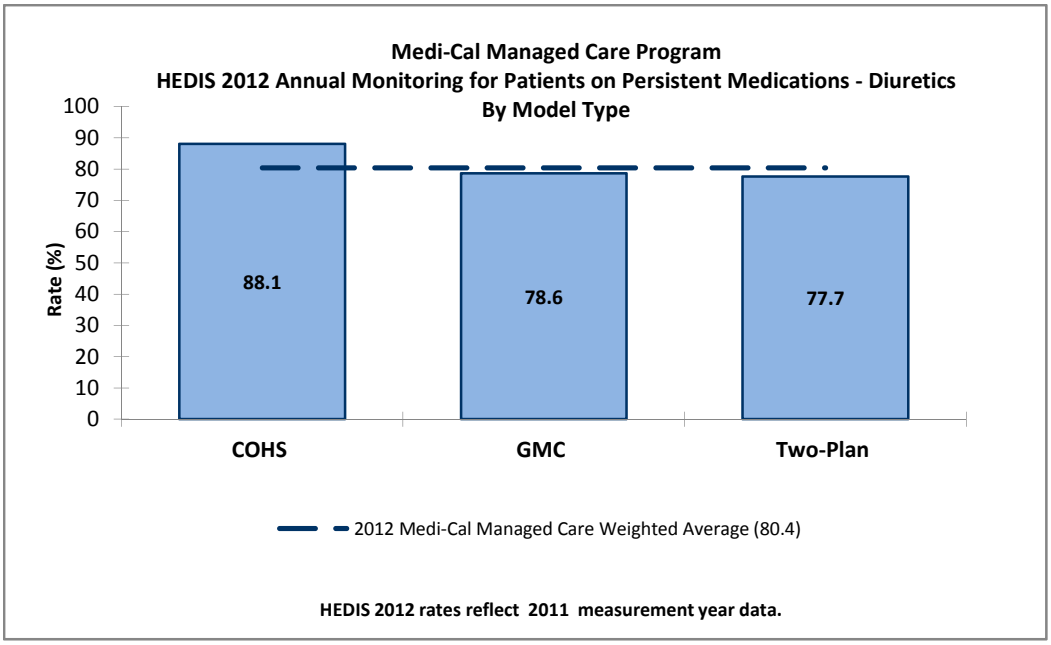
Medi-Cal Managed Care
HEDIS 2012 Annual Monitoring for Members on Digoxin



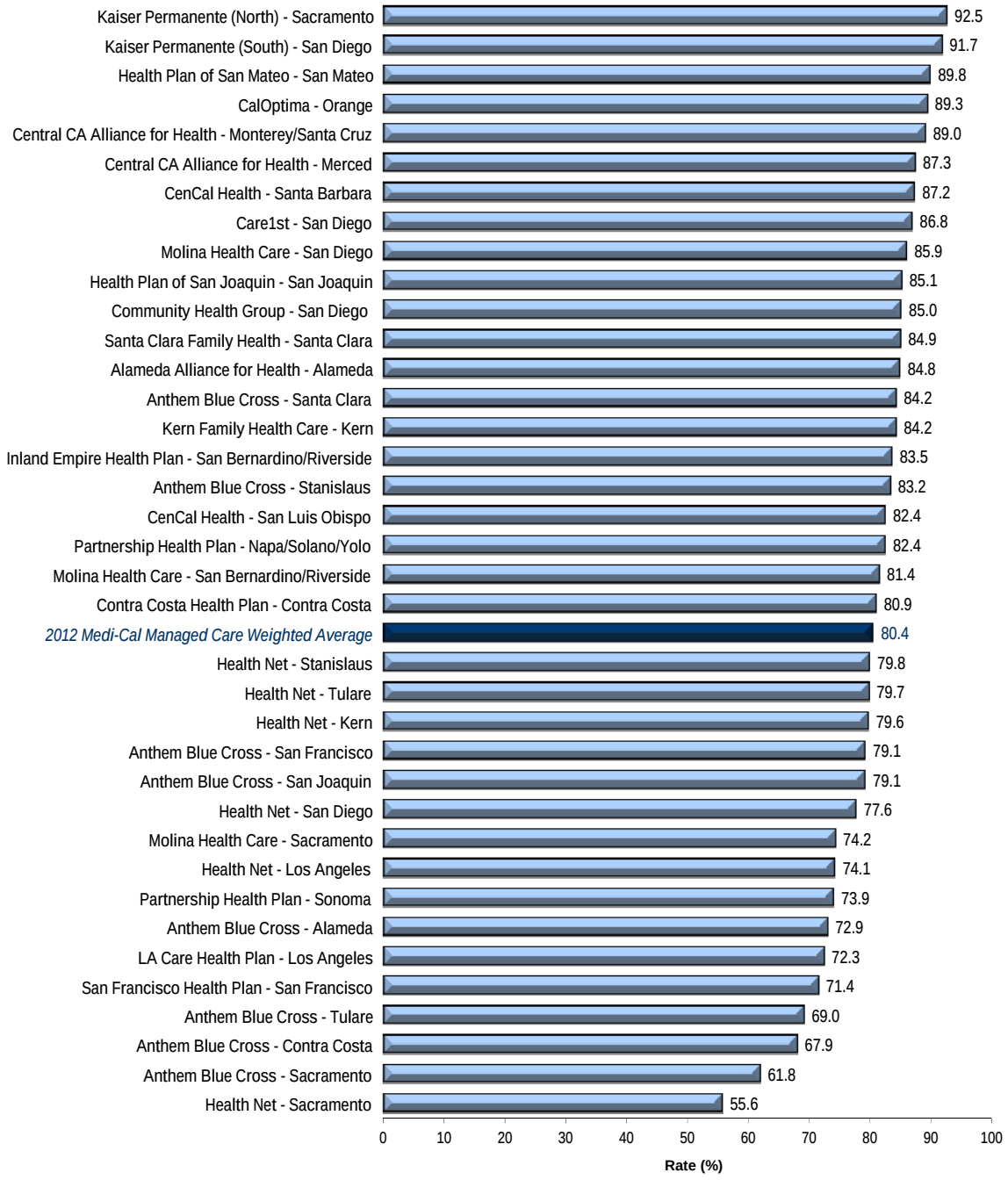
The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS required the measure.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Performance Results—Annual Monitoring for Members on Diuretics



Medi-Cal Managed Care
HEDIS 2012 Annual Monitoring for Members on Diuretics



The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS required the measure.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MPLs and HPLs are not applied to these indicators (1) when the DHCS opts not to apply them, (2) in the first year of significant changes to a measure's technical specifications, or (3) in the first year the DHCS requires the measure. There were no established MPLs and HPLs for the three sub-indicators for the *Annual Monitoring for Patients on Persistent Medications (MPM)* measure since 2012 was the first year that DHCS required plans to report this measure.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Measure Definition

The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure assesses the percentage of members 18 to 64 years of age with a primary diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Importance

While only about 5 percent of adults report an episode of acute bronchitis each year; 90 percent seek treatment.[15] Acute bronchitis consistently ranks among the top 10 conditions that account for the most ambulatory office visits to U.S. physicians. The majority of acute bronchitis cases (more than 90 percent) have a nonbacterial cause (i.e., are viral in origin) making the prescribing of antibiotics for the treatment of acute bronchitis inappropriate. However, antibiotics are prescribed for the treatment of acute bronchitis 65 percent to 80 percent of the time.[16] The prescribing of antibiotics for smokers with acute bronchitis is even greater. More than 90 percent of smokers with acute bronchitis receive antibiotics; however, there is no evidence that smokers are in greater need of antibiotics than nonsmokers.[17]

When the treatment of acute bronchitis was compared between patients who received an antibiotic and patients who received a placebo, it was found that there were few benefits in terms of reducing impairments such as coughing, sore throat, sputum build up, and fever. Antibiotic use did, however, show a significantly higher level of adverse medication side effects such as nausea, vomiting, headaches, and rash.[18] A review of the literature suggests that many patients with a diagnosis of acute bronchitis have not received a correct diagnosis and that their acute cough is more likely due to acute asthma, an acute exacerbation of chronic bronchitis, or even the common cold.[19] Routine antibiotic treatment of acute bronchitis does not have a consistent impact on the duration, severity of illness, or potential complications.[20]

Recent studies suggest that the reasons for unnecessary antibiotic prescribing are more complex, having as much or more to do with patient and physician expectations as with physicians'

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[15] National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C: NCQA 2009.

[16] Agency for Healthcare Research and Quality. National Quality Measures Clearinghouse. Available at: http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?doc_id=13042 Accessed on: April 3, 2012.

[17] Braman SS. Chronic Cough Due to Acute Bronchitis: ACCP Evidence-Based Clinical Practice Guidelines. *Chest*. 2006; 129; 95S-103S.

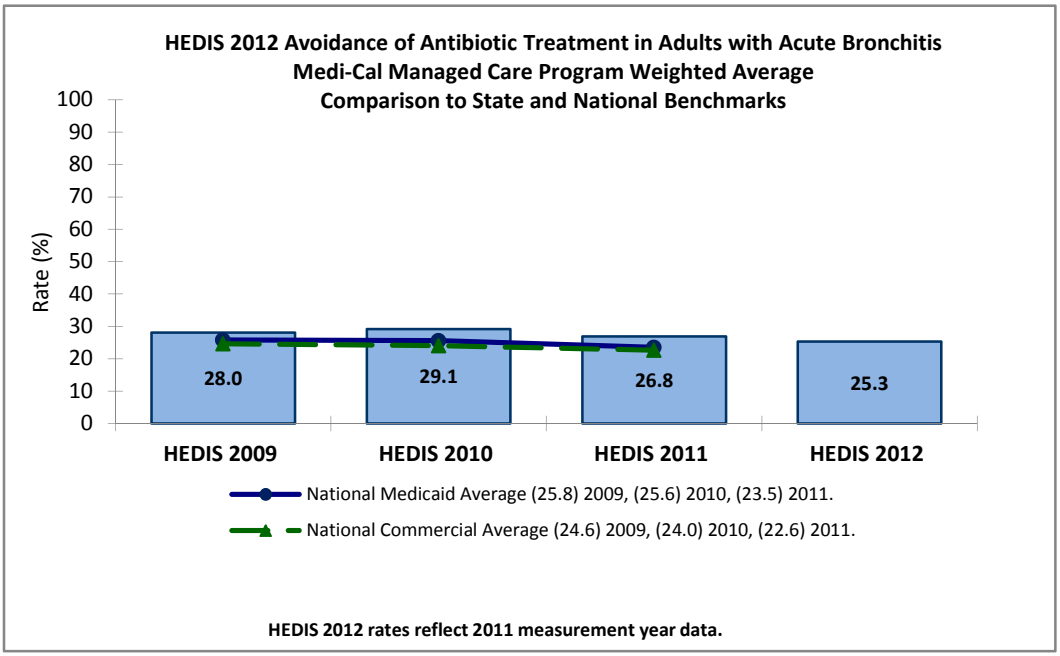
[18] Chandran R. Should We Prescribe Antibiotics for Acute Bronchitis? *American Family Physician*. 2001.

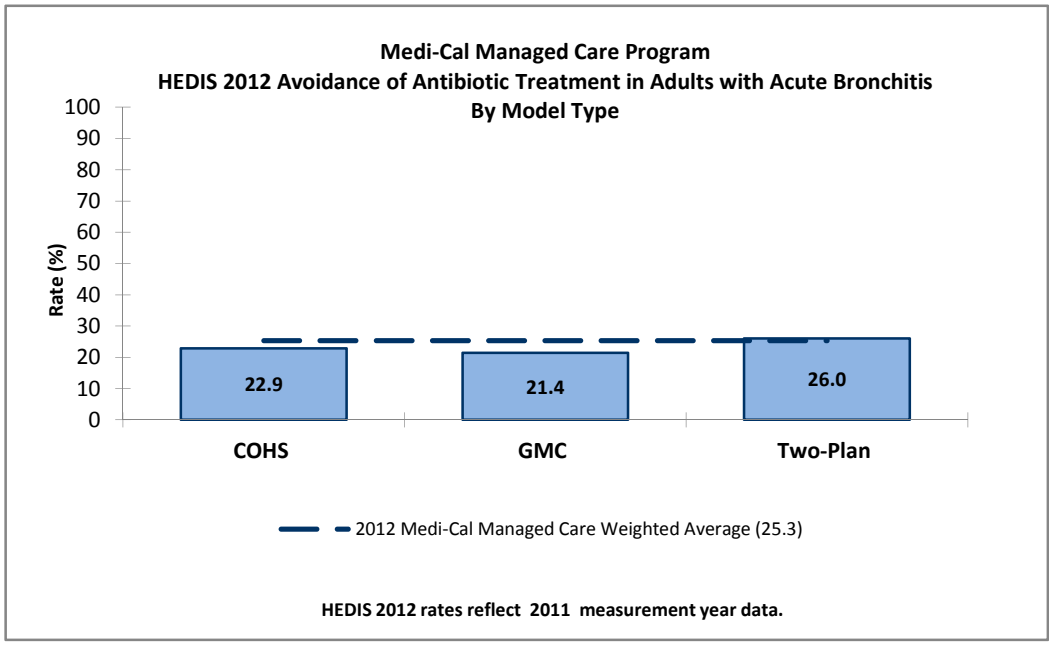
[19] Scott JG, Cohen D, DiCicco-Bloom B, et al. Antibiotic Use in Acute Respiratory Infections and the Ways Patients Pressure Physicians for a Prescription. *The Journal of Family Practice*. 2001; 50(10): 853-858.

[20] Gonazles R, Bartlett JG, Besser RE, et al. Principles of Appropriate Use for Treatment of Uncomplicated Acute Bronchitis: Background. *Annals of Internal Medicine*. 2001; 134: 521-529.

diagnostic skills. Patient satisfaction with care for acute bronchitis depends more on physician patient communication than on antibiotic treatment.[21]

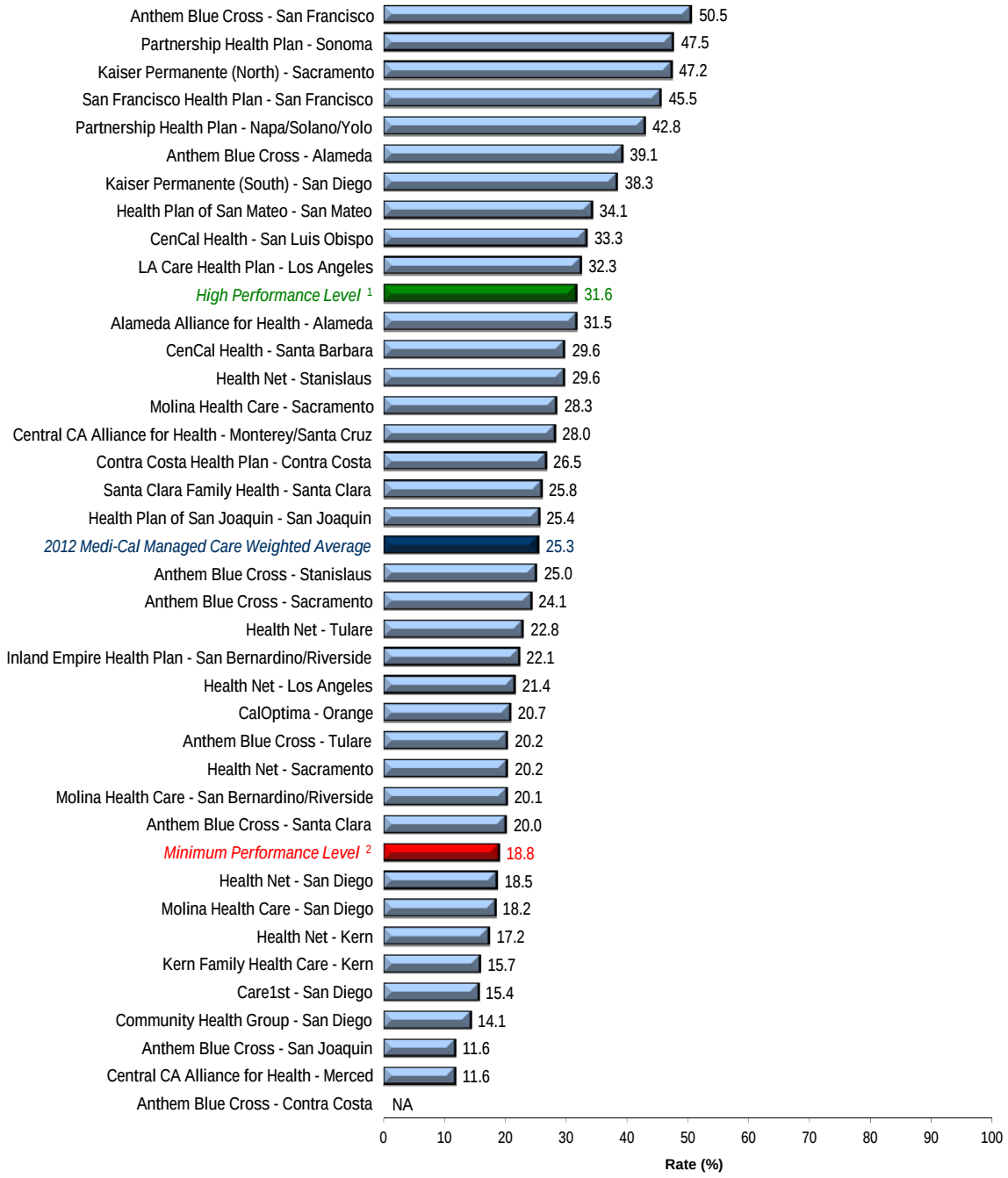
Performance Results





[21] Scott JG, Cohen D, DiCicco-Bloom B, et al. Antibiotic Use in Acute Respiratory Infections and the Ways Patients Pressure Physicians for a Prescription. *The Journal of Family Practice.* 2001; 50(10): 853-858.

Medi-Cal Managed Care
HEDIS 2012 Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's 2012 weighted average for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure experienced a slight decrease from the 2011 result and has decreased for four consecutive years. Ten plans exceeded the HPL and eight plans performed below the MPL. The Two-Plan model performed better than the COHS and GMC model types.

High and Low Performers

Four rates had a statistically significant increase in 2012 compared to 2011 rates, while two rates showed statistically significant declines (refer to Appendix B). Most notable was the increase in Partnership Health Plan—Sonoma County's rate, 26.5 percentage points.

Best and Emerging Practices

Patient Education

There is a need to increase patient awareness about not only the dangers of antibiotic use for treating acute bronchitis but also the lack of effectiveness. Patient education should emphasize that the condition does not require antibiotic treatment and that antibiotic treatment is not recommended. Furthermore, use of the term "chest cold" has been associated with a decrease in a patient's belief that he or she needs an antibiotic. In one study, 44 percent of patients thought that antibiotics were more important for acute bronchitis compared to 11 percent for chest colds. For those patients whose acute bronchitis may be associated with smoking, smoking cessation advise and tools can help to reduce the symptoms of acute bronchitis caused by smoking.[22] Education provided directly to the patient at the time of the visit is more effective than educational efforts involving pamphlets or newsletters.[23]

Provider Education

Educational interventions for providers should focus on describing appropriate diagnosis and treatment of acute bronchitis. Methods that can be used to target providers include educational newsletters, seminars, workshops, and printed materials. Mass media campaigns that target all clinicians have also been found to be effective. Examples include e-cards and billboards. Another

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[22] Braman SS. Chronic Cough Due to Acute Bronchitis: ACCP Evidence-Based Clinical Practice Guidelines. *Chest*. 2006; 129: 95S-103S.

[23] Ranji, S.R., Steinman, M.A., Shojania, K.G., et al. Closing the quality gap: a critical analysis of quality improvement strategies. Volume 4—Antibiotic prescribing behavior. Technical Review 9. 2006. AHRQ Publication No. 04(06)-0051-4. Available at: http://www.ahrq.gov/downloads/pub/evidence/pdf/medigap/medigap.pdf. Accessed on: September 7, 2012.

method of ensuring appropriate prescribing practices would be to conduct a medical audit on antibiotic prescribing and give feedback to the provider.[24]

Physicians should be educated about the subtle approaches patients use to pressure them for antibiotic treatment and should be shown techniques for responding to these pressures without prescribing antibiotics unnecessarily. In one study of physician prescribing practices, physicians prescribed antibiotics inappropriately in 80 percent of encounters with patient pressures. Examples of patient pressures include:[25]

- Explicit request—patient directly requests antibiotic treatment
- Presenting the chief complaint
  - Candidate diagnosis—patient reports a possible diagnosis
  - Implied candidate diagnosis—patient reports symptoms that indicate a specific condition
  - Portraying severity of illness—patient portrays severe symptoms as well as an inability to conquer the illness on his or her own
- Appeals to nonmedical conditions
  - Appealing to life-world circumstances—patient reports an important event that makes the case for receiving the antibiotic quickly
  - Previous positive experience with antibiotics—patients suggests that they have an illness for which they have received a prescription for antibiotics

Physicians should be educated on these patient pressures and provided techniques on how to respond to these pressures without prescribing a prescription.

Decision Support Systems

The use of decision support systems based on evidence-based guidelines can improve the effectiveness and efficiency of prescribing decisions. Decision support systems are used to help providers make clinical decisions (e.g., an algorithm for antibiotic prescribing).[26] Many prescribing applications include information on pathogens, diagnosis, medication, and treatment; therefore, adherence to clinical guidelines is greater.[27,28] NCQA developed a 60-minute Webinar for providers and quality managers, which outlines an algorithm to improve appropriate antibiotic use with

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[24] Razon Y, Ashkenazi S, Cohen A, et al. Effect of educational intervention on antibiotic prescription practices for upper respiratory infections in children: a mulitcentre study. *Journal of Antimicrobial Chemotherapy*. 2005; 56: 937-940.

[25] Scott JG, Cohen D, DiCicco-Bloom B, et al. Antibiotic Use in Acute Respiratory Infections and the Ways Patients Pressure Physicians for a Prescription. *The Journal of Family Practice*. 2001; 50(10): 853-858.

[26] Ranji SR, Steinman MA, Shojania, KG, et al. Interventions to Reduce Unnecessary Antibiotic Prescribing: A Systematic Review and Quantitative Analysis. *Medical Care*. 2008; 46: 847-862.

[27] Sintchenko V, Coiera E, Gilbert GL. Decision support systems for antibiotic prescribing. *Current Opinion in Infectious Disease*. 2008; 21:573-579.

[28] Agency for Healthcare Research and Quality. Real-Time Decision and Documentation Support Increases Adherence to Recommended Care for Respiratory Infections, Diabetes, and Heart Disease. *AHRQ Health Care Innovations Exchange*. Available at: http://www.innovations.ahrq.gov/content.aspx?id=2431. Updated: August 2012. Accessed on: May 1, 2012.

acute bronchitis. In the study, both posters and EHR systems were successful in improving the outcome.[29]

Delayed Prescribing Practices

Delayed prescribing includes the delay in prescribing antibiotics unless a patient has continuing, severe symptoms for a specified time after an initial visit with a provider. Patients can be given the prescription at the initial visit or can be required to return to the office to pick up the prescription after the specified length of time. Delayed prescribing practices curtail inappropriate antibiotic use, result in a reduction of overall use of antibiotics and a change in consulting patterns, and allow for the adequate control of symptoms. Studies recommend delaying prescribing antibiotics for 48 to 72 hours. In one study, delaying the prescribing of antibiotics for 48 hours resulted in 62 percent of patients not using antibiotics.[30]

Intervention Combinations

To improve the effectiveness of the above intervention categories, interventions are often implemented in combination, resulting in a synergistic effect. For example, one study combined patient and provider interventions to achieve statistically significant improvement in the reduction of antibiotic prescribing. The intervention included patient education that consisted of a newsletter, posters, and pamphlets in providers' waiting rooms. The provider education aspect of the improvement strategy included pharmacist-led seminars, written materials, and provider-specific prescription profiling. This intervention took place during a 20-minute presentation by a clinical pharmacist at regular staff meetings. Feedback of provider detailing was provided confidentially in a folder, which also contained educational materials.[31]

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[29] National Committee for Quality Assurance. *An algorithm to improve appropriate antibiotic use for patients with acute bronchitis.* 2011. Available at: http://www.ncqa.org/LinkClick.aspx?fileticket=JqpiGDmycag%3D&tabid=385&mid=1501&forcedownload=true Accessed on: August 27, 2012.

[30] Little P. Delayed Prescribing—A Sensible Approach to the Management of Acute Otitis Media" *JAMA*. 2006; 296(10): 1290-1291.

[31] Hickman, D.E., Stebbins, M.R., Hanak, J.R., et al. Pharmacy-based intervention to reduce antibiotic use for acute bronchitis. Annals of Pharmacotherapy. 2003. 37(2):187.

Cervical Cancer Screening

Measure Definition

The *Cervical Cancer Screening* measure reports the percentage of women 21 through 64 years of age who received one or more Pap tests within the prior three years.

Importance

In the United States during 2012, the American Cancer Society estimates 12,170 new cases of invasive cervical cancer and 4,220 deaths resulting from cervical cancer.[32] In the United States, Hispanic women are most likely to get cervical cancer, followed by African-Americans, Asians and Pacific Islanders, and Whites.[33]

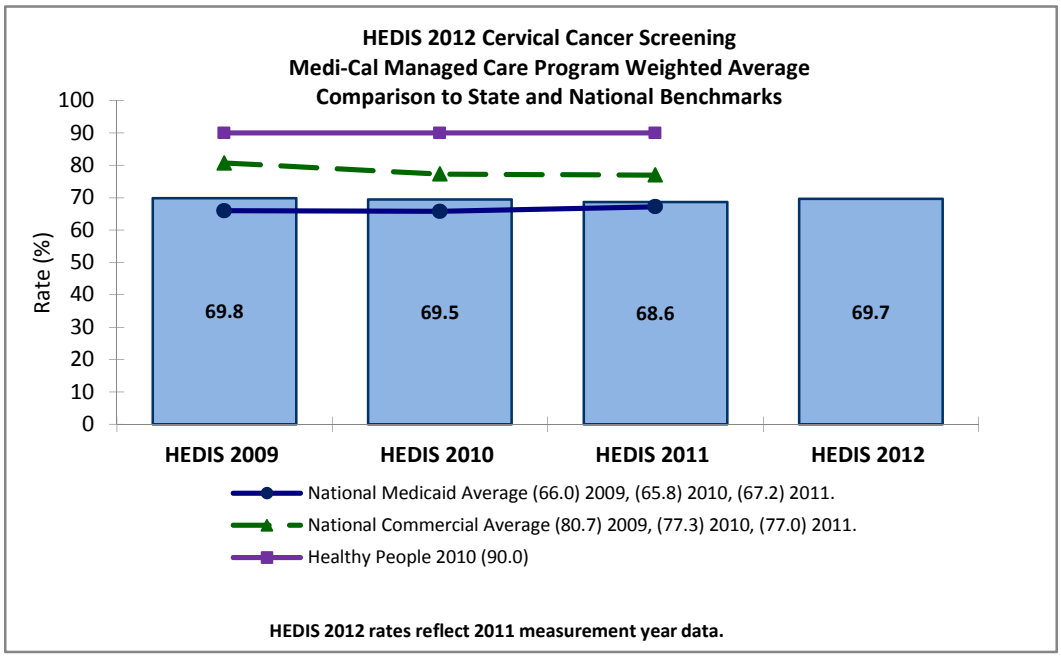
A well-proven way to prevent cervical cancer is to have testing (screening) to find pre-cancers before they can turn into invasive cancer. The Pap test (or Pap smear) is the most common way to do this. If a pre-cancer is found it can be treated, stopping cervical cancer before it starts. The five-year relative survival rate for early stages of invasive cervical cancer is 93 percent.[34]

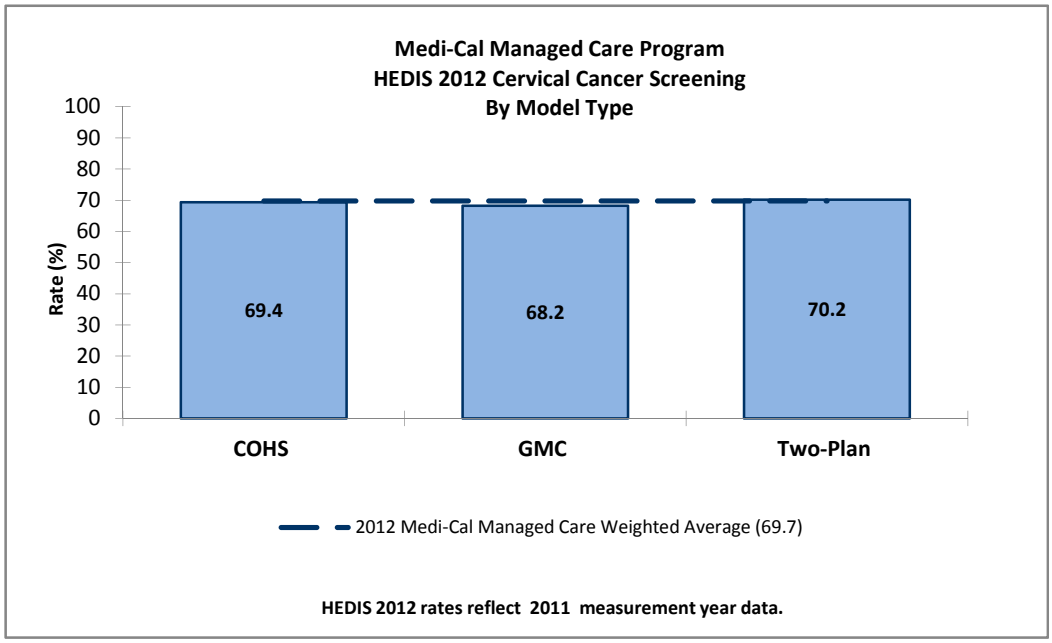
[32] American Cancer Society. Cancer Facts and Figures 2012. Available at: http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-031941.pdf Accessed on: August 21, 2012.

[33] American Cancer Society. Detailed Guide: Cervical Cancer. Updated 2012. Available at: http://www.cancer.org/acs/groups/cid/documents/webcontent/003094-pdf.pdf. Accessed on: August 21, 2012.

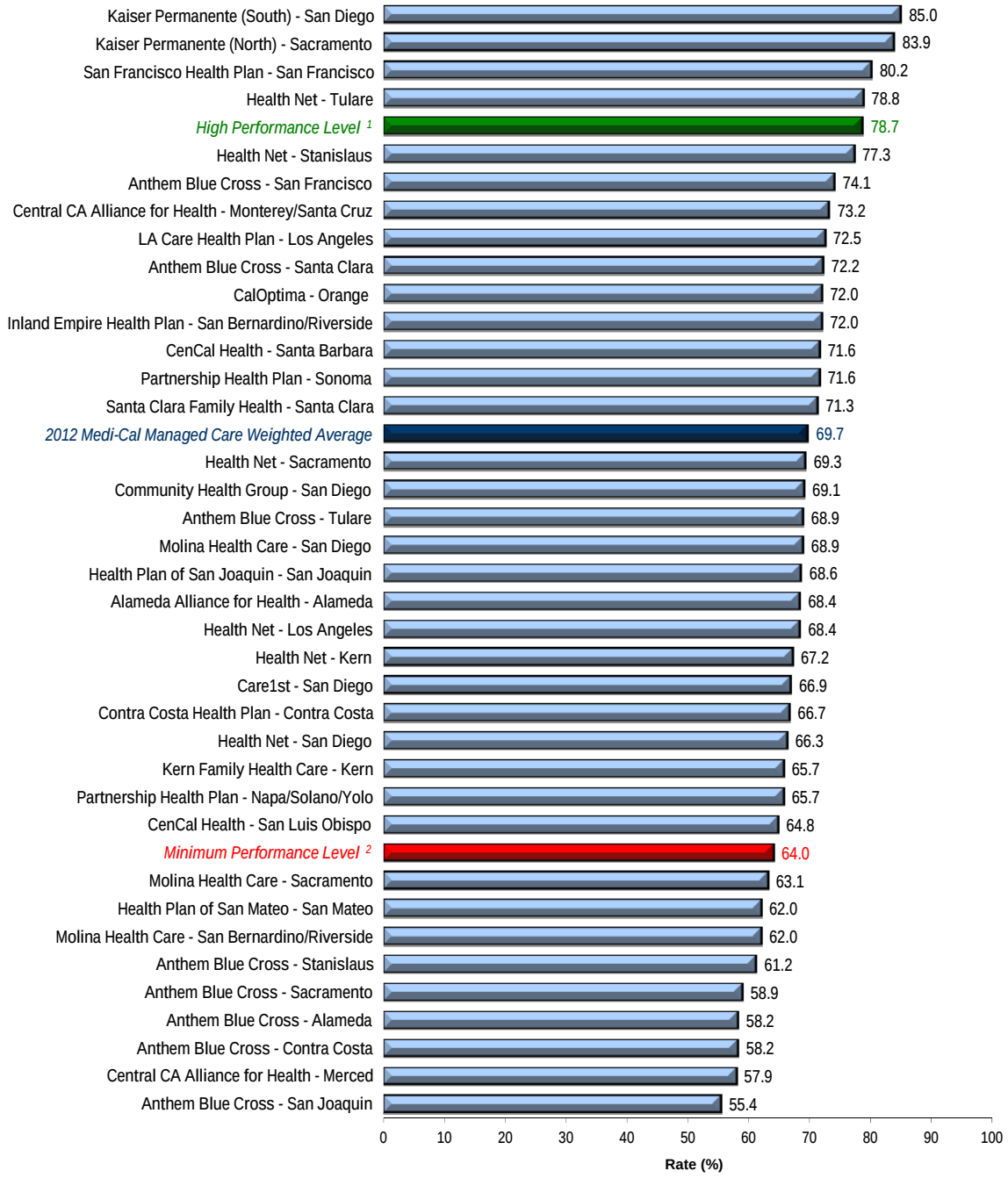
[34] Ibid.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Cervical Cancer Screening



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's 2012 weighted average for the *Cervical Cancer Screening* measure increased slightly from the 2011 rate but has remained constant (approximately 69 percent) since 2009.

There was essentially no difference in performance by model type for this measure.

High and Low Performers

Both Kaiser Permanente counties in Sacramento and San Diego, San Francisco Health Plan—San Francisco County, and Health Net—Tulare County performed above the HPL in 2012. Furthermore, both of the Kaiser Permanente counties and San Francisco Health Plan—San Francisco County also exceeded the HPL in 2011 showing some strength and consistency in this measure.

Nine rates performed below the MPL in 2012, which was the same number as 2011. Four rates showed statistically significant improvement in 2012 compared to 2011 rates, and there were no reported rates with a statistically significant decline (refer to Appendix B).

Best and Emerging Practices

Physician and Patient Communication/Patient Education[35]

If a physician is able to properly communicate with his or her patient about various topics such as birth control, STDs, pregnancy, underage sex, and the importance of getting routine Pap tests, there is a higher chance the patient will be compliant.

Many health plans and medical groups are now giving formal training to practitioners in communication skills. This training can be completed by either in-house programs or through communications programs offered by outside organizations. Most of the time this type of training is optional; however, some organizations have made the classes mandatory. In other organizations, the training is only required for doctors who consistently receive low scores in the area of communication.

The purpose of the training programs is to improve providers' effectiveness as both managers of health and as educators of patients. It is also thought that trained physicians will allocate a greater percent of the clinic-visit time to patient education which leads to greater patient knowledge, better compliance with treatment, and improved health outcomes.

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[35] Agency for Healthcare Research and Quality. *The CAHPS Quality Improvement Guide*. Available at: https://www.cahps.ahrq.gov/qiguide/default.aspx
Accessed on: April 3, 2012. Note–not available as of 6/27/12 until new contract is awarded.

The most effective and efficient way of offering physician-patient communication training is in the form of a workshop or seminar. With this method, many strategies can be covered for improved communication in a short period of time. Workshops also have the advantage of using case studies to illustrate the importance of communication and suggest approaches for improving the relationship between the physician and patient.

Health Education Materials[36,37]

Printed and electronic health education materials have been shown to be useful as long as the patient can understand them. These health education materials can include topics such as the benefits of smoking cessation, STDs, and cervical cancer risks. The health plan or physician can mail or submit electronically materials explaining risks associated with cervical cancer to identified females.

Reminder Systems for Preventive Care

Research has found that reminder systems are useful for ensuring that members receive preventive services. Health plans can send out reminders to females to schedule a Pap test for those who have not obtained a Pap test by targeting a certain date (e.g., the member's birthday).[38] The health plan can also send a list of members who have not received their Pap test to primary care providers and OB/GYNs. Another method that has been found to be useful is for the health plan to have an interactive voice response telephone system that provides education and encourages members to receive a Pap test.

California Plan Example[39]

San Francisco Health Plan—San Francisco County has shown consistently high performance for cervical cancer screening, exceeding the HPL in both 2011 and 2012. The plan identified and standardized several approaches to improve the rates for this measure including:

- In-Reach Panel Management:
  - Train medical assistants or other support staff to prepare the chart in advance of the visit.
  - Identify patients who are in the office for a sick visit and due for a Pap test, and schedule an appointment for the test.

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36 Agency for Healthcare Research and Quality. *The CAHPS Quality Improvement Guide*. Available at: https://www.cahps.ahrq.gov/qiguide/default.aspx
Accessed on: April 3, 2012. Note–not available as of June 27, 2012, until new contract is awarded.

37 Select Health. HEDIS 2009. Available at: http://selecthealth.org/Static/Files/hedisreport.pdf Accessed on: April 3, 2012.

38 Ibid.

39 SFHP 2012 HEDIS Criteria Cervical Cancer Screening. Available at: http://www.sfhp.org/files/PDF/providers/HEDIS/Cervical_Cancer_Screening.pdf Accessed on August 21, 2012.

  - Inform patients of the need for having a Pap test, even when presenting for an urgent care visit.
- Standing orders: Train support staff to order Pap tests whenever they are due. (Standing orders for medical assistants are allowed by the State for diagnostics, as long as there is no triage or treatment component.)
- Problem lists or tracking: Designate a place in the chart for easy identification of when the last Pap test was performed.
- Outreach: Call and/or send letters to patients who are overdue for Pap testing, based on EHR reports. For escalation, one best practice is to send a letter, then follow up with a telephone call from non-clinical staff. If the patient does not make an appointment within a month or 6 weeks, then follow up with a call; if the patient still has not had the test, follow up with a call from the provider.
- SFHP assistance: SFHP can provide robo-calls or personalized outreach letters.
- Document correctly: Ensure proper documentation in the medical record. Hysterectomy documentation will assist in excluding the member from the HEDIS sample.
- Train coding staff: Use correct diagnosis and procedure codes.

Childhood Immunization Status—Combination 3

Measure Definition

The *Childhood Immunization Status—Combination 3* measure calculates the percentage of children identified as having the following vaccinations: four diphtheria, tetanus, and pertussis (DTaP); three inactivated poliovirus (IPV); one measles, mumps, and rubella (MMR); three Haemophilus influenza type B (HiB); three hepatitis B; one varicella-zoster virus (chicken pox or VZV); and four pneumococcal conjugate vaccinations on or before the child's second birthday.

Importance

Disease prevention is the key to public health, and one of the most basic methods for the prevention of diseases is immunization. Immunizations are the safest and most effective tools for protecting children from various potentially serious childhood diseases. Vaccines are proven to help children stay healthy and avoid the harmful effects of diseases such as diphtheria, tetanus, hepatitis, polio, measles, mumps, and rubella. While the rates of vaccine-preventable diseases are very low in the United States, the viruses and bacteria that cause these infectious diseases still exist. Measles is one of the most infectious diseases in the world and frequently is imported into the United States. More than 90 percent of people who are not immunized will get the virus if exposed and as many as three out of every 1,000 cases will result in death in the United States.[40] Additionally, the Centers for Disease Control and Prevention (CDC) estimates that one-third of the lifelong hepatitis B virus infections in the United States resulted from infections acquired during infancy or during the first few years of life.[41] Furthermore, without proper immunization, the potential to pass on vaccine-preventable diseases such as measles, mumps, and pertussis (whooping cough) to unprotected persons increases drastically. For example, in 2006, an outbreak of mumps among college students in the U.S. led to more than 6,500 reported cases of mumps across multiple states.[42]

The social and direct economic costs of ensuring each child receives the Centers for Disease Control and Prevention (CDC) Advisory Committee for Immunization Practices' (ACIP's) recommended schedule of vaccines far outweighs the costs of not providing routine

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[40] Centers for Disease Control and Prevention. What Would Happen If We Stopped Vaccinations? Updated 2003. Available at: http://www.cdc.gov/vaccines/vac-gen/whatifstop.htm Accessed on: April 3, 2012.

[41] National Committee for Quality Assurance. The State of Health Care Quality in 2009. Washington, D.C.: NCQA; 2009.

[42] Centers for Disease Control and Prevention. Mumps Outbreaks. Updated July 2010. Available at: http://www.cdc.gov/mumps/outbreaks.html#e Accessed on: April 3, 2012.

immunizations. Childhood vaccines prevent 10.5 million diseases among all children born in the United States in a given year and are a cost-effective preventive measure. It is estimated that for every $1 spent on immunizations, as many as $29 can be saved in direct and indirect costs.[43] A child with chicken pox on average misses five to six days of school and adult caretakers three to four days of work. Based on an estimate of the 2001 U.S. birth cohort, routine childhood immunizations (as recommended by the ACIP) net an economic and societal cost savings of $9.9 billion and $43.3 billion, respectively.[44]

Despite the established guidelines and documented benefits and risks associated with childhood immunization, a gap in coverage still exists. Evidence has shown that the population at greatest risk for under-immunization are minority children from low-income families or children that live in inner-city or rural areas.[45] In 2007, almost 25 percent of children in the United States 19 to 35 months old did not receive the recommended vaccinations.[46] For these reasons, leading health care organizations and professionals widely agree that the need to focus on increasing childhood immunization rates in the United States still remains crucial.[47] Intentional undervaccination, often due to parents' concern with vaccine adverse events, has also led to preventable disease outbreaks. In 2008, an intentionally unvaccinated child unknowingly infected with measles resulted in the largest outbreak in San Diego, California, since 1991. Over 800 people were exposed and 12 additional cases were identified at a net public sector cost of $10, 376 per case.[48]

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43 National Committee for Quality Assurance. The State of Health Care Quality in 2009. Washington, D.C.: NCQA; 2009.

44 Zhou F, Santoli J, Messonier ML, et al. Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the United States, 2001. *Archives of Pediatrics and Adolescent Medicine*. 2005; 159(12): 1136-1144.

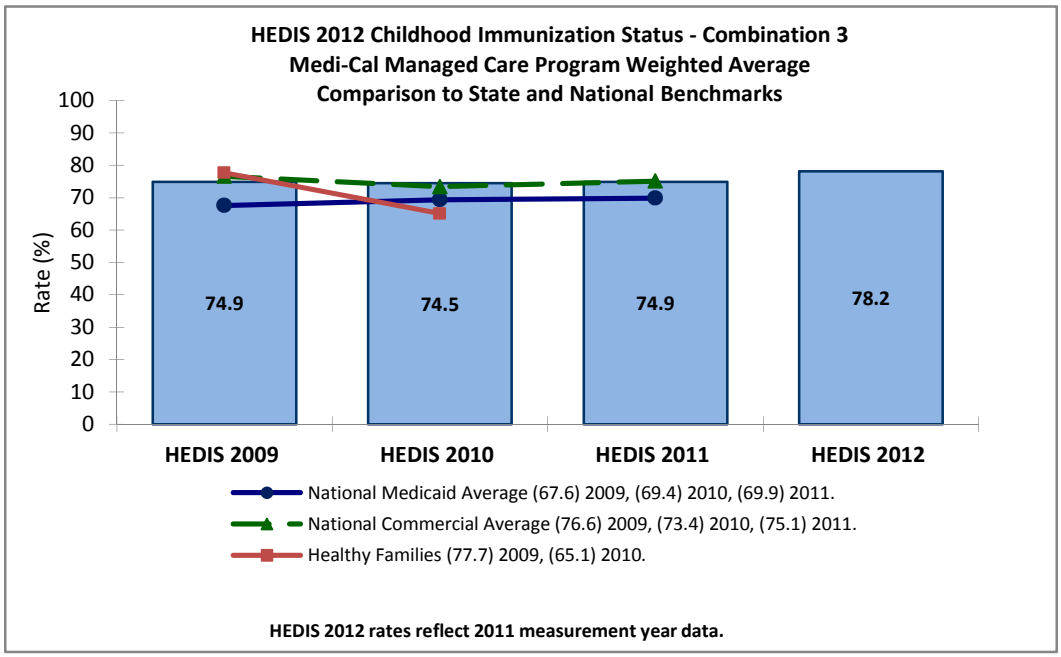
45 American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine and Council on Community Pediatrics. "Increasing Immunization Coverage." *Pediatrics*. 2003; 112(4): 993-996.

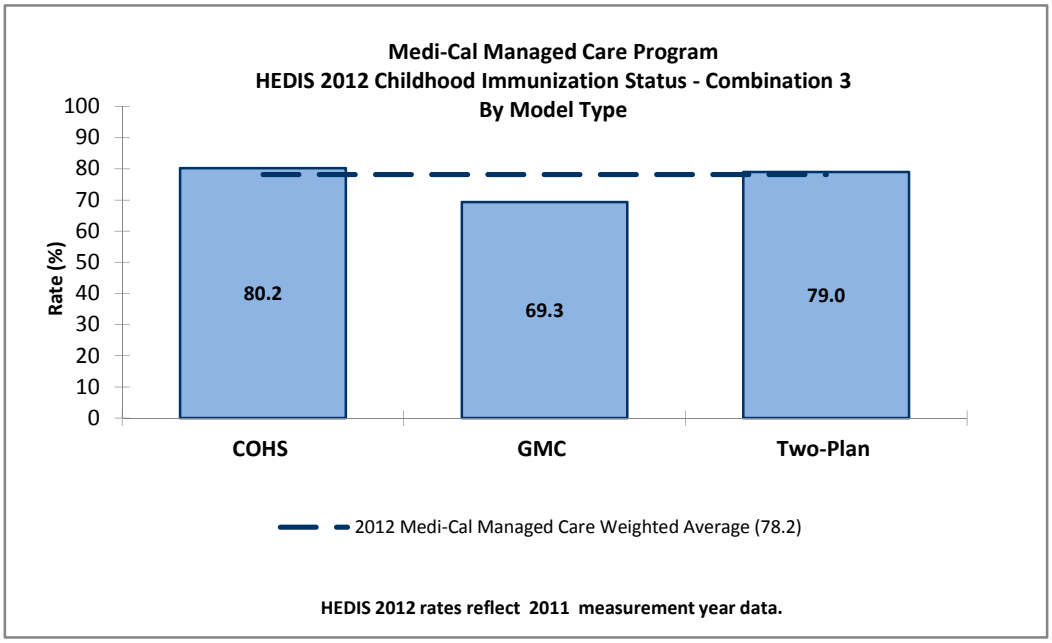
46 Agency for Healthcare Research and Quality. Childhood immunization status. *National Quality Measures Clearinghouse*. Available at http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?doc_id=14920&string=CIS Accessed on: April 3, 2012.

