2013 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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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS California Department of HealthCareServices

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1. EXECUTIVE SUMMARY

During the 2012 calendar year, the Department of Health Care Services (DHCS) held contracts with 22 full-scope managed care plans (MCPs) and three specialty MCPs to provide health care services to approximately 4.9-million members enrolled in the Medi-Cal Managed Care program (MCMC).[1]

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

The DHCS 2013 EAS for the full-scope MCPs consisted of 15 performance measures with 32 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.

DHCS based all selected performance measures for full-scope MCPs 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 (QIP). The 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 an MCP's Medicare, Medicaid, and commercial lines of business.

In addition to reporting the EAS in 2013, full-scope MCPs were required to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of measures. DHCS provided the stratification methodology for the MCPs to use and MCPs reported the rates for the SPD population separately via a Microsoft Excel reporting template. A summary of the findings related to the SPD population is included in Section 8 of this report.

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[1] Medi-Cal Managed Care Enrollment Report, December 2012. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: July 15, 2013.

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

Due to the small size of specialty MCP populations, DHCS established different performance measure requirements for the specialty MCPs. Instead of requiring a specialty MCP to annually report the full list of performance measure rates as full-scope MCPs do, DHCS requires specialty MCPs to report only two performance measures. In collaboration with DHCS, a specialty MCP may select HEDIS measures or develop measures that are appropriate to the MCP's population. The measures put forth by the specialty MCP are subject to approval by DHCS. Furthermore, the specialty MCP must report performance measure results specific to the MCP's Medi-Cal managed care members, not for the MCP's entire population.

As part of the EAS, DHCS requires MCPs to undergo an NCQA HEDIS Compliance Audit™[3] conducted by an external quality review organization (EQRO). The EQRO assesses the MCPs' information systems (IS) capabilities and compliance with HEDIS specifications to ensure standardized reporting of performance measure results. For MCPs reporting non-HEDIS measures, the CMP protocol for validating performance measures is used. DHCS contracted with Health Services Advisory Group, Inc. (HSAG), to perform these on-site compliance audits in 2013, analyze MCMC HEDIS and non-HEDIS rates objectively, and evaluate each MCP's current performance level relative to local and national thresholds and benchmarks.

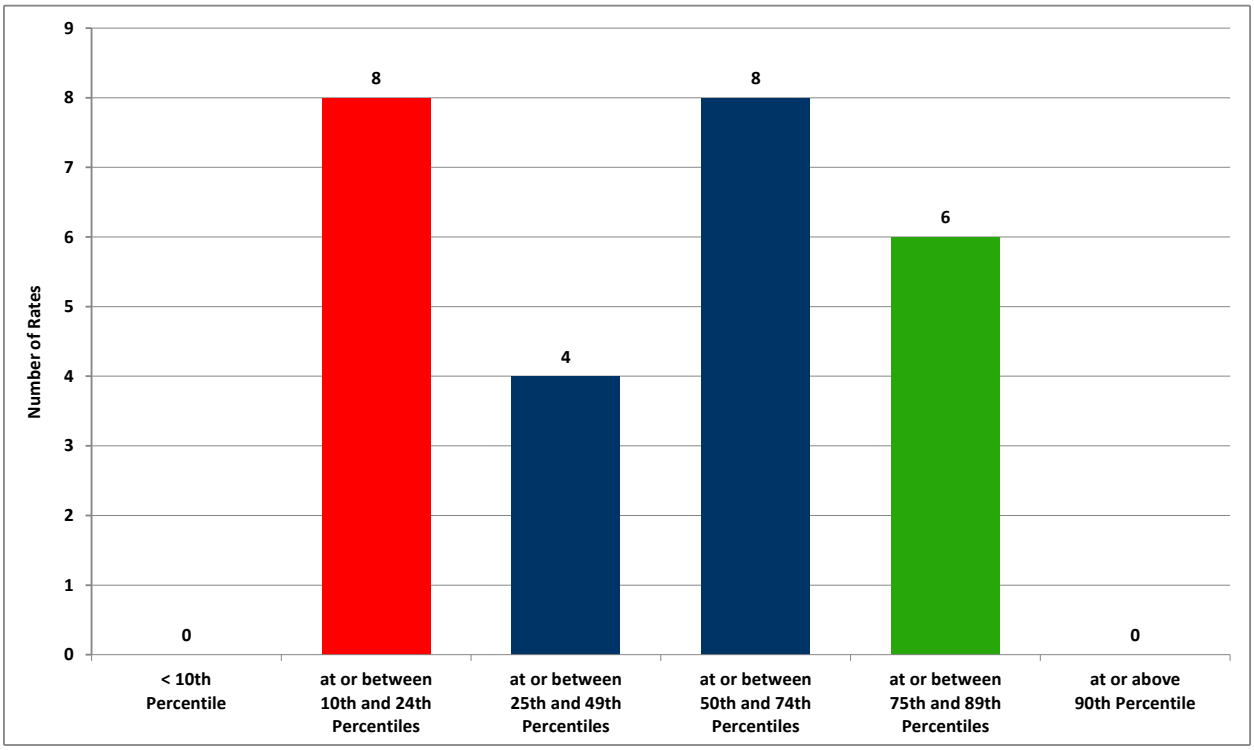
This report presents MCMC HEDIS 2013 results for the 2012 measurement period of January 1, 2012, through December 31, 2012 for all MCPs except Family Mosaic Project. The 2013 results for Family Mosaic Project are for non-HEDIS measures, but are for the same 2012 measurement period as the other MCPs. Full-scope MCP results are included in Section 5 of this report, and specialty MCP results are included in Section 6.

Key Findings—Full-Scope Managed Care Plans

MCMC's 2013 results were very similar to 2012. MCMC as a whole demonstrated average performance for most measures, noting some strengths as well as areas that need improvement. As shown in Figure1.1, 31 percent of the MCMC 2013 performance results were at or between the 10th and 24th national Medicaid percentiles, and 31 percent were at or between the 50th and 74th national Medicaid percentiles, with 16 weighted averages falling into these categories. None of the MCMC weighted averages were below the 10th percentile or at or above the 90th national percentile. MCMC had six measures that scored between the 75th and 89th national Medicaid percentiles, and four measures ranked between the 25th and 49th national Medicaid percentiles.

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

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



Six performance measures were not measured against DHCS's established high performance levels (HPLs) and minimum performance levels (MPLs) in 2013. Three were new measures for the 2013 reporting year, two were utilization measures, and one was an internally developed measure for the statewide collaborative QIP. These measures were:

- *All-Cause Readmissions*
- *Ambulatory Care*
  - *Outpatient Visits*
  - *Emergency Department Visits*
- *Controlling High Blood Pressure*
- *Medication Management for People with Asthma*
  - *Medication Compliance 50% Total*
  - *Medication Compliance 75% Total*

The top three performance measure rates, those with the smallest differences between the MCMC weighted averages and the HPLs, were *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, 3.37 percentage points; *Comprehensive Diabetes Care—LDL-C Screening*, 4.91 percentage points; and *Use of Imaging Studies for Low Back Pain,* 1.20 percentage points.

Conversely, for eight measures, the MCMC weighted average was below the MPLs. These eight measures included:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Prenatal and Postpartum Care—Postpartum Care*

High and Low Performance

Two full-scope MCPs demonstrated high performance across the EAS, exceeding 18 or more of DHCS's established HPLs, which represent the national Medicaid 90th percentiles; and neither of these MCPs performed below the MPLs for any single measure. HSAG also identified these MCPs as the top performers in 2011 and 2012. Kaiser—Sacramento County exceeded the HPLs on 18 measures, and Kaiser—San Diego County exceeded the HPLs on 21 measures.