47 Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 11th ed. Washington, DC: Public Health Foundation; 2009. Available at: http://www.cdc.gov/vaccines/pubs/pinkbook/pink-chapters.htm. Accessed on: April 3, 2012.

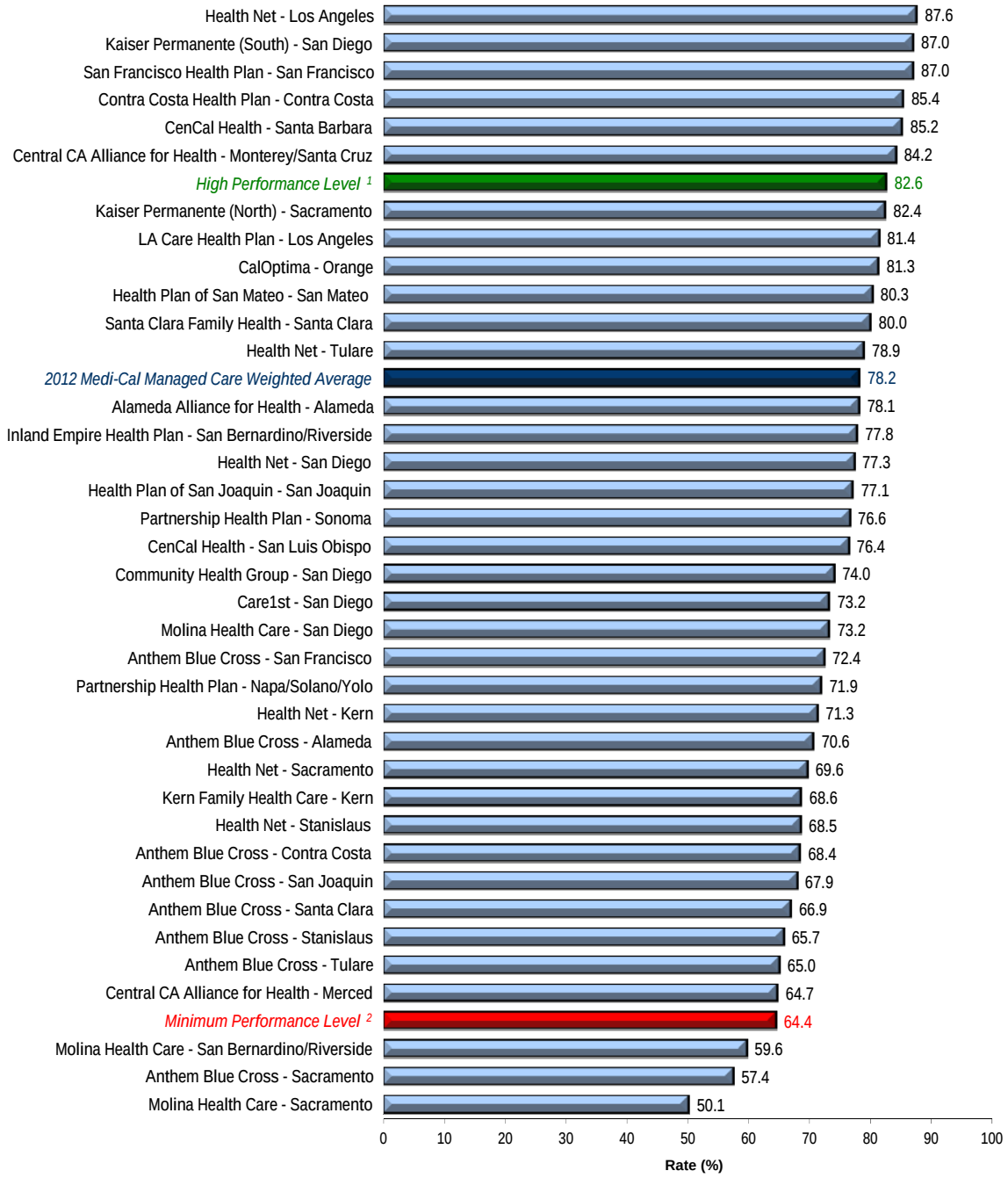
48 Sugarman, D.E., Barskey, A.E., Delea, M.G., et al. Measles outbreak in a highly vaccinated population, San Diego, 2008: role of the intentionally undervaccinated. 2010. *Pediatrics*. 1653. Available at: http://pediatrics.aappublications.org/content/early/2010/03/22/peds.2009-1653.full.pdf+html Accessed on: September 7, 2012.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Childhood Immunization Status—Combination 3



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Childhood Immunization Status—Combination 3* measure showed an increase of just over 3 percentage points from 2011 to 2012, its biggest increase in the last three years.

The COHS and Two-Plan model types performed similarly and outperformed the GMC model type by approximately 10 percentage points.

High and Low Performers

Six rates scored above the HPL in 2012, which is similar to what had occurred in 2011. However, only three rates scored below the MPL in 2012 compared to seven plan-level rates in 2011, thus showing an overall improvement in this measure.

Six rates showed statistically significant improvement from 2011 to 2012 rates, while only two rates showed a statistically significant decrease (refer to Appendix B).

Best and Emerging Practices

Patient Reminders/Recalls: A Stepped Intervention

A stepped intervention of reminder/recall/case management has been found to improve childhood immunization rates.[49] The steps involve:

- Mailing language-appropriate reminder postcards to members before every visit.
- Following up by postcard and telephone to non-responders for missed appointments and/or immunizations.
- Offering case management and/or home visits lastly for children still missing or behind on immunizations.

This multi-level approach proved successful in achieving higher immunization rates for a population of children who were at risk for receiving delayed immunizations.

Parent Education

Educating parents through language-appropriate materials about the benefits, safety, and risks associated with vaccine-preventable diseases and the impact immunizations have on the prevalence of these diseases has shown to improve coverage. In addition, providing parents with

[49] Hambridge SJ, Phibbs SL, Chandramouli V, et al. A Stepped Intervention Increases Well-Child Care and Immunization Rates in a Disadvantaged Population. *Pediatrics*. 2009; 124(2): 455-464.

information as to where they can find reliable and accurate immunization and vaccine information online can assist in minimizing the negative impact of false and inaccurate information.[50]

Provider Reminders

Studies have shown that provider reminders are helpful in increasing childhood immunization rates. Health plans can give providers a list of patients who are due or past due for receiving routine immunizations so that they can follow up with them. In addition, providers should be encouraged to use internal reminder systems such as posting notices on patient charts when certain vaccines are not on record or an immunization is due/past due. These reminders can prompt providers to offer immunizations to patients during routine or sick visits.[51]

Identify Alternative Venues

Identifying alternative settings where children can receive immunizations can be helpful in improving the delivery and rates of vaccinations. Additional venues could include Women, Infants, and Children (WIC) program offices, school-based health clinics, organized child care centers, and home visits.[52]

Collaborating with WIC programs to provide immunization services, to refer clients to clinics where they can receive vaccinations, or to provide vaccinations on site all contributed to improved immunization coverage among children.[53]

Expand Access to Immunization

Multi-component interventions to expand access to immunizations in health care settings, such as reducing the distance from vaccination settings to patient homes, increasing or changing hours to include after-hours or weekend services, developing "drop-in" clinics or "express-lane" vaccination services, have proven to be effective in increasing childhood immunization rates.[54]

Home health interventions to promote vaccinations increased childhood immunization rates. Providing clients with services such as education on the importance of vaccinations, assessment of need, referrals, and provision of vaccinations during home visits were all found to be successful.

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[50] American Academy of Pediatrics. Increasing Immunization Coverage. *Pediatrics*. 2010; 125(6): 1299-1304.

[51] Centers for Disease Control and Prevention (CDC). *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 11th ed. Washington, DC: Public Health Foundation; 2009. Available at: http://www.cdc.gov/vaccines/pubs/pinkbook/pink-chapters.htm Accessed on: April 3, 2012.

[52] Community Preventive Services Task Force. Vaccinations to prevent diseases: universally recommended vaccines. Available at: http://www.thecommunityguide.org/vaccines/universally/index.html. Last updated: January 3, 2011. Accessed on: September 4, 2012.

[53] Ibid.

[54] Ibid.

Conduct Regular Assessments

Conducting regular assessments of immunization rates is proven to increase vaccination coverage in a range of clinical settings and across populations.[55] Assessments are most effective when they combine chart reviews to determine coverage with the provision of results to health care professionals and staff. Provider assessment can be performed by the clinical practice staff or by outside organizations, such as state and local health departments. Effective interventions may also include provider incentives or a comparison of performance to a goal or standard (i.e., benchmarking). This process is commonly referred to as AFIX (assessment, feedback, incentives, and exchange of information). Annual assessment of immunization levels is recommended so that reasons for low coverage in a practice, or in a subpopulation of patients, can be identified and addressed.[56]

Immunization Registries

Immunization registries (also known as Immunization Information Systems) are widely used by health plans and their participating providers because of the numerous benefits they offer. These benefits include (1) reducing or eliminating the need for physician office staff to conduct manual chart abstraction to collect immunization data and (2) assisting in identifying high risk, under-immunized patient groups, which in turn allows providers to focus their time and money on reaching the children most in need. Studies have also shown that registries can help to increase overall immunization rates and the data completeness and quality of immunization records.[57] For example, Columbia United Providers (CUP) in partnership with Washington State developed a registry system called CHILD Profile. In utilizing the registry data, CUP has been able to significantly widen their net for capturing immunization data for their members for HEDIS reporting, as well as, lower the time and money spent on medical record review. The registry is able to capture vaccine dates not captured in the administrative data.[58]

Participating in the sharing and exchange of immunization data across registries has also proven to be successful in increasing immunization rates among health plans and providers.[59] Health plans exchange data with numerous immunization registries. In doing so, health plans are able to combine immunization data from numerous locations where members receive vaccine services, hence increasing the accuracy of their immunization data and reported immunization rates.

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[55] Task Force on Community Preventive Services. Recommendations Regarding Interventions to Improve Vaccination Coverage in Children, Adolescents, and Adult. *The American Journal of Preventive Medicine*. 2000; 18 (1S): 92-96.

[56] Nordin J, Anderson R, Anderson R, et al. Institute for Clinical Systems Improvement. Immunizations. Available at: http://www.icsi.org/immunizations___guideline__/immunizations__guideline__38400.html Updated March 2012. Accessed on: September 4, 2012.

[57] Canavan BC. "Using registry data to improve immunization rates for children covered under Medicaid Managed Care." Presented at the 36th National Immunization Conference of CDC. 2002. Available at: http://cdc.confex.com/cdc/nic2002/techprogram/paper_210.htm Accessed on: April 3, 2012.

[58] Zavolinsky J. Immunization Registries Boost Rates and Improve Quality. *America's Health Insurance Plans*. 2004.

[59] Ibid.

Children and Adolescents' Access to Primary Care Practitioners

Measure Definition

This measure is used to assess the percentage of members 12 months through 24 months and 25 months through 6 years age who had a visit with a primary care practitioner and members 7 years through 11 years and 12 years through 19 years of age who had a visit with a primary care practitioner during the measurement year or the year prior. The plan reports separate percentages for each of the four age stratifications.

Importance

The health of children depends partially on their access to health care services.[60] Theoretical and empirical studies of access to health care have emphasized the importance of having health insurance and a regular source of care to ensure that children have access to health services.[61] Health services and interventions are needed to deal with crises such as child abuse, which has risen to 850,000 substantiated cases a year; teen suicides, which have almost doubled since 1970; and teen homicides, which have doubled in the past decade. In addition, although the rates of many health conditions among children have remained stable, rates of respiratory conditions, especially asthma, have increased dramatically, and immunization rates for preschool children have been below recommended guidelines.[62]

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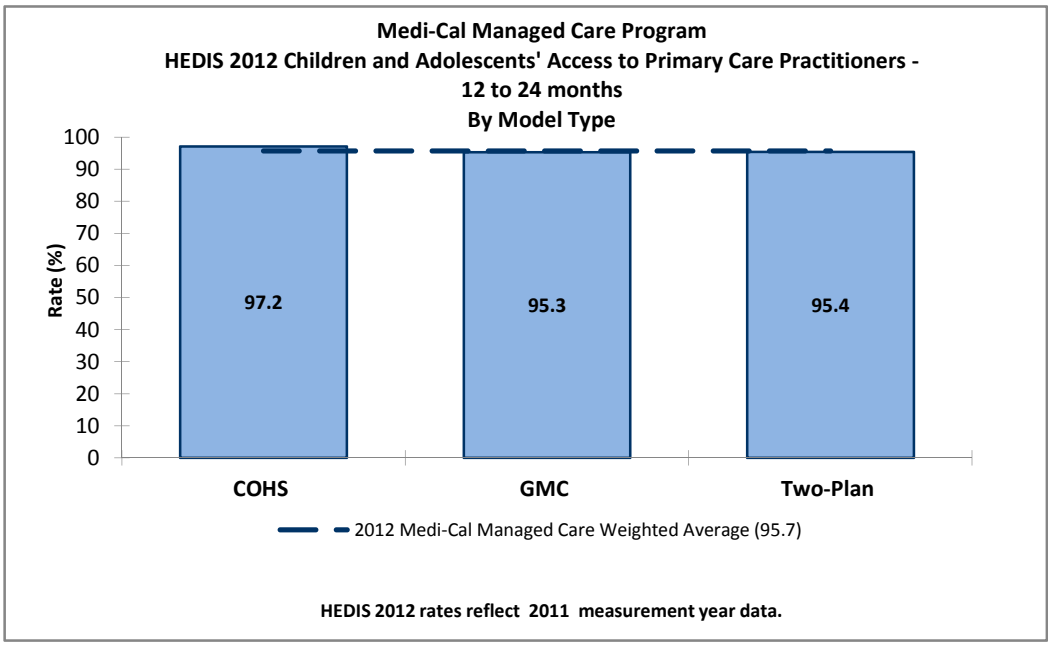
[60] Centers for Disease Control and Prevention. *Vital and Health Statistics: Access to Health Care Part 1: Children.* July 1997. Available at: http://www.cdc.gov/nchs/data/series/sr_10/sr10_196.pdf. Accessed on: September 4, 2012.

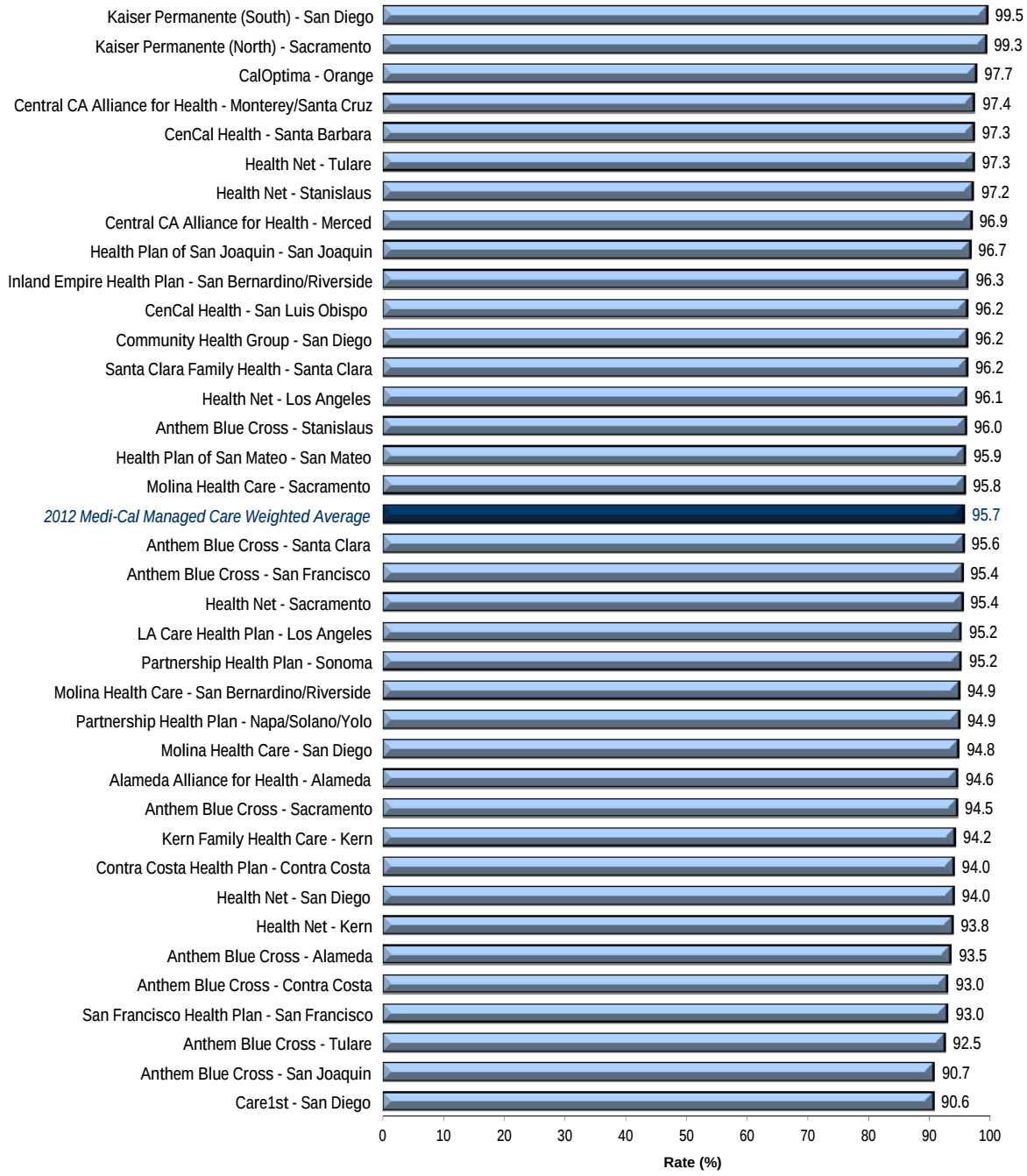
[61] Institute of Medicine Committee on Monitoring Access to Personal Health Care Service. Access to health care in America. Michael Millman (ed.) National Academy of Sciences. National Academy Press. Washington, D.C. 1993.

[62] U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. Trends in the well-being of America's children and youth: 1996. Washington. 1996.

Performance Results—12 to 24 Months of Age



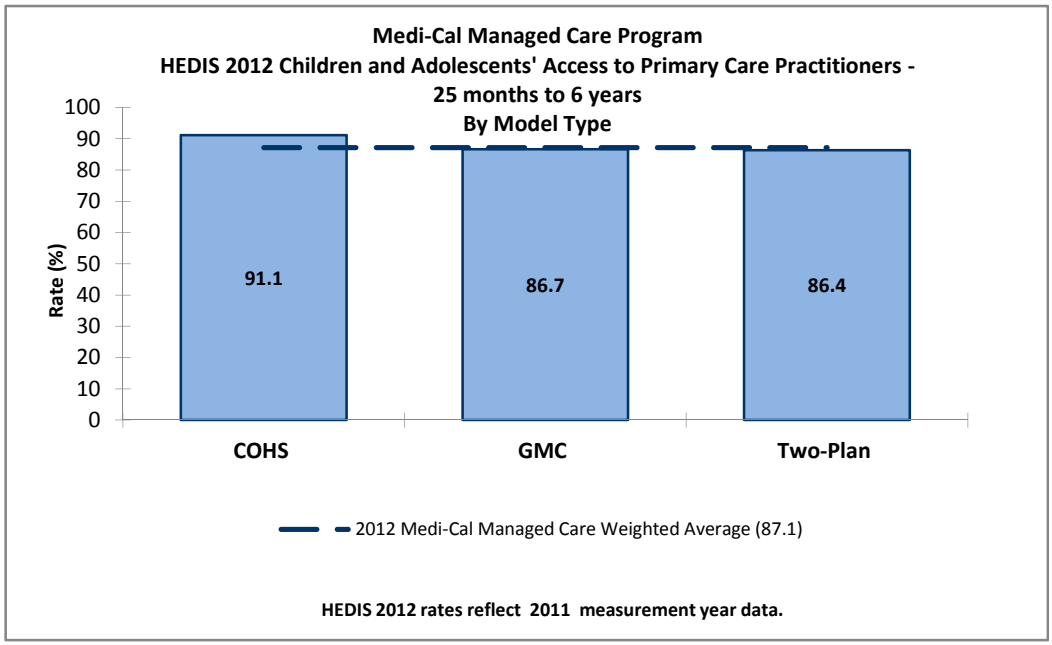
Medi-Cal Managed Care
HEDIS 2012 Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months



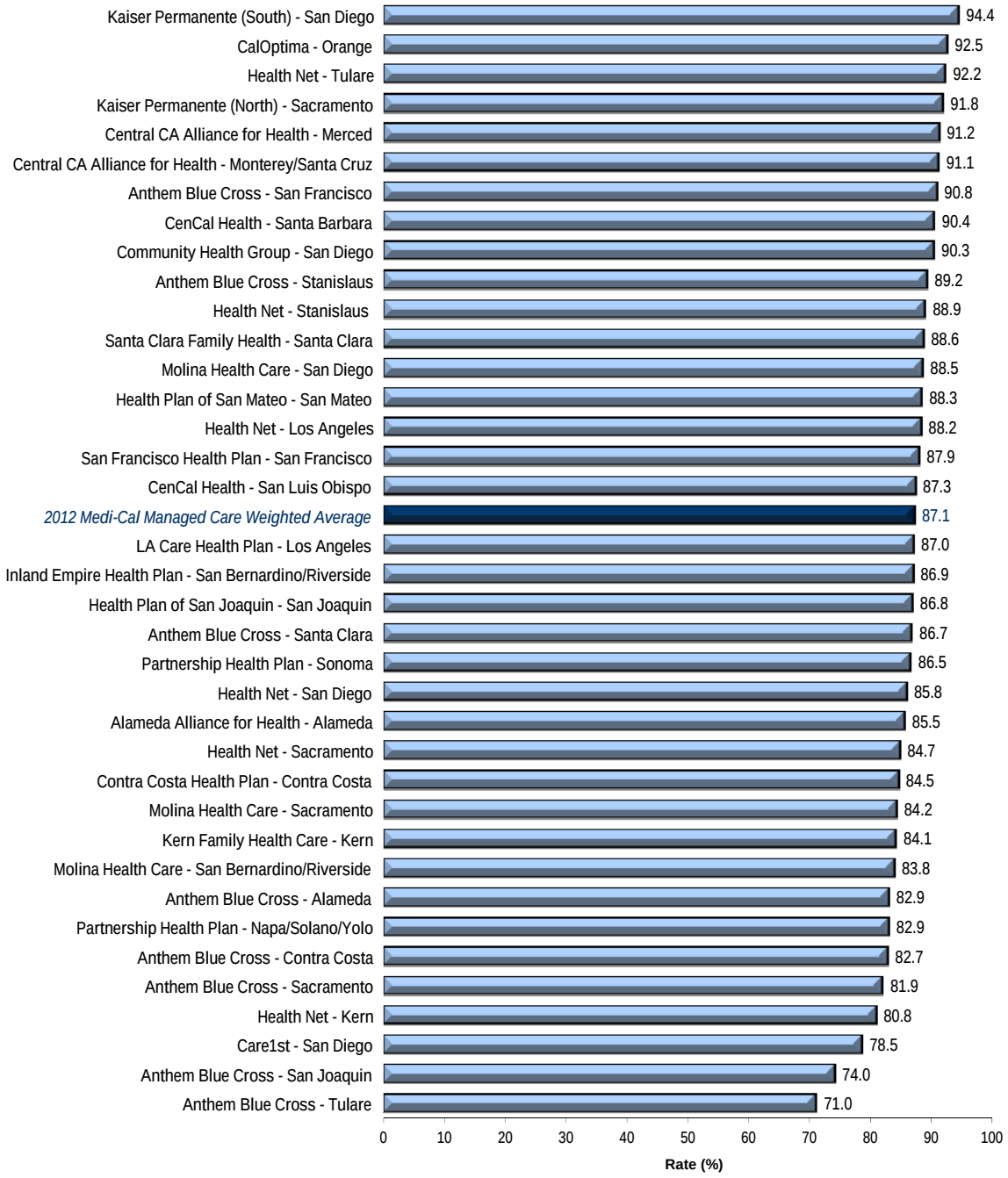
The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS required the measure.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Performance Results—25 Months to 6 Years of Age



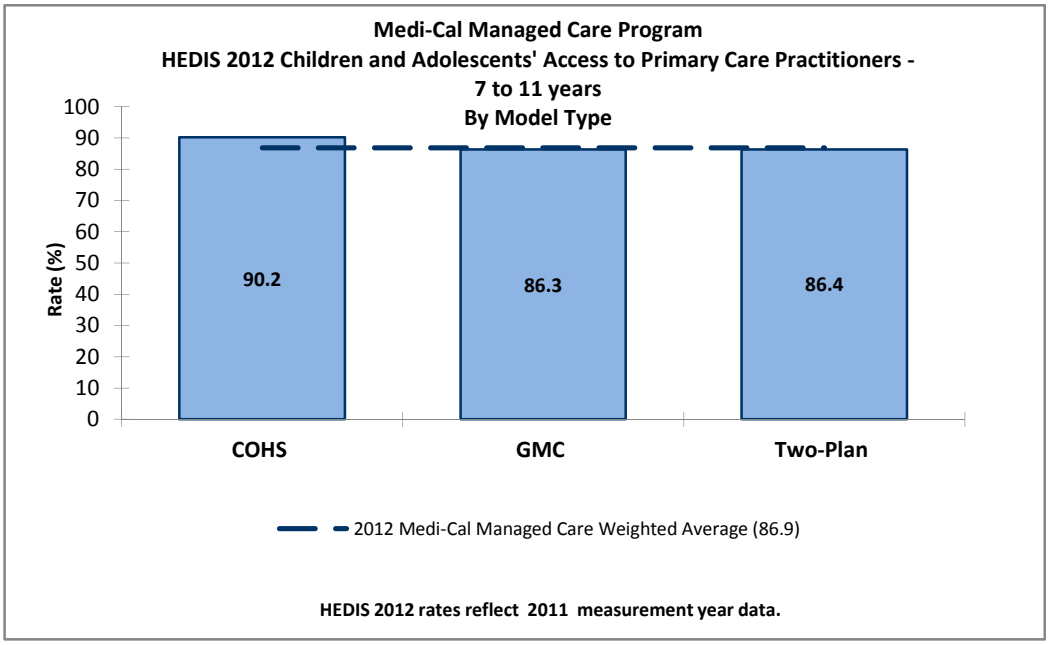
Medi-Cal Managed Care
HEDIS 2012 Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years



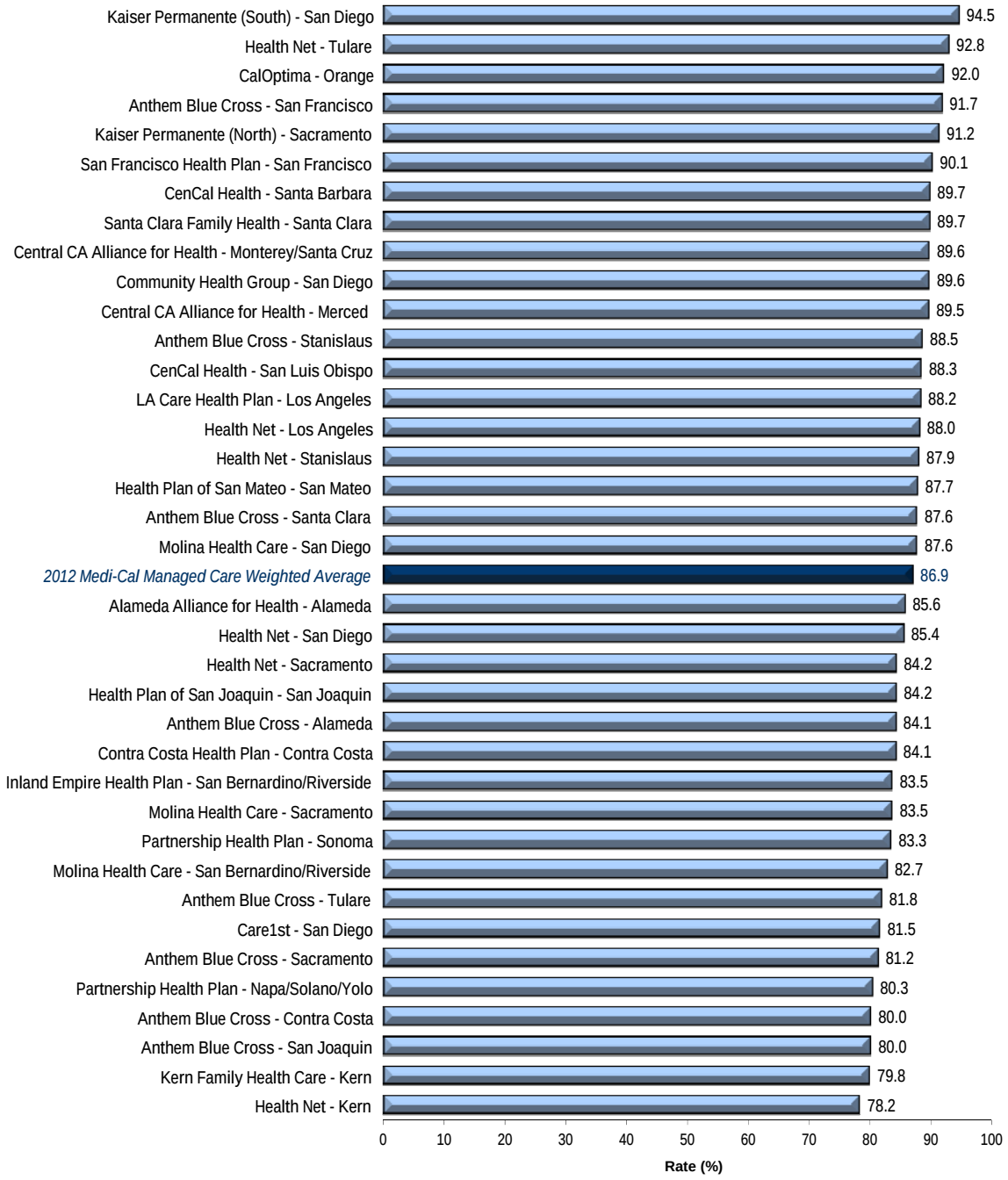
The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS required the measure.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Performance Results—7 to 11 Years of Age



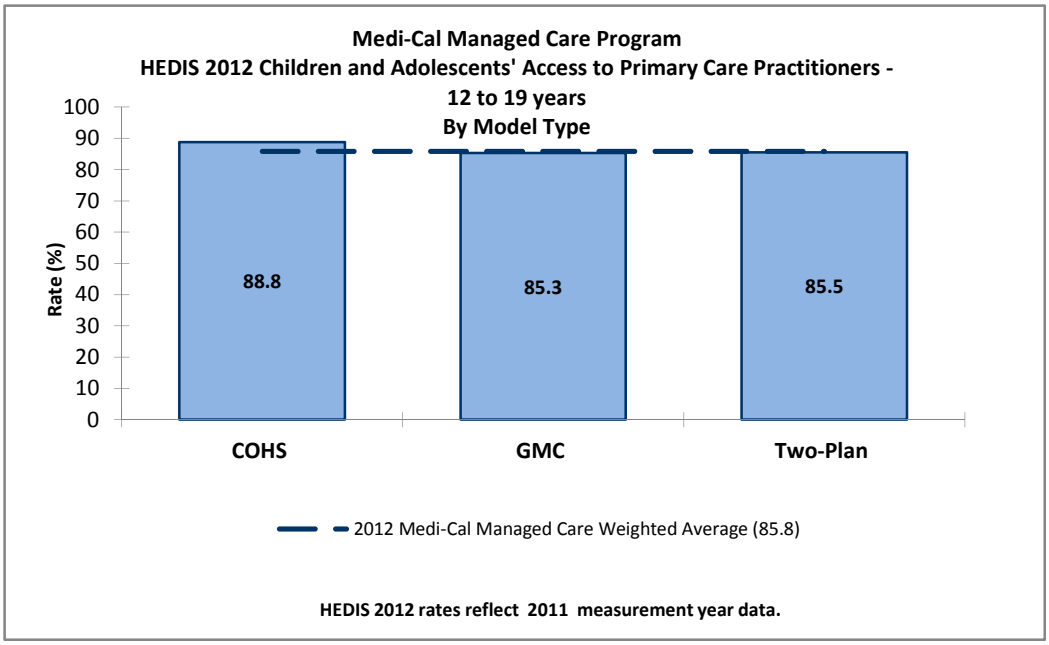
Medi-Cal Managed Care
HEDIS 2012 Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years



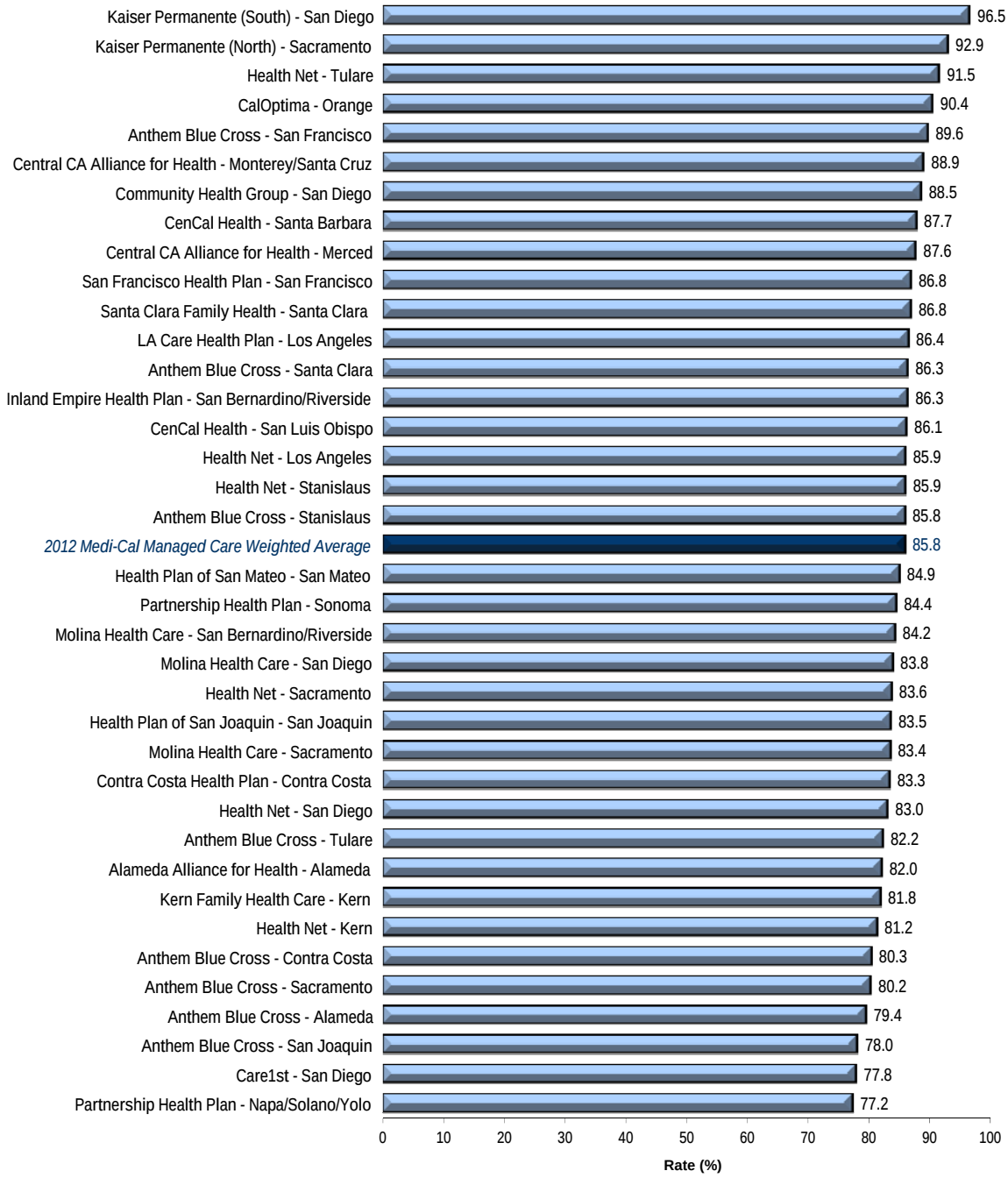
The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS required the measure.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Performance Results—12 to 19 Years of Age



Medi-Cal Managed Care
HEDIS 2012 Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years



The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS required the measure.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MPL and HPL are not applied to a measure (1) when the DHCS opts not to apply them, (2) in the first year of significant changes to a measure's technical specifications, or (3) in the first year the DHCS requires the measure. DHCS required its plans to report the *Children and Adolescents' Access to Primary Care Practitioners (CAP)* measure in 2012 for the first time; therefore, there were no established HPLs and MPLs for the four sub-indicators.

Best and Emerging Practices

Improve Access

Open-access appointments can increase compliance by expanding provider availability.[63] Providers offering evening or weekend clinic hours can help accommodate parents who cannot take time off from work or adolescents with extracurricular activities. For example, one Saturday a month could be set aside for children and adolescents, with clinicians designated to perform well visits on that day. Visits on certain days could be made available on a walk-in, first-come, first-served basis. Additionally, providers should encourage parents to schedule their next visit before leaving the clinic. Plans also may consider improved access to transportation as a strategy to increase well-visit compliance. Another approach is to deliver preventive services to adolescents at alternate settings, such as schools. School-based clinics have been successful in improving immunization rates among this age group.[64]

Increase Funding to Improve Transportation

One potential barrier to care is the patient's inability to obtain access to consistent transportation. The State can work with stakeholders and policy makers to increase funding for transportation programs.[65] This best practice would likely result in an increase in postpartum visit rates, particularly in rural areas with less public transportation. Another option is to provide bus tokens or taxi vouchers for transportation.

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[63] O'Connor ME, Matthews BS, Gao D. Effect of Open Access Scheduling on Missed Appointments, Immunizations, and Continuity of Care for Infant Well-Child Care Visits. *Archives of Pediatrics & Adolescent Medicine.* 2006; 160: 889-893.

[64] Middleman, A.B. Coordinating delivery of vaccinations and other preventive health care recommendations for adolescents. *Preventive Medicine.* 2011. 53:522-528. Available at: http://ac.els-cdn.com/S0091743511003057/1-s2.0-S0091743511003057main pdf?_tid=79bed26b9e3b786a8e5d9bab9758b851&acdnat=1345747824_b3e26f66640d39dbab97f742e458f57c. Accessed on: August 23, 2012.

[65] Tough S, Siever J, and Johnson D. "Retaining Women in a Prenatal care Randomized Controlled Trial in Canada: Implications for Program Planning." BMC Public Health 2007, 7: 148.

Reminder Systems

Postcards are an easy and effective tool for increasing visits. They can be sent to parents as a reminder to schedule their adolescent's visit to a PCP. To be most effective, postcards should include contact information for either doctors' offices near the member's address or the member's assigned PCP. To increase effectiveness, follow-up telephone calls should be conducted with members who have not scheduled visits after the initial postcard mailing.

Confidentiality is a concern for adolescents within the older age group and is associated with decreased well care visits. Plans should assess providers' practices related to confidentiality and increase providers' awareness concerning how often they discuss confidentiality policies with adolescent patients and their parents.

Parent Education

Educating parents through language-appropriate materials about the benefits of children visiting a primary care provider even when they appear healthy is another strategy to help increase the number of children and adolescents who visit PCPs.

Patient-Centered Care

Using a patient-centered care model has been associated with improved health outcomes and a stronger alliance with the family in promoting each child's health and development.[66] Primary care providers are essential to the success of this model.[67]

Conduct Regular Assessments

Conducting regular assessments of children's access to providers is proven to increase rates in a range of clinical settings and across populations.[68] Effective interventions may also include provider incentives or a comparison of performance to a goal or standard (i.e., benchmarking). This process is commonly referred to as AFIX (assessment, feedback, incentives, and exchange of information). Annual assessment of children's access to PCPs is necessary so that reasons for low coverage in a practice, or in a subpopulation of patients, can be identified and addressed.[69]

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[66] Holm KE, Patterson JM, Gurney JG. Parental involvement and family-centered care in the diagnostic and treatment phases of childhood cancer: results from a qualitative study. J Pediatr Oncol Nurs. 2003;20(6):301–313.

[67] Committee in Hospital Care and Institute for Patient- and Family-Centered Care. *Pediatrics*. 2012. Available at: http://pediatrics.aappublications.org/content/129/2/394.full.html Accessed on: September 7, 2012.

[68] Task Force on Community Preventive Services. Recommendations Regarding Interventions to Improve Vaccination Coverage in Children, Adolescents, and Adult. *The American Journal of Preventive Medicine*. 2000; 18 (1S): 92-96.

[69] Nordin J, Anderson R, Anderson R, et al. Institute for Clinical Systems Improvement. Immunizations. Available at: http://www.icsi.org/immunizations___guideline_/immunizations__guideline__38400.html Updated March 2012. Accessed on September 4, 2012.

Identify Alternative Venues

Identifying alternative settings where children can access a primary care provider can improve the percentage of children receiving the necessary visit. Additional venues could include school-based health clinics, organized child care centers, and home visits.[70]

Comprehensive Diabetes Care—HbA1c Testing

Measure Definition

The *Comprehensive Diabetes Care—HbA1c Testing* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who had one or more HbA1c test(s) conducted within the last year.

Importance

Blood tests to measure HbA1c (A1c) levels (glycosylated hemoglobin levels) are critical for diabetics. Diabetics with a high A1c level are at an increased risk of:[71]

- Eye disease.
- Heart disease.
- Kidney disease.
- Nerve damage.
- Stroke.

These risks increase if A1c levels are not controlled.[72] The reduction of A1c level by 1 percent, decreases the risk of: [73]

- Heart failure by 16 percent.
- Heart attack by 14 percent.
- Stroke by 12 percent.
- Diabetes-related death by 21 percent.
- Death from all causes by 14 percent.
- Amputation by 43 percent.
- Small blood vessel disease by 37 percent.

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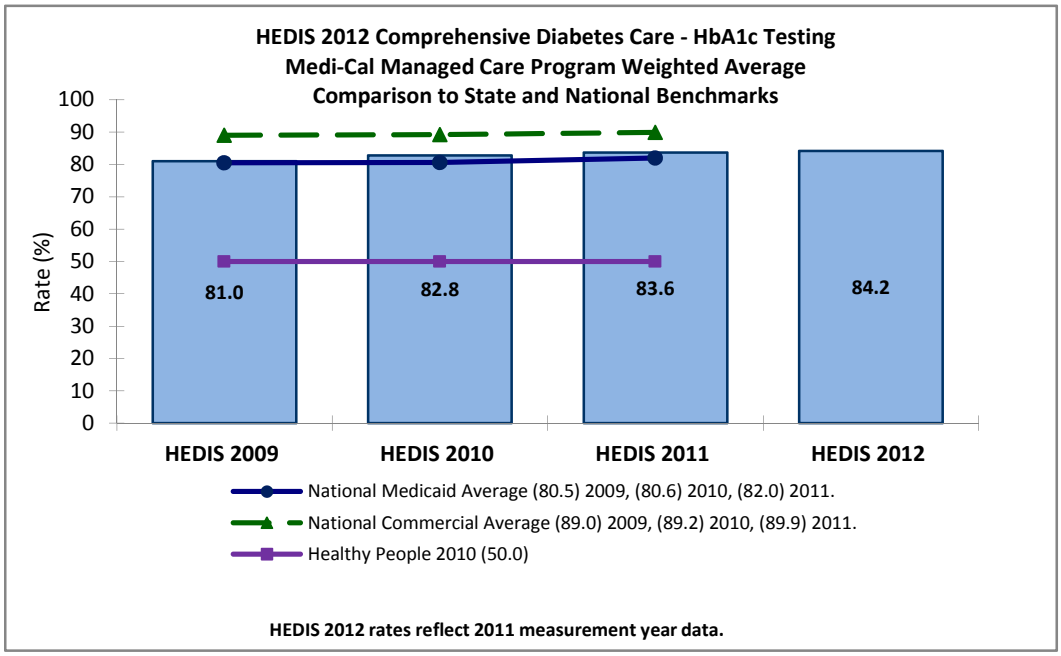
[70] Community Preventive Services Task Force. Vaccinations to prevent diseases: universally recommended vaccines. Available at: http://www.thecommunityguide.org/vaccines/universally/index.html. Last updated: 1/3/2011. Accessed on: September 4, 2012.

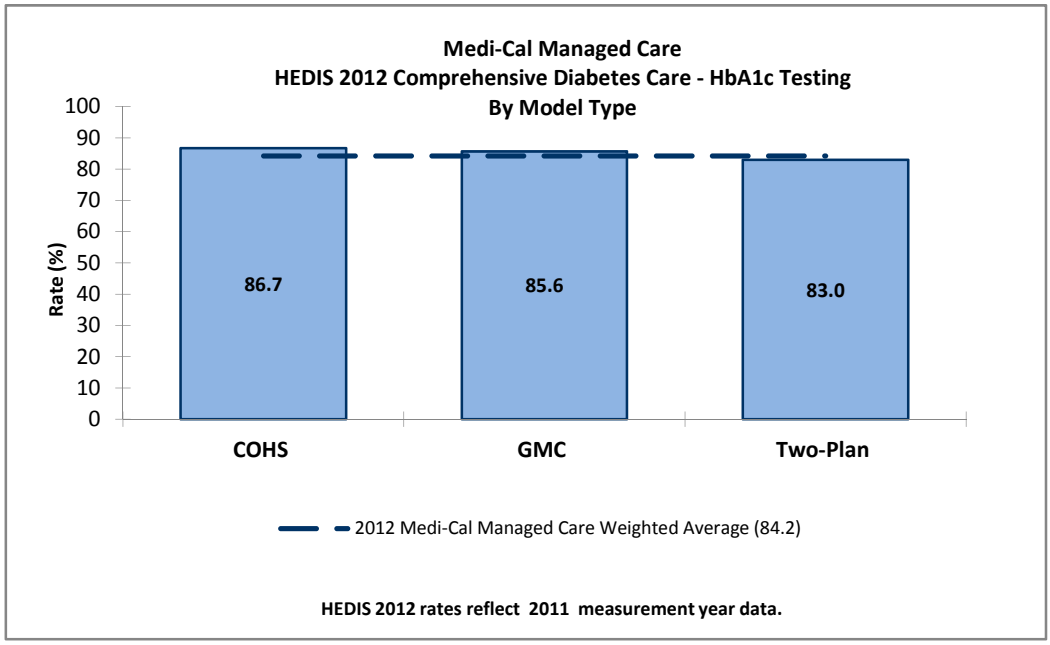
[71] American Diabetes Association. A1c. Available at: http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/a1c/ Accessed on: April 3, 2012.

[72] Everybody. Diabetes and HbA1c Testing. Available at: http://www.everybody.co.nz/page-46cae434-1bb8-4f84-8d15-76be9785eae2.aspx Accessed on: April 3, 2012.

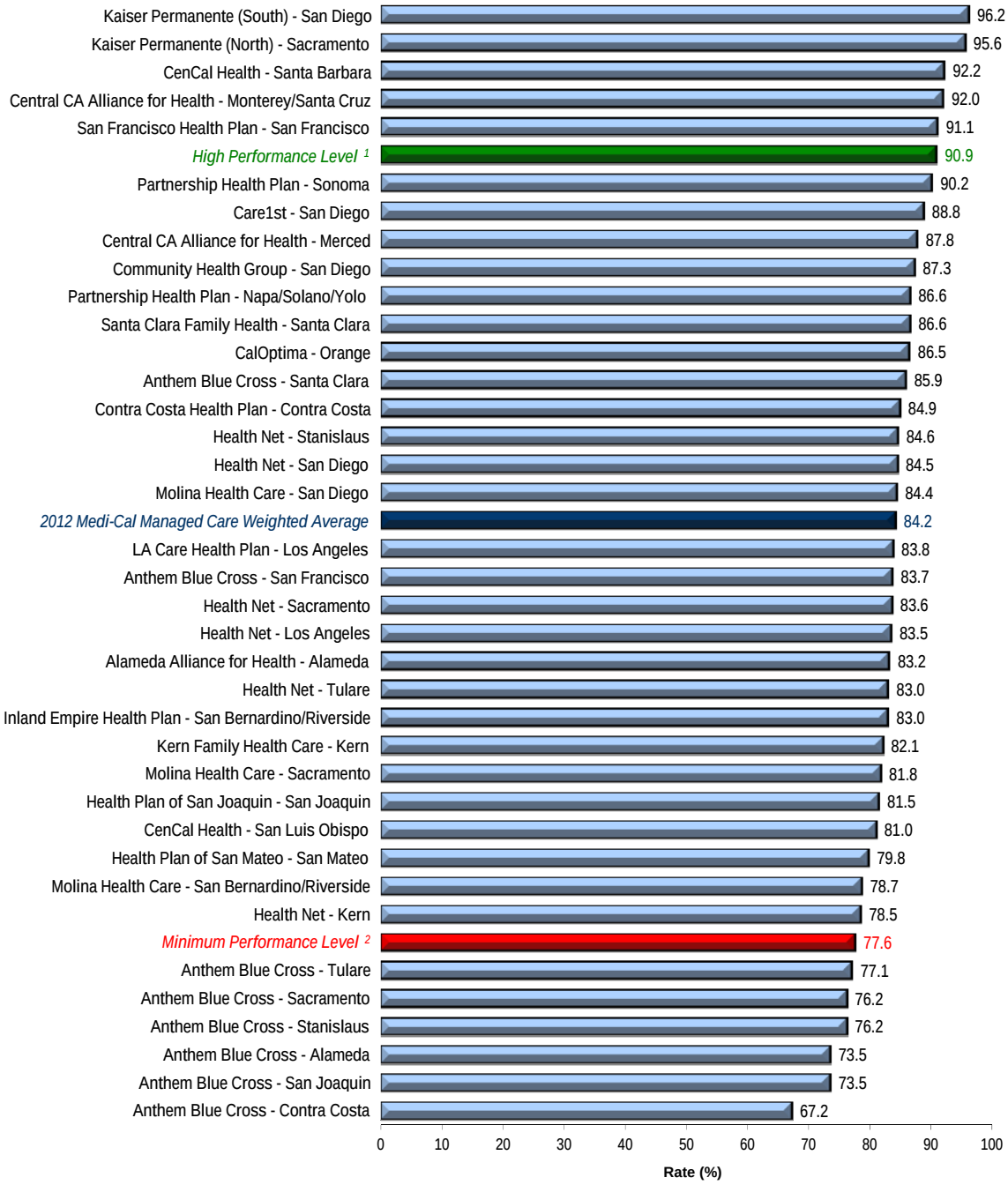
[73] Ibid.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Comprehensive Diabetes Care—HbA1c Testing



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Comprehensive Diabetes Care—HbA1c Testing* measure reflects a general trend of improvement over the past four years. The program's weighted average exceeded the national Medicaid average and the Healthy People 2010 goal from 2009 through 2012; however, the Program's weighted average has yet to exceed the national commercial average for any of the reporting years.

COHS, GMC, and Two-Plan model types performed similarly in 2012.

High and Low Performers

Five reported rates performed above the HPL of 90.9 percent for this measure in 2012 as opposed to three that finished above the HPL in 2011. A few plans have shown consistent strength in this measure; both of the Kaiser Permanente plans in Sacramento and San Diego counties performed above the HPL in 2008–2012, and San Francisco Health Plan—San Francisco County exceeded the HPL in 2009–2012. Six plans performed below the MPL in 2012 as opposed to three in 2011.

Two rates reported by CenCal Health—Santa Barbara and San Luis Obispo counties showed statistically significant improvement over 2011 rates, and one rate reported by Health Plan of San Mateo—San Mateo County experienced a statistically significant decline during the same measurement period (refer to Appendix B).

Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)

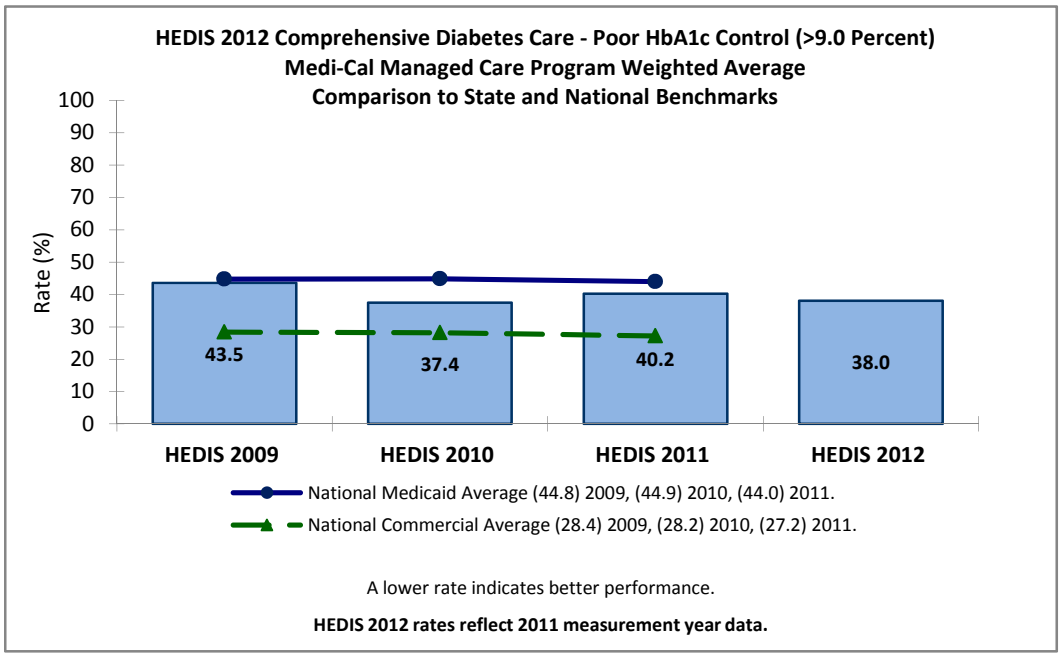
Measure Definition

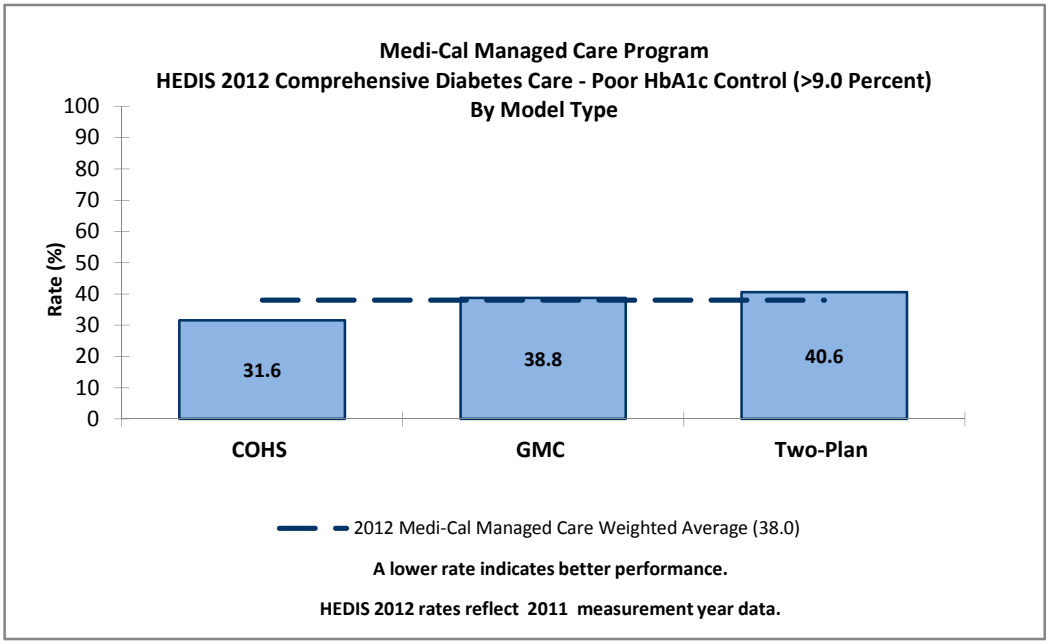
The *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) whose most recent HbA1c test conducted during the measurement year showed a greater than 9 percent HbA1c level, indicating poor control.

Importance

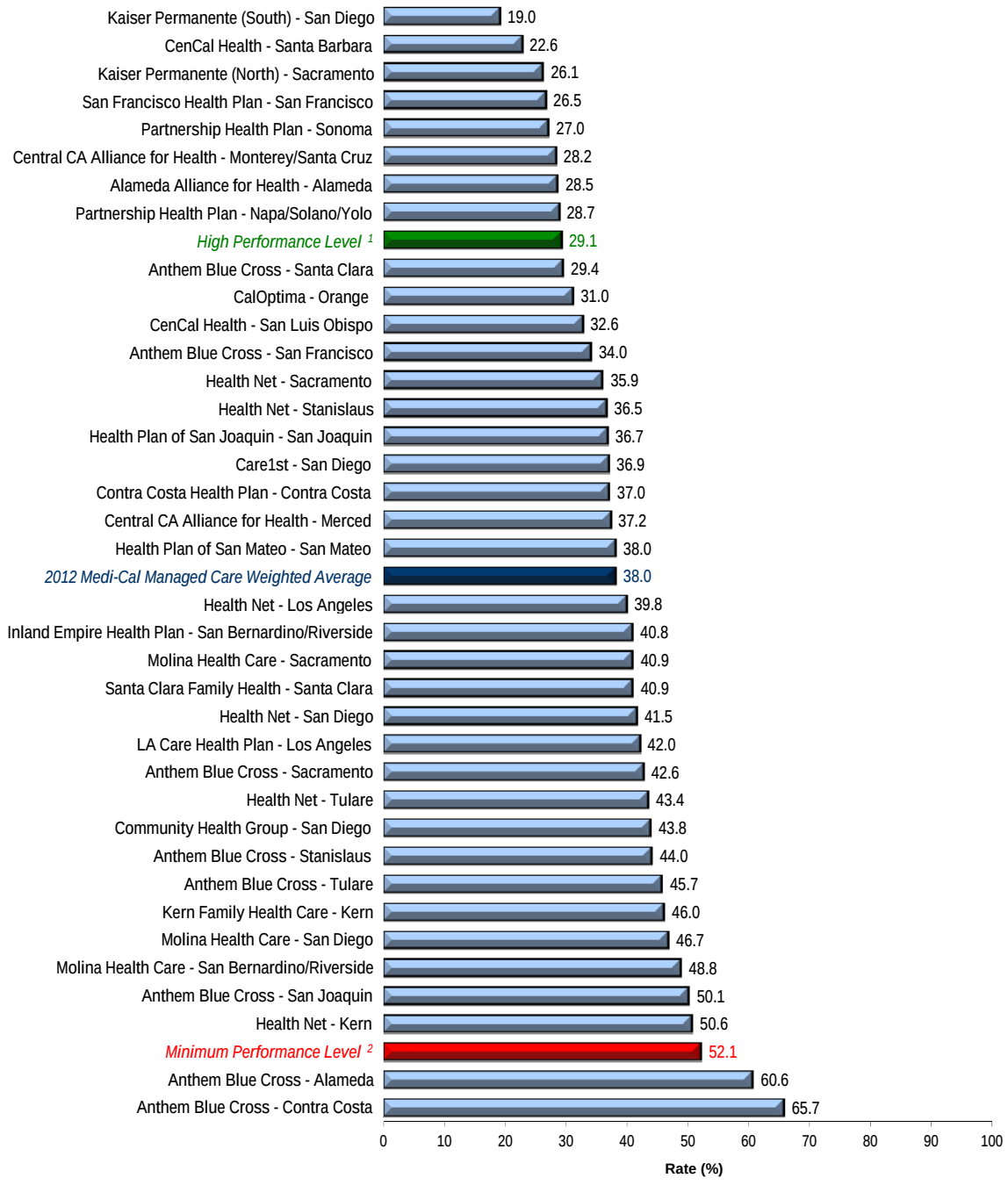
HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Decreasing the HbA1c level lowers the risk of diabetes-related death. Controlling blood glucose levels in people with diabetes significantly reduces the risk for blindness, heart disease, end-stage renal disease (ESRD), stroke, nerve damage, and lower extremity amputation.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)



[1] High Performance Level is HEDIS 2011 national Medicaid 10th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 75th Percentile.

A lower rate indicates better performance.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

For this measure, a lower rate indicates better performance. The MCMC Program's weighted average decreased by approximately 2 percentage points from 2011 to 2012, indicating an increase in performance. The MCMC Program demonstrated better performance when compared to the 2011 national Medicaid average; however, the 2012 weighted average was higher than the 2011 national commercial average.

The COHS model type outperformed both the Two-Plan and GMC model types in 2012, which remained consistent with 2011's performance.

High and Low Performers

Eight rates exceeded the 2012 established HPL for this measure, an increase of five from 2011, when three performed above the HPL. The number of reported rates that did not achieve the established MPL decreased from seven in 2011 to two (Anthem Blue Cross—Alameda and Contra Costa counties) in 2012.

In 2012, nine rates showed statistically significant improvement over 2011 rates (i.e., a significant decrease in the rate). Only two rates had statistically significant declines in performance in 2012 rates, showing an overall improvement in performance for the *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)* measure (refer to Appendix B).

Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)

Measure Definition

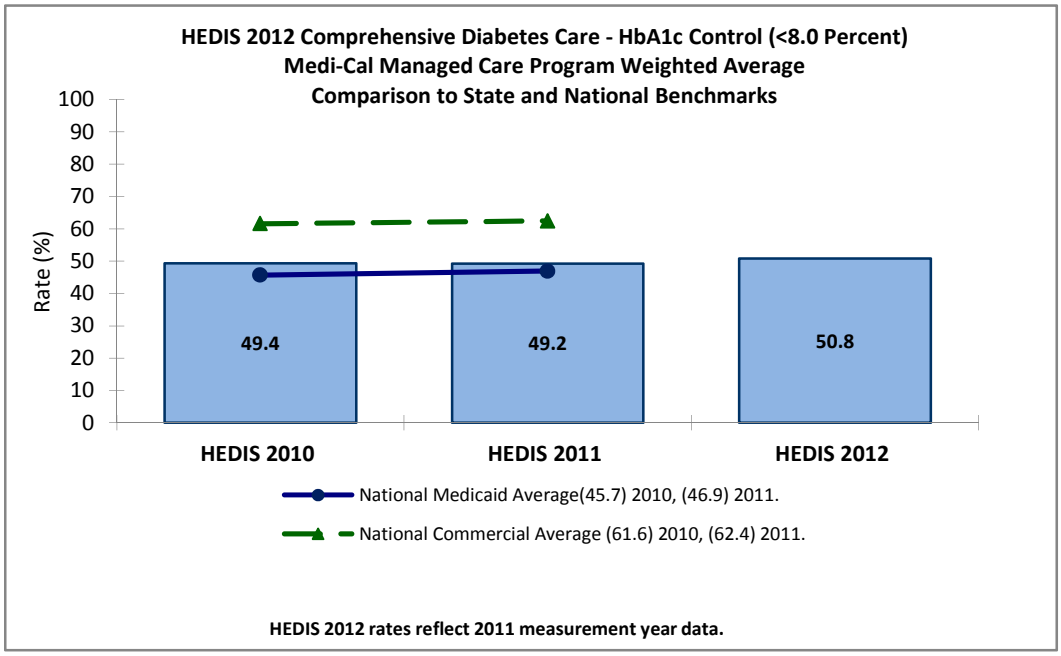
The *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* measure reports the percentage of members 18 through 64 years of age with diabetes (Type 1 and Type 2) whose most recent HbA1c test conducted during the year showed an HbA1c level of less than 8 percent.

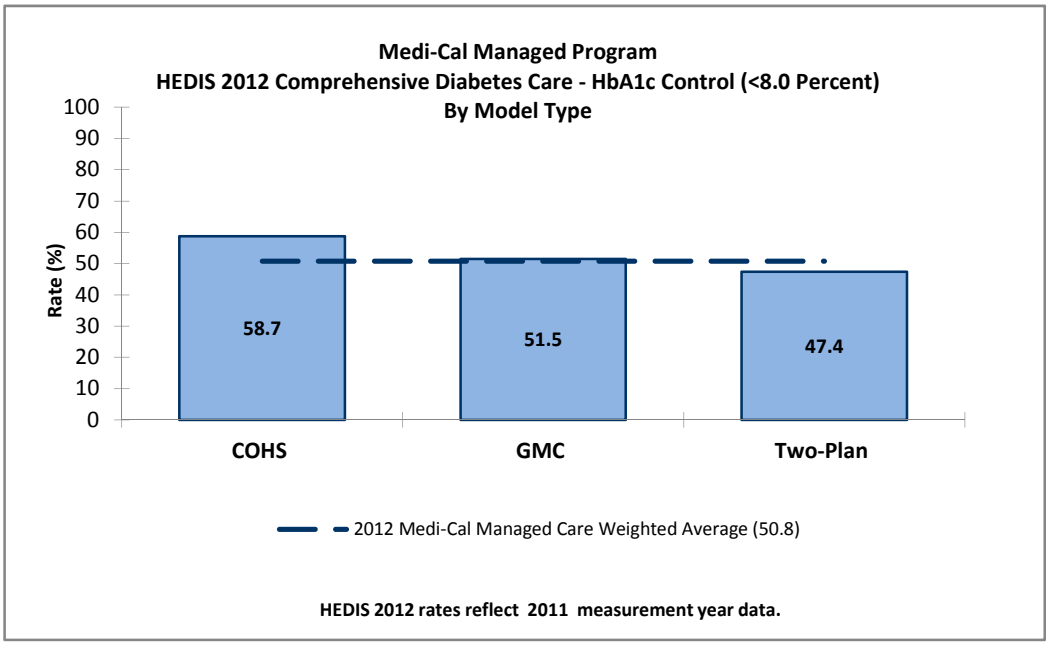
Importance

HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Controlling the HbA1c level also lowers the risk of diabetes-related death. In addition, controlling blood glucose levels in people with diabetes significantly reduces the risk of blindness, ESRD, and lower extremity amputation.[74]

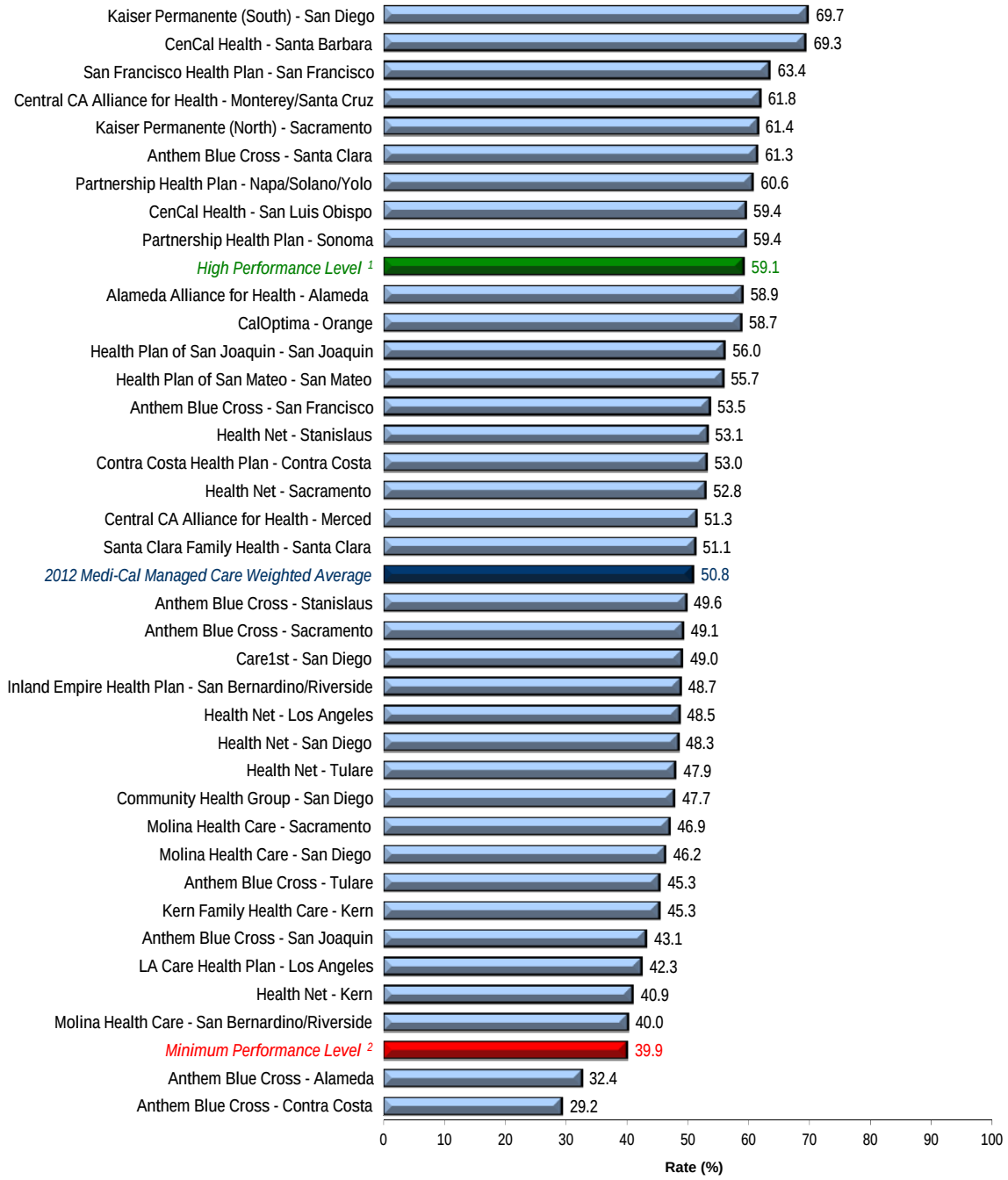
[74] National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's 2012 weighted average was 50.8 percent, which was a slight improvement over the 2011 weighted average. The COHS model type outperformed the GMC and Two-Plan model types; this result remained consistent with results from 2010 and 2011.

High and Low Performers

Nine rates earned a score greater than the HPL in 2012, as compared to only six achieving the HPL in 2011. Only two rates performed below the MPL in 2012, as compared to seven in 2011. These results display an overall improvement in performance for the plans in 2012.

Comprehensive Diabetes Care—LDL-C Screening

Measure Definition

The *Comprehensive Diabetes Care—LDL-C Screening* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who had an LDL-C test during the measurement year.

Importance

LDL-C screening is important for diabetics and is used to test cholesterol levels in the blood. High LDL-C levels are associated with increased risk for cardiovascular mortality, heart disease, heart attack, and stroke.[75,76]

Patients with diabetes are at a two to three times greater risk of cardiovascular mortality compared to patients who are non-diabetics. A 30 percent reduction in LDL-C has been shown to reduce major vascular events by approximately 25 percent, regardless of the baseline LDL.[77]

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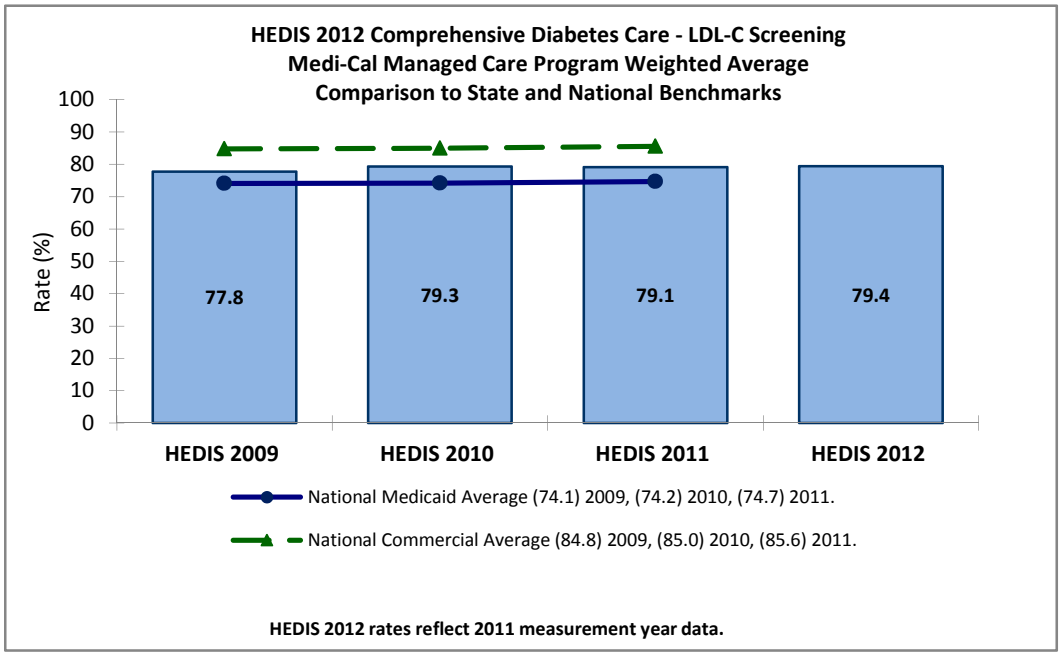
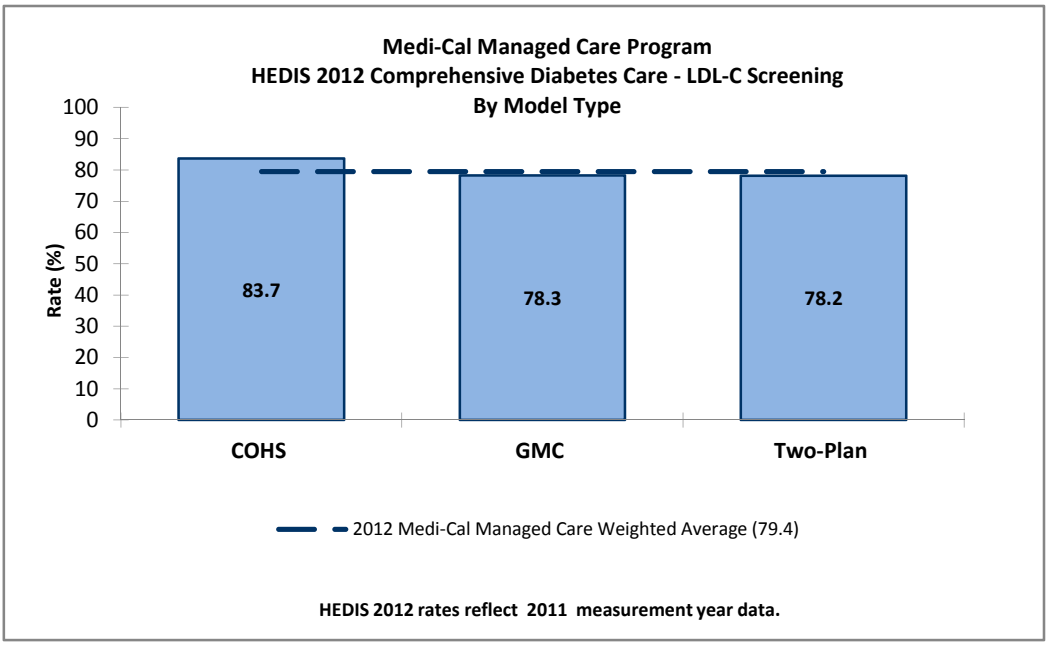
[75] Nesto, R.W. LDL Cholesterol Lowering in Type 2 Diabetes: What Is the Optimum Approach? *Clinical Diabetes*. 2008. Available at: http://clinical.diabetesjournals.org/content/26/1/8.full Accessed on: April 3, 2012.

[76] Lab Tests Online. LDL Cholesterol. Available at: http://www.labtestsonline.org/understanding/analytes/ldl/test.html. Accessed on: April 3, 2012.

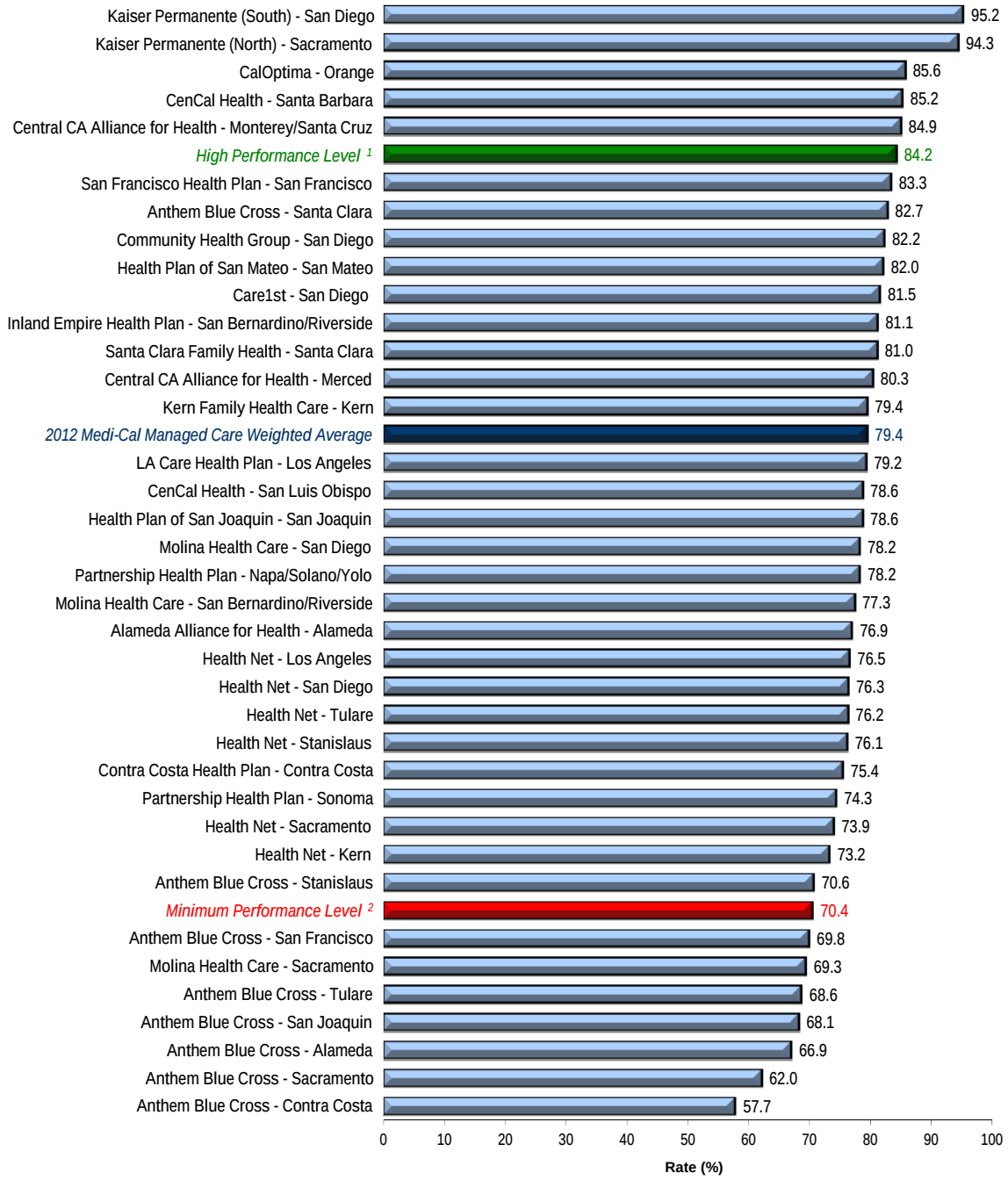
[77] Goliath. LDL in Diabetes: How Low Should They Go? Little Evidence Supports Adding a Statin or Increasing the Dose Once Your Patient Achieves an LDL of <100 mg/dL. Available at: http://goliath.ecnext.com/coms2/gi_0199-7038473/LDL-levels-in-diabetes-how.html. Accessed on: May 1, 2012.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Comprehensive Diabetes Care—LDL-C Screening



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Comprehensive Diabetes Care—LDL-C Screening* had no significant change from 2011 to 2012. The program's 2012 weighted average was above the national Medicaid average but below the national commercial average from 2009 to 2011.

The COHS remained consistent with previous years as the highest-scoring model type, while the GMC and Two-Plan models performed almost identically at 78 percent.

High and Low Performers

Five rates performed above the HPL in 2012, compared to seven in 2011. Also, seven performed below the MPL in 2012.

Two rates had statistically significant increases from 2011 to 2012, demonstrating performance similar to the previous 2010–2011 reporting period when two rates also had statistically significant increases. There were no reported rates with significantly significant decreases in 2012 (refer to Appendix B).

Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)

Measure Definition

The *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure calculates the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) whose most recent LDL-C test (performed during the measurement year) indicated an LDL-C level less than 100 mg/dL.

Importance

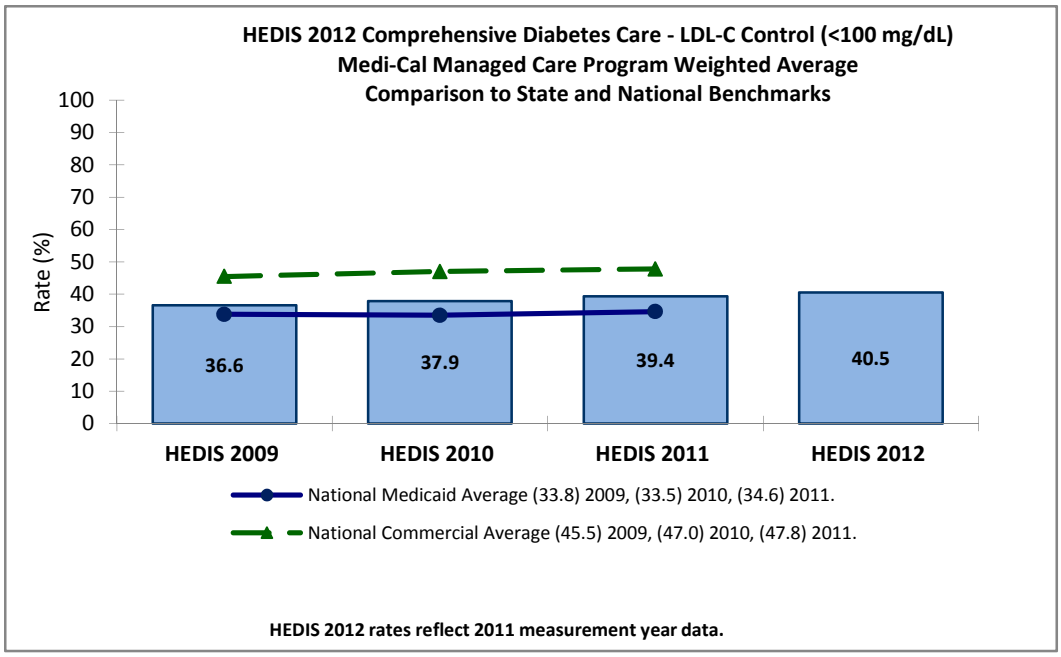
Patients with diabetes have a two to three times greater risk of cardiovascular mortality compared to patients who are non-diabetics.[78] Therefore, maintaining a desirable LDL-C level is important because it can decrease the risk of cardiovascular complications in individuals with diabetes.

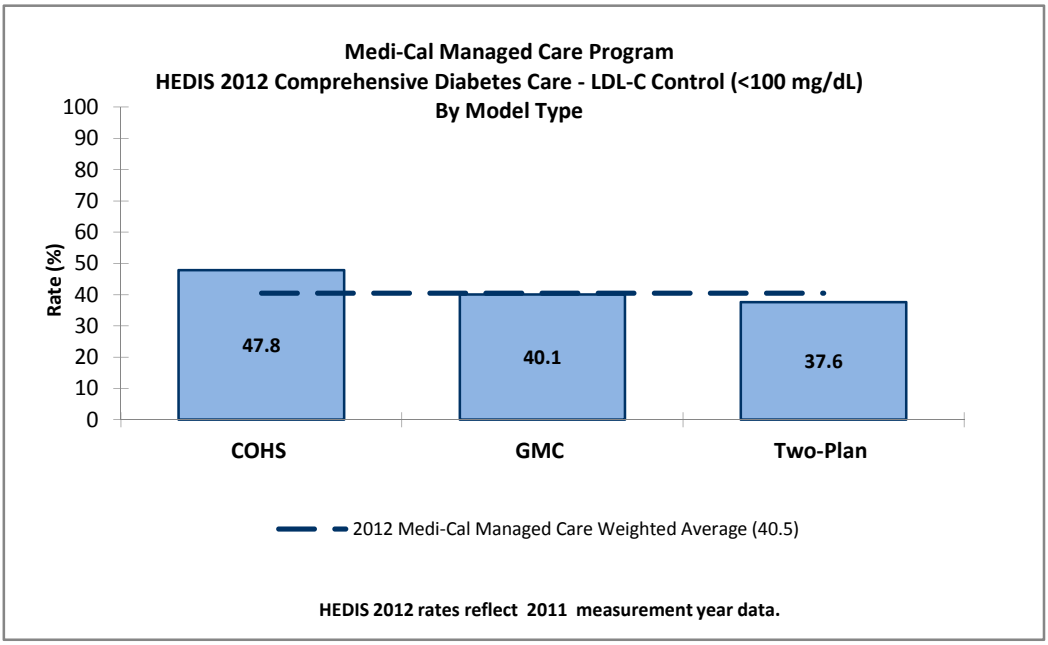
A 30 percent reduction in LDL-C levels has been shown to reduce major vascular events by approximately 25 percent, regardless of the baseline LDL.[79]

[78] Goliath. LDL in Diabetes: How Low Should They Go? Little Evidence Supports Adding a Statin or Increasing the Dose Once Your Patient Achieves an LDL of <100 mg/dL. Available at: http://goliath.ecnext.com/coms2/gi_0199-7038473/LDL-levels-in-diabetes-how.html Accessed on: April 3, 2012.

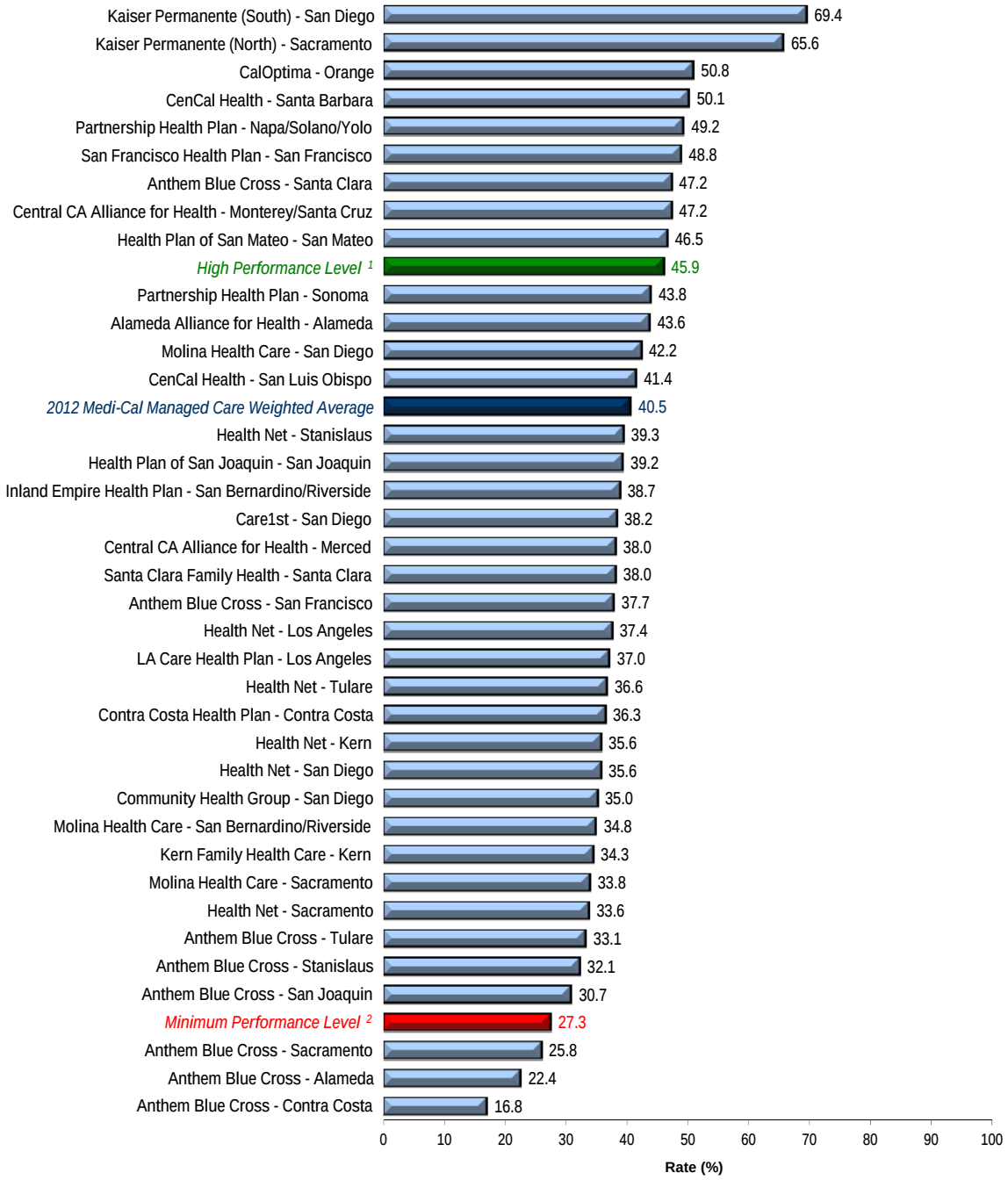
[79] Ibid.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure has shown steady improvement year over year since 2009. The weighted average has been above the national Medicaid average from 2009 through 2012 but below the national commercial average during the same time frame.

Just as in 2011, the COHS model type ranked highest of the three model types, followed by the GMC and Two-Plan model types.

High and Low Performers

Nine rates performed above the established HPL for this measure in 2012, compared to twelve in 2011. Three rates fell below the MPL, compared to two in 2011, they were Anthem Blue Cross—Sacramento, Alameda, and Contra Costa counties. Contra Costa showed the poorest performance in 2012, and was the only repeat county from 2011 to fall below the MPL.

Four rates had statistically significant increases from 2011 to 2012, and two had a statistically significant decrease within the same time frame. Santa Clara Family Health Plan—Santa Clara County had the largest significant decrease in performance of 13.3 percentage points (refer to Appendix B).

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

Measure Definition

The *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who had an eye screening for diabetic retinal diseases (i.e., a retinal exam by an eye care professional) or a negative retinal exam in the year prior to the measurement year.

Importance

High blood sugar levels increase diabetics' risk of eye complications.[80] The three most common eye complications in diabetics are retinopathy, cataracts, and glaucoma.[81] Diabetics have an increased chance of 60 percent of obtaining cataracts over non-diabetics.[82] Furthermore, diabetics are 40 percent more likely to have glaucoma than those without diabetes. The risk of getting glaucoma increases with age and the length of time someone has diabetes.[84]

Detecting and treating diabetics with an eye disease can reduce the development of severe vision loss by approximately 50 to 60 percent. While most eye complications are minor, diabetics are at an increased risk of blindness.[83] Diabetes is the leading cause of blindness for adults between 20 and 74 years of age.[84] Diabetic retinopathy accounts for approximately 12,000 to 24,000 new cases of blindness every year.[85]

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80 National Diabetes Information Clearinghouse. *National Diabetes Statistics, 2011*. Available at: http://diabetes.niddk.nih.gov/DM/PUBS/statistics/ Accessed May 1, 2012.

81 WebMD. *Eye Problems and Diabetes*. Available at: http://diabetes.webmd.com/eye-problems Accessed May 1, 2012.

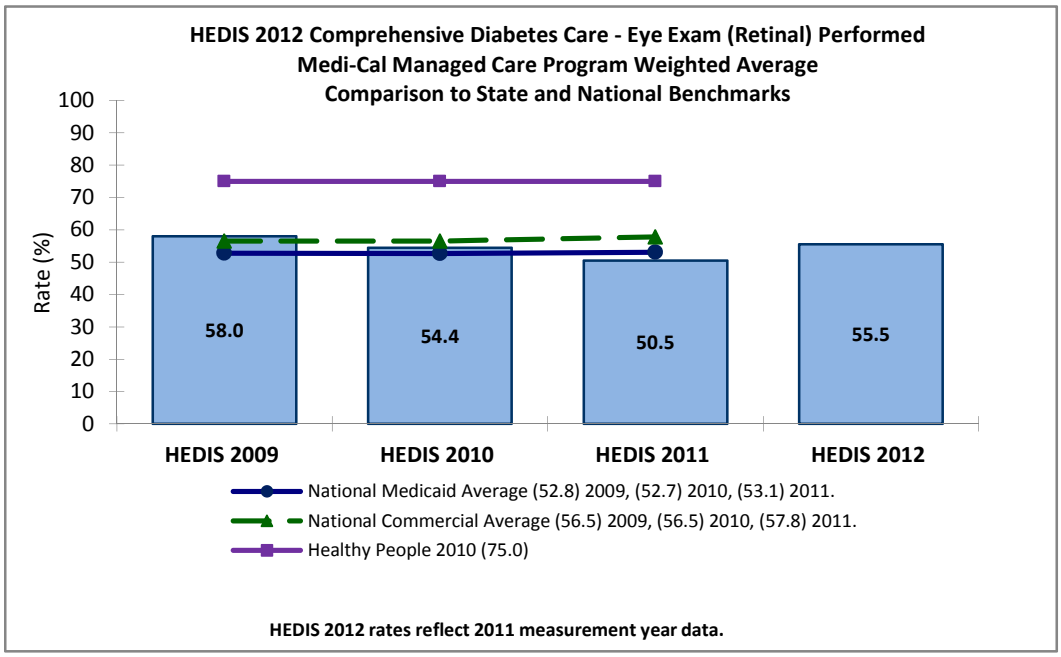
82 American Diabetes Association. *Eye Complications*. Available at: http://www.diabetes.org/living-with-diabetes/complications/eye-complications. Accessed May 1, 2012.