Four MCPs, in a total of 12 counties, showed the greatest opportunity for improvement by having 10 or more performance measures below the DHCS-established MPLs, which represents the national Medicaid 25th percentiles: Anthem Blue Cross Partnership Plan (Anthem Blue Cross)—Alameda, Contra Costa, Fresno, Kings, Sacramento, San Joaquin, Tulare counties; Gold Coast Health Plan (Gold Coast)—Ventura County; Health Net Community Solutions, Inc. (Health Net)—Kern, Los Angeles, and Sacramento counties; and Molina Healthcare of California Partner Plan, Inc. (Molina)—Sacramento County.

Seniors and Persons with Disabilities

The overall performance rates for the SPD population were better than for the non-SPD population for the *Comprehensive Diabetes Care* measures and the *Annual Monitoring for Patients on Persistent Medications* measures. This is consistent with what HSAG has observed in other states and may be attributed to SPD members having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. Conversely, the overall performance for the *All-Cause Readmissions* measure was worse for the SPD population when compared to the non-SPD population, which is also expected based on the greater and often more complicated health needs of these members. Additionally, the performance rates in several

counties for the *Children and Adolescent's Access to Primary Care Practitioners* measures were lower for the SPD population when compared to the non-SPD population. The lower rates on this measure may be attributed to children and adolescents in the SPD population relying on a specialist provider as their care source, based on complicated health care needs, rather than accessing care from a primary care provider.

Model Type Performance

The County-Operated Health System (COHS) model type outperformed the Geographic Managed Care (GMC) and TPM types on 24 of the 30 performance measures (*Ambulatory Care—Outpatient Visits* and *Ambulatory Care—ED Visits* were not considered because they are utilization measures, and *All-Cause Readmissions* was included in this comparison). The TPM outperformed the other model types for three measures, and the GMC model type outperformed the other model types on the remaining three measures.

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

Performance Measure HEDIS Compliance Audit—Key Findings

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

Conclusions and Recommendations

DHCS demonstrates a commitment to monitor and improve the quality of care delivered to its MCMC beneficiaries through its development of an EAS that supports MCMC's overall quality strategy. MCMC's overall weighted averages were at or above the national Medicaid average for 14 of 26 measures.

DHCS continued a variety of mechanisms that support the improvement efforts of MCPs. The auto-assignment program offers an increased incentive for MCPs in the GMC model and TPM types to perform well by rewarding higher-performing MCPs with increased default membership. During 2012, DHCS met with its contracted MCPs to obtain input on potential measure changes to the 2013 EAS, including changes that may impact auto-assignment. DHCS may make modifications to the auto-assignment measures in 2014 to continue to emphasize improved performance across the measure set. Additionally, DHCS has supported MCPs in

selecting performance measures for formal QIPs to help structure improvement efforts to increase the likelihood of achieving statistically significant and sustained improvement. DHCS has taken a more active role in reviewing the MCPs' QIP proposals to ensure that MCPs are selecting areas that are actionable and need improvement rather than selecting topics of consistent or high performance. DHCS evaluates its EAS and auto-assignment program measures annually to rotate out measures that show consistent, high performance among MCPs. For the 2013 EAS, DHCS retired the *Adolescent Well-Care Visits (AWC)* measure to focus on three new measures. This process allows DHCS to identify and select new measures as opportunities for improvement. Finally, DHCS has improved its oversight process of the MCPs' performance over time and has begun to work with MCPs that have demonstrated poor performance over several years on multiple measures.