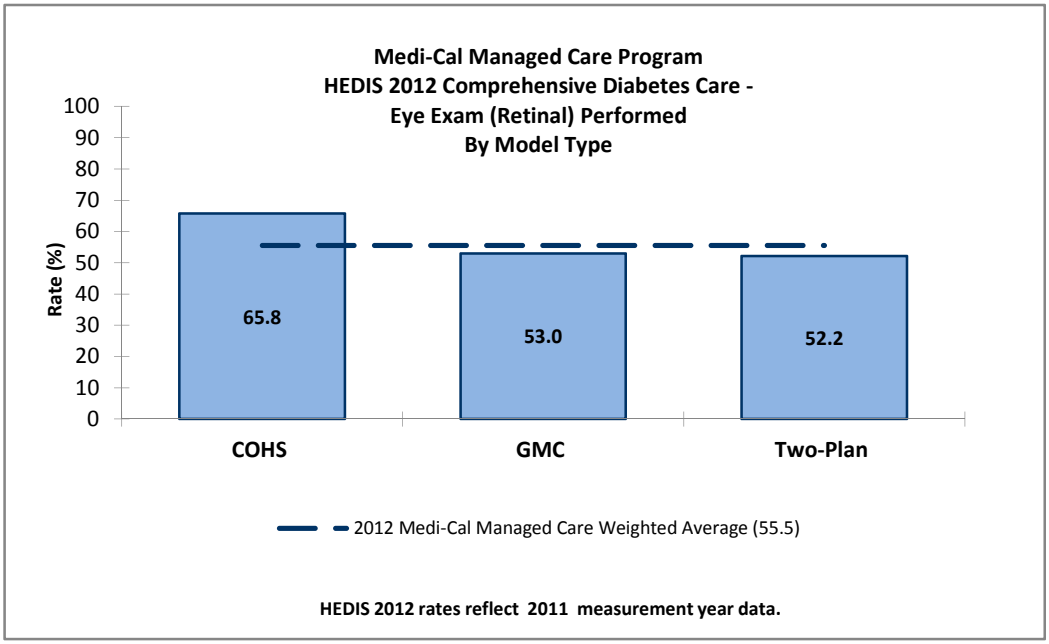
83 2011 National Diabetes Fact Sheet. *Diagnosed and undiagnosed diabetes in the United States, all ages, 2010*. Available at: http://www.cdc.gov/diabetes/pubs/estimates11.htm. Accessed on: September 4, 2012.

84 WebMD. *Eye Problems and Diabetes*. Available at: http://diabetes.webmd.com/eye-problems. Accessed on: May 1, 2012.

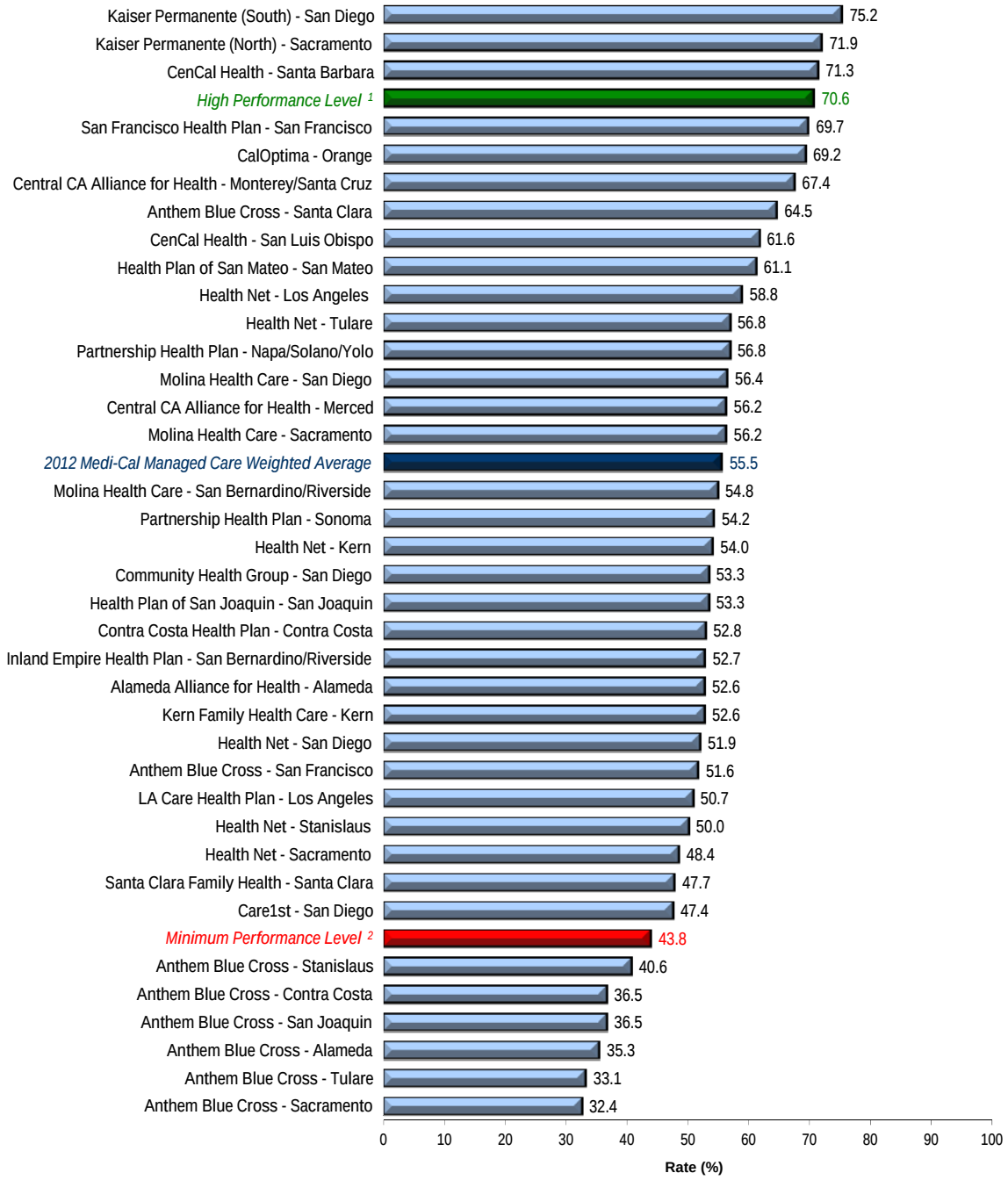
85 National Diabetes Information Clearinghouse. *National Diabetes Statistics, 2007*. Available at: http://diabetes.niddk.nih.gov/DM/PUBS/statistics/. Accessed May 1, 2012.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Comprehensive Diabetes Care—Eye Exam (Retinal) Performed



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure increased by 5 percentage points in 2012. The weighted average performed above the 2011 national Medicaid average but below the 2011 national commercial average.

The COHS model type outperformed the GMC and Two-Plan model types in 2012 by over 12 percentage points.

High and Low Performers

Three rates reported by Kaiser Permanente–South—San Diego County, Kaiser Permanente–North—Sacramento County, and CenCal Health—Santa Barbara County performed above the established HPL, while six Anthem Blue Cross counties performed below the MPL in 2012.

Twelve rates had a statistically significant increase from 2011 to 2012; and only one rate had a statistically significant decrease during the same time frame. During the previous measurement period, 10 rates had a statistically significant decline in performance (refer to Appendix B).

Comprehensive Diabetes Care—Medical Attention for Nephropathy

Measure Definition

The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure is intended to assess whether diabetic patients are being monitored for nephropathy (kidney disease). It reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who were screened for nephropathy or who received treatment for nephropathy. The rate includes patients who have been screened for nephropathy or who already have evidence of nephropathy.

Importance

Clinical Importance of Nephropathy in CDC

Nephropathy refers to damage or disease of the kidney. Diabetes has been shown to be a leading cause of kidney failure and end-stage renal disease (ESRD), and 20 to 30 percent of diabetics will develop evidence of nephropathy.[86,87] In the U.S., diabetic nephropathy accounts for approximately 40 percent of all new cases of ESRD. While nephropathy is more common in patients with Type 1 diabetes, the higher prevalence of patients with Type 2 diabetes accounts for a greater number of Type 2 diabetics on dialysis to treat kidney failure. Over half of the diabetics on dialysis have Type 2 diabetes. For patients with Type 2 diabetes, Native Americans, Hispanics, and African Americans are at a greater risk of developing ESRD.[88,89] In 2005, 46,739 diabetics began ESRD treatment in the U.S. and Puerto Rico, and 178,689 diabetics were living on chronic dialysis or with a kidney transplant.[90]

Furthermore, nephropathy is associated with increased risks for hypertension and high cholesterol.[91] Blood sugar control reduces the risk of microalbuminuria (having small amounts of protein in the urine) by one-third and reduces the risk of microalbuminuria progressing by 50 percent. It has also been shown that tight control of blood sugar may even reverse microalbuminuria.[92]

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86 Andersen, A.R., Sandahl Christiansen, J., Andersen, J.K., Kreiner, S., Deckert, T. Diabetic Nephropathy in Type 1 (Insulin-Dependent) Diabetes: An Epidemiological Study. *Diabetologia.* 2004. Available at: http://www.springerlink.com/content/p18342661010n640/ Accessed on: May 1, 2012.

87 National Kidney and Urologic Diseases Information Clearinghouse. *IgA Nephropathy*, Available at: http://kidney.niddk.nih.gov/kudiseases/pubs/iganephropathy/. Updated September 2010. Accessed on: May 1, 2012.

88 American Diabetes Association. Nephropathy in Diabetes. *Diabetes Care.* 2004. Available at: http://care.diabetesjournals.org/content/27/suppl_1/s79.full. Accessed on: May 1, 2012.

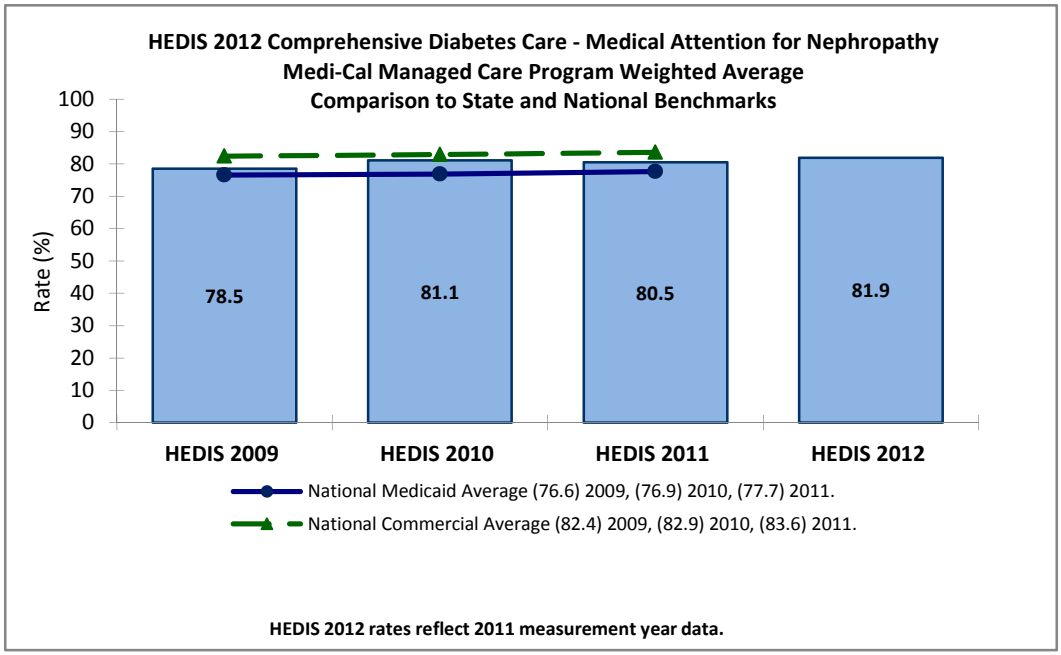
89 National Kidney and Urologic Diseases Information Clearinghouse. *IgA Nephropathy*, Available at: http://kidney.niddk.nih.gov/kudiseases/pubs/iganephropathy/. Updated September 2010. Accessed on: May 1, 2012.

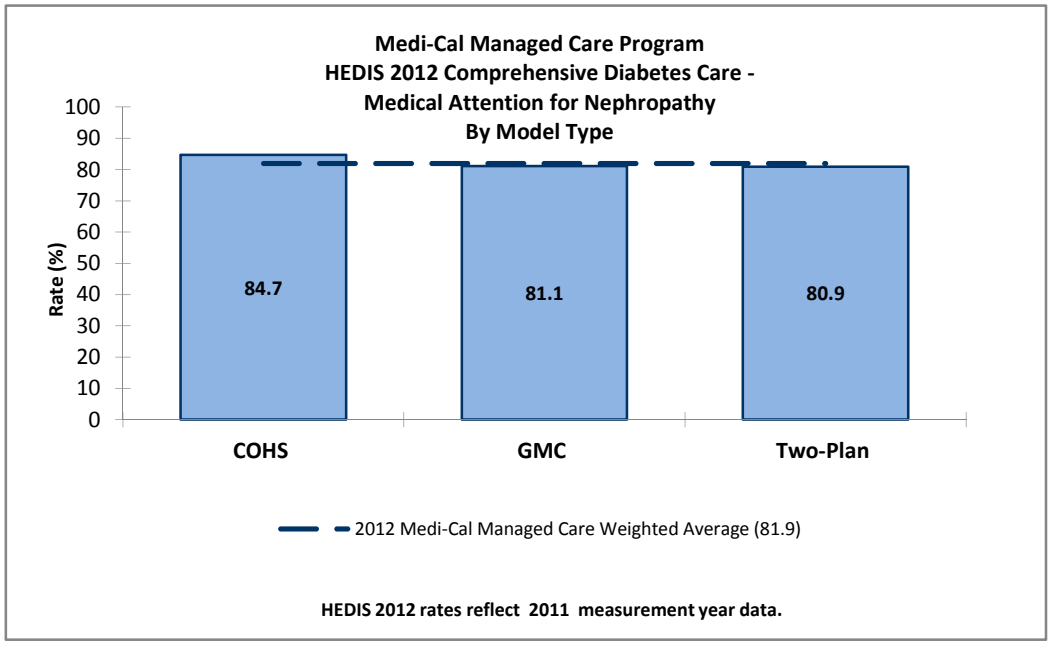
90 American Diabetes Association. Diabetes Statistics. 2011. Available at: http://www.diabetes.org/diabetes-basics/diabetes-statistics/. Accessed on: May 1, 2012.

91 National Kidney and Urologic Diseases Information Clearinghouse. *IgA Nephropathy*, Available at: http://kidney.niddk.nih.gov/kudiseases/pubs/iganephropathy/. Updated September 2010. Accessed on: May 1, 2012.

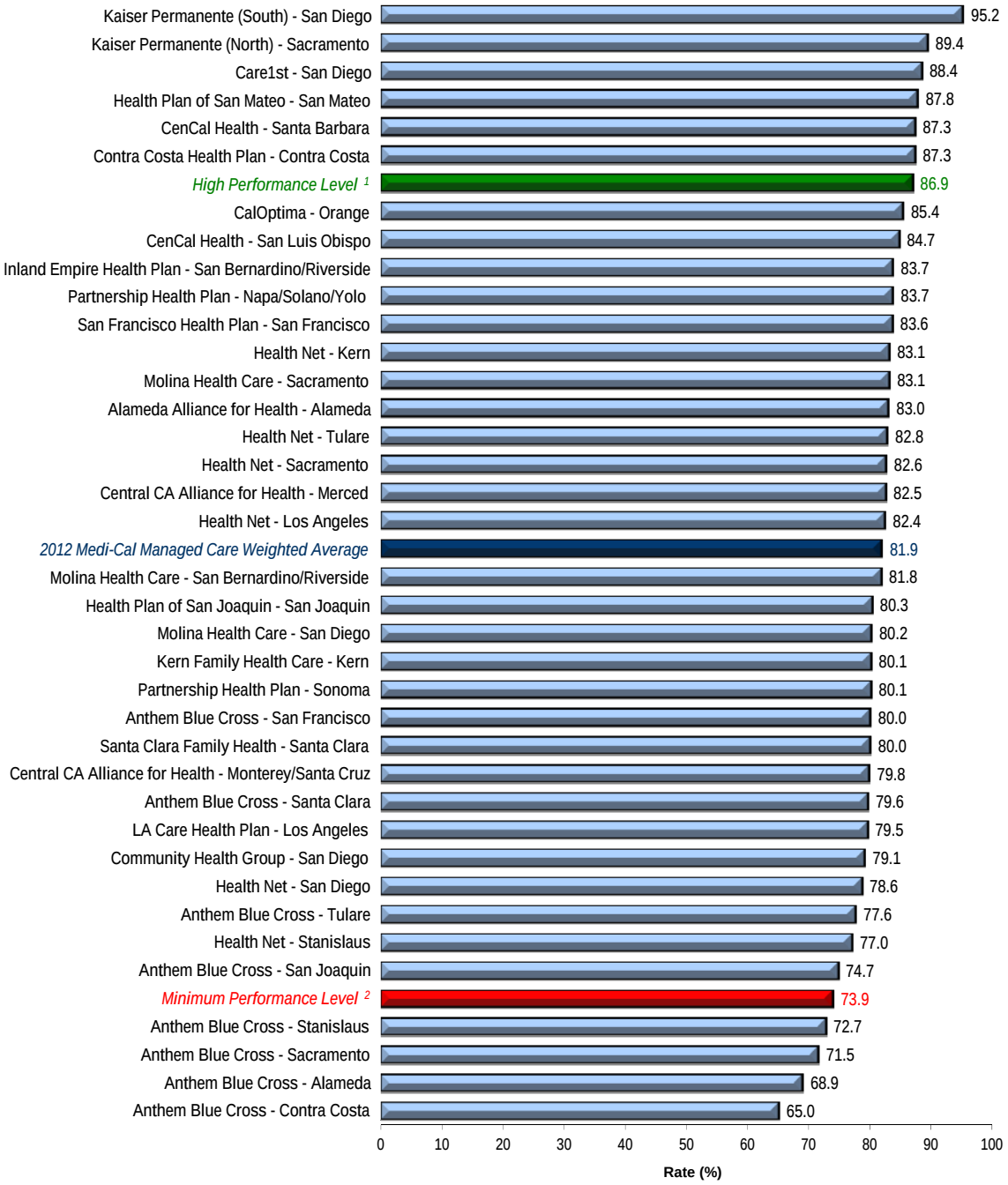
92 Ibid.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Comprehensive Diabetes Care—Medical Attention for Nephropathy



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure had a slight increase in performance over 2011's results. The program's weighted average has remained above the national Medicaid average from 2009 through 2012. The 2012 weighted average fell just below the 2011 national commercial average of 83.6 percent.

The COHS model type outperformed the GMC and Two-Plan model types for 2012 just as it did in 2011.

High and Low Performers

Six rates exceeded the HPL, and four rates fell below the MPL in 2012; the same number of rates exceeded and fell below these performance levels in 2011. Kaiser Permanente–South—San Diego County, Contra Costa Health Plan—Contra Costa County, and Health Plan of San Mateo—San Mateo County all maintained performance above the HPL from 2011 and 2012. Conversely, Anthem Blue Cross—Sacramento, Alameda, and Contra Costa counties have all remained below the MPL for three consecutive years. Note that all of the reported rates that performed below the MPL were Anthem Blue Cross counties.

Six rates had statistically significant increases in rates from 2011 to 2012, and there were no rates that had a statistically significant decrease (refer to Appendix B).

Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)

Measure Definition

The *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure is intended to assess whether the blood pressure of diabetic patients is being monitored. It reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who had a blood pressure reading of <140/90 mm Hg.

Importance

High blood pressure (i.e., hypertension) is one of the leading complications of diabetes.[93] Two-thirds of diabetics have hypertension. Diabetics are at an increased risk for developing hypertension due to the affect diabetes has on a person's arteries, which can increase the risk of heart attack and stroke.[94,95] A person who has a combination of diabetes and hypertension is four times more likely to develop heart disease than someone who does not have either condition.[96,97,98] Furthermore, people with diabetes are two to four time more likely to have a stroke than non-diabetics. Other complications from high blood pressure include:

- Enlargement of the heart which may lead to heart failure.
- Formation of aneurysms in blood vessels throughout the body (e.g., heart, brain, legs, intestines, and spleen).
- Narrowing of the blood vessels in the kidney which may lead to kidney failure.
- Hardening of the arteries throughout the body (e.g., heart, brain, kidneys, and legs) which may lead to heart attack, stroke, kidney failure, or amputation.
- Bursting or bleeding of blood vessels in the eyes, which may cause vision changes and can ultimately result in blindness.

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93 American Diabetes Association. *High Blood Pressure (Hypertension).* Available at: http://www.diabetes.org/living-with-diabetes/complications/high-blood-pressure-hypertension.html. Accessed on: May 1, 2012.

94 WebMD. *Diabetes and High Blood Pressure.* Available at: http://www.webmd.com/hypertension-high-blood-pressure/guide/high-blood-pressure Reviewed on: May 2012. Accessed on: May 1, 2012.

95 National Diabetes Information Clearinghouse. *National Diabetes Statistics, 2011.* Available at: http://diabetes.niddk.nih.gov/DM/PUBS/statistics/. Accessed on: May 1, 2012.

96 Ibid.

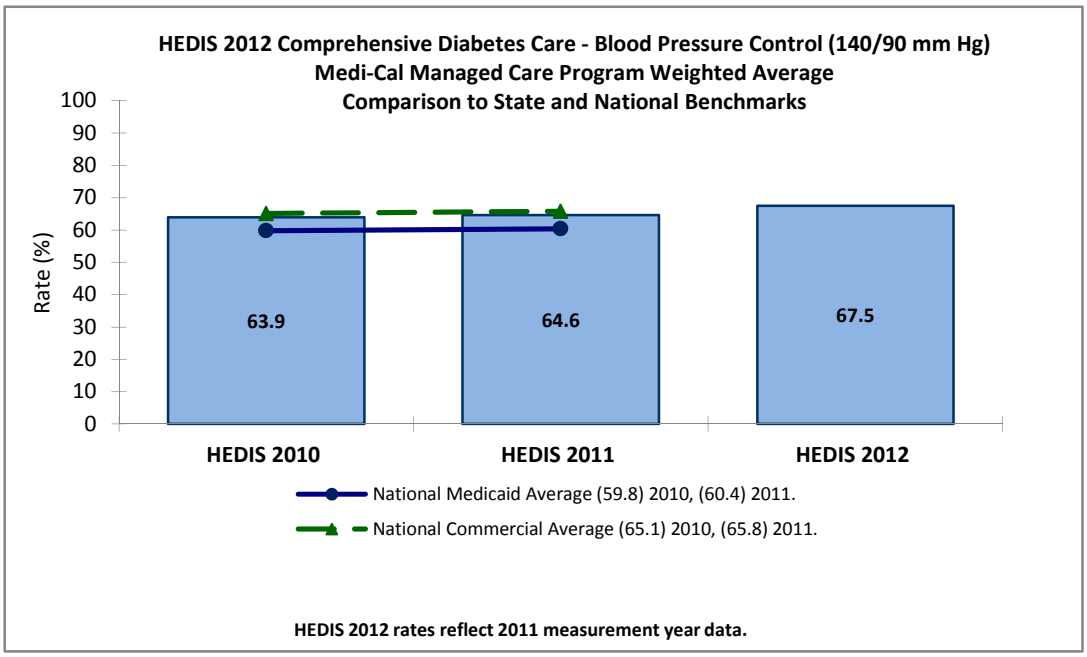
97 American Diabetes Association. *High Blood Pressure (Hypertension).* Available at: http://www.diabetes.org/living-with-diabetes/complications/high-blood-pressure-hypertension.html. Accessed on: May 1, 2012.

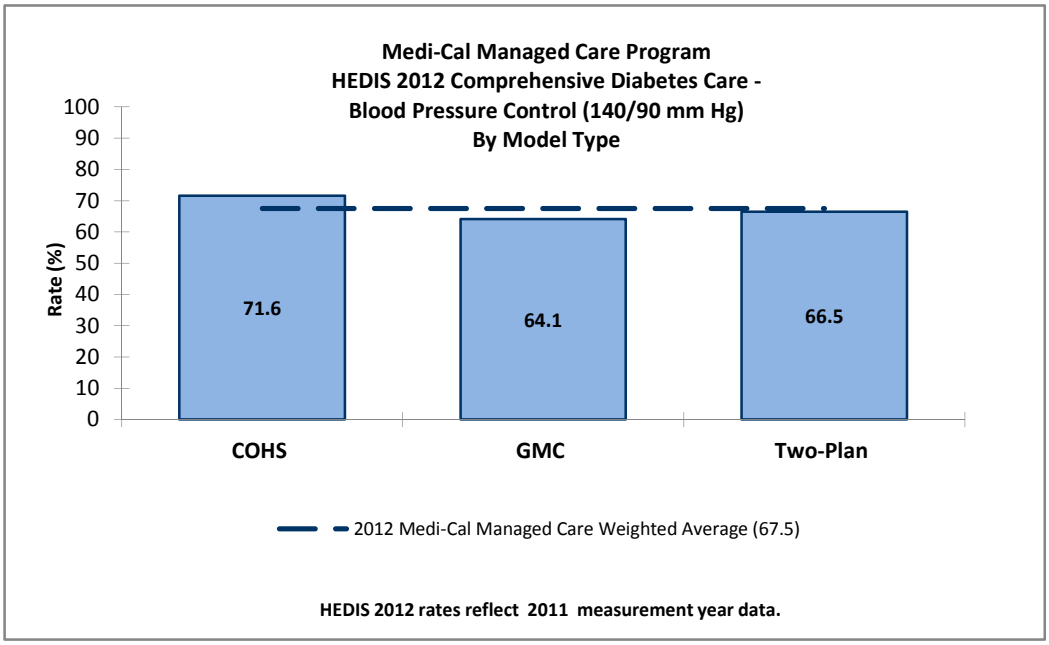
98 New York-Presbyterian. *Diabetes and High Blood Pressure.* 2008. Available at: http://nyp.org/health/diabetes-hpb.html. Accessed on: May 1, 2012.

By controlling blood pressure, the occurrence of these complications is lowered. Blood pressure control in diabetics reduces the risk of heart disease and stroke by 33 and 50 percent, respectfully. Additionally, blood pressure control reduces the risk of microvascular complications (e.g., eye, kidney, and nerve diseases) by approximately 33 percent. In early treatment of diabetic kidney disease, the decline in kidney function decreases by 30 to 70 percent when blood pressure is controlled. For every 10 mm Hg reduction in systolic blood pressure, the risk for any complication related to diabetes is decreased by 12 percent.[99]

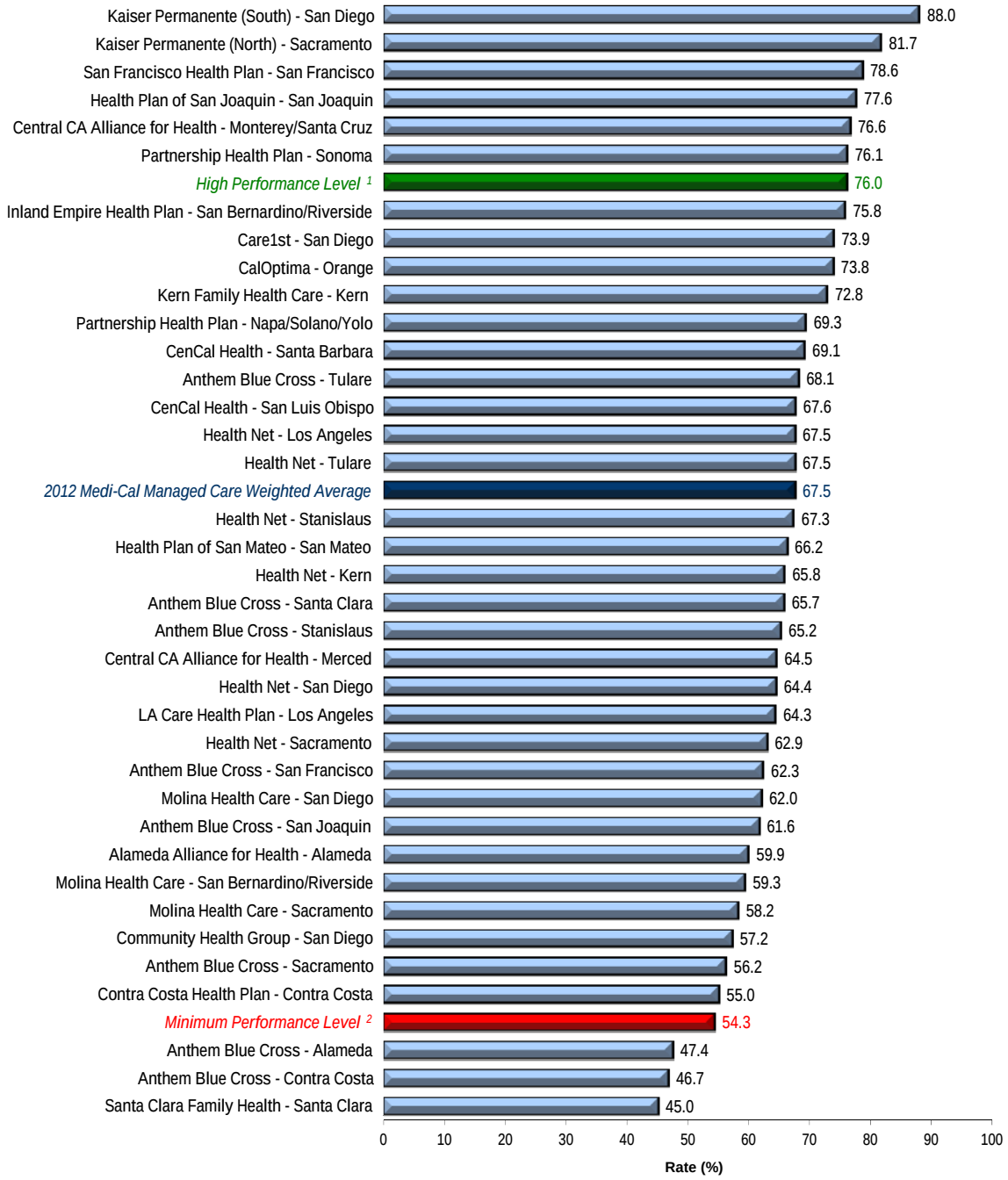
[99] National Diabetes Information Clearinghouse. National Diabetes Statistics, 2011. Available at: http://diabetes.niddk.nih.gov/DM/PUBS/statistics/. Accessed on: May 1, 2012.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure was 67.5 percent in 2012, an approximate three-percentage-point improvement over 2011's results. The weighted average was higher than both the national Medicaid average and the national commercial average in 2012.

The COHS model type outperformed the GMC and Two-Plan model types, and the performance of each model type remained consistent with their 2011 results.

High and Low Performers

Six rates scored higher than the HPL in 2012 (Kaiser Permanente—Sacramento and San Diego counties, Central CA Alliance for Health—Monterey/Santa Cruz counties, Partnership Health Plan—Sonoma County, Health Plan of San Joaquin—San Joaquin County, and San Francisco Health Plan—San Francisco County). Three rates fell below the MPL in 2012 as opposed to one in 2011. These three were: Anthem Blue Cross—Alameda and Contra Costa counties and Santa Clara Family Health Plan—Santa Clara County.

Seven rates had statistically significant increases in rates from 2011 to 2012, while five plans had a statistically significant decline. Note that Partnership Health Plan—Sonoma County had the largest increase of 13.9 percentage points and Santa Clara Family Health Plan—Santa Clara County had the largest decrease of 17.7 points (refer to Appendix B).

Comprehensive Diabetes Care—Best and Emerging Practices

Quality improvement projects should aim to eliminate barriers associated with improving any combination of diabetes-related health care factors. Successful improvement projects have implemented interventions that manage other chronic disease measures and/or employed unique methods and tools developed specifically for a particular population of chronically ill members.

Support Groups

Support groups are programs that operate under the idea that patients can learn to take responsibility for day-to-day disease management. These group meetings may be face-to-face or via the Internet. Support group programs focus on teaching patients with chronic health problems to manage their own care (i.e., self-care), providing emotional support, and offering other types of support (e.g., getting groceries and medical transportation).

Using support groups can increase patients' knowledge about their condition, as well as assist in improving compliance with prescribed treatment. Additionally, patients who participate in support groups have been shown to have improved health status while using fewer health care resources.

Anecdotal evidence shows such programs also may have a positive correlation to long-term health outcomes. The following improvements have been seen with support groups:

- Increased communication with physicians.
- Improved self-reported health.
- Enhanced social/role activities.
- Reduced need for hospitalizations.

Evidence further suggests that other factors such as pain and psychological well-being have significant improvements in the long-term with the help of support groups. Support groups also have significant correlation with cost savings. These groups also allow patients to become more confident in caring for themselves.

Support groups have proven to be helpful for diabetics when it comes to controlling blood glucose levels, blood pressure, and blood lipids. Additionally, those in support groups tend to receive preventive care in a more timely manner.[100]

Healthy Eating and Weight-Loss Programs

Healthy eating programs teach diabetics how to efficiently adjust and monitor their own diet. Research has shown healthy eating programs are effective in reducing the risk of developing high blood pressure and lowering blood pressure in those patients who currently have high blood pressure.[101] Healthy eating also reduces the risks of heart disease, high cholesterol, and stroke.[102]

Weight loss programs offer a structured framework in which diabetics can work together to lose weight and provide solutions for lifestyle changes (e.g., increased physical activity) that will result in weight loss. Many times weight loss programs are offered in collaboration with a healthy eating program. Research has shown that health can be improved in many ways by losing weight, including, but not limited to:[103,104]

- Lowered cholesterol.
- Reduced blood pressure.
- Prevention of angina and chest pain.
- Decreased risk of heart disease and stroke.

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[100] Agency for Healthcare Research and Quality. *The CAHPS Improvement Guide*. Available at: http://www.cahps.ahrq.gov/qiguide/. Accessed on: October 3, 2011. Note–not available as of 6/27/12 until new contract awarded.

[101] National Diabetes Information Clearinghouse. *What I Need to Know About Eating and Diabetes*. 2007. Available at: http://diabetes.niddk.nih.gov/dm/pubs/eating_ez/index.htm. Accessed on: May 1, 2012.

[102] American Diabetes Association. *High Blood Pressure (Hypertension)*. Available at: http://www.diabetes.org/living-with-diabetes/complications/high-blood-pressure-hypertension.html. Accessed on: May 1, 2012.

[103] National Diabetes Information Clearinghouse. *What I Need to Know About Eating and Diabetes*. 2007. Available at: http://diabetes.niddk.nih.gov/dm/pubs/eating_ez/index.htm. Accessed on: May 1, 2012.

[104] About.com. *The Health Benefits of Losing Weight*. 2012. Available at: http://weightloss.about.com/library/blhealthbenefits.htm. Accessed on: May 1, 2012.

- Prevention of acquiring Type 2 diabetes.
- Improved blood sugar levels.

Reminder Systems for Preventive Care

Research has shown that reminder systems (e.g., letters and telephone calls) are an effective method for contacting diabetics about needed preventive services and about noncompliance with prescribed treatment.[105] The use of targeted interventions is also necessary. To increase retinal eye exams, a health plan conducted a mailing of focused eye care educational materials, which consisted of three mailings sent during the year to members who had not received a retinal eye examination. These mailings included a reminder written partially in blurry text to encourage members to make an appointment, reinforcing the fact that eye exams are important.[106]

Provider Education

Interventions related to provider education are more successful if they are repeated numerous times and distributed using varied modalities. Effective methods for provider education include:

- Informing providers of member incentives.
- Sending report cards to providers that document their care of diabetic members including a list of diabetic members, summary of diabetic services that they received, and a chart tool.
- Recognizing top-performing practitioners in diabetes care.
- Mailing diabetes clinical care guidelines to practitioners with an assessment tool.
- Posting diabetes clinical care guidelines to practitioners via a Web site.
- Distributing monthly newsletters to practitioners.[107]

Patient Outreach

Interventions related to patient education also are more successful if they are repeated numerous times and are distributed using varied modalities. Effective methods for patient education include:

- Identifying diabetic members in a new member welcome call assessment.
- Distributing health report cards to members with testing and result history.
- Providing incentives to members if they are compliant with all screening and testing requirements.
- Distributing quarterly newsletters with diabetes-related articles and updates.[108]

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[105] Health Services Advisory Group, Inc. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 2009.

[106] National Committee for Quality Assurance. *Quality Profiles. The Leadership Series. Focus on Diabetes.* 2008. Available at: http://www.qualityprofiles.org/leadership_series/diabetes/diabetes_prevention.asp#. Accessed on: May 1, 2012.

[107] Health Services Advisory Group, Inc. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 2009.

[108] Ibid.

Immunizations for Adolescents—Combination 1

Measure Definition

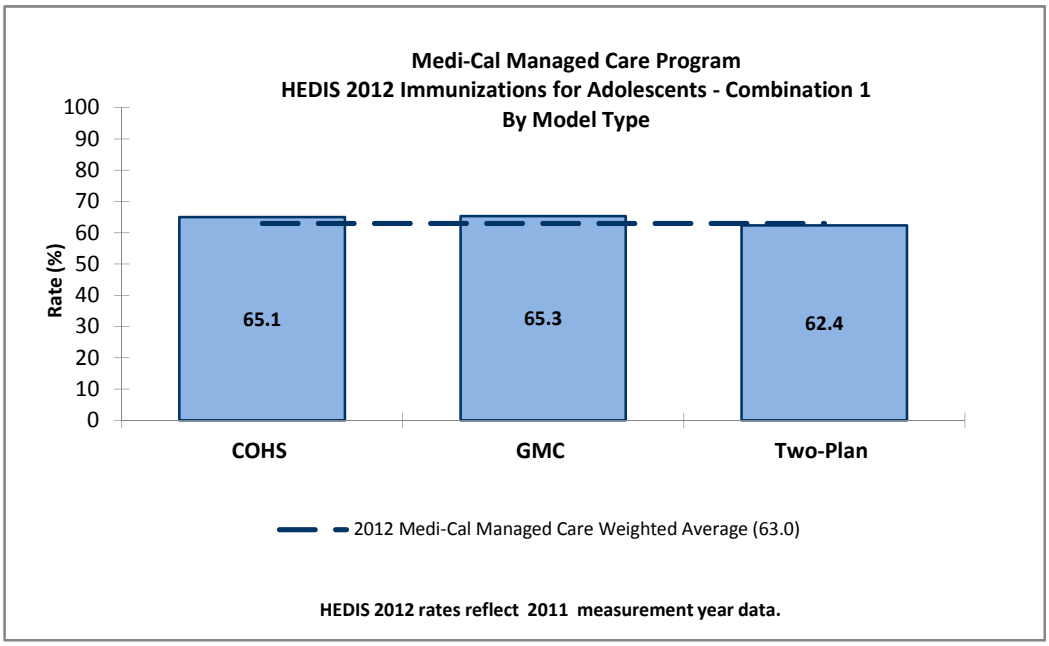
The *Immunizations for Adolescents—Combination 1* measure assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Importance

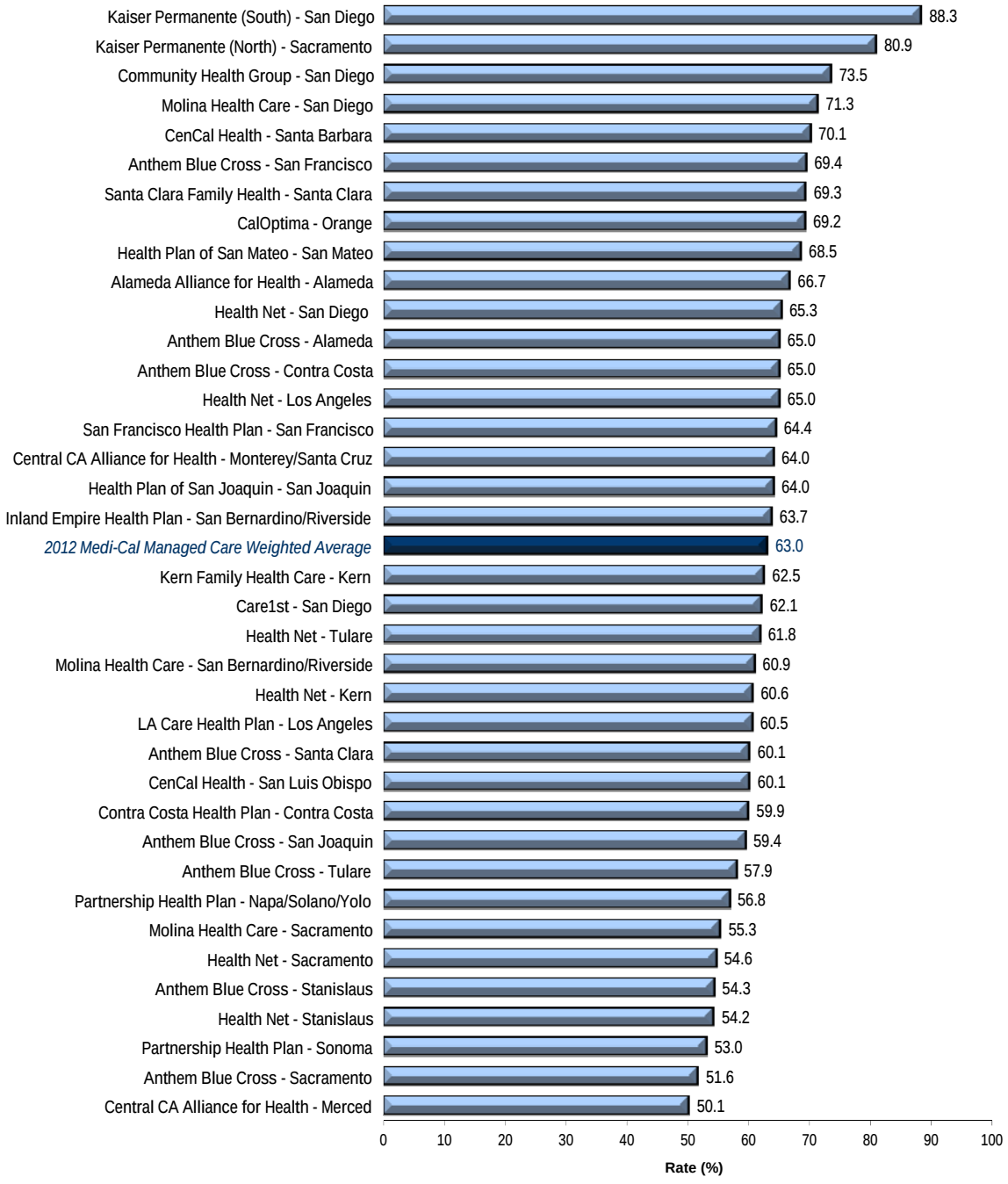
Adolescent immunization rates have historically lagged behind early childhood immunization rates in the United States. In 2000, the American Academy of Pediatrics (AAP) reported that 3 million adolescents failed to receive at least one recommended vaccination. Low immunization rates among adolescents have the potential to cause outbreaks of preventable diseases and to establish reservoirs of disease in adolescents that can affect other populations including infants, the elderly, and individuals with chronic conditions. Immunization recommendations for adolescents have changed in recent years. In addition to assessing for immunizations that may have been missed, there are new vaccines targeted specifically to adolescents.

This measure follows the Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations.

Performance Results



Medi-Cal Managed Care
HEDIS 2012 Immunizations for Adolescents—Combination 1



The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year the DHCS required the measure.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MPL and HPL are not applied to a measure (1) when the DHCS opts not to apply them, (2) in the first year of significant changes to a measure's technical specifications, or (3) in the first year the DHCS requires the measure. The first year that DHCS reported *Immunizations for Adolescents—Combination 1 (IMA-1)* was 2012; therefore, there were no established HPLs and MPLs for this measure.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

Measure Definition

The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure calculates the percentage of women who delivered a live birth who received a prenatal care visit as a member of the plan in the first trimester or within 42 days of enrollment in the plan.

Importance

Effective prenatal care aids in the identification of high-risk pregnancies and provides educational opportunities to prevent subsequent poor birth outcomes.[109] Timely and frequent prenatal care visits allow health problems to be detected early. A lack of timely prenatal care may indicate weak therapeutic alliances, lack of peer support, hesitation regarding health plans, and residential instability throughout the gestational period.[110] Studies reveal that women in the U.S. who are at risk for inadequate prenatal care are more likely to be non-Caucasian, not a high school graduate, enrolled in Medicaid, unmarried, a smoker, a drug user, and under 20 years of age.[111] Socioeconomic status is a determinant of health outcomes, including poor birth outcomes.[112] Socioeconomic factors that present barriers to consistent care are common in the Medicaid populations. Due to this lack of care, poor birth outcomes are particularly high among these populations.[113] Studies revealed that receiving timely prenatal care is associated with the timing of Medicaid coverage.[114] In 2008, only 82 percent of Medicaid members received timely prenatal care, compared to approximately 92 percent for members in commercial plans.[115]

In contrast to women who received prenatal care, women who did not receive prenatal care were three to four times more likely to die from complications of pregnancy and were three times more likely to have an infant death. When comparing the infant mortality rate for women who had timely prenatal care and those that did not, the infant mortality rate was five times greater.

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109 National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington DC: NCQA, 2009.

110 Tough, S., Siever, J., Johnson, D. "Retaining Women in a Prenatal care Randomized Controlled Trial in Canada: Implications for Program Planning." BMC Public Health 2007, 7: 148.

111 Ibid.

112 Zeka, Ariana, Melly, Steve, Schwartz. "The Effects of Socioeconomic Status and Indices of Physical Environment on Reduced Birth Weight and Preterm Births in Eastern Massachusetts."

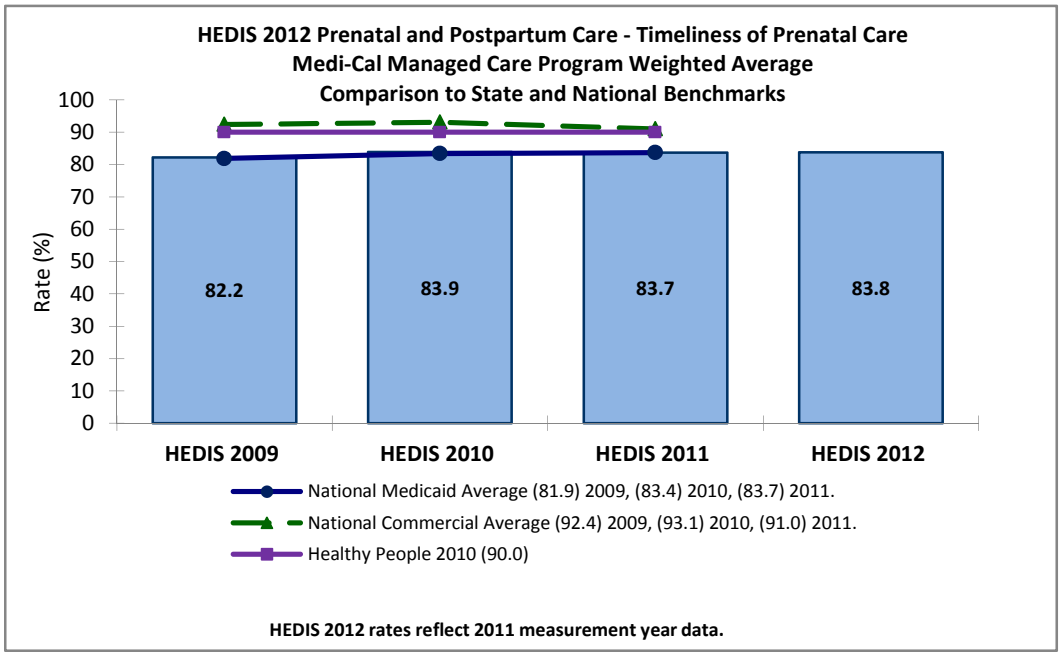
113 Shulman, Shanna. "Poor Preventive Care Achievement and Program Retention Among Low Birth Weight Infant Medicaid Enrollees." *Pediatrics*. Nov 2006. 118(5): e1509-e1515. Available at: http://pediatrics.aappublications.org/cgi/reprint/118/5/e1509 Accessed on: May 1, 2012.

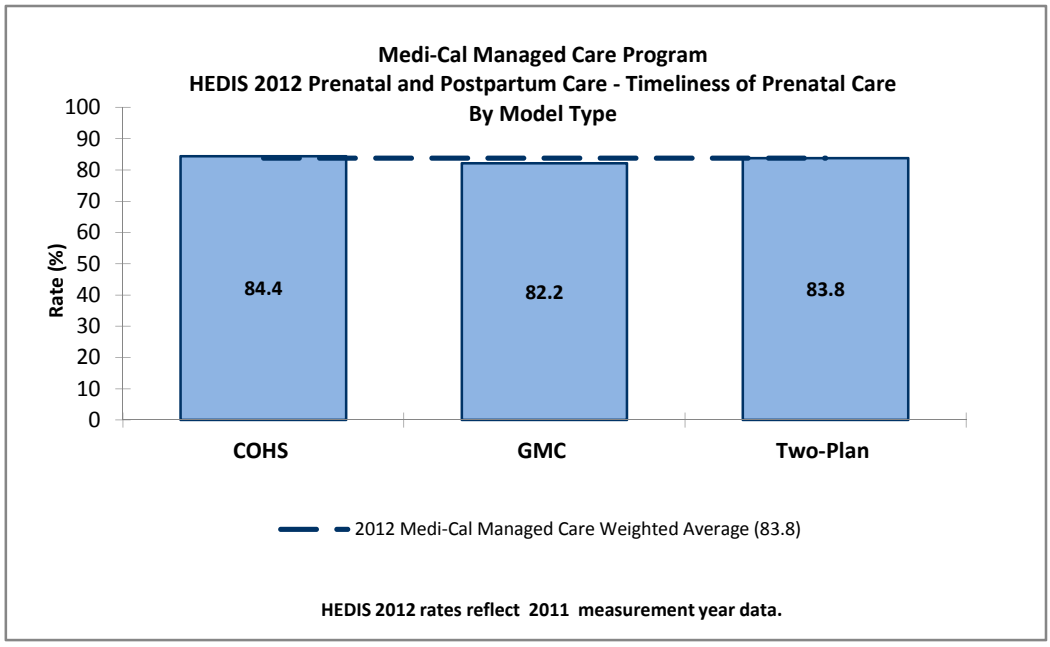
114 Gavin, N., Adams, K., Manning, W., et al. 2007 August. "The Impact of Welfare Reform on Insurance Coverage before Pregnancy and the Timing of Prenatal Care Initiation." *Health Services Research 42(4):* 1564-1588.

115 National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington DC: NCQA, 2009.

In a 2006 report, more than $26 billion in health care costs in 2005 were attributed to preterm births.[116] Further, 6,500 babies per week are born, on average, with a low birth weight. Low birth weights may be prevented by continuous prenatal care.[117]

Performance Results

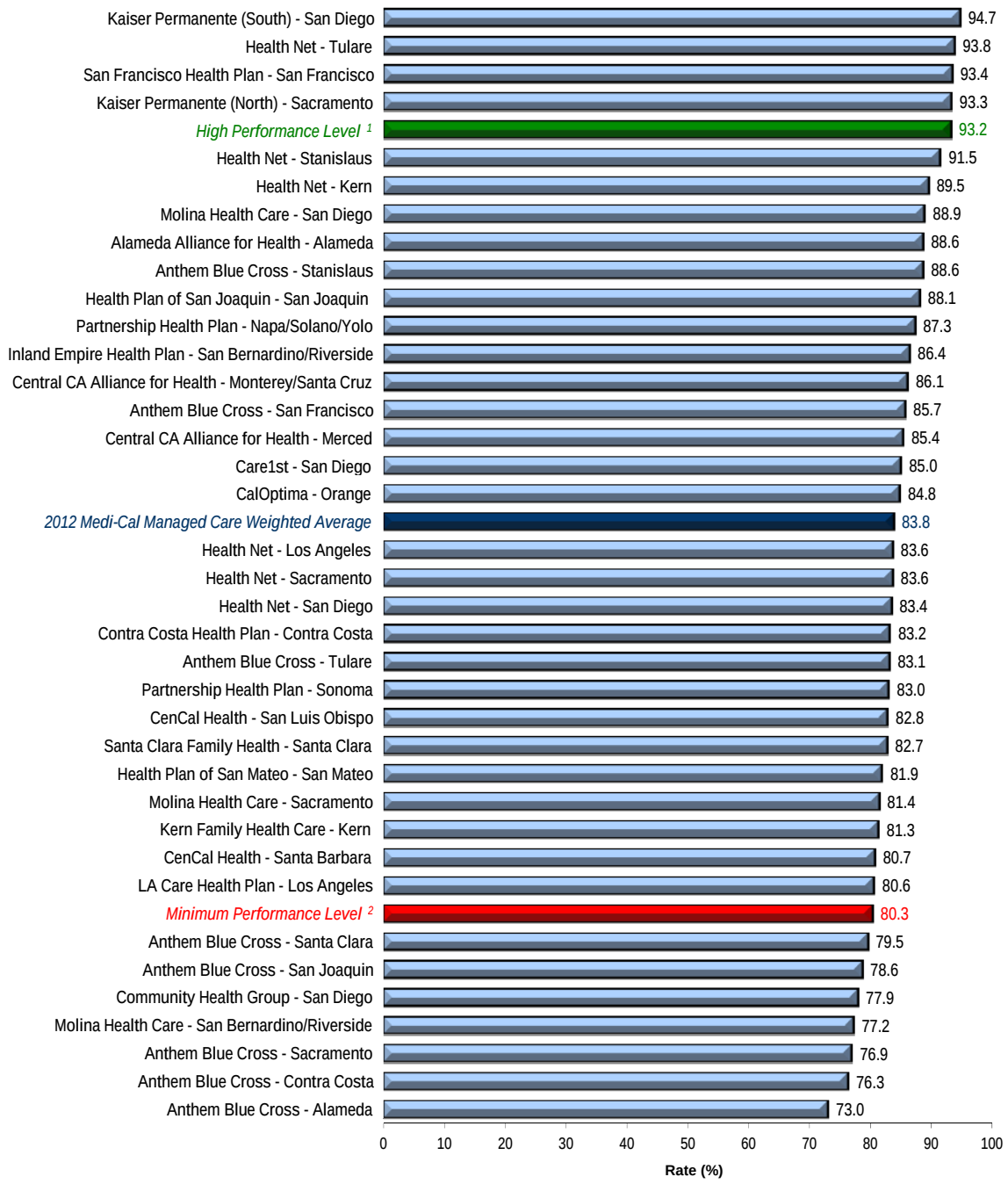




116 Institute of Medicine. Preterm Birth: Causes, Consequences, and Prevention. Report Brief. July 2006.

117 Boss, Douglas, Timbrook, Rodney. "Clinical Obstetric Outcomes Related to Continuity in Prenatal Care." *JABPF*. Nov-Dec 2001. 14(6).

Medi-Cal Managed Care
HEDIS 2012 Prenatal and Postpartum Care—Timeliness of Prenatal Care



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's 2012 weighted average for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure has remained constant over the last three years. Since 2009, the weighted average has been consistent with the national Medicaid average but below the national commercial average and the Healthy People 2010 goal.

The COHS model type slightly outperformed both the GMC and Two-Plan model types, but the difference was not significant.

High and Low Performers

Despite this measure being part of the DHCS's auto-assignment program just as it was in 2011, only four rates (Kaiser Permanente—San Diego and Sacramento counties, Health Net—Tulare County, and San Francisco Health Plan—San Francisco County) performed above the HPL in 2012. Seven rates fell below the MPL, down from 11 rates in 2011.

Seven rates demonstrated statistically significant improvement over 2011 rates, and three rates had a statistically significant decrease in 2012. One improvement of note was Alameda Alliance for Health—Alameda County; the plan had an improvement of 23.9 percentage points (refer to Appendix B).

Best and Emerging Practices

System and Provider Interventions

Educate and ensure that providers are accurately capturing prenatal care visits through the use of CPT and CPT Category II codes. The use of these codes will help to facilitate the administrative capture of prenatal visits and subsequently increase rates. One study revealed that 94 percent of members received a prenatal care visit in the first trimester based on medical record review; however, HEDIS rates only reflected that 75 percent of women received a timely prenatal care visit for the same time period evaluated. This suggests a lack of accurate and complete administrative data.[118] Working with providers to ensure that accurate data are captured may help to increase rates.

Engage Medical Directors

It is important to distribute the results of the HEDIS measures to medical directors and those staff members most intimately involved with quality improvement efforts aimed at increasing

[118] Green, D., Koplan, J., Cutler, C. "Prenatal Care In the First Trimester: Misleading Findings from HEDIS." *International Journal for Quality in Health Care*. 1999. 11(6): 465-473. Available at: http://intqhc.oxfordjournals.org/cgi/reprint/11/6/465.pdf. Accessed on: May 1, 2012.

rates. Engaging pertinent staff members will help to promote change throughout the organization. It is also important to provide staff members with benchmark data (e.g., national and state data) so they can see how their plan is performing relative to comparable entities.

Member Incentives

The State or individual health plans can offer incentives to members for completing a prenatal care visit such as baby books and car seats. Incentives help to encourage prenatal care visits.

Coordination of Care

The prenatal care measure directly links to other HEDIS measures. Plans that coordinate care and validate practice guidelines between internists, family practitioners, and obstetricians can positively affect maternal health. Incorporating alternative types of providers, such as nurses and midwives, has been associated with increased member satisfaction. Interventions that incorporate member tools for well-child visits and immunization schedules as part of the prenatal visit increase the corresponding HEDIS rates. Additionally, providing members with schedules of future screening requirements for breast and cervical cancer positively affects members' compliance with the clinical guidelines.

Streamline Maternal Health Care Services

Collaborate with providers to offer necessary prenatal care services in one place. For example, if early pregnancy tests, prenatal tests, social services, family planning, postpartum care, and parent training are all provided in the same location, this would decrease the burden on women to receive necessary care. Priority scheduling should also be offered to late-entry prenatal patients to ensure that they receive a timely prenatal care visit.

Educational Outreach Programs

Develop and implement educational outreach programs aimed at educating women who are pregnant about the importance of timely prenatal care. Educational programs can be implemented throughout the community in various settings. For example, State Medicaid agencies can disseminate information at women's health care facilities, such as family planning services and OB-GYN offices. Media campaigns can also be employed to further publicize the importance of receiving adequate care. Working with multiple contact sources will also help locate patients who need to receive prenatal care visits.[119]

[119] Tough, S., Siever, J., Johnson, D. "Retaining Women in a Prenatal care Randomized Controlled Trial in Canada: Implications for Program Planning." BMC Public Health 2007, 7: 148.

Informational mailings can be sent to members identified through administrative data who are of childbearing age. These mailings can include information on women's health, including prenatal health care visits.

Increase Funding to Improve Transportation

One potential barrier to care is the patient's inability to obtain access to consistent transportation. The State can work with stakeholders and policy makers to increase funding for transportation programs.[120] This best practice would likely result in an increase in postpartum visit rates, particularly in rural areas with less public transportation. Another option is to provide bus tokens or taxi vouchers for transportation.

Automated Appointment Scheduling and Reminders

An automated process for identifying members who have not scheduled a prenatal care visit can also be implemented. This process should identify members who may have missed a necessary prenatal care visit.

Expectant Mother Outreach Program

Create an expectant mother outreach program that involves contacting all pregnant women and asking them to participate in an expectant mother informational program. The purpose of this program is to provide expectant women with pertinent information about pregnancy, nutrition, and newborn care. It also provides an opportunity for women to ask questions regarding their pregnancy. Participants should receive a minimum of three telephone calls. However, if a woman is identified as having a high-risk pregnancy, additional telephone calls should be made.[121] Alternatively, plans are using text messages for members that prefer that method of communication.

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[120] Tough S, Siever J, and Johnson D. "Retaining Women in a Prenatal care Randomized Controlled Trial in Canada: Implications for Program Planning." BMC Public Health 2007, 7: 148.

[121] National Committee for Quality Assurance. *Check-Ups After Delivery: Improving Program Participation.* Quality Profiles: Women's Health Case Studies. 2009.

Prenatal and Postpartum Care—Postpartum Care

Measure Definition

The *Prenatal and Postpartum Care—Postpartum Care* measure reports the percentage of women who delivered a live birth who completed a postpartum visit between 21 days and 56 days after delivery.

Importance

Postpartum care is an important determinant of quality health care outcomes for women giving birth. Since medical complications can occur after a woman has given birth, postpartum visits can address any adverse effects that giving birth had on a woman's body, such as persistent bleeding, inadequate iron levels, blood pressure, pain, emotional changes, and infections. For example, heavy bleeding can be an indicator of a retained placenta, uterine atony, lacerations, hematoma, or coagulation disorders. However, socioeconomic factors that present barriers to consistent care are common in the Medicaid populations. In 2008, almost 82 percent of members enrolled in commercial health plans received timely postpartum care; however, only 63 percent of Medicaid members received timely postpartum care.[122]

Postpartum depression is one of the most prevalent complications that can occur after delivery. Approximately 30 to 70 percent of women experience postpartum sadness immediately after delivery (i.e., within the first week).[123] An estimated 10 percent of these women suffer from postpartum depression for which a postpartum care visit is needed.[124] This figure increases to 25 percent if the woman has a history of postpartum depression.[125] Postpartum depression has been associated with marital happiness, mother-child relationship, and infant behavior.[126] If untreated, postpartum depressed usually lasts around seven months.[127] Receiving appropriate postpartum care can address these emotional issues.

In addition to emotional issues, there are physical issues associated with pregnancy that should be closely monitored during the postpartum period. For example, 1 to 3 percent of vaginal deliveries result in postpartum endometritis. Urinary incontinence is prevalent in 3 to 23 percent of pregnancies after the first year of delivery. Approximately 4 to 7 percent of pregnancies result in a thyroid disorder during the first year of pregnancy. Women at risk for any of these risks should be tested and treated during the postpartum period. Postpartum visits also provide an opportunity for women to be instructed on certain health care guidelines, such as contraceptive use.[128]

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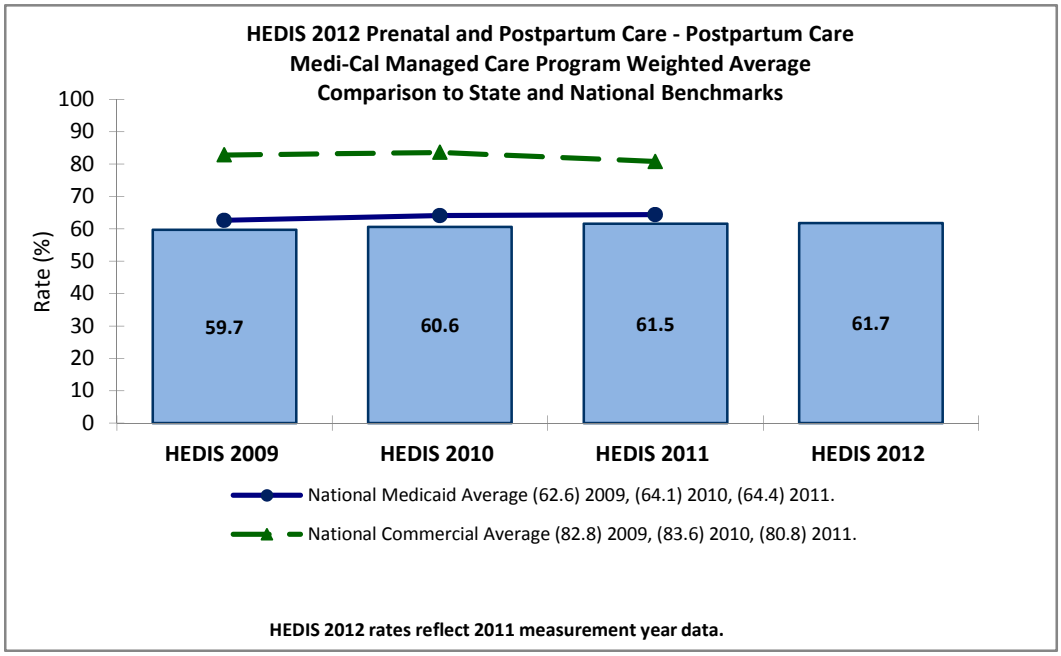
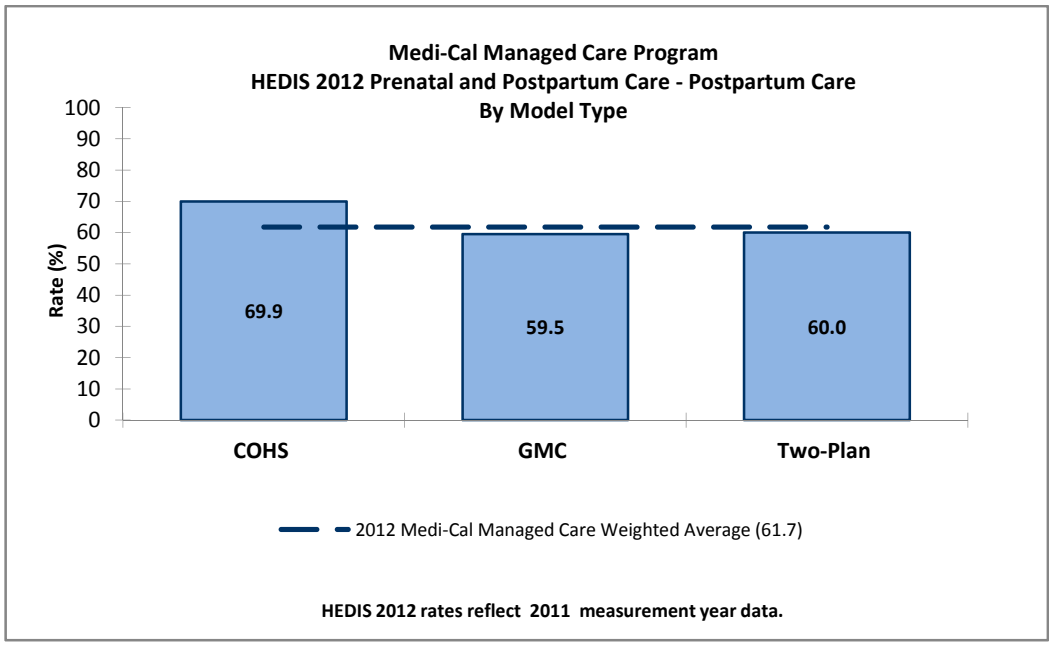
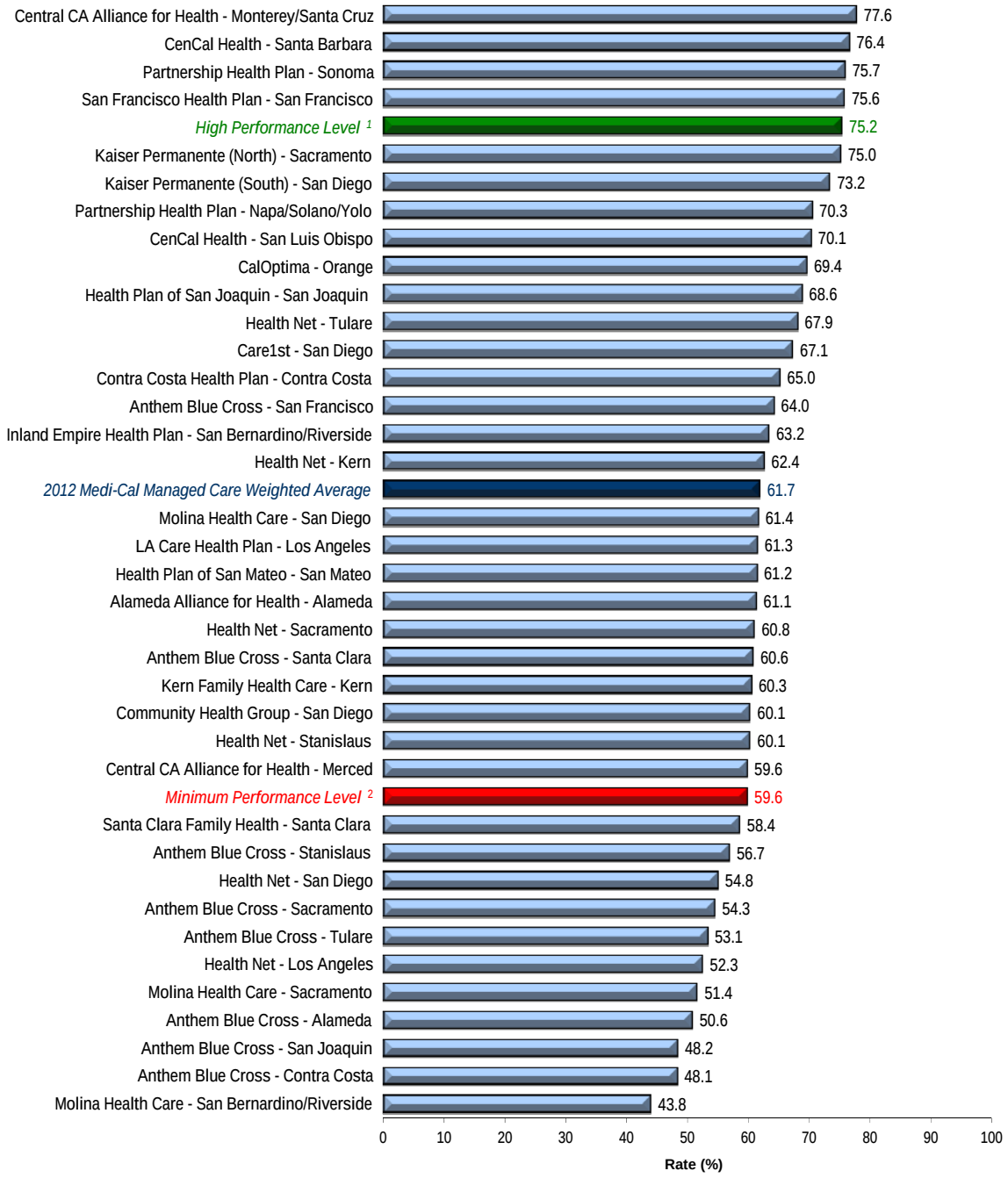
122 National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington DC: NCQA, 2009.
123 Blenning, C., Paladine, H., " An Approach to the Postpartum Office Visit." *Am Fam Physician.* 2005 Dec 15;72(12):2491-2496. Available at: http://www.aafp.org/afp/2005/1215/p2491.html Accessed on: May 1, 2012.
124 Centers for Disease Control and Prevention. *PRAMS and Postpartum Depression.* Atlanta, GA: CDC, June 2004.
125 Blenning, C., Paladine, H., " An Approach to the Postpartum Office Visit." *Am Fam Physician.* 2005 Dec 15;72(12):2491-2496. Available at: http://www.aafp.org/afp/2005/1215/p2491.html Accessed on: May 1, 2012.
126 Centers for Disease Control and Prevention. *PRAMS and Postpartum Depression.* Atlanta, GA: CDC, June 2004.
127 Blenning, C., Paladine, H., " An Approach to the Postpartum Office Visit." *Am Fam Physician.* 2005 Dec 15;72(12):2491-2496. Available at: http://www.aafp.org/afp/2005/1215/p2491.html Accessed on: May 1, 2012.
128 Ibid.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Prenatal and Postpartum Care—Postpartum Care



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Prenatal and Postpartum Care—Postpartum Care* measure has slightly increased each year since 2009; however, it still remains below both the national Medicaid and national commercial average.

The COHS model type outperformed the GMC and Two-Plan model types in 2012, as was the case in 2011.

High and Low Performers

Four rates (Central CA Alliance for Health—Monterey/Santa Cruz counties, CenCal Health—Santa Barbara County, Partnership Health Plan—Sonoma County, and San Francisco Health Plan—San Francisco County) performed above the established HPL in 2012. In contrast, 11 rates were below the 2012 established MPL.

Two rates showed statistically significant increases from 2011 rates, and there were three rates that had statistically significant declines (refer to Appendix B).

Best and Emerging Practices

Coordination of Care

The postpartum care measure directly links to other HEDIS measures. Plans that coordinate care and validate practice guidelines between internists, family practitioners, and obstetricians can positively affect maternal health. Incorporating alternative types of providers such as nurses and midwives has been associated with increased member satisfaction. Interventions that include member tools for well-child visits and immunization schedules as part of the postpartum visit increase the corresponding HEDIS rates. Additionally, providing members with schedules of future screening requirements for breast and cervical cancer positively affects members' compliance with clinical guidelines.

Educational Outreach Programs

Develop and implement educational outreach programs aimed at educating women who are either pregnant or just gave birth about the importance of postpartum care. Educational programs can be implemented throughout the community in various settings. For example, State Medicaid agencies can disseminate information at women's health care facilities, such as family planning services and OB-GYN offices. Media campaigns can also be employed to further publicize the

importance of receiving adequate care. Working with multiple contact sources will also help locate patients who need to receive postpartum care visits.[129]

Informational mailings can be sent to members, identified through administrative data, who are pregnant or who recently gave birth. These mailings can include information on women's health, including postpartum health care visits.

System and Provider Interventions

Educate and ensure that providers are accurately capturing postpartum care visits through the use of CPT and CPT Category II codes. The use of these codes will help to facilitate the administrative capture of postpartum visits and subsequently increase rates.

Engage Medical Directors

It is important to distribute the results of the HEDIS measures to medical directors and those staff members most intimately involved with quality improvement efforts aimed at increasing rates. Engaging pertinent staff members will help to promote change throughout the organization. It is also important to provide staff members with benchmark data (e.g., national and state data) so they can see how their plan is performing relative to comparable entities.

Member Incentives

The State or individual health plans can offer incentives to members for completing a postpartum care visit such as baby books and car seats. Incentives help to encourage postpartum care visits.

Improve Providers' Understanding of Medicaid Reimbursement

The State Medicaid agency should work with providers to educate them about the reimbursement process for patients who are presumed to be eligible for Medicaid benefits after birth. This would help decrease the number of providers who will not see patients for postpartum care visits due to a fear of not being reimbursed for the services rendered. An increase in provider education may help to increase postpartum care rates.

Increase Funding to Improve Transportation

One potential barrier to care is the patient's inability to obtain access to consistent transportation. The State can work with stakeholders and policy makers to increase funding for transportation programs.[130] This best practice would likely result in an increase in postpartum visit rates,

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[129] Tough, S., Siever, J., Johnson, D. "Retaining Women in a Prenatal care Randomized Controlled Trial in Canada: Implications for Program Planning." BMC Public Health 2007, 7: 148.

[130] Ibid.

particularly in rural areas with less public transportation. Another option is to provide bus tokens or taxi vouchers for transportation.

Automated Appointment Scheduling and Reminders

Implement an automated process for identifying members who are at 36 weeks gestation to schedule a postpartum appointment approximately four to eight weeks after birth. An automated process should be developed to identify those members who have not scheduled or who have missed a necessary postpartum care visit. An obstetrical database can be used to facilitate this process. Another best practice is to work with the appointment scheduling department to set up a postpartum appointment at the time the woman is discharged from the hospital.

Use of Imaging Studies for Low Back Pain

Measure Definition

The *Use of Imaging Studies for Low Back Pain* measure assesses the percentage of members between 18 and 50 years of age who had a primary diagnosis of low back pain and who did not have an imaging study (X-ray, magnetic resonance imaging [MRI], computed topography [CT] scan) within 28 days of diagnosis.

Importance

Low back pain is a common and expensive cause of lost productivity and work days in the United States. Each year, approximately half of American adults will experience low back pain.[131] Frequently, low back pain is also the cause for patients' calls and visits to a primary care clinician. For most patients, acute low back pain is non-specific. A history and physical examination can provide clues to the rare but potentially serious causes of low back pain. While imaging may be appropriate for patients at risk for more serious conditions, the majority of patients experience low back pain that is non-specific and with no identifiable cause. According to the American College of Radiology, acute low back pain without complications is usually benign and self-limiting, and does not necessitate early imaging studies, such as X-rays, MRIs, or CT scans. Most patients return to their usual activities within a month.

Studies have shown that complications from unnecessary surgery potentially increase the duration of low back pain. Additionally, low back pain is the most costly ailment in the workplace. It accounts for nearly one-third of workers' compensation claims, with an average cost of $8,000 per claim.[132] In 2001, the estimated annual national bill for the care of low back pain problems was as much as $50 billion when indirect costs are included.[133] It is important to keep in mind that these estimated costs do not take into account inflation and the prevalence of increasing health care costs in the United States today.

Furthermore, despite this evidence, imaging studies are commonly overused in the evaluation of patients with acute low back pain. Less than 1 percent of radiographs find the cause of low back pain.[134] Abnormalities found when imaging patients with and without back pain had similar

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131 Koes BW, van Tulder MW, Thomas S. Diagnosis and Treatment of Low Back Pain. *British Medical Journal.* 2006; 332: 1430-1434.

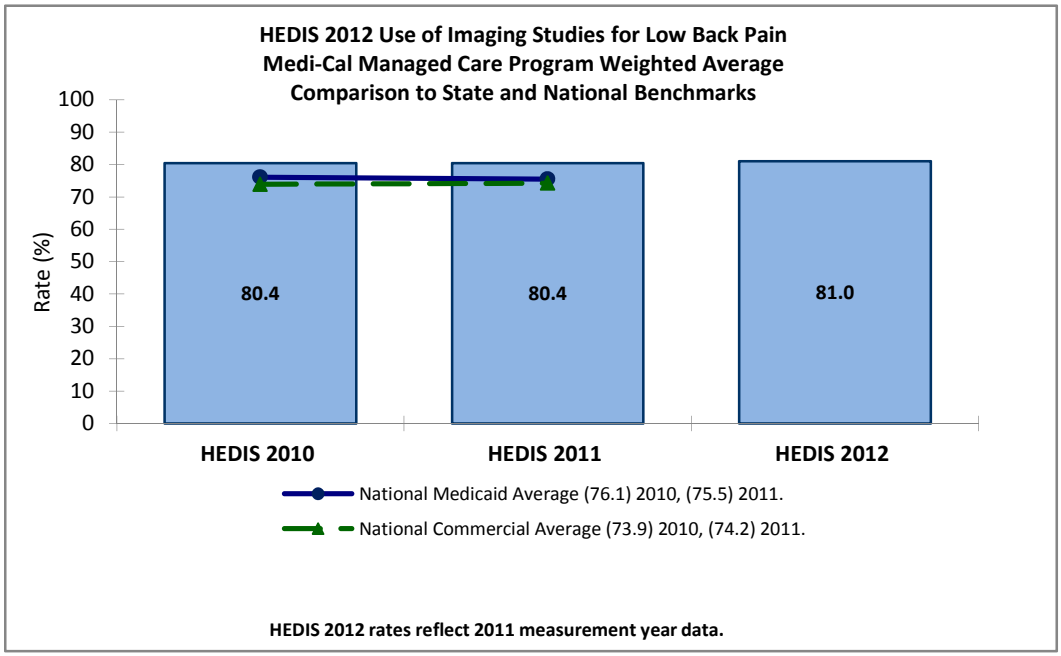
132 Atlas SJ, Deyo RA. Evaluating and Managing Acute Low Back Pain in the Primary Care Setting. *Journal of General Internal Medicine.* 2001; 16: 120-131.

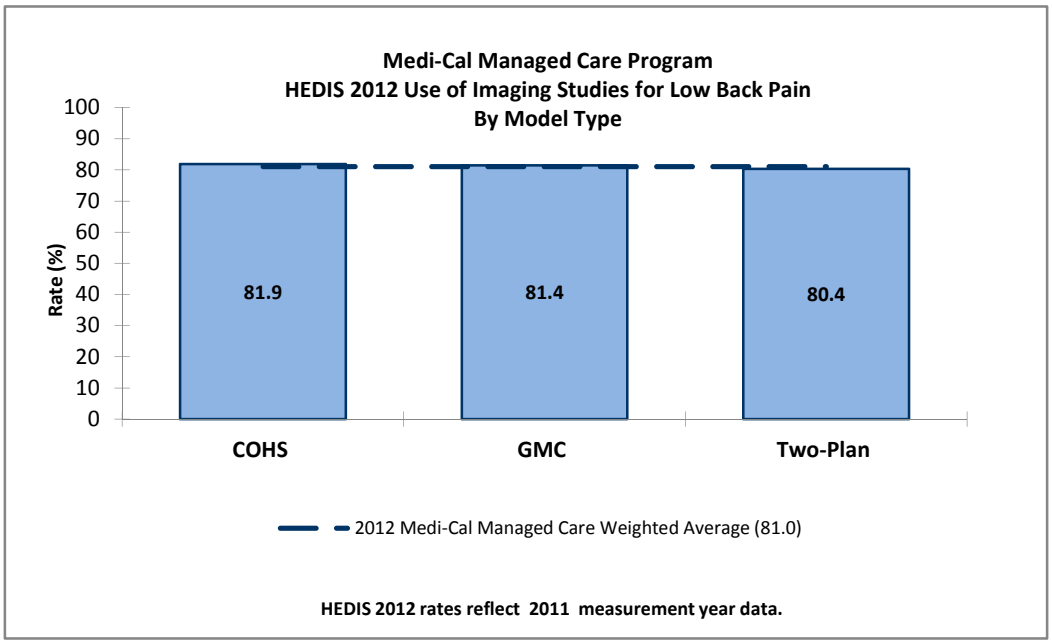
133 Patel AT, Ogle AA. Diagnosis and Management of Acute Low Back Pain. *American Family Physician.* 2000. Available at: http://www.aafp.org/afp/20000315/1779.html. Accessed on: May 1, 2012.

134 Manek NJ, MacGregor AJ. Epidemiology of Back Disorders: Prevalence, Risk Factors, and Prognosis. *Current Opinion in Rheumatology.* 2005; 17:134-140.

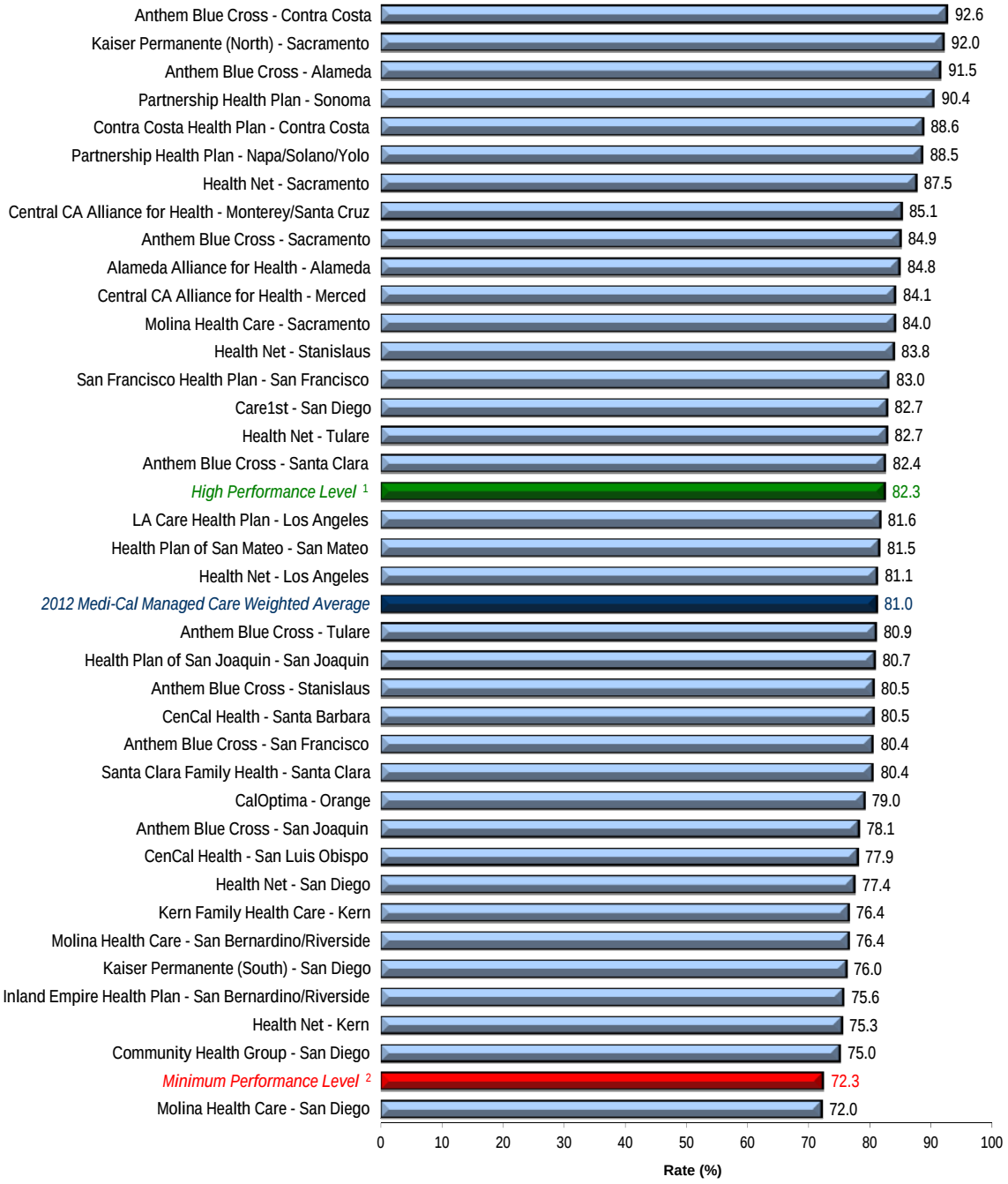
prevalence. Other than patient satisfaction, most patients given standard low back care experienced no difference in health outcomes compared to those given lower back radiographs.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Use of Imaging Studies for Low Back Pain



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Use of Imaging Studies for Low Back Pain* measure was 81 percent in 2012, a slight increase over the 2010 and 2011 averages. The rate exceeded the national Medicaid average and the national commercial average for the third straight year.

The COHS model type outperformed the GMC and Two-Plan model types for the third straight year, with little variation from 2011's results. However, there was no significant difference in the performance of the three model types.

High and Low Performers

Seventeen rates met or exceeded the HPL in 2012 as opposed to 12 in 2011, while only one rate (Molina Health Care—San Diego County) fell below the MPL in 2012.

Five rates showed statistically significant increases from 2011 rates, and only one rate (Inland Empire Health Plan—San Bernardino/Riverside counties) had statistically significant declines during the same time frame (refer to Appendix B).

Best and Emerging Practices

Focus on Identifying Red Flag Indicators

About 90 percent of all patients with low back pain will have non-specific low back pain. In clinical practice as well as in the literature, non-specific low back pain is usually classified by the duration of the pain. During the initial assessment of patients with low back pain, clinical guidelines recommend focusing on obtaining a complete medical history and physical examination.[135] The history and physical examination will generally provide "red flag" indicators to rare but potentially serious causes of low back pain and identify if a patient is at risk for chronic disabling back pain. When these red flag indicators are not present, the patient is considered to have non-specific low back pain. In clinical guidelines these findings have led to the recommendation to be restrictive in referral for imaging in patients with non-specific low back pain. Only in cases with red flag conditions should imaging be indicated.[136]

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[135] Agency for Health Care Quality and Research. "Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society." 2007. National Guideline Clearinghouse. Available at: http://www.guideline.gov/summary/summary.aspx?doc_id=11515. Accessed on: May 1, 2012.

[136] Ibid.

Meet Patient Expectations through Education

Information about why an imaging test is not indicated is generally sufficient for most patients.[137] Providing patients with evidence-based information on low back pain regarding the natural history of low back pain (i.e., its expected course), advising them to remain active, and providing them with information about effective self-care options and how to prevent future episodes can help ensure the patient's expectations are met.

Provide Alternative Therapy

In managing patients' expectations, for those patients who do not improve with self-care options, clinicians should consider recommending nonpharmacologic therapy with proven benefits. For patients with chronic or subacute low back pain, this might include intensive interdisciplinary rehabilitation, exercise therapy, acupuncture, massage therapy, spinal manipulation, yoga, cognitive-behavioral therapy, or progressive relaxation.

[137] Atlas SJ, Deyo RA. Evaluating and Managing Acute Low Back Pain in the Primary Care Setting. *Journal of General Internal Medicine*. 2001; 16: 120-131.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Measure Definition

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure calculates the percentage of enrolled members between 3 and 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of body mass index (BMI) percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year.

Importance

The emergence of obesity in children and adolescents has been one of the most important developments in pediatrics, and its rapidly increasing prevalence is one of the most challenging dilemmas pediatricians face today in the United States. In 1980, it was estimated that 6.9 percent of children ages 6 to 11 and 5 percent of adolescents ages 12 to 19 were obese. However, in the past 30 years the prevalence of obesity among children and adolescents has increased sharply. The Centers for Disease Control and Prevention (CDC) estimates that as of 2008, 17 percent (or 12.5 million) of children ages 2 to 19 years were obese. Since 1980, obesity prevalence among children and adolescence has almost tripled based on the 2007–2008 National Health and Nutrition Examination Survey (NHANES). Also of great concern are children who are overweight and at risk for becoming obese. Overweight children and adolescents are more likely to become obese as adults.

Additionally, according to a study conducted by the CDC, it was reported that almost 25 percent of children ages 9 to 13 did not engage in any free-time physical activity.[138] For young people in grades 9 through 12, the level of physical activity decreases drastically. Almost two-thirds of young people in grades 9 through 12 do not meet the recommended levels of physical activity and only 54 percent participate in physical education class at least once a week. Evidence has also shown that daily participation in physical education classes among high school students dropped from 42 percent in 1991 to 33 percent in 2005.[139]

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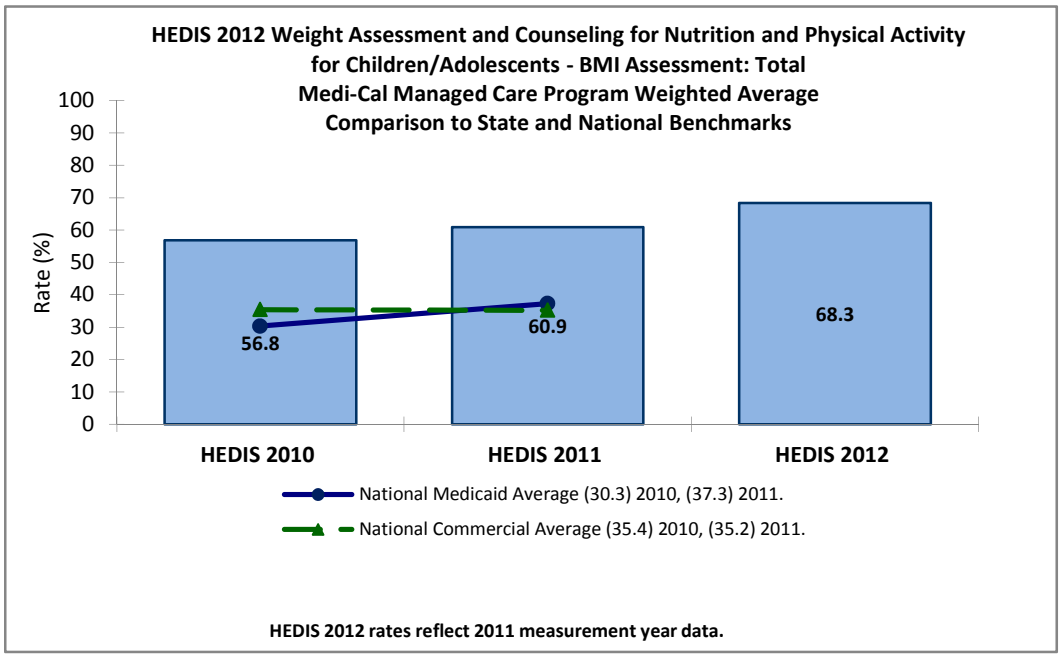
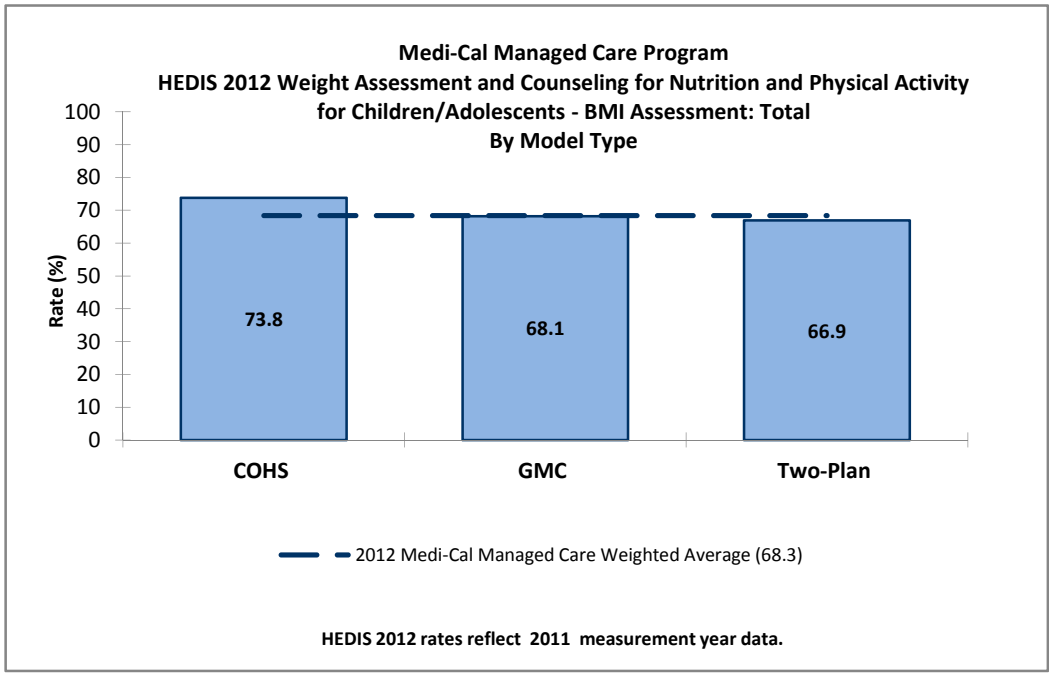
[138] Physical Activity Levels Among Children 9–13 Years—United States, 2002. *Morbidity and Mortality Weekly Report*. 2003; 52(33): 785-788. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5233a1.htm. Accessed on: May 1, 2012.

[139] Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Surveillance—United States, 2009. Surveillance Summaries. *Morbidity and Mortality Weekly Report*. 2010; 59(No. SS-5). Available at: http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf. Accessed on: May 1, 2012.

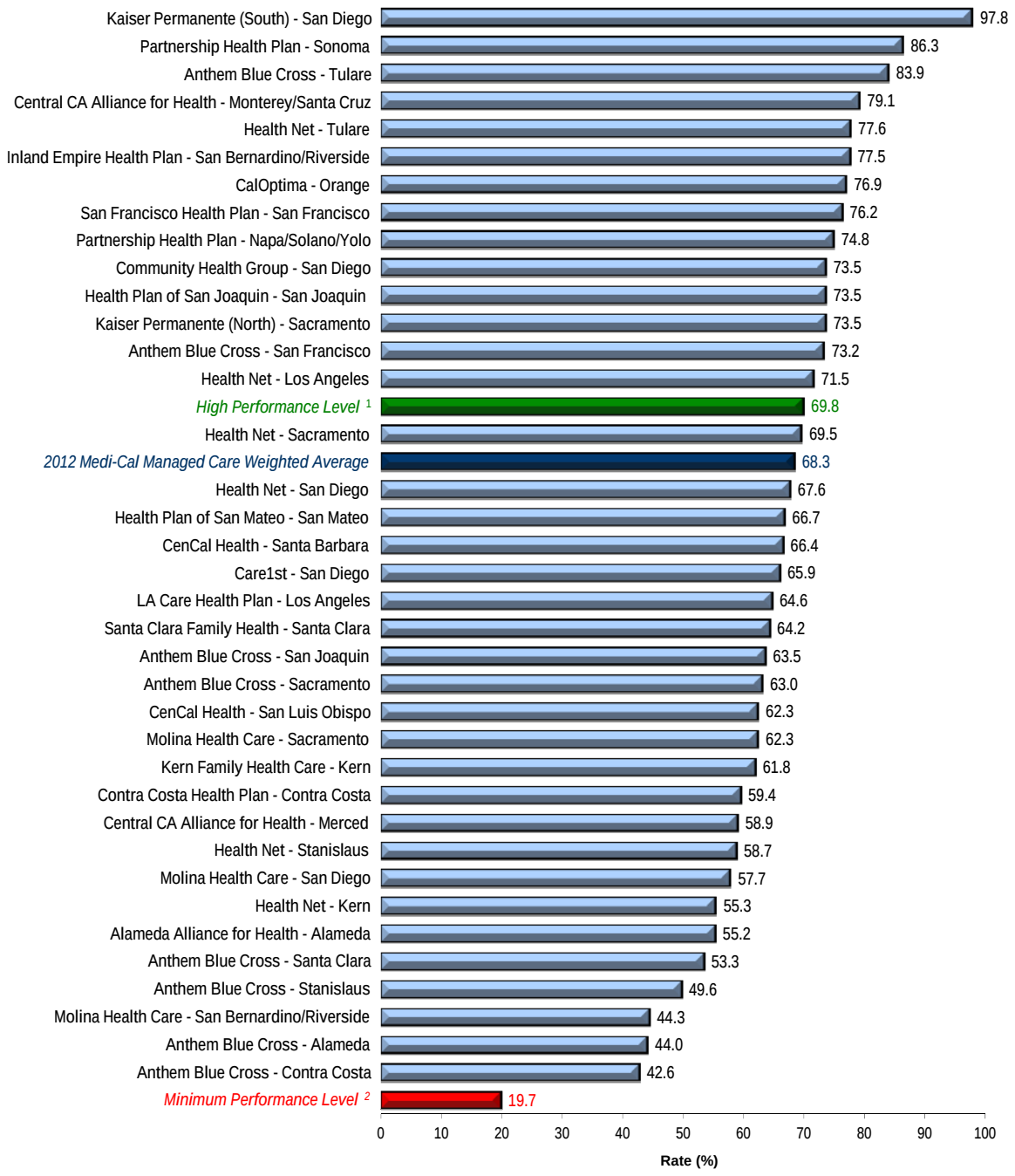
For these reasons, it is essential that children and adolescents in the United States receive adequate weight assessment and counseling for nutrition and physical activity. The first step involves screening for overweight and obesity in the physician's office with the calculation of body mass index (BMI). With this tool physicians can estimate a child's BMI percentile for age and gender. In addition, it has been found that BMI is a useful screening tool for assessing and tracking the degree of obesity among adolescents. To address the lack of physical activity and nutritional education among children and adolescents in the United States today, health care providers should promote regular exercise activity and healthy eating and assist parents in creating an environment that supports these healthy habits.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's weighted average for the BMI Assessment indicator of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure was 68.3 percent in 2012, only 1.5 percentage points away from the HPL. The weighted average was considerably higher than the national Medicaid average and the national commercial average in 2012.

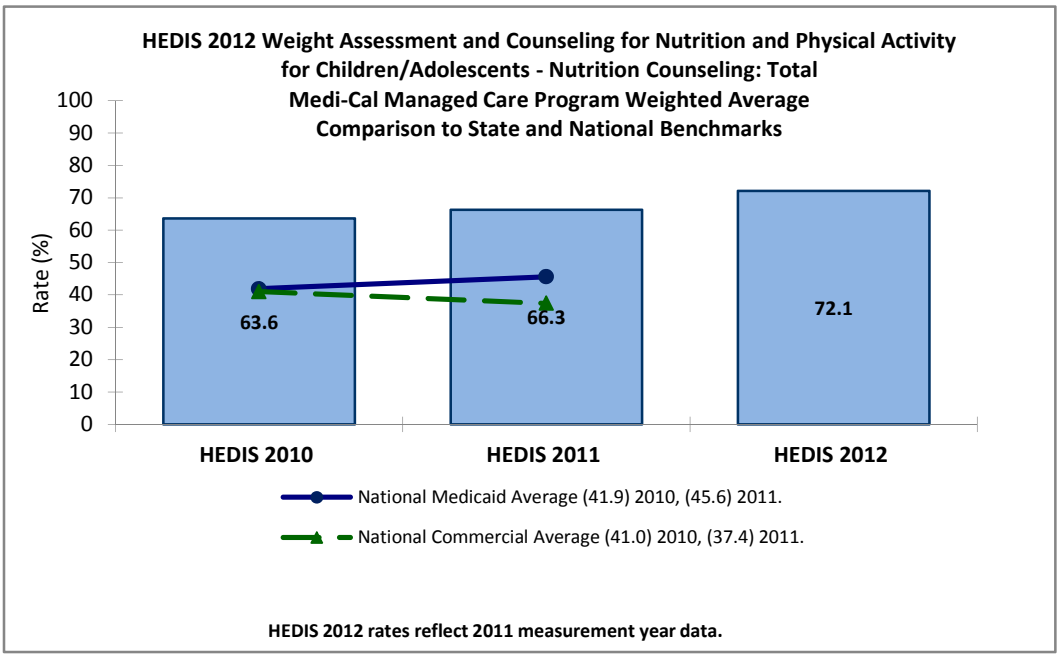
The COHS model type performed better than the GMC and Two-Plan model types for the third consecutive year.

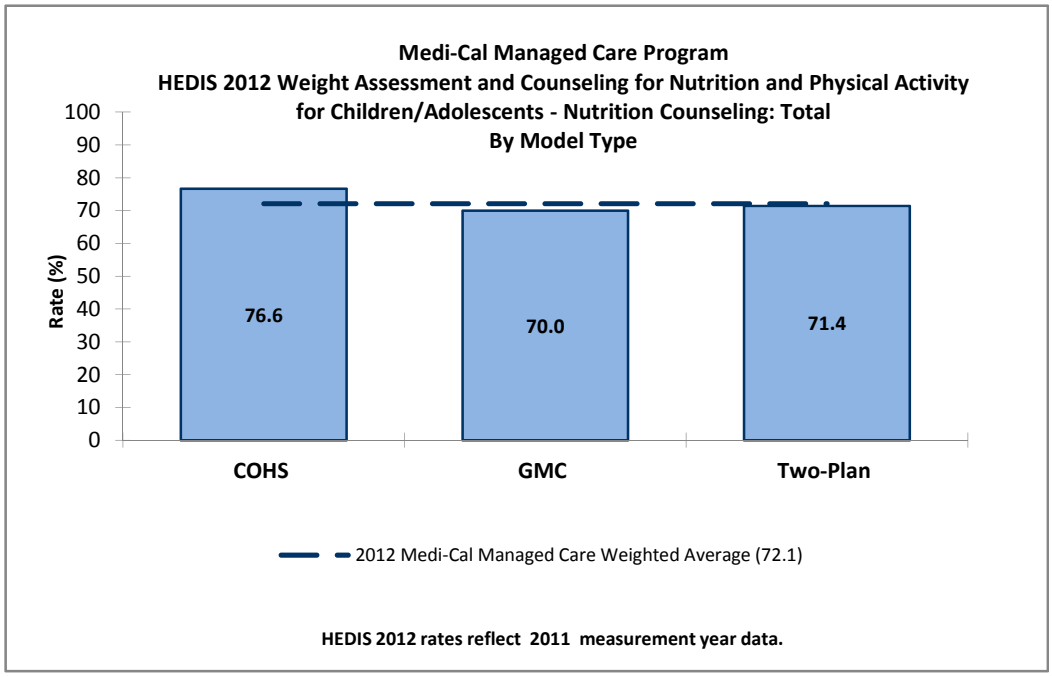
High and Low Performers

Fourteen plans surpassed the HPL, while no plans fell below the MPL for the second consecutive year.

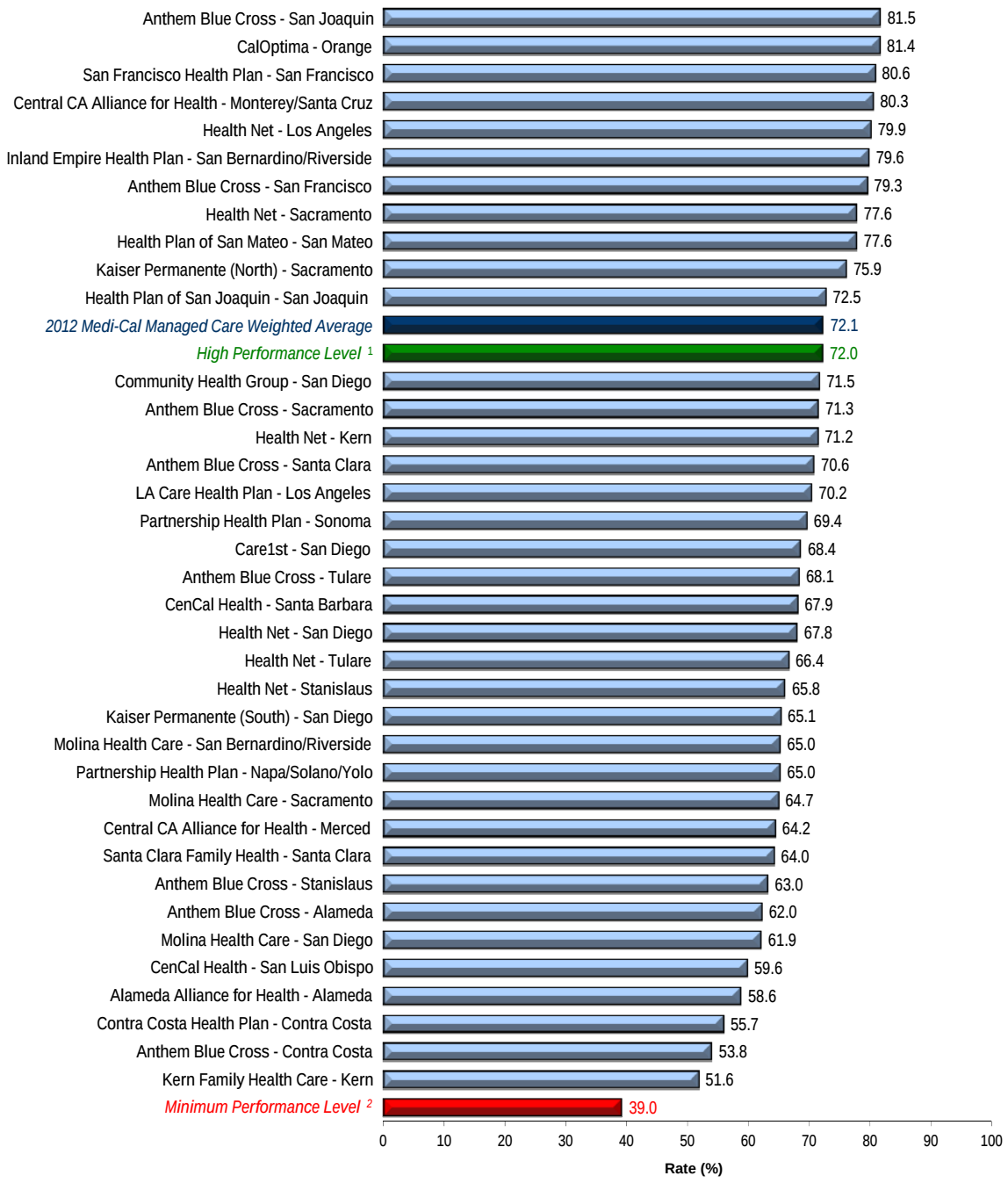
Twenty-one rates showed statistically significant increases over 2011 rates, and only one rate (Anthem Blue Cross—Santa Clara County) had a statistically significant decline during the same time frame (refer to Appendix B).

Performance Results—Nutrition Counseling





Medi-Cal Managed Care
HEDIS 2012 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's 2012 weighted average for the Nutritional Counseling indicator of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure was 72.1 percent, which was higher than the HPL. This rate exceeded both the national Medicaid average as well as the national commercial average for the third consecutive year.

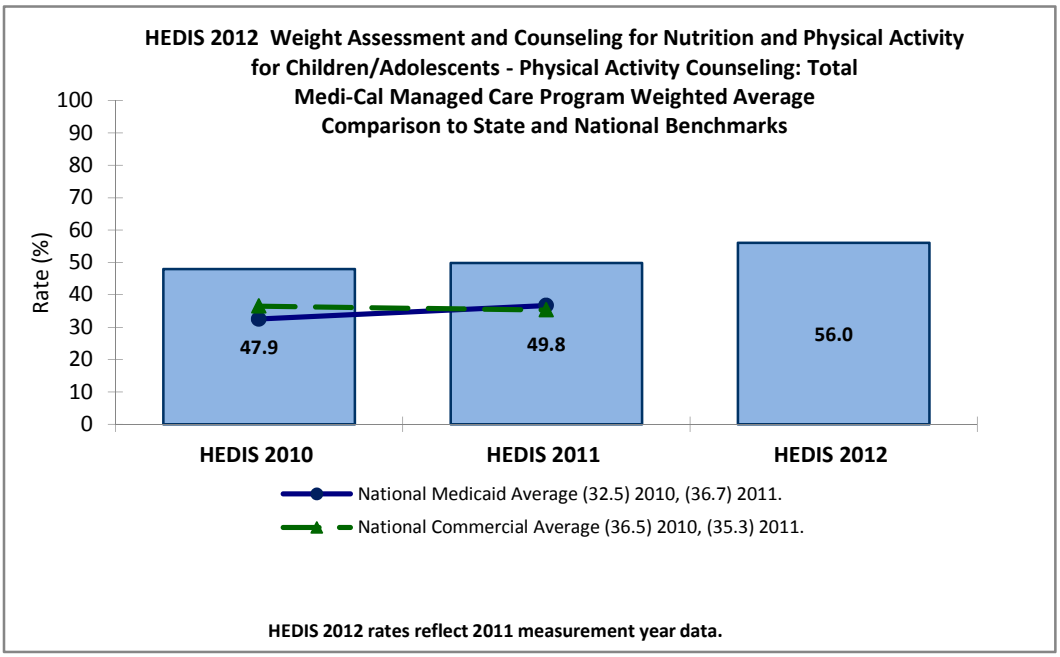
The COHS model type outperformed the GMC and Two-Plan model types for the third straight year.

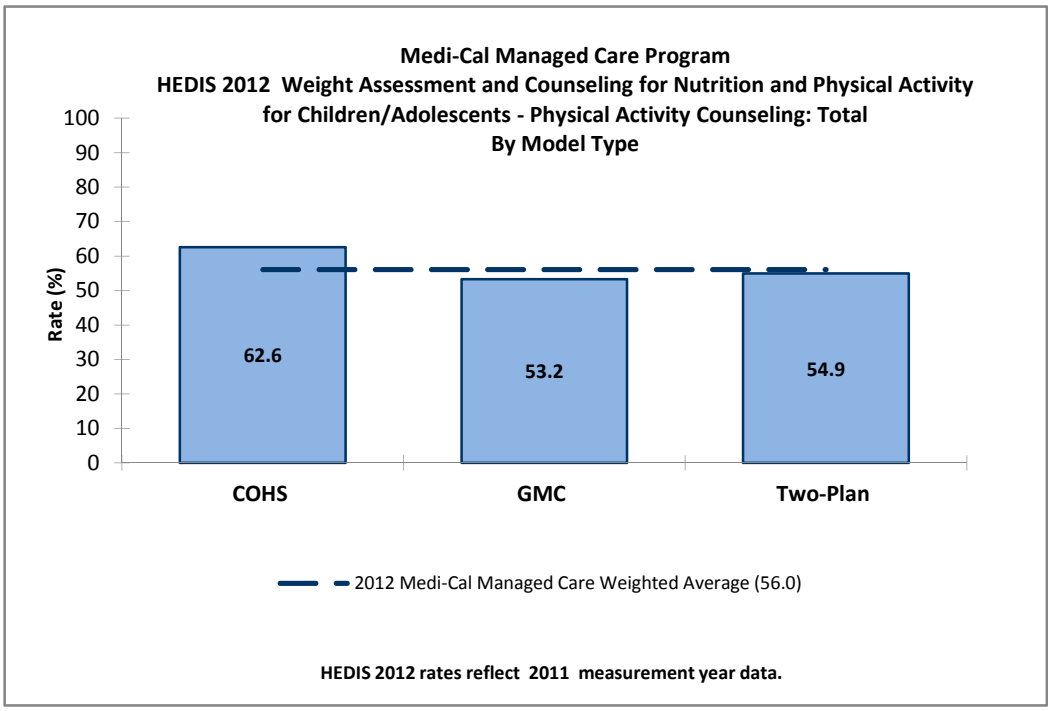
High and Low Performers

Eleven rates met or exceeded the HPL in 2012, and there were no rates that failed to meet the MPL.

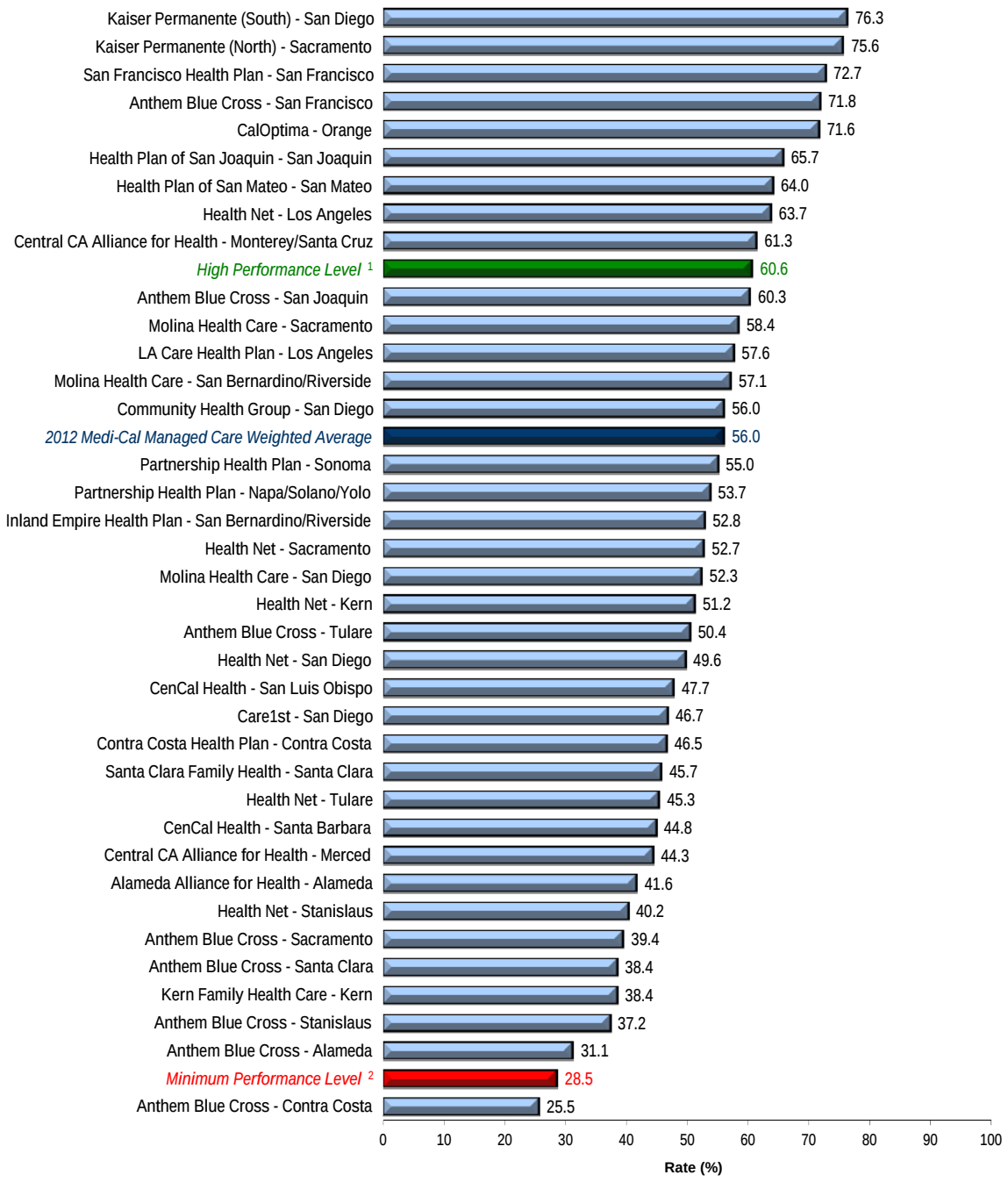
Sixteen rates showed statistically significant increases over 2011 rates, and only one rate (Alameda Alliance for Health—Alameda County) had a statistically significant decrease in 2012 (refer to Appendix B).

Performance Results—Physical Activity Counseling





Medi-Cal Managed Care
HEDIS 2012 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's weighted average for the Physical Activity Counseling indicator of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure was 56 percent in 2012. This was approximately 6 percentage points higher than in 2011. This score was significantly higher than both the national Medicaid average as well as the national commercial average.

The COHS model type outperformed the GMC and Two-Plan model types in 2012.

High and Low Performers

Nine health plans surpassed the HPL, and there was only one plan (Anthem Blue Cross—Contra Costa County) that failed to meet the MPL in 2012.

Nineteen rates showed statistically significant increases over 2011 rates, and two rates had statistically significant decreases in 2012. One increase of note was Anthem Blue Cross—San Joaquin County, which had a 31.6 percentage point increase (refer to Appendix B).

Best and Emerging Practices

Educate Parents and Guardians

Educating parents and guardians on the importance of providing children and adolescents with a healthy diet and the significance of encouraging daily physical activity can be highly beneficial. Educational information and resources can include printed or Web-based materials with information on the value of BMI assessment and information on community-based physical activity/weight management programs. Evidence also suggests that providing information and practical strategies related to good nutrition and meal preparation will lead to an increase in knowledge about healthy nutrition and an increase in healthy eating behaviors.[140]

For example, in Arizona the Cochise County Steps Program implemented the Washington State Dairy Council's Healthy Habits for Life program, a six-week intervention designed for women who traditionally purchase and prepare foods for their families. The program involved interactive slide shows offered by trained health educators in a variety of community-based settings. Slide show topics included physical activity and meal planning, including calorie counting, grocery shopping tips, and dietary journaling. Additionally, health educators collaborated with local women's fitness clubs to offer monthly membership discounts to program participants. By the conclusion of the six-week program, participants' knowledge about the importance of eating fruits

[140] U.S. Department of Health and Human Services (HHS) and U.S. Department of Agriculture (USDA). *Dietary Guidelines for Americans, 2005*. Washington, D.C.: HHS; 2005. Available at: http://www.health.gov/dietaryguidelines/dga2005/report/ Accessed on: May 1, 2012.

and vegetables daily increased by 17 percent. Participants also reported eating more than three additional servings of vegetables and two more servings of fruits each week, as well as choosing healthier alternatives to shortening and butter for meal preparation.[141]

Educate Health Care Professionals

Educating health care professionals and providing them with the tools, skills, and knowledge necessary to identify and screen children and adolescents for overweight and obesity in a primary care setting is crucial. Nearly 75 percent of American adolescents see a physician at least once a year.[142] Physician visits offer health care providers and other clinicians the opportunity to provide preventive services, such as BMI assessments, dietary counseling, and related weight management and nutrition services. Studies indicate that adolescents view their physicians as a trustworthy source of health information and that parents want clinicians to provide these services.[143]

Promote Increased Physical Activity

In Fayette County, Pennsylvania, local school nurses and pediatricians identified a need for a weight management program to help children and their family members reach and maintain a healthy weight through physical activity and healthy eating. In an effort to address this need, Fayette County's Steps Program partnered with Highmark Blue Cross Blue Shield to bring KidShape to their county. KidShape is an evidence-based weight management program that focuses on increasing awareness about good nutrition and healthy eating among overweight children ages 6 to 14, children at risk of becoming overweight, and their family members. As a result of this program, participating families reported eating more fruits and vegetables and spending more time being physically active. In addition, Fayette County school districts, which regularly assess students' body weight, are now able to connect overweight children and their families with KidShape to assist in reaching and maintaining a healthy weight.[144]

In the 2006 Behavioral Risk Factor Surveillance System (BRFSS) survey, more than 60 percent of respondents from Broome County, New York, reported being overweight or obese. In an effort to combat obesity in rural areas, the Steps Program implemented a walking program called BC

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141 Centers for Disease Control and Prevention (CDC). *The Steps Program in Action: Success Stories on Community Initiatives to Prevent Chronic Diseases*. Atlanta, GA: HHS; 2008. Available at: http://www.cdc.gov/healthycommunitiesprogram/evaluation-innovation/pdf/StepsInAction.pdf. Accessed on: May 1, 2012.

142 Park MJ, Macdonald TM, Ozer EM, et al. Investing in Clinical Preventive Health Services for Adolescents. University of California, San Francisco, Policy Information and Analysis Center for Middle Childhood and Adolescence, and National Adolescent Health Information Center. 2001. Available at: http://nahic.ucsf.edu/downloads/CPHS.pdf. Accessed on: May 1, 2012.

143 Ibid.

144 Centers for Disease Control and Prevention (CDC). *The Steps Program in Action: Success Stories on Community Initiatives to Prevent Chronic Diseases*. Atlanta, GA: HHS; 2008. Available at: http://www.cdc.gov/healthycommunitiesprogram/evaluation-innovation/pdf/StepsInAction.pdf. Accessed on: May 1, 2012.

Walks. More than 80,000 people have enrolled in the program over the last four years, and results show an almost 10 percent increase in the number of people who walk 30 minutes or more five days a week. The Steps Program also helped to expand the Mission Meltaway Program, which uses a group approach to weight management and incorporates diabetes prevention strategies. In addition, the Broome County YMCA offers free memberships for eight weeks to participants of Mission Meltaway.[145]

Community-Wide Wellness Campaign

The Step Programs in Salinas, California, launched a multi-tiered campaign to improve the health of its Latino community, which makes up 70 percent of its population. This community-wide communications campaign was aimed at changing not only Latino behaviors but the broader community as well (e.g., media, restaurants, churches, policymakers, schools, and retailers). By successfully mobilizing every sector of the community, the Steps Program was able to help improve the health behaviors of Salinas' residents. At the completion of the 18-month campaign, the community saw a marked decrease in obesity and diabetes rates and a 12 percent increase in healthy weight for Salinas' Latino population.[146]

Increase Family Fitness Opportunities

To address overweight and obesity among Minnesota's Women, Infant, and Children (WIC) members, the Rochester, Minnesota, Steps Program established a supplemental nutrition program called Fit WIC. The Fit WIC program offers tools and resources to help parents and their children become more physically active through a series of play, recreation, physical activity, and structured skill-building activities. To further expand the program's reach, a picture activity book for non-English speaking members was also made available to clients. In partnering with the Rochester YMCA, WIC parents were given free access to the YMCA programs, which includes free child care for infants and toddlers and access for older children to YMCA's children's program. After the course of one year, parents reported a 10 percent increase in moderate activity level in addition to an increase in the time spent playing with their children. On average, 88 percent of participants reported using the tool kit more than two to three days per week.[147]

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145 Levi J, Trust for America's Health (TFAH), et al. *F as in Fat: How Obesity Policies Are Failing in America 2009*. Washington, D.C.: TFAH; 2009. Available at: http://healthyamericans.org/reports/obesity2009/Obesity2009Report.pdf. Accessed on: May 1, 2012.

146 Centers for Disease Control and Prevention (CDC). CDC's Step Communities. Steps in the News. Available at: http://www.cdc.gov/steps/in_the_news/index.htm. Accessed on: May 1, 2012.

147 Centers for Disease Control and Prevention (CDC). *The Steps Program in Action: Success Stories on Community Initiatives to Prevent Chronic Diseases*. Atlanta, GA: HHS; 2008. Available at: http://www.cdc.gov/healthycommunitiesprogram/evaluation-innovation/pdf/StepsInAction.pdf. Accessed on: May 1, 2012.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Measure Definition

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure calculates the percentage of members three to six years of age as of December 31 of the measurement year who received one or more well-child visits with a PCP during the measurement year.

Importance

Children in preschool and early school years benefit from well-child visits to obtain early detection of vision, speech, or language problems. These visits are also important for:

- Assessing school readiness.
- Completing preschool immunization.
- Reinforcing accident and injury prevention.
- Educating about appropriate weight.[148]

In addition to performing preventive services, well-child visits foster communication between parents and doctors. This allows doctors to offer guidance and counseling on a variety of health care topics, including safety, nutrition, normal development, and general health care.

Children with poorer health status are more likely to **not** receive recommended well-child visits since these children tend to use more acute or specialty care.[149] Furthermore, there is evidence that timely preventive care in children has a positive impact on overall health care utilization. Researchers have found associations between increased well-child visits and reductions in avoidable hospitalizations, reductions in emergency department use, and improved child health.[150]

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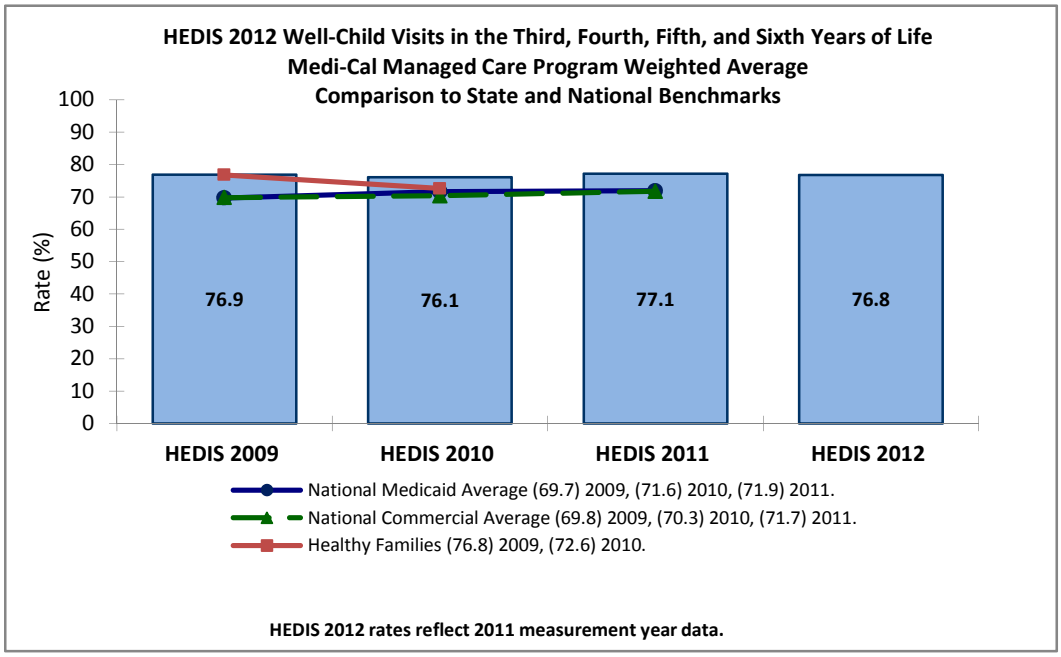
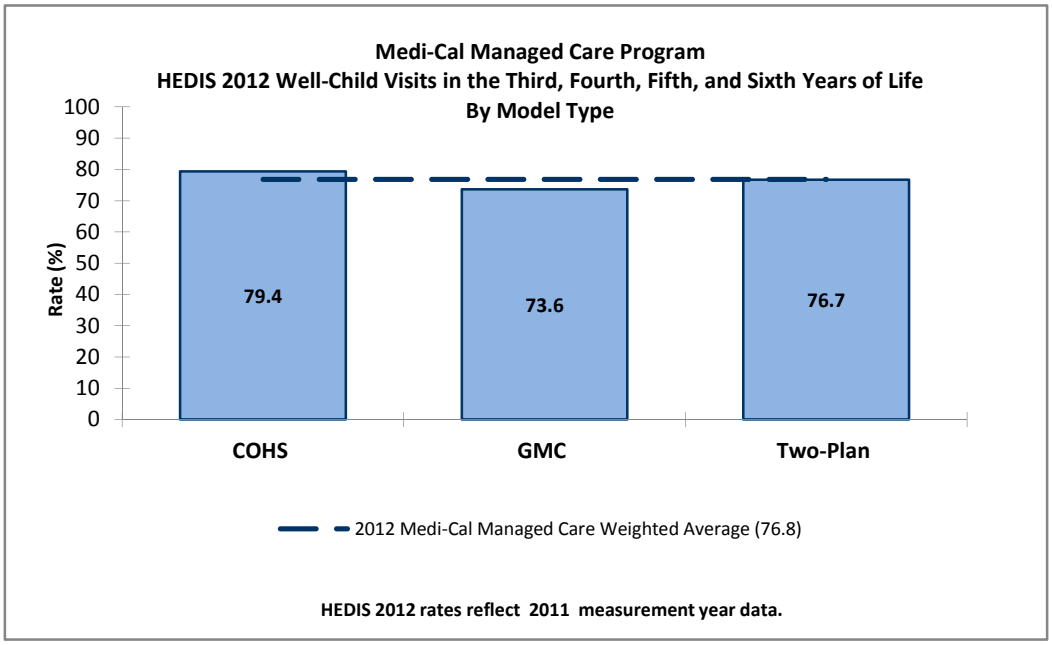
[148] Medicaid Managed Care Services. *Components of Well Child Screenings.* Available at: http://mmcs.afmc.org/HealthCareProfessionals/ProviderRelations/WellChildEPSDT/ComponentsofWellChildScreenings.aspx Accessed on: October 3, 2011.

[149] Yu SM, Bellamy HA, Kogan MD, et al. Factors That Influence Receipt of Recommended Preventive Pediatric Health and Dental Care. 2002. *Pediatrics* 110(6):73. Available at: http://pediatrics.aappublications.org/content/110/6/e73.full.pdf+html. Accessed on: May 1, 2012.

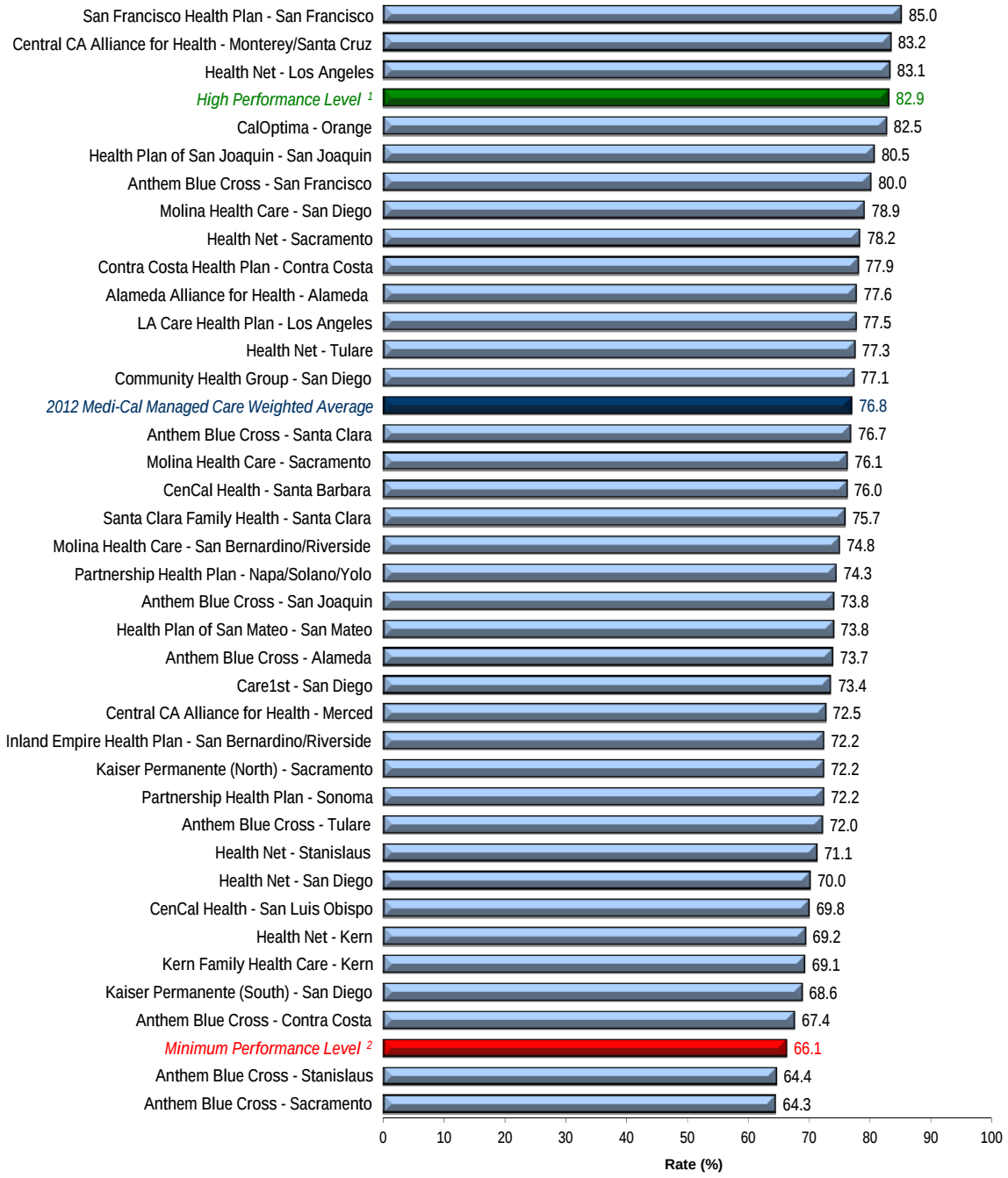
[150] Selden TM. Compliance with Well-Child Visit Recommendations: Evidence from the Medical Expenditure Panel Survey, 2000-2002. 2006. *Pediatrics* 118(6):1766-1778. Available at: http://pediatrics.aappublications.org/cgi/content/full/118/6/e1766. Accessed on: September 7, 2012.

Performance Results





Medi-Cal Managed Care
HEDIS 2012 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life



[1] High Performance Level is HEDIS 2011 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2011 national Medicaid 25th Percentile.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Summary of Results

The MCMC Program's weighted average for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure dropped slightly from 2011 to 76.8 in 2012. The MCMC Program weighted average exceeded the national Medicaid average and the national commercial average for the fourth consecutive year.

The COHS model type outperformed the GMC and Two-Plan model types, just as it did in 2011.

High and Low Performers

Three rates (San Francisco Health Plan—San Francisco County, Central CA Alliance for Health—Monterey/Santa Cruz counties, and Health Net—Los Angeles County) exceeded the established HPL, and two Anthem Blue Cross counties, Stanislaus and Sacramento, reported rates below the MPL in 2012.

Six rates showed statistically significant improvement over 2011 rates, while one plan showed a statistically significant decline from 2011 to 2012 (refer to Appendix B).

Best and Emerging Practices

Access

Open access reduces well-child visit no-shows.[151] Evening or weekend clinic hours for providers can accommodate parents who cannot take time off from work. For example, one Saturday a month could be set aside for children, with clinicians designated to perform well-child visits on that day. Visits on certain days would be available on a walk-in, first-come, first-served basis. Additionally, parents should be encouraged to schedule their next visit before leaving the clinic.

Providing improved access to transportation would likely increase well-child visit compliance. One method that could be used to improve transportation would be to coordinate with community volunteers and other outreach services to provide transportation to and from doctor's offices and clinics.

Outreach

Registries are used to identify and track when well-child exam and immunizations are needed and when member reminder cards need to be sent out. Reminders are often associated with the child's birthday. To be more effective, the postcards should suggest doctor's offices near the member's address, or list their assigned PCP with contact telephone numbers. Also, age-specific forms for

[151] O'Connor ME, Matthews BS, Gao D. Effect of Open Access Scheduling on Missed Appointments, Immunizations, and Continuity of Care for Infant Well-Child Care Visits. *Arch Pediatr Adolesc Med.* 2006;160:889-893.

missed appointments, detailing what services should be provided and why they are important to the well-being of the child, help educate parents.

Training and Education

Quarterly provider reports that highlight children in need of well-child visits are useful for promoting visit reminders and helping providers track their performance. Children who saw a doctor but did not have a well-child visit can be flagged as missed opportunities. To make this information pertinent to providers, their performance may be tied to a recognition program for providers who display outstanding performance with adolescent members.

A simple practice that can improve well-child visit compliance is educating providers and their front office staff about reviewing the health records of all adolescent family members before any of the family members schedule an appointment. This allows physicians to personally remind parents of the need for well-child visits for their teenagers. This practice also increases awareness of the proper billing codes for well-child visits, which can reduce missed opportunities.

Physician's offices that call parents the day before a scheduled visit to remind them of the appointment time reduce the number of missed appointments. Text messages are another convenient and increasingly popular mode of communication and can be sent out automatically from a computer.

The DHCS contracts with three specialty plans. These plans are required to report annual scores for two performance measures. The DHCS chooses these performance measures in collaboration with each plan as appropriate for each plan's Medi-Cal managed care population. This section includes results from the specialty plans' 2012 performance measures, which reflect data from January 1, 2011, to December 31, 2011. As each specialty plan provides unique services relevant to its population, HSAG includes local and national benchmarks as available.

AHF Healthcare Centers

AHF Healthcare Centers is a Medi-Cal managed care specialty plan operating in Los Angeles County and providing services primarily to members living with HIV or acquired immunodeficiency syndrome (AIDS). Some of the plan's members are dual eligible (covered by both Medicare and Medi-Cal). The plan has been previously referred to as AIDS Healthcare Centers or Positive Healthcare.

AHF Healthcare Centers' 2012 performance measures were the HEDIS measures *Controlling High Blood Pressure* and *Colorectal Cancer Screening*.

Controlling High Blood Pressure

Measure Definition

This measure is used to assess the percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than or equal to 140/90 mm Hg) during the measurement year.

Importance

In 2012, approximately 76.4 million people over the age of 20 have high blood pressure (hypertension) in the United States. Hypertension was the cause of 61,005 deaths in the United States in 2008. Hypertension is considered to be a "silent" condition. Fortunately, high blood pressure is easily detected and usually controllable.[152]

[152] American Heart Association. Statistical Fact Sheet 2012 Update. High Blood Pressure. Available at: http://www.heart.org/idc/groups/heart-public/@wcm/@sop/@smd/documents/downloadable/ucm_319587.pdf. Accessed on: September 7, 2012.

Controlling high blood pressure is important since it can lead to many further complications. Complications due to high blood pressure include[153]:

- Heart attack or stroke
- Aneurysm
- Heart failure
- Weakened and narrowed blood vessels in your kidneys
- Thickened, narrowed or torn blood vessels in the eyes
- Metabolic syndrome
- Trouble with memory or understanding

Performance Results

Table 6.1—HEDIS 2012 Rates for AHF Healthcare Centers

	Controlling High Blood Pressure 2011	Controlling High Blood Pressure 2012
Rate	**69.6%**	**68.2%**
HPL	NA*	67.6%
MPL	NA*	47.9%

*There was no MPL and HPL in 2011.

Summary of Results

Although the *Controlling High Blood Pressure* measure displayed a statistically insignificant decrease in 2012, AHF Healthcare Centers still exceeded the HPL.

[153] The Mayo Clinic: High blood pressure (hypertension). Complications. Updated August 2012. Available at: http://www.mayoclinic.com/health/high-blood-pressure/DS00100/DSECTION=complications. Accessed on: September 7, 2012.

Colorectal Cancer Screening

Measure Definition

The *Colorectal Cancer Screening* measure calculates the percentage of adults 50 to 75 years of age who had appropriate screening for colorectal cancer.

Importance[154]

Not counting skin cancers, colorectal cancer is the third most common cancer found in men and women in this country. Overall, the lifetime risk of developing colorectal cancer is about 1 in 20. The death rate from colorectal cancer has been going down for more than 20 years. One reason is that there are fewer cases and with preventative colorectal cancer screening, polyps can be found and removed before they turn into cancer.

The American Cancer Society's most recent estimates for colorectal cancer in the United States are for 2011:

- About 101,340 new cases of colon cancer
- About 39,870 new cases of rectal cancer
- About 49,380 deaths from colorectal cancer

Colorectal cancer screening saves lives. Screening can find precancerous polyps—abnormal growths in the colon or rectum—so that they can be removed before turning into cancer. Screening also helps find colorectal cancer at an early stage, when treatment often leads to a cure. About nine out of every 10 people whose colorectal cancer is found early and treated are still alive five years later.

Performance Results

Table 6.2—HEDIS 2011–2012 Rates for AHF Healthcare Centers

	Colorectal Cancer Screening 2011	Colorectal Cancer Screening 2012
Rate	**60.2%**	**64.2%**
HPL	72.3%	74.2%
MPL	56.1%	57.3%

[154] Centers for Disease Control and Prevention. *Basic Information About Colorectal Cancer*. Last updated July 2011. Available at: http://www.cdc.gov/cancer/colorectal/basic_info/index.htm Accessed on: May 1, 2012.

Summary of Results

AHF Healthcare Centers performed above the MPL but below the HPL for this measure in 2012. There was an increase of our percentage points in AHF's rate from 2011 to 2012; however, it was not statistically significant. The DHCS based the MPL and HPL on the 2011 national commercial 25th and 90th percentiles, respectively, since no Medicaid benchmark exists for this measure.

Family Mosaic Project

The Family Mosaic Project (FMP), operated by the City and County of San Francisco Department of Public Health, is a specialty managed care plan in San Francisco County. FMP became operational with the Medi-Cal managed care program in February 1993.

FMP is part of the Child, Youth & Family System of Care operated by the City and County of San Francisco Department of Public Health, Community Behavioral Health Services. FMP provides Medi-Cal managed care to children and adolescents at risk for out-of-home placement with intensive case management and wraparound services through a capitation agreement. To receive services in the Medi-Cal managed care program, a member must meet specific enrollment criteria, including being a San Francisco resident between 3 and 18 years of age, having serious mental health care needs, and being at imminent risk of out-of-home placement or already in an out-of-home placement. FMP submits appropriate clients to the DHCS for approval to be enrolled in FMP's Medi-Cal managed care program. Once a client is approved and under its contract with the DHCS, FMP receives a per-member, per-month capitated rate to provide mental health and related wraparound services to these members.

Due to the unique services FMP provides, standardized HEDIS measures were not appropriate. FMP, with consultation from HSAG, developed two performance measures for 2012 reporting.

Inpatient Hospitalizations

Measure Definition

The percentage of members enrolled into Family Mosaic Project with one or more acute, mental health inpatient hospitalizations during the measurement year. For this measure, a lower rate indicates better performance.

Importance

A goal of FMP is to reduce the number of psychiatric hospitalizations by providing the mental health services and family support needed to avert crises that land children and youth in the hospital. Maintaining members in an outpatient setting and avoiding acute inpatient hospitalization

is one indicator that can be used to determine the effectiveness of FMP's case-management and wraparound services.

Performance Results

Table 6.3—2011–2012 Performance Measure Rates for FMP

Inpatient Hospitalizations			
Data Element	1 Admission*	2 Admissions*	3+ Admissions*
2011	1.7%	0.6%	0%
2012	1.5%	0.5%	0%

*There are no MPLs or HPLs for these measures.

Summary of Results

There was a slight decrease in the rate for one admission from 2011 to 2012 and a slight decrease for two admissions from 2011 to 2012. The rate for three or more admissions remained unchanged. All percentage changes were statistically insignificant.

Reduce Rate of Out-of-Home Placements

Measure Definition

The percentage of members enrolled in Family Mosaic Project who were discharged to an out-of-home placement (foster care, group home, or residential treatment facility) during the measurement period.

Importance

Research has shown adverse effects on the health and well-being of children and adolescents who were placed out-of-home in foster care, group home, and residential treatment facilities, as well as community treatment facilities.[155] Out-of-home placements can be overly restrictive and contribute to behavioral health deterioration. Ensuring that members are maintained in a home-like setting is one goal of FMP.

[155] Family Mosaic Project. Quality Improvement Project, Reducing the Rate of Out-of-Home Placements, 2010 submission.

Performance Results

Table 6.4—2011–2012 Performance Measure Rate for FMP

Out-of-Home Placements		
	Out-of-Home Placements* 2011	Out-of-Home Placements* 2012
Rate	12.2%	6.3%

*There is no MPL or HPL for this measure.

Summary of Results

The rate of *Out-of-Home Placements* dropped from 12.2 percent in 2011 to 6.3 percent in 2012. The percentage decrease in the rate for this measure reflected an improvement in performance, although the change was not statistically significant.

SCAN Health Plan

Senior Care Action Network Health Plan (SCAN Health Plan or SCAN) is a not-for-profit organization that contracts with the DHCS as a specialty plan. SCAN is a Medicare Advantage Special Needs Plan that provides a full range of health care services for elderly members who reside in Los Angeles, Riverside, and San Bernardino counties and who are dually eligible under both the Medicare and Medi-Cal Programs.

SCAN provides a full range of health care services for elderly members who are dually eligible. The plan provides comprehensive medical coverage, prescription benefits, and support services specifically designed for seniors with a goal to enhance the ability of plan members to manage their health and remain independent. SCAN became operational in Los Angeles County with the MCMC Program in 1985. The plan expanded into Riverside and San Bernardino counties in 1997.

SCAN's 2012 performance measures were the HEDIS measures *Breast Cancer Screening* and *Osteoporosis Management in Women Who Had a Fracture*

Breast Cancer Screening

Measure Definition

The *Breast Cancer Screening* measure is reported using only the administrative method. This measure calculates the percentage of women 40 through 69 years of age who had a mammogram in the prior two years.

Importance

Breast cancer is the most prevalent cancer and is the second leading cause of cancer deaths among women.[156] There is a one-in-eight lifetime risk that a woman in the United States will develop breast cancer.[157] The risk factors and mortality rate varies across age and racial/ethnic groups. For example, breast cancer mortality rates tend to be higher in Hispanic and African American women.[158,159] Older women are more at risk for breast cancer than younger women. While women of age 65 years and older make up only 13 percent of the population, they account for 50 percent of new cases and approximately two-thirds of deaths.[160]

Since breast cancer is not preventable, screening tests that allow for the detection of cancer in the early stages is the preeminent method to reduce mortality.[161] Screenings typically detect tumors at an earlier stage of development (i.e., Stage I) than those found outside of screening and can detect cancer in 85 percent of women without symptoms.[162,163] For women 50 to 69 years of age, mammogram screenings decrease breast cancer mortality by up to 35 percent.[164]

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156 Community Preventive Services Task Force. Recommendations for client- and provider-directed interventions to increase breast, cervical, and colorectal cancer screening. *American Journal of Preventive Medicine.* 2008; 35 (1 Supplement): S21-S25.

157 National Committee for Quality Assurance. *The State of Health Care Quality 2009*: NCQA; 2009.

158 Centers for Disease Control and Prevention (CDC). *Cancer Among Women.* Atlanta, GA: CDC 2010. Available at: http://www.cdc.gov/cancer/dcpc/data/women.htm Accessed on: May 1, 2012.

159 Harper S, Lynch J, Meersman SC, et al. Trends in Area-Socioeconomic and Race-Ethnic Disparities in Breast Cancer Incidence, Stage at Diagnosis, Screening, Mortality, and Survival Among Women Ages 50 Years and Over (1987-2005). *Cancer Epidemiology, Biomarkers & Prevention.* 2009; 18(1): 121-131.

160 Mandelblatt JS, Schechter CB, Yabroff KR, et al. Toward optimal screening strategies for older women. Costs, benefits, and harms of breast cancer screening by age, biology, and health status. *Journal of General Internal Medicine.* 2005; 20(6): 487-496.

161 USPSTF. Screening for breast cancer: U.S. Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine.* 2009; 151(10): 716-726, W-236.

162 National Committee for Quality Assurance. *The State of Health Care Quality 2009*: NCQA; 2009.

163 Shen Y, Yang Y, Inoue LY, et al. Role of Detection Method in Predicting Breast Cancer Survival: Analysis of Randomized Screening Trials. *Journal of the National Cancer Institute.* 2005; 97(16): 1195-1203.

164 National Committee for Quality Assurance. *The State of Health Care Quality 2009*: NCQA; 2009.

In addition to the personal loss, breast cancer accounts for substantial costs to the U.S. health care system. Breast cancer accounts for 20 percent to 25 percent of all cancer costs.[165] It is estimated that breast cancer in the United States costs $7 billion per year. However, treatment for breast cancer detected in earlier stages costs significantly less than treatment for more advanced stages.[166]

Performance Results

Table 6.5—HEDIS 2011–2012 Rates for SCAN Health Plan

	Breast Cancer Screening 2011	Breast Cancer Screening 2012
Rate	**76.2%**	**79.9%**
HPL*	NA	62.9%
MPL*	NA	45.3%

* 2011 was the first year of measurement for the Breast Cancer Screening measure, so no HPL or MPL was available.

Summary of Results

SCAN improved its performance in 2012 by 3.6 percentage points; the plan also performed above the HPL in 2012.

Osteoporosis Management in Women Who Had a Fracture

Measure Definition

This measure is used to assess the percentage of women 67 years of age and older who suffered a fracture, and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

Importance

Osteoporosis is a skeletal disorder characterized by compromised bone strength that puts a person at increased risk for fracture. Morbidity and mortality related to osteoporotic fractures are a major health issue. Ten million Americans have osteoporosis, and another 18 million are at risk for osteoporosis due to low bone mass. Eighty percent of people with osteoporosis are women. Women who suffer a fracture are at increased risk of suffering additional fractures.[172]

Treatment of osteoporotic fractures is estimated at $10 to $15 billion annually in the U.S. In 1995, osteoporotic fractures caused 432,000 hospital admissions, 2.5 million physician visits and 180,000 nursing home admissions.[172] The aging U.S. population is likely to increase the future financial cost of osteoporosis care.

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165 Radice D, Redaelli A. Breast Cancer Management: Quality-of-Life and Cost Considerations. *Pharmacoeconomics*. 2003; 21(6): 383-396.

166 National Committee for Quality Assurance. *The State of Health Care Quality 2009*: NCQA; 2009.

One study showed that less than 5 percent of patients with osteoporotic fractures are referred for medical evaluation and treatment. Another retrospective study of over 1,000 postmenopausal women who sustained a fracture of the distal radius found that only 2 percent received either a diagnostic evaluation or treatment for the condition.

Performance Results

Table 6.6—HEDIS 2012 Rates for SCAN Health Plan

	Osteoporosis Management in Women Who Had a Fracture 2012
Rate	**29.7%**
HPL*	29.8%
MPL*	15.6%

* MPLs/HPLs for OMW were based on NCQA's Medicare HEDIS 2011 Audit Means, Percentiles, and Ratios. MPLs and HPLs are established using the National Medicare 25th and 90th percentiles. Medicaid percentiles were used as there are no Medicaid benchmarks available for this measure.

Summary of Results

In 2012, SCAN Health Plan reported rates for the *Osteoporosis Management in Women Who Had a Fracture* measure for the first time. Additional analysis of performance measure results will be provided in subsequent years when more than one year of data is available for comparison.

Utilization information can be helpful to plans in reviewing patterns of suspected under- and overutilization of services; however, data should be used with caution as high and low rates do not necessarily indicate better or worse performance. For this reason, the DHCS does not establish performance thresholds for these measures, and HSAG does not provide comparative analysis.

Ambulatory Care

Measure Definition

This measure summarizes utilization of ambulatory services in the following categories:

- Outpatient visits
- Emergency department (ED) visits

Outpatient visits include office visits or routine visits to hospital outpatient departments. Emergency rooms often deliver nonemergency care.[167]

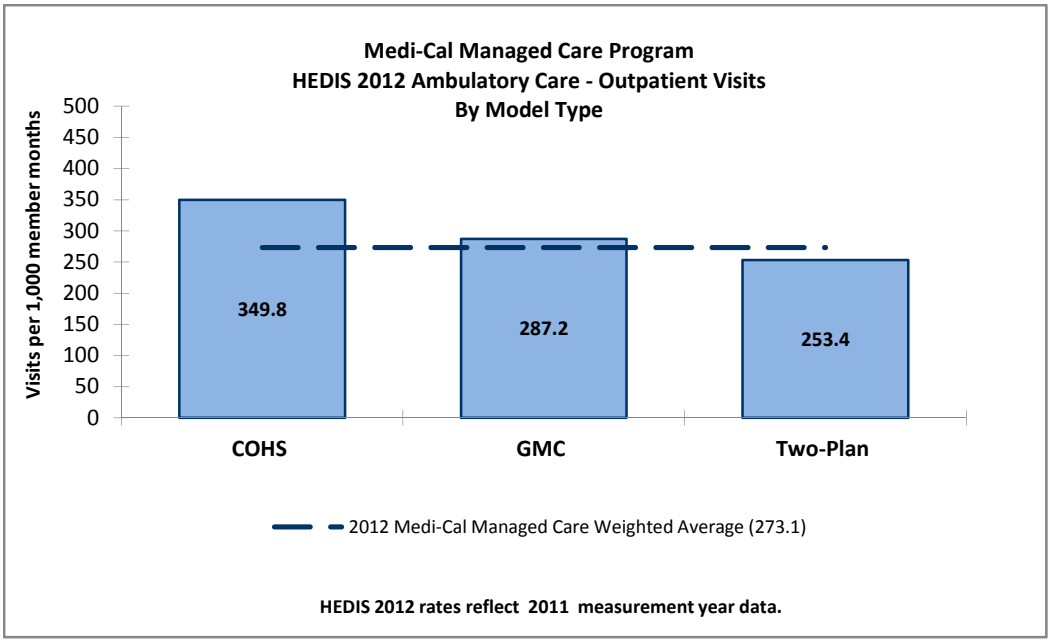
Importance

Use of services measures provide information about how plans manage the provision of care to their members and use and manage resources. However, use of services measures are not totally controlled by the plans and are affected by many member characteristics, which can vary greatly among plans, and include age and sex, current medical condition, socioeconomic status, and regional practice patterns. The results of these measures should be considered informational and a starting point for discussion about how resources are used, the extent of care, and possible inappropriate care.[168]

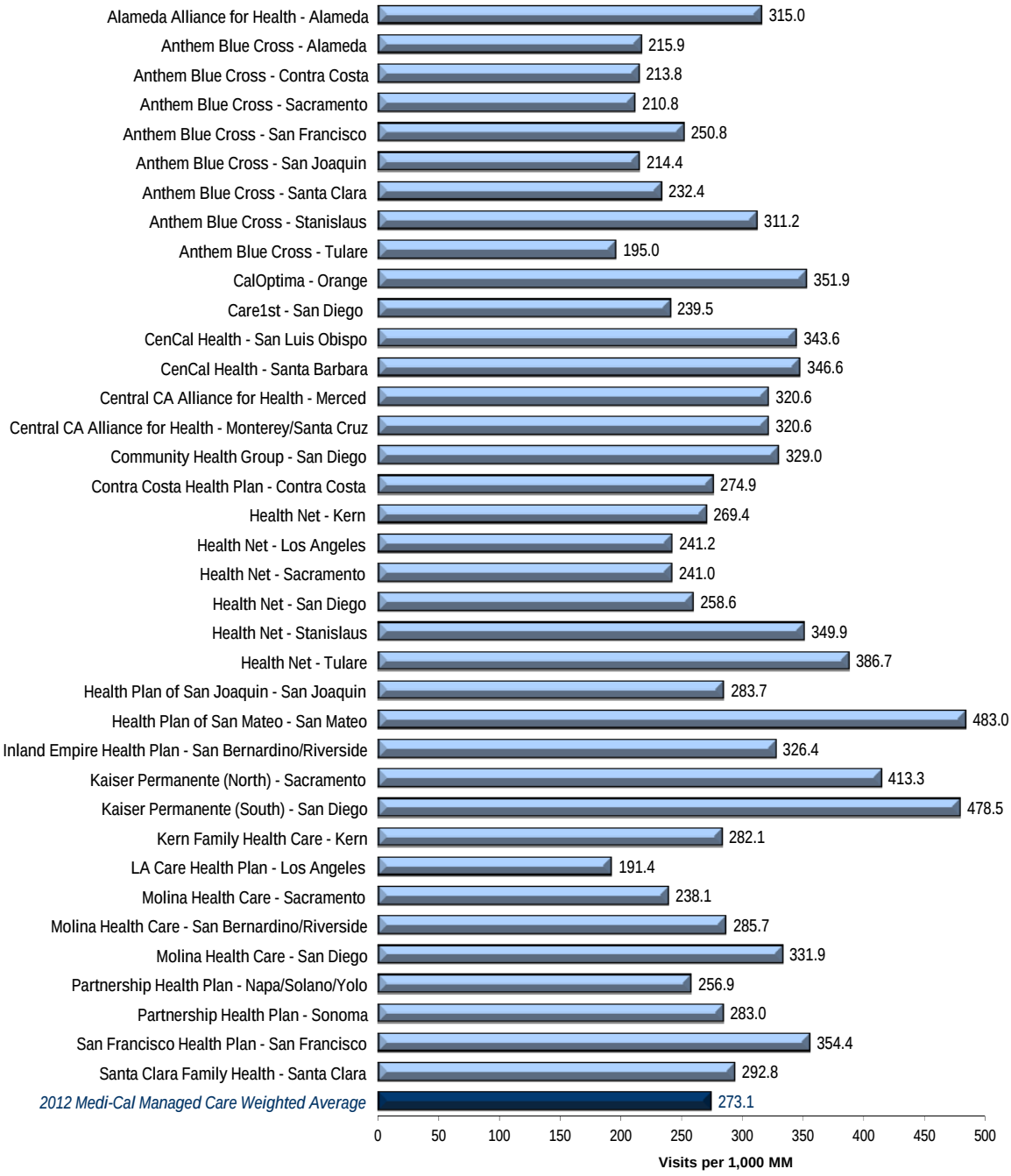
[167] National Quality Measures Clearinghouse. Measure Summary, *Ambulatory care: summary of utilization of ambulatory care in the following categories: outpatient visits and emergency department visits*. AHRQ. 2010. Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=34130.Accessed on: August 20, 2012.

[168] Ibid

Performance Results—Outpatient Visits



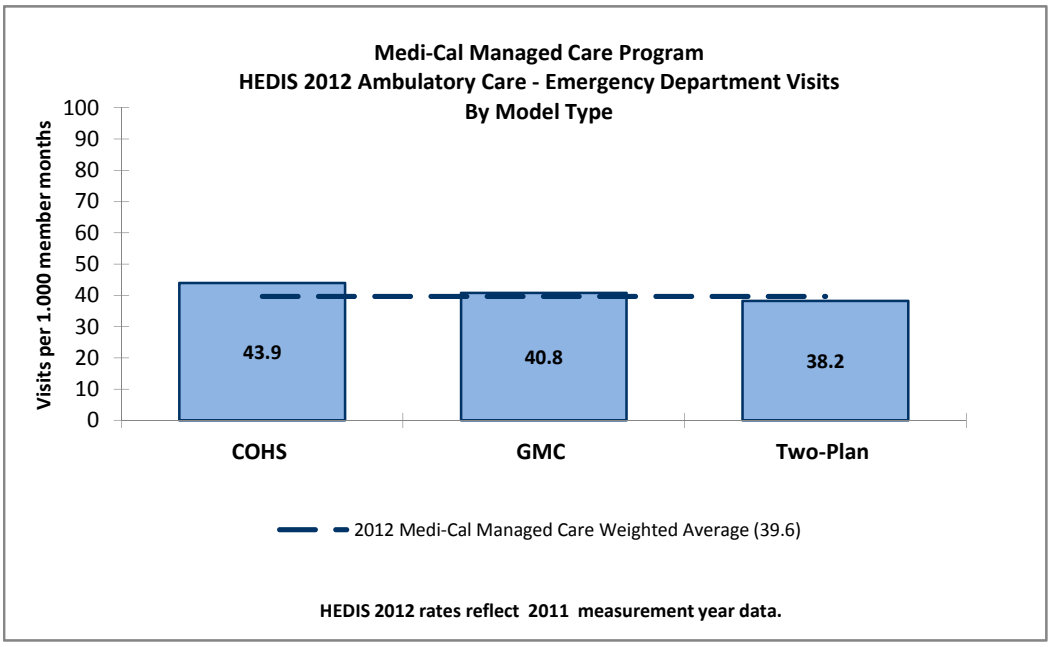
Medi-Cal Managed Care
HEDIS 2012 Ambulatory Care—Outpatient Visits



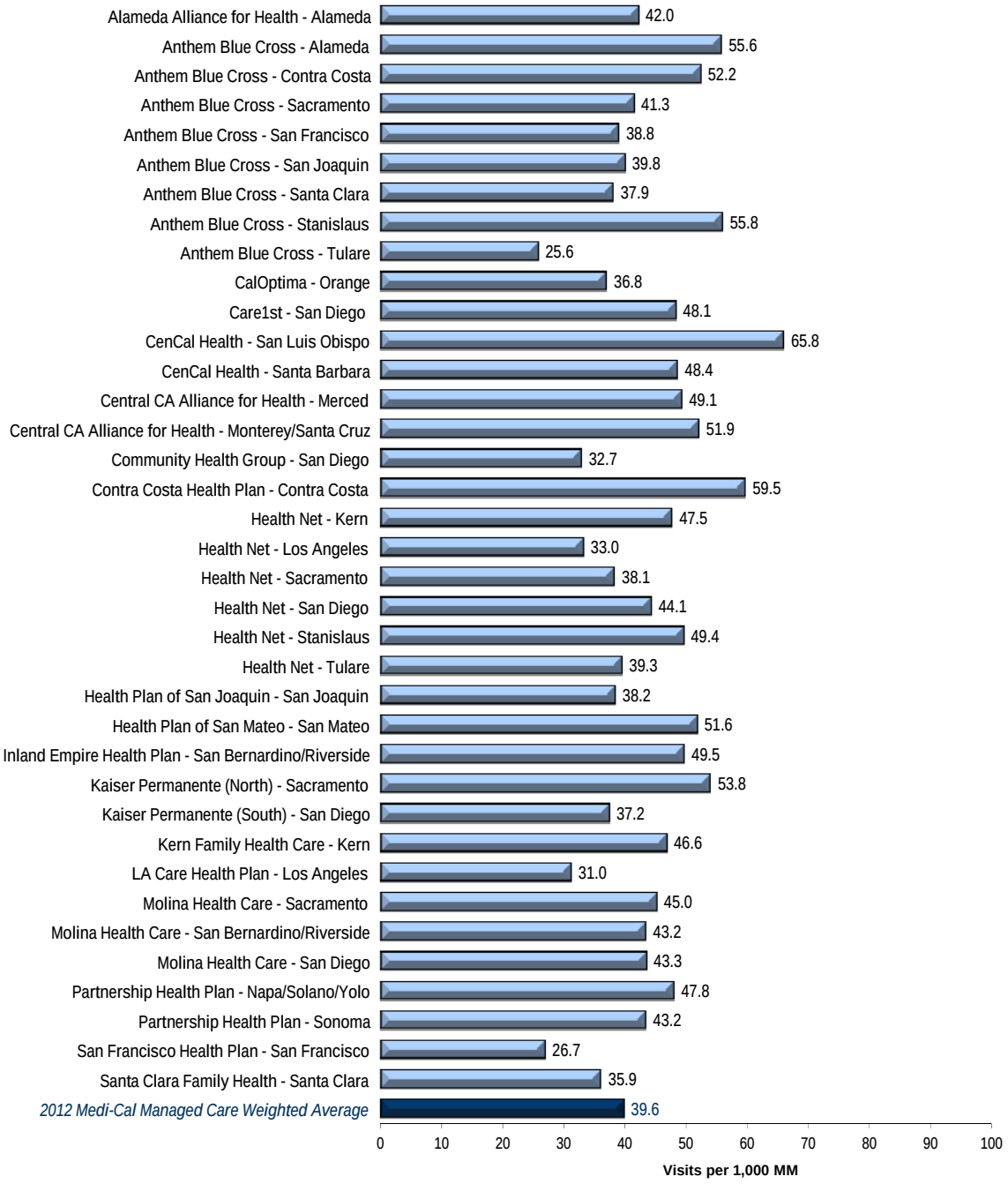
The DHCS did not require a Minimum Performance Level and High Performance Level for this measure because high and low rates do not necessarily indicate better or worse performance.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Performance Results—Emergency Department Visits



Medi-Cal Managed Care
HEDIS 2012 Ambulatory Care—Emergency Department Visits



The DHCS did not require a Minimum Performance Level and High Performance Level for this measure because high and low rates do not necessarily indicate better or worse performance.

Note: HEDIS 2012 rates reflect 2011 measurement year data.

Table A.1—National HEDIS 2011 Medicaid Percentiles

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Adolescent Well-Care Visits	35.0%	39.6%	46.1%	57.2%	64.1%
Ambulatory Care—Emergency Department Visits per 1,000 MM	44.4	55.7	63.3	70.5	76.6
Ambulatory Care—Outpatient Visits per 1,000 MM	264.5	314.7	349.5	391.9	439
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	79.9%	83.6%	86.5%	88.6%	90.6%
Annual Monitoring for Patients on Persistent Medications—Digoxin	80.4%	87.5%	90.3%	93.3%	95.5%
Annual Monitoring for Patients on Persistent Medications—Diuretics	79.3%	82.8%	85.8%	88.6%	90.7%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	15.1%	18.8%	22.0%	26.2%	31.6%
Cervical Cancer Screening	53.0%	64.0%	69.7%	74.2%	78.7%
Childhood Immunization Status—Combination 3	56.8%	64.4%	71.0%	76.7%	82.6%
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	92.6%	95.1%	97.0%	97.8%	98.6%
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	82.0%	86.8%	89.6%	91.2%	92.7%
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	85.2%	87.9%	91.3%	93.3%	94.7%
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	81.1%	86.5%	89.7%	91.9%	93.4%
Comprehensive Diabetes Care—HbA1 Testing	73.6%	77.6%	82.2%	87.1%	90.9%
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	29.1%	34.9%	42.6%	52.1%	60.4%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	33.8%	39.9%	47.4%	54.8%	59.1%
Comprehensive Diabetes Care—LDL-C Screening	63.7%	70.4%	75.4%	80.3%	84.2%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	21.5%	27.3%	35.2%	41.4%	45.9%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	34.0%	43.8%	52.8%	63.7%	70.6%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.1%	73.9%	78.5%	82.5%	86.9%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	43.8%	54.3%	61.2%	68.3%	76.0%
Immunizations for Adolescents—Combination 1	33.8%	40.0%	49.8%	63.7%	75.5%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	71.4%	80.3%	86.0%	90.0%	93.2%
Prenatal and Postpartum Care—Postpartum Care	53.7%	59.6%	64.6%	70.6%	75.2%

Table A.1—National HEDIS 2011 Medicaid Percentiles

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Use of Imaging Studies for Low Back Pain	67.0%	72.3%	75.6%	79.7%	82.3%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	0.7%	19.7%	37.5%	58.8%	69.8%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	0.7%	39.0%	51.1%	61.6%	72.0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	0.0%	28.5%	40.6%	51.0%	60.6%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.9%	66.1%	72.3%	77.6%	82.9%

*For this measure, a lower rate indicates better performance.
Source: NCQA. Medicaid HEDIS 2011 Audit Means, Percentiles, and Ratios.

Tables B.1 through B.37 provide three-year trending information for each plan across the reported measures. The following audit findings are provided within the table:

– = A year that data was not collected.

NR = A *Not Report* audit finding. The rate could not be publically reported because it was either materially biased or the plan chose not to report the result.

NA = A *Not Applicable* audit finding because the plan's denominator was too small.

Within Tables B.1 through B.37, HSAG calculated statistical significance testing between the 2011 and 2012 rates for each measure using a chi-square test and displayed this information within the "2011–2012 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2012 were significantly higher than they were in 2011.

↓ = Rates in 2012 were significantly lower than they were in 2011.

↔ = Rates in 2012 were not significantly different than they were in 2011.

Different symbols (▲▼) are used to indicate a performance change for *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2012 rate from the 2011 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2012 rate from the 2011 rate.

Not comparable = A 2011–2012 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Table B.1—HEDIS 2012 Trend Table for Alameda Alliance for Health—Alameda County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	38.7%	40.7%	45.0%	↔
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	42.0	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	315.0	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	87.0%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	86.4%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	84.8%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	29.8%	35.6%	31.5%	↔
Cervical Cancer Screening	62.1%	67.7%	68.4%	↔
Childhood Immunization Status—Combination 3	71.3%	47.9%	78.1%	↑
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	94.6%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	85.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	85.6%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	82.0%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	77.5%	84.0%	83.2%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	54.3%	49.9%	28.5%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	36.9%	40.0%	58.9%	↑
Comprehensive Diabetes Care—LDL-C Screening	70.3%	74.3%	76.9%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.5%	34.1%	43.6%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	25.5%	40.0%	52.6%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.2%	81.7%	83.0%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	57.1%	55.7%	59.9%	↔
Immunizations for Adolescents—Combination 1	—	—	66.7%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	60.5%	64.7%	88.6%	↑
Prenatal and Postpartum Care—Postpartum Care	50.9%	58.8%	61.1%	↔
Use of Imaging Studies for Low Back Pain	87.1%	84.3%	84.8%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	37.0%	39.6%	55.2%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	83.8%	80.1%	58.6%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	60.4%	55.8%	41.6%	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.9%	68.8%	77.6%	↑

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.2—HEDIS 2012 Trend Table for Anthem Blue Cross—Alameda County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	26.5%	32.8%	39.4%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	55.6	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	215.9	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	79.4%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	72.9%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	32.0%	34.3%	39.1%	↔
Cervical Cancer Screening	61.6%	54.0%	58.2%	↔
Childhood Immunization Status—Combination 3	54.3%	66.9%	70.6%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	93.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	82.9%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	84.1%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	79.4%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	72.5%	72.7%	73.5%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	33.8%	53.5%	60.6%	▼
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	34.5%	37.7%	32.4%	↔
Comprehensive Diabetes Care—LDL-C Screening	63.7%	68.4%	66.9%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	22.1%	29.2%	22.4%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	32.4%	28.0%	35.3%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	65.9%	68.9%	68.9%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	40.1%	50.6%	47.4%	↔
Immunizations for Adolescents—Combination 1	—	—	65.0%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	75.9%	65.9%	73.0%	↑
Prenatal and Postpartum Care—Postpartum Care	43.3%	51.1%	50.6%	↔
Use of Imaging Studies for Low Back Pain	86.4%	86.9%	91.5%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	23.4%	47.0%	44.0%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	33.3%	55.2%	62.0%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	20.4%	28.5%	31.1%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	54.0%	62.0%	73.7%	↑

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.3—HEDIS 2012 Trend Table for Anthem Blue Cross—Contra Costa County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	21.2%	26.8%	40.1%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	52.2	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	213.8	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	76.7%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	67.9%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	42.9%	30.0%	NA	Not Comparable
Cervical Cancer Screening	55.0%	53.0%	58.2%	↔
Childhood Immunization Status—Combination 3	48.9%	68.6%	68.4%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	93.0%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	82.7%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	80.0%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	80.3%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	66.7%	69.6%	67.2%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	34.3%	58.4%	65.7%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	25.9%	35.2%	29.2%	↔
Comprehensive Diabetes Care—LDL-C Screening	63.9%	61.6%	57.7%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	19.4%	26.4%	16.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	23.1%	26.4%	36.5%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	63.0%	66.4%	65.0%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	39.8%	55.2%	46.7%	↔
Immunizations for Adolescents—Combination 1	—	—	65.0%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	66.1%	69.4%	76.3%	↔
Prenatal and Postpartum Care—Postpartum Care	28.8%	43.5%	48.1%	↔
Use of Imaging Studies for Low Back Pain	82.4%	85.9%	92.6%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	33.8%	49.1%	42.6%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	36.7%	52.8%	53.8%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	29.2%	35.3%	25.5%	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	37.0%	63.3%	67.4%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.4—HEDIS 2012 Trend Table for Anthem Blue Cross—Sacramento County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	36.5%	28.7%	51.3%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	41.3	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	210.8	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	61.7%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	61.8%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	30.9%	23.1%	24.1%	↔
Cervical Cancer Screening	58.4%	61.8%	58.9%	↔
Childhood Immunization Status—Combination 3	53.0%	57.7%	57.4%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	94.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	81.9%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	81.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	80.2%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	71.8%	76.4%	76.2%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	47.7%	47.9%	42.6%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.7%	43.6%	49.1%	↔
Comprehensive Diabetes Care—LDL-C Screening	65.0%	64.5%	62.0%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	22.9%	29.7%	25.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	30.9%	28.2%	32.4%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	63.3%	72.0%	71.5%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	50.4%	55.0%	56.2%	↔
Immunizations for Adolescents—Combination 1	—	—	51.6%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	71.8%	70.3%	76.9%	↑
Prenatal and Postpartum Care—Postpartum Care	52.1%	49.9%	54.3%	↔
Use of Imaging Studies for Low Back Pain	83.9%	83.7%	84.9%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	33.6%	49.9%	63.0%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	42.3%	59.6%	71.3%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	27.5%	27.7%	39.4%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.3%	73.7%	64.3%	↓

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.5—HEDIS 2012 Trend Table for Anthem Blue Cross—San Francisco County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	53.8%	55.7%	63.3%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	38.8	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	250.8	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	80.1%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	79.1%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	52.1%	50.0%	50.5%	↔
Cervical Cancer Screening	70.1%	74.5%	74.1%	↔
Childhood Immunization Status—Combination 3	75.2%	79.1%	72.4%	↓
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	95.4%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	90.8%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	91.7%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	89.6%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	84.3%	84.2%	83.7%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	18.6%	32.5%	34.0%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.7%	55.7%	53.5%	↔
Comprehensive Diabetes Care—LDL-C Screening	77.1%	75.4%	69.8%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	35.7%	36.0%	37.7%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	46.7%	46.3%	51.6%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.9%	81.8%	80.0%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	68.6%	75.4%	62.3%	↓
Immunizations for Adolescents—Combination 1	—	—	69.4%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.4%	88.0%	85.7%	↔
Prenatal and Postpartum Care—Postpartum Care	57.4%	55.5%	64.0%	↔
Use of Imaging Studies for Low Back Pain	77.4%	85.4%	80.4%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	59.1%	53.5%	73.2%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	69.6%	70.8%	79.3%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	52.1%	56.2%	71.8%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.5%	76.4%	80.0%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.6—HEDIS 2012 Trend Table for Anthem Blue Cross—San Joaquin County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	41.4%	41.1%	51.1%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	39.8	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	214.4	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	80.1%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	79.1%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	21.5%	8.8%	11.6%	↔
Cervical Cancer Screening	58.9%	61.6%	55.4%	↔
Childhood Immunization Status—Combination 3	69.1%	64.5%	67.9%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	90.7%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	74.0%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	80.0%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	78.0%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	75.0%	77.9%	73.5%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	34.2%	57.4%	50.1%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	34.4%	35.5%	43.1%	↑
Comprehensive Diabetes Care—LDL-C Screening	72.8%	72.5%	68.1%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	24.0%	28.7%	30.7%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	36.1%	37.7%	36.5%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	75.7%	76.9%	74.7%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	50.7%	56.7%	61.6%	↔
Immunizations for Adolescents—Combination 1	—	—	59.4%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.9%	79.3%	78.6%	↔
Prenatal and Postpartum Care—Postpartum Care	48.9%	51.3%	48.2%	↔
Use of Imaging Studies for Low Back Pain	79.8%	76.4%	78.1%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	55.5%	49.9%	63.5%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	60.6%	70.6%	81.5%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	20.2%	28.7%	60.3%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.3%	74.9%	73.8%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.7—HEDIS 2012 Trend Table for Anthem Blue Cross—Santa Clara County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	48.7%	44.3%	52.8%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	37.9	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	232.4	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	85.0%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	84.2%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.7%	28.8%	20.0%	↓
Cervical Cancer Screening	71.3%	72.0%	72.2%	↔
Childhood Immunization Status—Combination 3	64.2%	70.6%	66.9%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	95.6%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	86.7%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	87.6%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	86.3%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	81.3%	87.3%	85.9%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	22.6%	31.9%	29.4%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	50.1%	60.1%	61.3%	↔
Comprehensive Diabetes Care—LDL-C Screening	81.8%	84.7%	82.7%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.0%	46.7%	47.2%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.5%	53.8%	64.5%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.1%	83.0%	79.6%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	66.4%	72.5%	65.7%	↓
Immunizations for Adolescents—Combination 1	—	—	60.1%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.1%	83.5%	79.5%	↔
Prenatal and Postpartum Care—Postpartum Care	55.5%	65.7%	60.6%	↔
Use of Imaging Studies for Low Back Pain	80.1%	83.9%	82.4%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	56.0%	65.7%	53.3%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	55.0%	63.5%	70.6%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	55.0%	35.5%	38.4%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.9%	70.1%	76.7%	↑

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.8—HEDIS 2012 Trend Table for Anthem Blue Cross—Stanislaus County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	34.3%	29.9%	45.5%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	55.8	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	311.2	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	83.0%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	83.2%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	22.0%	24.9%	25.0%	↔
Cervical Cancer Screening	67.9%	67.2%	61.2%	↔
Childhood Immunization Status—Combination 3	65.2%	58.9%	65.7%	↑
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	96.0%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	89.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	88.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	85.8%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	80.5%	76.2%	76.2%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	30.0%	58.4%	44.0%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	43.2%	34.1%	49.6%	↑
Comprehensive Diabetes Care—LDL-C Screening	78.0%	72.3%	70.6%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.8%	24.8%	32.1%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	38.5%	22.4%	40.6%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	75.6%	71.3%	72.7%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	56.6%	57.7%	65.2%	↑
Immunizations for Adolescents—Combination 1	—	—	54.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.1%	84.6%	88.6%	↔
Prenatal and Postpartum Care—Postpartum Care	54.3%	53.7%	56.7%	↔
Use of Imaging Studies for Low Back Pain	81.5%	79.5%	80.5%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	34.5%	33.1%	49.6%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	40.9%	45.0%	63.0%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	20.2%	23.1%	37.2%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.7%	69.3%	64.4%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.9—HEDIS 2012 Trend Table for Anthem Blue Cross—Tulare County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	29.9%	35.8%	48.7%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	25.6	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	195.0	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	70.5%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	69.0%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.6%	15.8%	20.2%	↑
Cervical Cancer Screening	71.0%	67.2%	68.9%	↔
Childhood Immunization Status—Combination 3	68.1%	69.1%	65.0%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	92.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	71.0%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	81.8%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	82.2%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	76.6%	77.1%	77.1%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	27.3%	49.6%	45.7%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	43.1%	42.1%	45.3%	↔
Comprehensive Diabetes Care—LDL-C Screening	72.5%	69.8%	68.6%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.4%	31.9%	33.1%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	27.7%	29.2%	33.1%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.7%	76.9%	77.6%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.5%	65.0%	68.1%	↔
Immunizations for Adolescents—Combination 1	—	—	57.9%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	74.0%	82.7%	83.1%	↔
Prenatal and Postpartum Care—Postpartum Care	46.5%	64.0%	53.1%	↓
Use of Imaging Studies for Low Back Pain	78.1%	79.6%	80.9%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	43.8%	32.6%	83.9%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	48.7%	48.9%	68.1%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	39.4%	30.2%	50.4%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.1%	73.2%	72.0%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.10—HEDIS 2012 Trend Table for CalOptima—Orange County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	55.7%	60.1%	67.5%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	36.8	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	351.9	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	90.3%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	90.4%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	89.3%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	21.8%	21.8%	20.7%	↔
Cervical Cancer Screening	71.7%	75.4%	72.0%	↔
Childhood Immunization Status—Combination 3	82.4%	84.5%	81.3%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	97.7%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	92.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	92.0%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	90.4%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	87.3%	86.1%	86.5%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	29.5%	28.5%	31.0%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	62.3%	61.2%	58.7%	↔
Comprehensive Diabetes Care—LDL-C Screening	85.3%	84.5%	85.6%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	45.5%	48.1%	50.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.1%	61.7%	69.2%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.0%	83.2%	85.4%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	72.1%	70.4%	73.8%	↔
Immunizations for Adolescents—Combination 1	—	—	69.2%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.5%	85.8%	84.8%	↔
Prenatal and Postpartum Care—Postpartum Care	68.0%	72.4%	69.4%	↔
Use of Imaging Studies for Low Back Pain	77.8%	77.2%	79.0%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	68.3%	72.3%	76.9%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	75.2%	76.3%	81.4%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	63.9%	68.1%	71.6%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	86.1%	82.5%	82.5%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.11—HEDIS 2012 Trend Table for Care1st Health Plan—San Diego County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	42.6%	45.0%	52.6%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	48.1	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	239.5	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	89.2%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	86.8%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.3%	28.0%	15.4%	↔
Cervical Cancer Screening	68.4%	64.5%	66.9%	↔
Childhood Immunization Status—Combination 3	79.8%	79.8%	73.2%	↓
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	90.6%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	78.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	81.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	77.8%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	81.4%	83.6%	88.8%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	39.8%	30.9%	36.9%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.9%	52.7%	49.0%	↔
Comprehensive Diabetes Care—LDL-C Screening	77.9%	80.6%	81.5%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	47.8%	46.1%	38.2%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	51.3%	41.8%	47.4%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.3%	87.3%	88.4%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	69.9%	66.1%	73.9%	↔
Immunizations for Adolescents—Combination 1	—	—	62.1%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.5%	80.0%	85.0%	↔
Prenatal and Postpartum Care—Postpartum Care	60.0%	60.5%	67.1%	↔
Use of Imaging Studies for Low Back Pain	75.4%	61.0%	82.7%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	50.4%	57.2%	65.9%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	49.6%	63.3%	68.4%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	29.2%	36.3%	46.7%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.9%	76.8%	73.4%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.12—HEDIS 2012 Trend Table for CenCal Health—Santa Barbara County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	41.0%	40.9%	48.9%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	48.4	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	346.6	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	86.9%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	87.2%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	60.3%	31.6%	29.6%	↔
Cervical Cancer Screening	68.5%	73.9%	71.6%	↔
Childhood Immunization Status—Combination 3	81.7%	82.3%	85.2%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	97.3%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	90.4%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	89.7%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	87.7%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	81.1%	81.8%	92.2%	↑
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	29.1%	29.0%	22.6%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	61.8%	61.6%	69.3%	↑
Comprehensive Diabetes Care—LDL-C Screening	79.6%	76.9%	85.2%	↑
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	45.6%	45.7%	50.1%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.9%	70.3%	71.3%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.2%	79.6%	87.3%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	69.8%	69.6%	69.1%	↔
Immunizations for Adolescents—Combination 1	—	—	70.1%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	81.7%	83.5%	80.7%	↔
Prenatal and Postpartum Care—Postpartum Care	74.4%	77.6%	76.4%	↔
Use of Imaging Studies for Low Back Pain	87.8%	80.7%	80.5%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	55.0%	59.1%	66.4%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	65.9%	72.5%	67.9%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	11.6%	39.2%	44.8%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.3%	74.4%	76.0%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.13—HEDIS 2012 Trend Table for CenCal Health—San Luis Obispo County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	36.3%	41.8%	39.9%	↔
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	65.8	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	343.6	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	82.9%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	82.4%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	55.7%	34.4%	33.3%	↔
Cervical Cancer Screening	56.2%	58.5%	64.8%	↔
Childhood Immunization Status—Combination 3	74.5%	76.3%	76.4%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	96.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	87.3%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	88.3%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	86.1%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	79.2%	73.7%	81.0%	↑
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	32.8%	41.1%	32.6%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	55.9%	51.3%	59.4%	↑
Comprehensive Diabetes Care—LDL-C Screening	77.6%	75.4%	78.6%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	39.9%	38.7%	41.4%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	69.4%	60.8%	61.6%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.3%	79.3%	84.7%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.5%	66.9%	67.6%	↔
Immunizations for Adolescents—Combination 1	—	—	60.1%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.7%	84.5%	82.8%	↔
Prenatal and Postpartum Care—Postpartum Care	69.4%	70.4%	70.1%	↔
Use of Imaging Studies for Low Back Pain	86.9%	78.4%	77.9%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	33.2%	47.0%	62.3%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	50.8%	57.9%	59.6%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	20.0%	34.8%	47.7%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.5%	63.7%	69.8%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.14—HEDIS 2012 Trend Table for Central CA Alliance for Health—Monterey/Santa Cruz Counties

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	51.8%	46.5%	64.7%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	51.9	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	320.6	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	88.3%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	87.9%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	89.0%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.3%	26.4%	28.0%	↔
Cervical Cancer Screening	74.7%	71.3%	73.2%	↔
Childhood Immunization Status—Combination 3	81.5%	82.7%	84.2%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	97.4%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	91.1%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	89.6%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	88.9%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	90.3%	89.1%	92.0%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	21.4%	33.3%	28.2%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	58.6%	56.4%	61.8%	↔
Comprehensive Diabetes Care—LDL-C Screening	85.2%	84.4%	84.9%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	47.7%	45.7%	47.2%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.3%	65.9%	67.4%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.6%	82.5%	79.8%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	70.8%	71.8%	76.6%	↔
Immunizations for Adolescents—Combination 1	—	—	64.0%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.1%	93.4%	86.1%	↓
Prenatal and Postpartum Care—Postpartum Care	77.9%	75.4%	77.6%	↔
Use of Imaging Studies for Low Back Pain	82.7%	86.1%	85.1%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	50.6%	69.8%	79.1%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	58.6%	72.3%	80.3%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	34.1%	61.3%	61.3%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	82.5%	83.5%	83.2%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.15—HEDIS 2012 Trend Table for Central CA Alliance for Health—Merced County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	—	37.2%	48.9%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	49.1	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	320.6	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	86.4%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	87.3%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	15.1%	11.6%	↔
Cervical Cancer Screening	—	53.0%	57.9%	↔
Childhood Immunization Status—Combination 3	—	55.2%	64.7%	↑
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	96.9%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	91.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	89.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	87.6%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	—	86.1%	87.8%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	—	44.0%	37.2%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	46.7%	51.3%	↔
Comprehensive Diabetes Care—LDL-C Screening	—	80.0%	80.3%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	36.0%	38.0%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	41.6%	56.2%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	86.4%	82.5%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	67.2%	64.5%	↔
Immunizations for Adolescents—Combination 1	—	—	50.1%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	88.3%	85.4%	↔
Prenatal and Postpartum Care—Postpartum Care	—	63.0%	59.6%	↔
Use of Imaging Studies for Low Back Pain	—	79.9%	84.1%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	46.7%	58.9%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	62.3%	64.2%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	40.4%	44.3%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	74.0%	72.5%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.16—HEDIS 2012 Trend Table for Community Health Group—San Diego County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	37.0%	42.9%	51.8%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	32.7	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	329.0	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	87.1%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	85.0%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.2%	17.3%	14.1%	↔
Cervical Cancer Screening	63.0%	65.2%	69.1%	↔
Childhood Immunization Status—Combination 3	72.3%	78.1%	74.0%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	96.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	90.3%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	89.6%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	88.5%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	81.0%	88.3%	87.3%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	44.0%	37.7%	43.8%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	38.2%	52.3%	47.7%	↔
Comprehensive Diabetes Care—LDL-C Screening	73.4%	84.7%	82.2%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	26.5%	40.6%	35.0%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.6%	61.1%	53.3%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	71.0%	77.2%	79.1%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.0%	65.7%	57.2%	↓
Immunizations for Adolescents—Combination 1	—	—	73.5%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	76.6%	79.1%	77.9%	↔
Prenatal and Postpartum Care—Postpartum Care	52.1%	57.2%	60.1%	↔
Use of Imaging Studies for Low Back Pain	79.1%	77.7%	75.0%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	38.4%	63.3%	73.5%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	44.8%	69.8%	71.5%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	34.5%	40.4%	56.0%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.9%	75.0%	77.1%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.17—HEDIS 2012 Trend Table for Contra Costa Health Plan—Contra Costa County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	38.7%	40.6%	41.6%	↔
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	59.5	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	274.9	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	85.6%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	80.9%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	31.9%	29.6%	26.5%	↔
Cervical Cancer Screening	69.3%	70.6%	66.7%	↔
Childhood Immunization Status—Combination 3	77.1%	87.2%	85.4%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	94.0%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	84.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	84.1%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	83.3%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	85.4%	86.9%	84.9%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	31.8%	33.9%	37.0%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	52.6%	56.6%	53.0%	↔
Comprehensive Diabetes Care—LDL-C Screening	78.6%	77.7%	75.4%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	40.7%	40.7%	36.3%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.5%	49.1%	52.8%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.5%	89.2%	87.3%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	53.1%	55.1%	55.0%	↔
Immunizations for Adolescents—Combination 1	—	—	59.9%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.7%	81.8%	83.2%	↔
Prenatal and Postpartum Care—Postpartum Care	68.1%	67.4%	65.0%	↔
Use of Imaging Studies for Low Back Pain	87.1%	88.6%	88.6%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	18.5%	61.1%	59.4%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	49.1%	58.9%	55.7%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	38.4%	46.5%	46.5%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.7%	78.8%	77.9%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.18—HEDIS 2012 Trend Table for Health Net—Kern County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	32.4%	38.0%	49.9%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	47.5	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	269.4	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	77.7%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	79.6%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	17.6%	18.2%	17.2%	↔
Cervical Cancer Screening	66.2%	63.7%	67.2%	↔
Childhood Immunization Status—Combination 3	66.2%	70.4%	71.3%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	93.8%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	80.8%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	78.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	81.2%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	83.3%	79.1%	78.5%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	39.8%	48.8%	50.6%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	49.1%	40.6%	40.9%	↔
Comprehensive Diabetes Care—LDL-C Screening	81.4%	76.4%	73.2%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.1%	36.5%	35.6%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	54.0%	50.2%	54.0%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	87.2%	82.7%	83.1%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58.4%	58.4%	65.8%	↑
Immunizations for Adolescents—Combination 1	—	—	60.6%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.5%	86.3%	89.5%	↔
Prenatal and Postpartum Care—Postpartum Care	61.5%	62.4%	62.4%	↔
Use of Imaging Studies for Low Back Pain	79.0%	73.5%	75.3%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	49.4%	53.2%	55.3%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	59.7%	69.7%	71.2%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	23.8%	41.7%	51.2%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.3%	72.0%	69.2%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.19—HEDIS 2012 Trend Table for Health Net—Los Angeles County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	40.1%	46.2%	55.4%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	33.0	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	241.2	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	74.0%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	77.0%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	74.1%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	31.0%	20.2%	21.4%	↔
Cervical Cancer Screening	75.4%	69.5%	68.4%	↔
Childhood Immunization Status—Combination 3	73.1%	77.1%	87.6%	↑
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	96.1%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	88.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	88.0%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	85.9%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	86.8%	84.0%	83.5%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	39.0%	40.7%	39.8%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	50.2%	46.3%	48.5%	↔
Comprehensive Diabetes Care—LDL-C Screening	81.6%	80.8%	76.5%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.4%	37.3%	37.4%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	64.6%	55.3%	58.8%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.1%	86.6%	82.4%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	61.7%	63.9%	67.5%	↔
Immunizations for Adolescents—Combination 1	—	—	65.0%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.3%	86.6%	83.6%	↔
Prenatal and Postpartum Care—Postpartum Care	58.1%	58.2%	52.3%	↔
Use of Imaging Studies for Low Back Pain	77.8%	80.0%	81.1%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	62.6%	63.6%	71.5%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	73.3%	71.3%	79.9%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	46.7%	53.7%	63.7%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.2%	79.1%	83.1%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.20—HEDIS 2012 Trend Table for Health Net—Sacramento County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	39.6%	44.5%	53.8%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	38.1	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	241.0	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	59.3%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	55.6%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	22.3%	28.5%	20.2%	↔
Cervical Cancer Screening	66.8%	59.5%	69.3%	↑
Childhood Immunization Status—Combination 3	63.3%	67.3%	69.6%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	95.4%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	84.7%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	84.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	83.6%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	79.8%	83.8%	83.6%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	39.7%	40.0%	35.9%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	49.9%	49.2%	52.8%	↔
Comprehensive Diabetes Care—LDL-C Screening	74.9%	76.4%	73.9%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.8%	37.8%	33.6%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.8%	45.6%	48.4%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.3%	81.6%	82.6%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	64.7%	59.6%	62.9%	↔
Immunizations for Adolescents—Combination 1	—	—	54.6%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.7%	87.9%	83.6%	↔
Prenatal and Postpartum Care—Postpartum Care	66.4%	60.6%	60.8%	↔
Use of Imaging Studies for Low Back Pain	85.7%	87.8%	87.5%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	62.8%	67.9%	69.5%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	67.0%	73.5%	77.6%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	33.0%	41.6%	52.7%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	79.2%	81.8%	78.2%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.21—HEDIS 2012 Trend Table for Health Net—San Diego County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	32.1%	37.1%	45.7%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	44.1	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	258.6	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	78.1%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	77.6%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.8%	18.1%	18.5%	↔
Cervical Cancer Screening	68.2%	58.1%	66.3%	↑
Childhood Immunization Status—Combination 3	75.3%	69.8%	77.3%	↑
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	94.0%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	85.8%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	85.4%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	83.0%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	88.7%	84.6%	84.5%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	39.1%	46.5%	41.5%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	51.6%	42.0%	48.3%	↔
Comprehensive Diabetes Care—LDL-C Screening	80.7%	73.4%	76.3%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.0%	31.4%	35.6%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	65.2%	47.4%	51.9%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.6%	82.2%	78.6%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	64.3%	53.8%	64.4%	↑
Immunizations for Adolescents—Combination 1	—	—	65.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.6%	88.8%	83.4%	↓
Prenatal and Postpartum Care—Postpartum Care	65.9%	62.5%	54.8%	↓
Use of Imaging Studies for Low Back Pain	78.4%	74.1%	77.4%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	56.0%	51.3%	67.6%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	64.6%	61.3%	67.8%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	36.1%	43.1%	49.6%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.4%	72.8%	70.0%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.22—HEDIS 2012 Trend Table for Health Net—Stanislaus County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	31.5%	32.9%	42.6%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	49.4	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	349.9	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	75.9%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	79.8%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.5%	26.5%	29.6%	↔
Cervical Cancer Screening	68.9%	64.0%	77.3%	↑
Childhood Immunization Status—Combination 3	67.1%	67.8%	68.5%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	97.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	88.9%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	87.9%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	85.9%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	86.5%	82.0%	84.6%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	29.0%	37.1%	36.5%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	60.1%	52.8%	53.1%	↔
Comprehensive Diabetes Care—LDL-C Screening	79.5%	75.4%	76.1%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.6%	37.4%	39.3%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.1%	48.7%	50.0%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.8%	82.0%	77.0%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	68.6%	67.8%	67.3%	↔
Immunizations for Adolescents—Combination 1	—	—	54.2%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	92.3%	93.2%	91.5%	↔
Prenatal and Postpartum Care—Postpartum Care	54.9%	62.3%	60.1%	↔
Use of Imaging Studies for Low Back Pain	85.5%	77.6%	83.8%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	40.4%	55.2%	58.7%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	50.6%	63.3%	65.8%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	19.5%	41.1%	40.2%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.9%	75.6%	71.1%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.23—HEDIS 2012 Trend Table for Health Net—Tulare County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	35.2%	42.9%	58.5%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	39.3	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	386.7	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	83.6%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	79.7%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.7%	17.5%	22.8%	↔
Cervical Cancer Screening	72.0%	77.7%	78.8%	↔
Childhood Immunization Status—Combination 3	76.5%	76.3%	78.9%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	97.3%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	92.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	92.8%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	91.5%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	85.2%	86.5%	83.0%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	42.7%	41.7%	43.4%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.5%	48.6%	47.9%	↔
Comprehensive Diabetes Care—LDL-C Screening	77.0%	77.5%	76.2%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.4%	32.2%	36.6%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	66.3%	56.4%	56.8%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	84.0%	82.9%	82.8%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	68.6%	71.3%	67.5%	↔
Immunizations for Adolescents—Combination 1	—	—	61.8%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.0%	93.2%	93.8%	↔
Prenatal and Postpartum Care—Postpartum Care	63.1%	68.4%	67.9%	↔
Use of Imaging Studies for Low Back Pain	82.9%	73.1%	82.7%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	53.0%	73.4%	77.6%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	56.7%	66.7%	66.4%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	28.8%	49.2%	45.3%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.3%	81.3%	77.3%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.24—HEDIS 2012 Trend Table for Health Plan of San Joaquin—San Joaquin County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	51.1%	48.9%	55.5%	↔
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	38.2	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	283.7	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	85.6%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	85.1%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.6%	27.1%	25.4%	↔
Cervical Cancer Screening	65.5%	68.6%	68.6%	↔
Childhood Immunization Status—Combination 3	74.0%	74.5%	77.1%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	96.7%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	86.8%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	84.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	83.5%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	77.6%	80.5%	81.5%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	44.5%	41.4%	36.7%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.7%	51.8%	56.0%	↔
Comprehensive Diabetes Care—LDL-C Screening	77.6%	75.9%	78.6%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	30.2%	31.4%	39.2%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.1%	52.3%	53.3%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.9%	76.2%	80.3%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	66.2%	75.2%	77.6%	↔
Immunizations for Adolescents—Combination 1	—	—	64.0%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	81.0%	87.8%	88.1%	↔
Prenatal and Postpartum Care—Postpartum Care	62.8%	65.2%	68.6%	↔
Use of Imaging Studies for Low Back Pain	74.5%	82.4%	80.7%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	62.3%	67.2%	73.5%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	60.6%	69.6%	72.5%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	41.8%	58.2%	65.7%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	82.2%	81.3%	80.5%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.25—HEDIS 2012 Trend Table for Health Plan of San Mateo—San Mateo County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	43.8%	40.4%	53.3%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	51.6	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	483.0	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	89.3%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	92.7%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	89.8%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	33.5%	26.5%	34.1%	↔
Cervical Cancer Screening	62.6%	61.2%	62.0%	↔
Childhood Immunization Status—Combination 3	87.3%	83.7%	80.3%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	95.9%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	88.3%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	87.7%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	84.9%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	86.6%	86.6%	79.8%	↓
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	35.8%	34.1%	38.0%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.9%	57.4%	55.7%	↔
Comprehensive Diabetes Care—LDL-C Screening	80.5%	84.2%	82.0%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	45.0%	47.0%	46.5%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	60.3%	59.9%	61.1%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.4%	86.6%	87.8%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.3%	63.3%	66.2%	↔
Immunizations for Adolescents—Combination 1	—	—	68.5%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.3%	83.2%	81.9%	↔
Prenatal and Postpartum Care—Postpartum Care	63.5%	61.8%	61.2%	↔
Use of Imaging Studies for Low Back Pain	86.5%	84.6%	81.5%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	59.6%	47.9%	66.7%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	67.9%	75.4%	77.6%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	56.7%	59.1%	64.0%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.7%	75.4%	73.8%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.26—HEDIS 2012 Trend Table for Inland Empire Health Plan—San Bernardino/Riverside Counties

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	45.1%	43.1%	49.9%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	49.5	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	326.4	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	84.2%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	89.4%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	83.5%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.3%	23.9%	22.1%	↔
Cervical Cancer Screening	69.6%	71.7%	72.0%	↔
Childhood Immunization Status—Combination 3	70.1%	69.4%	77.8%	↑
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	96.3%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	86.9%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	83.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	86.3%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	79.4%	79.5%	83.0%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	45.3%	43.8%	40.8%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.9%	45.9%	48.7%	↔
Comprehensive Diabetes Care—LDL-C Screening	79.4%	79.7%	81.1%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.0%	37.4%	38.7%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.6%	42.3%	52.7%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.0%	80.3%	83.7%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	71.3%	70.9%	75.8%	↔
Immunizations for Adolescents—Combination 1	—	—	63.7%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.7%	85.1%	86.4%	↔
Prenatal and Postpartum Care—Postpartum Care	60.8%	62.9%	63.2%	↔
Use of Imaging Studies for Low Back Pain	76.4%	78.4%	75.6%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	67.4%	57.6%	77.5%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	69.0%	66.0%	79.6%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	61.3%	38.2%	52.8%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.1%	74.3%	72.2%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.27—HEDIS 2012 Trend Table for Kaiser Permanente—Sacramento County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	32.1%	39.0%	46.8%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	53.8	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	413.3	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	93.0%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	92.5%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	61.4%	54.8%	47.2%	↔
Cervical Cancer Screening	81.9%	84.1%	83.9%	↔
Childhood Immunization Status—Combination 3	75.5%	80.2%	82.4%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	99.3%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	91.8%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	91.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	92.9%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	92.8%	94.0%	95.6%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	23.6%	21.5%	26.1%	▼
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	64.6%	63.1%	61.4%	↔
Comprehensive Diabetes Care—LDL-C Screening	89.9%	92.1%	94.3%	↑
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	63.3%	62.7%	65.6%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.1%	67.5%	71.9%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.1%	83.1%	89.4%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	79.0%	77.8%	81.7%	↑
Immunizations for Adolescents—Combination 1	—	—	80.9%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.4%	91.6%	93.3%	↔
Prenatal and Postpartum Care—Postpartum Care	75.9%	71.7%	75.0%	↔
Use of Imaging Studies for Low Back Pain	88.4%	87.5%	92.0%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	38.1%	52.8%	73.5%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	46.7%	60.3%	75.9%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	24.5%	59.8%	75.6%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.3%	69.0%	72.2%	↑

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.28—HEDIS 2012 Trend Table for Kaiser Permanente—San Diego County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	28.1%	44.0%	51.2%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	37.2	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	478.5	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	92.2%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	91.7%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	28.0%	20.5%	38.3%	↑
Cervical Cancer Screening	83.3%	84.3%	85.0%	↔
Childhood Immunization Status—Combination 3	80.0%	84.1%	87.0%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	99.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	94.4%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	94.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	96.5%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	94.0%	94.0%	96.2%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	23.4%	21.2%	19.0%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	63.7%	65.5%	69.7%	↔
Comprehensive Diabetes Care—LDL-C Screening	90.1%	93.6%	95.2%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	56.2%	66.5%	69.4%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	66.7%	77.1%	75.2%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	91.7%	94.6%	95.2%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	83.3%	85.8%	88.0%	↔
Immunizations for Adolescents—Combination 1	—	—	88.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.1%	89.2%	94.7%	↑
Prenatal and Postpartum Care—Postpartum Care	67.9%	68.5%	73.2%	↔
Use of Imaging Studies for Low Back Pain	85.0%	84.2%	76.0%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	95.5%	98.1%	97.8%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	14.6%	51.2%	65.1%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	14.2%	59.8%	76.3%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.6%	64.6%	68.6%	↑

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.29—HEDIS 2012 Trend Table for Kern Family Health Care—Kern County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	38.2%	35.0%	51.3%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	46.6	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	282.1	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	83.8%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	84.2%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.3%	18.3%	15.7%	↔
Cervical Cancer Screening	62.4%	63.2%	65.7%	↔
Childhood Immunization Status—Combination 3	66.7%	74.2%	68.6%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	94.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	84.1%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	79.8%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	81.8%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	79.9%	79.8%	82.1%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	51.3%	54.3%	46.0%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	40.0%	36.5%	45.3%	↑
Comprehensive Diabetes Care—LDL-C Screening	77.2%	76.4%	79.4%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.7%	29.2%	34.3%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	35.2%	32.4%	52.6%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.2%	74.5%	80.1%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	65.3%	65.0%	72.8%	↑
Immunizations for Adolescents—Combination 1	—	—	62.5%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.1%	78.3%	81.3%	↔
Prenatal and Postpartum Care—Postpartum Care	61.8%	61.1%	60.3%	↔
Use of Imaging Studies for Low Back Pain	75.3%	71.9%	76.4%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	58.9%	62.3%	61.8%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	57.7%	47.0%	51.6%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	46.2%	29.4%	38.4%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.0%	70.3%	69.1%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.30—HEDIS 2012 Trend Table for L.A. Care Health Plan—Los Angeles County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	53.1%	49.2%	58.1%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	31.0	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	191.4	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	73.4%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	78.8%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	72.3%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	30.4%	40.7%	32.3%	↓
Cervical Cancer Screening	71.8%	67.9%	72.5%	↔
Childhood Immunization Status—Combination 3	80.9%	80.0%	81.4%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	95.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	87.0%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	88.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	86.4%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	82.1%	85.0%	83.8%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	42.1%	41.5%	42.0%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.0%	45.7%	42.3%	↔
Comprehensive Diabetes Care—LDL-C Screening	80.1%	79.0%	79.2%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.8%	37.4%	37.0%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.8%	50.7%	50.7%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.3%	78.3%	79.5%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	60.8%	58.5%	64.3%	↔
Immunizations for Adolescents—Combination 1	—	—	60.5%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.5%	82.1%	80.6%	↔
Prenatal and Postpartum Care—Postpartum Care	61.5%	55.3%	61.3%	↔
Use of Imaging Studies for Low Back Pain	79.6%	80.2%	81.6%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	59.1%	65.6%	64.6%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	64.9%	68.3%	70.2%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	54.2%	58.4%	57.6%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.5%	80.6%	77.5%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.31—HEDIS 2012 Trend Table for Molina Health Care—San Bernardino/Riverside Counties

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	45.1%	42.6%	56.3%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	43.2	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	285.7	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	81.6%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	81.4%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.4%	21.5%	20.1%	↔
Cervical Cancer Screening	62.3%	62.2%	62.0%	↔
Childhood Immunization Status—Combination 3	60.0%	53.0%	59.6%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	94.9%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	83.8%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	82.7%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	84.2%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	79.6%	78.1%	78.7%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	57.9%	55.6%	48.8%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	32.8%	34.4%	40.0%	↔
Comprehensive Diabetes Care—LDL-C Screening	77.1%	75.6%	77.3%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.2%	28.7%	34.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	43.1%	37.4%	54.8%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.0%	79.7%	81.8%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58.6%	58.1%	59.3%	↔
Immunizations for Adolescents—Combination 1	—	—	60.9%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.5%	68.6%	77.2%	↑
Prenatal and Postpartum Care—Postpartum Care	52.3%	50.9%	43.8%	↓
Use of Imaging Studies for Low Back Pain	74.8%	76.1%	76.4%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	55.0%	42.5%	44.3%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	62.5%	55.2%	65.0%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	60.6%	44.1%	57.1%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.5%	71.5%	74.8%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.32—HEDIS 2012 Trend Table for Molina Health Care—Sacramento County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	52.3%	35.8%	60.4%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	45.0	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	238.1	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	78.8%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	74.2%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	29.5%	27.2%	28.3%	↔
Cervical Cancer Screening	67.3%	60.1%	63.1%	↔
Childhood Immunization Status—Combination 3	61.1%	54.3%	50.1%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	95.8%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	84.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	83.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	83.4%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	78.4%	79.3%	81.8%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	41.2%	41.8%	40.9%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	47.8%	45.8%	46.9%	↔
Comprehensive Diabetes Care—LDL-C Screening	74.0%	69.5%	69.3%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.8%	36.2%	33.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.9%	48.8%	56.2%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.9%	77.0%	83.1%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	61.6%	59.6%	58.2%	↔
Immunizations for Adolescents—Combination 1	—	—	55.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.8%	73.3%	81.4%	↑
Prenatal and Postpartum Care—Postpartum Care	53.2%	49.4%	51.4%	↔
Use of Imaging Studies for Low Back Pain	87.3%	78.9%	84.0%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	63.7%	61.9%	62.3%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	70.3%	62.6%	64.7%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	59.6%	55.7%	58.4%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	79.6%	73.5%	76.1%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.33—HEDIS 2012 Trend Table for Molina Health Care—San Diego County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	47.7%	41.5%	53.0%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	43.3	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	331.9	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	86.7%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	85.9%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.2%	17.3%	18.2%	↔
Cervical Cancer Screening	70.3%	70.8%	68.9%	↔
Childhood Immunization Status—Combination 3	78.9%	72.3%	73.2%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	94.8%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	88.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	87.6%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	83.8%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	82.0%	82.1%	84.4%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	48.4%	48.2%	46.7%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	42.1%	42.6%	46.2%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.4%	76.9%	78.2%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.8%	35.7%	42.2%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.7%	49.3%	56.4%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.1%	77.4%	80.2%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	60.8%	70.4%	62.0%	↓
Immunizations for Adolescents—Combination 1	—	—	71.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.7%	83.6%	88.9%	↑
Prenatal and Postpartum Care—Postpartum Care	57.7%	63.2%	61.4%	↔
Use of Imaging Studies for Low Back Pain	77.4%	77.7%	72.0%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	56.9%	53.0%	57.7%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	57.7%	58.6%	61.9%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	51.6%	54.6%	52.3%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.5%	74.7%	78.9%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.34—HEDIS 2012 Trend Table for Partnership Health Plan—Napa/Solano/Yolo Counties

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	38.7%	39.6%	50.0%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	47.8	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	256.9	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	82.1%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	80.9%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	82.4%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	27.0%	26.1%	42.8%	↑
Cervical Cancer Screening	61.6%	68.0%	65.7%	↔
Childhood Immunization Status—Combination 3	65.0%	70.1%	71.9%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	94.9%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	82.9%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	80.3%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	77.2%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	82.7%	84.0%	86.6%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	35.2%	34.6%	28.7%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	53.5%	54.8%	60.6%	↔
Comprehensive Diabetes Care—LDL-C Screening	79.0%	79.4%	78.2%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.9%	49.9%	49.2%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.8%	54.8%	56.8%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.5%	78.5%	83.7%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	64.8%	60.3%	69.3%	↑
Immunizations for Adolescents—Combination 1	—	—	56.8%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.8%	89.0%	87.3%	↔
Prenatal and Postpartum Care—Postpartum Care	64.8%	69.5%	70.3%	↔
Use of Imaging Studies for Low Back Pain	88.1%	88.4%	88.5%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	50.7%	57.4%	74.8%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	43.1%	49.8%	65.0%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	35.9%	42.1%	53.7%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.3%	67.5%	74.3%	↑

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.35—HEDIS 2012 Trend Table for Partnership Health Plan—Sonoma County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	—	36.3%	58.3%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	43.2	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	283.0	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	71.4%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	88.6%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	73.9%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	21.0%	47.5%	↑
Cervical Cancer Screening	—	60.3%	71.6%	↑
Childhood Immunization Status—Combination 3	—	71.0%	76.6%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	95.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	86.5%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	83.3%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	84.4%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	—	87.3%	90.2%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	—	37.1%	27.0%	▲
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	51.8%	59.4%	↑
Comprehensive Diabetes Care—LDL-C Screening	—	68.9%	74.3%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	38.4%	43.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	49.6%	54.2%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	77.3%	80.1%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	62.2%	76.1%	↑
Immunizations for Adolescents—Combination 1	—	—	53.0%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	88.2%	83.0%	↓
Prenatal and Postpartum Care—Postpartum Care	—	67.1%	75.7%	↑
Use of Imaging Studies for Low Back Pain	—	90.1%	90.4%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	77.3%	86.3%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	54.4%	69.4%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	47.7%	55.0%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	71.7%	72.2%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.36—HEDIS 2012 Trend Table for San Francisco Health Plan—San Francisco County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	60.6%	64.4%	65.2%	↔
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	26.7	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	354.4	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	73.2%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	71.4%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	46.6%	44.5%	45.5%	↔
Cervical Cancer Screening	79.7%	79.4%	80.2%	↔
Childhood Immunization Status—Combination 3	87.0%	87.3%	87.0%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	93.0%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	87.9%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	90.1%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	86.8%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	89.7%	90.4%	91.1%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	21.8%	26.3%	26.5%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	58.0%	64.1%	63.4%	↔
Comprehensive Diabetes Care—LDL-C Screening	82.8%	83.2%	83.3%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.0%	47.9%	48.8%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	67.8%	70.1%	69.7%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.9%	85.1%	83.6%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	74.1%	73.7%	78.6%	↔
Immunizations for Adolescents—Combination 1	—	—	64.4%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.8%	90.3%	93.4%	↔
Prenatal and Postpartum Care—Postpartum Care	66.4%	63.6%	75.6%	↑
Use of Imaging Studies for Low Back Pain	85.1%	82.2%	83.0%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	72.7%	60.6%	76.2%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	74.5%	78.5%	80.6%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	55.8%	70.4%	72.7%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	86.6%	85.2%	85.0%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table B.37—HEDIS 2012 Trend Table for Santa Clara Family Health Plan—Santa Clara County

Measure	2010	2011	2012	2011–2012 Rate Difference
Adolescent Well-Care Visits	41.0%	41.2%	53.3%	↑
Ambulatory Care—Emergency Department Visits per 1,000 MM	—	—	35.9	Not Comparable
Ambulatory Care—Outpatient Visits per 1,000 MM	—	—	292.8	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	86.1%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	87.2%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	84.9%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	30.4%	31.4%	25.8%	↔
Cervical Cancer Screening	72.5%	74.4%	71.3%	↔
Childhood Immunization Status—Combination 3	75.8%	79.4%	80.0%	↔
Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	96.2%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	88.6%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	89.7%	Not Comparable
Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	86.8%	Not Comparable
Comprehensive Diabetes Care—HbA1 Testing	86.4%	84.4%	86.6%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)**	24.4%	34.7%	40.9%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	52.0%	56.4%	51.1%	↔
Comprehensive Diabetes Care—LDL-C Screening	79.0%	78.3%	81.0%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	45.0%	51.3%	38.0%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	54.5%	51.5%	47.7%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.4%	76.2%	80.0%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	61.3%	62.7%	45.0%	↓
Immunizations for Adolescents—Combination 1	—	—	69.3%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.8%	83.6%	82.7%	↔
Prenatal and Postpartum Care—Postpartum Care	66.0%	62.7%	58.4%	↔
Use of Imaging Studies for Low Back Pain	84.1%	82.3%	80.4%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	44.7%	60.9%	64.2%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	58.5%	61.8%	64.0%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	33.6%	40.0%	45.7%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.8%	73.6%	75.7%	↔

**For the Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent) measure, a lower rate indicates better performance.*

Table C.1 provides abbreviations used throughout Appendix C.

Table C.1—HEDIS Performance Measures Name Key

Abbreviation	Full Name
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AMB-ED	*Ambulatory Care—Emergency Department Visits per 1,000 MM*
AMB-OP	*Ambulatory Care—Outpatient Visits per 1,000 MM*
AWC	*Adolescent Well-Care Visits*
CAP-1224	*Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 months*
CAP-256	*Children's and Adolescents' Access to Primary Care Practitioners—25 months to 6 years*
CAP-711	*Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 years*
CAP-1219	*Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 years*
CCS	*Cervical Cancer Screening*
CDC-BP	*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
CDC-E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC-H8	*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
CDC-H9	*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)*
CDC-HT	*Comprehensive Diabetes Care—HbA1 Testing*
CDC-LC	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC-LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC-N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS-3	*Childhood Immunization Status—Combination 3*
IMA-CO1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MPM-ACE	*Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
MPM-Dig	*Annual Monitoring for Patients on Persistent Medications— Digoxin*
MPM-Diu	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC-Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC-Pst	*Prenatal and Postpartum Care—Postpartum Care*
WCC-BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*
WCC-N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
WCC-PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Note: AMB-ED, AMB-OV, CAP-1224, CAP-256, CAP-711, CAP-1219, IMA-CO1, MPM-ACE, MPM-DIG, and MPM-DIU are not presented in the tables of this appendix because MPLs and HPLs were not applied to these measures in 2012.	

Tables C.2 and C.3 provide a summary of each plan's rates for each measure relative to the DHCS-established MPL and HPL.

Table C.2—Plan Comparisons to DHCS's Minimum Performance Level (MPL) and High Performance Level (HPL)

Health Plan Name	County	Total Measures Below MPL ●	Total Measures at or Above HPL ○
Alameda Alliance for Health	Alameda	0	2
Anthem Blue Cross	Alameda	12	2
Anthem Blue Cross	Contra Costa	12	1
Anthem Blue Cross	Sacramento	10	1
Anthem Blue Cross	San Francisco	1	4
Anthem Blue Cross	San Joaquin	7	1
Anthem Blue Cross	Santa Clara	1	3
Anthem Blue Cross	Stanislaus	6	0
Anthem Blue Cross	Tulare	4	1
CalOptima	Orange	0	6
Care1st Health Plan	San Diego	1	2
CenCal Health	Santa Barbara	0	9
CenCal Health	San Luis Obispo	0	2
Central CA Alliance for Health	Monterey/Santa Cruz	0	14
Central CA Alliance for Health	Merced	2	1
Community Health Group	San Diego	2	1
Contra Costa Health Plan	Contra Costa	0	3
Health Net	Kern	1	0
Health Net	Los Angeles	1	5
Health Net	Sacramento	0	2
Health Net	San Diego	2	0
Health Net	Stanislaus	0	1
Health Net	Tulare	0	4
Health Plan of San Joaquin	San Joaquin	0	4
Health Plan of San Mateo	San Mateo	1	5
Inland Empire Health Plan	San Bernardino/Riverside	0	2
Kaiser—North	Sacramento	0	15
Kaiser—South	San Diego	0	14
Kern Family Health Care	Kern	1	0
L.A. Care Health Plan	Los Angeles	0	1
Molina Health Care	San Bernardino/Riverside	4	0
Molina Health Care	Sacramento	4	1
Molina Health Care	San Diego	2	0
Partnership Health Plan	Napa/Solano/Yolo	0	6
Partnership Health Plan	Sonoma	0	7
San Francisco Health Plan	San Francisco	0	16
Santa Clara Family Health	Santa Clara	2	0

Legend:
● = Below the minimum performance level
○ = At or above the high performance level

Table C.3—HEDIS 2012 Performance Summary

Health Plan Name	County	AAB	AWC	CCS	CDC-H8	CDC-BP	CDC-LC	CDC-E	CDC-LS	CDC-N	CDC-H9	CDC-HT
Alameda Alliance for Health	Alameda										○	
Anthem Blue Cross	Alameda	○	●	●	●	●	●	●	●	●	●	●
Anthem Blue Cross	Contra Costa			●	●	●	●	●	●	●	●	●
Anthem Blue Cross	Sacramento			●			●	●	●	●		●
Anthem Blue Cross	San Francisco	○							●			
Anthem Blue Cross	San Joaquin	●		●				●	●			●
Anthem Blue Cross	Santa Clara				○		○					
Anthem Blue Cross	Stanislaus			●				●		●		●
Anthem Blue Cross	Tulare							●	●			●
CalOptima	Orange		○				○		○			
Care1st Health Plan	San Diego	●								○		
CenCal Health	Santa Barbara				○		○	○	○	○	○	○
CenCal Health	San Luis Obispo	○			○							
Central CA Alliance for Health	Monterey/Santa Cruz		○		○	○	○		○		○	○
Central CA Alliance for Health	Merced	●		●								
Community Health Group	San Diego	●										
Contra Costa Health Plan	Contra Costa									○		
Health Net	Kern	●										
Health Net	Los Angeles											
Health Net	Sacramento											
Health Net	San Diego	●										
Health Net	Stanislaus											
Health Net	Tulare			○								
Health Plan of San Joaquin	San Joaquin					○						

Table C.3—HEDIS 2012 Performance Summary (continued)

Health Plan Name	County	AAB	AWC	CCS	CDC-H8	CDC-BP	CDC-LC	CDC-E	CDC-LS	CDC-N	CDC-H9	CDC-HT
Health Plan of San Mateo	San Mateo	○		●			○			○		
Inland Empire Health Plan	San Bernardino/Riverside											
Kaiser—North	Sacramento	○		○	○	○	○	○	○	○	○	○
Kaiser—South	San Diego	○		○	○	○	○	○	○	○	○	○
Kern Family Health Care	Kern	●										
L.A. Care Health Plan	Los Angeles	○										
Molina Health Care	San Bernardino/Riverside			●								
Molina Health Care	Sacramento			●					●			
Molina Health Care	San Diego	●										
Partnership Health Plan	Napa/Solano/Yolo	○			○		○				○	
Partnership Health Plan	Sonoma	○			○	○					○	
San Francisco Health Plan	San Francisco	○	○	○	○	○	○				○	○
Santa Clara Family Health	Santa Clara					●						

Table C.3—HEDIS 2011 Performance Summary (continued)

Health Plan Name	County	CIS-3	LBP	PPC-Pst	PPC-Pre	W34	WCC-BMI	WCC-N	WCC-PA
Alameda Alliance for Health	Alameda		○						
Anthem Blue Cross	Alameda		○	●	●				
Anthem Blue Cross	Contra Costa		○	●	●				●
Anthem Blue Cross	Sacramento	●	○	●	●	●			
Anthem Blue Cross	San Francisco						○	○	○
Anthem Blue Cross	San Joaquin			●	●			○	
Anthem Blue Cross	Santa Clara		○		●				
Anthem Blue Cross	Stanislaus			●		●			
Anthem Blue Cross	Tulare			●			○		
CalOptima	Orange						○	○	○
Care1st Health Plan	San Diego		○						
CenCal Health	Santa Barbara	○		○					
CenCal Health	San Luis Obispo								
Central CA Alliance for Health	Monterey/Santa Cruz	○	○	○		○	○	○	○
Central CA Alliance for Health	Merced		○						
Community Health Group	San Diego				●		○		
Contra Costa Health Plan	Contra Costa	○	○						
Health Net	Kern								
Health Net	Los Angeles	○		●		○	○	○	○
Health Net	Sacramento		○					○	
Health Net	San Diego			●					
Health Net	Stanislaus		○						
Health Net	Tulare		○		○		○		
Health Plan of San Joaquin	San Joaquin						○	○	○
Health Plan of San Mateo	San Mateo							○	○

Table C.3—HEDIS 2011 Performance Summary (continued)

Health Plan Name	County	CIS-3	LBP	PPC-Pst	PPC-Pre	W34	WCC-BMI	WCC-N	WCC-PA
Inland Empire Health Plan	San Bernardino/Riverside						○	○	
Kaiser—North	Sacramento		○		○		○	○	○
Kaiser—South	San Diego	○			○		○		○
Kern Family Health Care	Kern								
L.A. Care Health Plan	Los Angeles								
Molina Health Care	San Bernardino/Riverside	●		●	●				
Molina Health Care	Sacramento	●	○	●					
Molina Health Care	San Diego		●						
Partnership Health Plan	Napa/Solano/Yolo		○				○		
Partnership Health Plan	Sonoma		○	○			○		
San Francisco Health Plan	San Francisco	○	○	○	○	○	○	○	○
Santa Clara Family Health	Santa Clara			●					

Abstraction Error

An error made by a medical record reviewer in documenting information from the medical record as part of the medical record abstraction process. An abstraction error occurs when a medical record reviewer miscodes information. The reviewer may, for example, indicate that a specified test or procedure was performed when the medical record does not show evidence of the test or procedure. A reviewer may document incorrect information such as a date, lab value, etc. Also, an abstraction error can occur when a medical record reviewer does not document a specified procedure or test when the medical record shows evidence that it was performed.

Administrative Data

Any automated data within a health plan (e.g., claims/encounter data, membership data, provider data, hospital billing data, pharmacy data, and laboratory data).

Administrative Method

The administrative method requires health plans to identify the eligible population (i.e., the denominator) using administrative data. In addition, the administrative method derives numerator(s), or services provided to members in the eligible population, solely from administrative data. Health plans cannot use medical records to retrieve information. The administrative method uses the entire eligible population as the denominator and does not allow sampling.

The administrative method is cost-efficient but can produce lower rates due to incomplete data submission by capitated providers. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care—Postpartum Care* measure. The health plan chooses to perform the administrative method and finds that 4,000 members out of the 10,000 had evidence of a postpartum visit using administrative data. The final rate for this measure, using the administrative method, would be 4,000/10,000, or 40 percent.

Audit Finding

The auditor's final determination, based on audit findings, of the appropriateness of the health plan publicly reporting its HEDIS measure rates. Each measure included in the HEDIS audit receives a *Report*, *Not Applicable*, *No Benefit*, or *Not Report* audit finding.

Capitation

A method of payment for providers. A capitated payment arrangement reimburses providers on a per-member/per-month basis. The provider receives payment each month, regardless of whether the member receives services or not. Because payment is not dependent upon submission of encounter data, providers have less incentive to submit individual encounters.

Certified HEDIS Software Vendor

A third party, with source code certified by NCQA, that contracts with a health plan to write source code for HEDIS measures. For a vendor's software to receive NCQA certification, the vendor must submit all of the programmed HEDIS measures to NCQA for automated testing of program logic, and a minimum percentage of the measures must receive a "Pass" or "Pass with Qualifications" designation.

CMS

The Centers for Medicare and Medicaid Services is a federal agency within the U.S. Department of Health and Human Services (DHHS) that regulates requirements and procedures for external quality review of managed care organizations. CMS provides health insurance to individuals through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). In addition, CMS regulates laboratory testing through Clinical Laboratory Improvement Amendments (CLIAs), develops coverage policies, and initiates quality-of-care improvement activities. CMS also maintains oversight of nursing homes and continuing care providers. These include home health agencies, intermediate care facilities for the intellectually disabled, and hospitals.

Continuous Enrollment Requirement

The minimum amount of time that a member must be enrolled in a health plan to be eligible for inclusion in a measure to ensure that the health plan has a sufficient amount of time to be held accountable for providing services to that member.

CPT®

Current Procedural Terminology (CPT) is a listing of billing codes generated by the AMA to report the provision of medical services and procedures.

Data Completeness

The degree to which occurring services/diagnoses appear in the health plan's administrative data systems.

Denominator

The number of members who meet all criteria specified in the measure for inclusion in the eligible population. When using the administrative method, the entire eligible population becomes the denominator. When using the hybrid method, a sample of the eligible population becomes the denominator.

The DHCS

The Department of Health Care Services. The DHCS works closely with health plans and county governments to provide a health care safety net for California's low-income population and individuals with disabilities. The DHCS finances and administers a number of individual health care service delivery programs, including the Medi-Cal program (both managed care and fee-for-service), the California Children's Services program, the Child Health and Disability Prevention program, and the Genetically Handicapped Persons Program.

DRG Coding

Diagnostic-Related Group (DRG) coding sorts diagnoses and procedures for inpatient encounters by groups under major diagnostic categories with defined reimbursement limits.

DTaP

Diphtheria and tetanus toxoids and acellular pertussis vaccine.

EDI

Electronic data interchange (EDI) is the direct, computer-to-computer transfer of data.

Electronic Data

Data maintained in a computer environment versus a paper environment.

Encounter Data

Billing data received from a capitated provider. Although the health plan does not reimburse the provider for each encounter, submission of encounter data to the health plan allows the health plan to collect the data for future HEDIS reporting and to meet DHCS encounter data submission requirements.

EQRO

An external quality review organization (EQRO) is an external, independent organization that has expertise in Medicaid health care quality. CMS requires that state Medicaid managed care programs contract with an EQRO to receive enhanced federal financial participation. CMS

requires that EQROs meet competency requirements that include having staff with demonstrated experience and knowledge of Medicaid members, policies, data systems, and processes; managed care delivery systems, organizations, and financing; quality assessment and improvement methods; and research design and methodology, including statistical analysis. CMS also requires that EQROs have the clinical and nonclinical resources necessary to conduct EQRO-related activities.

Exclusions

Conditions outlined in HEDIS measure specifications that describe when a member should not be included in the denominator.

FFS

Fee-for-service (FFS) is a reimbursement mechanism that pays providers for services billed.

Final Audit Report

The written report completed by the auditor, following the health plan's completion of any corrective actions, that documents all final findings and results of the HEDIS audit. The final report includes the summary report, IS capabilities assessment, medical record review validation findings, measure findings, and audit opinion (the final audit statement).

HbA1c

The HbA1c test (the hemoglobin A1c test or glycosylated hemoglobin test) is a lab test that reveals average blood glucose over a period of two to three months.

HCPCS

The Healthcare Common Procedure Coding System (HCPCS) is a standardized, alphanumeric coding system that maps to certain CPT® codes (see also CPT®).

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by managed health care organizations.

Formerly the Health Plan Employer Data and Information Set.

HEDIS Measure Determination Standards (HD)

The standards that auditors use during the audit process to assess a health plan's adherence to HEDIS measure specifications.

HEDIS Repository

The plan's data warehouse that stores all data used for HEDIS reporting.

HEDIS Warehouse

See HEDIS repository.

HiB Vaccine

Haemophilus influenzae type B vaccine.

HPL

High performance level: the DHCS defines the HPL as the most recent national HEDIS Medicaid 90th percentile, except for one measure, *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*. For this measure, a lower rate indicates better performance, with the 10th percentile (rather than the 90th percentile) showing excellent performance.

HSAG

Health Services Advisory Group, Inc. (HSAG) is an EQRO that serves as a contractor to state Medicaid plans to provide state-specified activities related to federal requirements for managed care plans. For the Medi-Cal program, the DHCS contracts with HSAG to validate performance measures for its external accountability set, validate quality improvement projects, and produce an annual technical report.

Hybrid Measures

Measures that health plans can report using the hybrid method.

Hybrid Method

The hybrid method requires health plans to identify the eligible population using administrative data and then extract a systematic sample, typically 411 members from the eligible population, which becomes the denominator. The health plans then use administrative data to identify services provided to those sampled members. Finally, the health plan conducts medical record review of members for whom administrative data does not show evidence that a service was provided.

The hybrid method generally produces higher rates but is considerably more labor intensive. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care—Postpartum Care* measure. The health plan chooses to perform the hybrid method. After

randomly selecting 411 eligible members, the health plan finds that 161 members have evidence of a postpartum visit using administrative data. The health plan then obtains and reviews medical records for the 250 members who do not have evidence of a postpartum visit using administrative data. Of those 250 members, the health plan finds that 54 have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would be (161 + 54) /411, or 52 percent.

IDSS

The Interactive Data Submission System (IDSS) is a Web-based tool used to submit data to NCQA.

Inpatient Data

Data derived from an inpatient hospital stay.

IRR

Interrater reliability (IRR) is the degree of agreement exhibited when a measurement is repeated under the same conditions by different raters.

IS

Information System(s) (IS) is an automated system for collecting, processing, and transmitting data.

IS Standard

Information System(s) Standards (ISS) is an NCQA-defined set of standards that measure how an organization collects, stores, analyzes, and reports medical, customer service, member, practitioner, and vendor data.

IPV

Inactivated poliovirus vaccine.

IT

Information technology (IT) is the technology used to create, store, exchange, and use information in its various forms.

LDL-C

Low-density lipoprotein cholesterol.

Manual Crosswalks

Written documentation that maps nonstandard service codes to industry standard codes. Manual crosswalks must contain one-to-one links between nonstandard codes and industry standard codes.

Manual Data Collection

Collection of data through a paper process rather than an automated one.

Mapping Codes

The process of translating a health plan's propriety or nonstandard billing codes to industry standard codes specified in HEDIS measures. Mapping documentation should include a crosswalk of relevant codes, descriptions, and clinical information, as well as the policies and procedures for implementing the codes.

Material Bias

For most measures reported as a rate, any error that causes a ± 5 percent difference in the reported rate is considered materially biased.

MCO

A managed care organization (MCO) is a federal designation. In California, most MCOs are Health Maintenance Organizations (HMOs).

Medical Record Abstraction

The process used by plans to retrieve and review medical records as part of the hybrid method. Medical record abstraction determines if there is evidence that a specified service was provided, such as a Pap test or an immunization, or gathers information about a specified lab value, such as a blood glucose or cholesterol level.

Medical Record Validation

The process that auditors follow to verify that a health plan's medical record abstraction meets industry standards and that abstracted data are accurate.

Medicaid Percentiles

The NCQA national percentiles for each HEDIS measure for the Medicaid product line, used to compare health plan performance and assess the reliability of a health plan's HEDIS rates.

Membership Data

Information about members in electronic health plan files, such as name, date of birth, gender, current address, and enrollment (i.e., date when the member became eligible for health plan coverage).

Mg/dL

Milligrams per deciliter.

MMR

Measles, mumps, and rubella vaccine.

MPL

The DHCS establishes the minimum performance level (MPL) as the most recent national HEDIS Medicaid 25th percentile, except for one measure, *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*. For this measure, a lower rate indicates better performance, with the 10th percentile (rather than the 90th percentile) showing excellent performance. The MPL for this measure is the 75th percentile.

NA

Not Applicable (*NA*) is a finding given to a result/rate when a health plan's denominator for a measure is too small (i.e., less than 30) to report a valid rate.

NCQA

The National Committee for Quality Assurance (NCQA) is a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed health care delivery systems. NCQA reports the results of these assessments to employers, consumers, public purchasers, and regulators, ultimately seeking to improve health care provided within the managed care industry.

NR

The *Not Report* HEDIS audit finding.

A measure has an *NR* audit finding for one of three reasons:

The health plan chose not to report the measure.
The health plan calculated the measure but the result was materially biased.
The health plan was not required to report.

Numerator

The number of members in the denominator who received all the services as specified in the measure.

Over-read Process

The process of re-reviewing a sample of medical records by a different abstractor to assess the degree of agreement between two different abstractors and ensure the accuracy of abstracted data. A health plan should conduct an over-read process as part of its medical record review process. Auditors over-read a sample of a health plan's medical records as part of the audit process.

Pharmacy Data

Data derived from the provision of pharmacy services.

Provider Data

Information about physicians in electronic files, such as type of physician, specialty, reimbursement arrangement, and office location.

Record of Administration, Data Management, and Processes (Roadmap)

The Roadmap, completed by each Managed Care Organization (MCO) undergoing the HEDIS audit process, provides information to auditors regarding an MCO's systems for collecting and processing data for HEDIS reporting. Auditors review the Roadmap prior to the scheduled on-site visit to gather preliminary information for planning and targeting assessment activities for the on-site visit; determining the core set of measures to be reviewed; determining which hybrid measures will be included in medical record validation; requesting the source code for core measures, as needed; identifying areas that require additional clarification during the on-site visit; and determining whether to expand the core set of measures.

Previously the Baseline Assessment Tool (BAT).

Source Code

The written computer programming logic for determining the eligible population and the denominators/numerators to calculate the rate for each measure.

Standard Codes

Industry standard billing codes such as ICD-9-CM, CPT®, DRG, Revenue, and UB-04 codes used for billing inpatient and outpatient health care services.

Vendor

Any third party that contracts with a health plan to perform services. The most common delegated services are pharmacy, vision care, laboratory, claims processing, HEDIS software, and provider credentialing.

VZV

Varicella-zoster virus (chicken pox) vaccine.