Based on the review of the 2013 HEDIS results, HSAG provides the following recommendations for continued improvement to the MCPs:

- MCPs need to place a greater emphasis on efforts that are data-driven and can actually improve health outcomes rather than approaching development of HEDIS improvement plans as an exercise in documentation.
- MCPs 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. Inclusion of the rendering provider is important for measures that require a specific provider specialty, such as the identification of a primary care provider for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, *Weight Assessment and Counseling for Nutrition and Physical Activity*; and *Children and Adolescent's Access to Primary Care Practitioners*; and for the identification of a nephrologist, optometrist, and ophthalmologist for the *Comprehensive Diabetes Care* measures. Improving capture of the rendering provider can decrease the resource burden of medical record review for measures that allow for hybrid reporting.
- MCPs should select performance measures with poor rates as the focus for formal QIPs in order to achieve acceptable performance for all measures.
- MCPs need to identify barriers based on available data and link improvement strategies to the barriers having the greatest negative effect on the targeted HEDIS rate.
- MCPs should evaluate the SPD and non-SPD populations during their barrier analyses and develop targeted interventions when appropriate.
- MCPs need to consider evidence-based strategies when selecting interventions.
- MCPs need to track and monitor interventions and critically evaluate intervention effectiveness to identify those interventions that have been successful, those that should be modified, and those that should be discontinued.
- MCPs should consider working with the EQRO as a source of more intensive technical assistance for measures that continue to perform low over consecutive years.

Medi-Cal Managed Care Overview

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

During the 2012 measurement year, DHCS contracted with 22 full-scope MCPs and three specialty MCPs operating throughout California in 30 of California's 58 counties, to provide health care services to approximately 4.9-million members enrolled in MCPs.

Medi-Cal Managed Care Delivery System

DHCS operates MCMC through a service delivery system that encompasses three different plan model types for its full-scope services: the GMC Model (TPM)—both local initiative (LI) and commercial plan (CP), the Geographic Managed Care (GMC) model, and the County Organized Health Systems (COHS) model. DHCS monitors MCP performance across model types. Table 2.1 shows participating MCPs by model type.

Two-Plan

In a TPM county, DHCS contracts with two MCPs to provide medical services to MCMC beneficiaries. Most TPM counties offer an LI MCP and a non-governmental CP. MCMC beneficiaries in a TPM county may enroll in the LI MCP or in the alternative commercial MCP.

Geographic Managed Care

In the GMC model, DHCS contracts with several commercial MCPs within a specified geographic area. This provides MCMC beneficiaries with more choices. The GMC model currently operates in San Diego and Sacramento counties.

County-Organized Health System

In a COHS model county, DHCS contracts with one county-organized and county-operated MCP to provide medical services to MCMC beneficiaries with designated, mandatory aid codes. Under a COHS MCP, MCMC beneficiaries can choose from a wide network of managed care providers.

Specialty Managed Care Plans

In addition to the full-scope MCPs, DHCS contracts with MCPs to provide health care services to specialized populations. During the 2012 measurement period, DHCS held contracts with three specialty MCPs.

Note: As of June 1, 2011, enrollment in Two-Plan and GMC MCPs became mandatory for SPDs who do not have other health care 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 Plans by Model Type as of December 31, 2012

Model Type		MCP Name	County
Two-Plan	Commercial	Anthem Blue Cross Partnership Plan	Alameda
		Anthem Blue Cross Partnership Plan	Contra Costa
		Anthem Blue Cross Partnership Plan	Fresno
		Anthem Blue Cross Partnership Plan	Kings
		Anthem Blue Cross Partnership Plan	Madera
		Anthem Blue Cross Partnership Plan	San Francisco
		Anthem Blue Cross Partnership Plan	San Joaquin
		Anthem Blue Cross Partnership Plan	Santa Clara
		Health Net Community Solutions, Inc.	Kern
		Health Net Community Solutions, Inc.	Los Angeles
		Health Net Community Solutions, Inc.	Stanislaus
		Health Net Community Solutions, Inc.	Tulare
		Molina Healthcare of California Partner Plan, Inc.	Riverside, San Bernardino
	Local Initiative	Alameda Alliance for Health	Alameda
		Anthem Blue Cross Partnership Plan	Stanislaus
		Anthem Blue Cross Partnership Plan	Tulare
		CalViva Health	Fresno
		CalViva Health	Kings
		CalViva Health	Madera
		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 Plan	Santa Clara
Geographic Managed Care		Anthem Blue Cross Partnership Plan	Sacramento
		Care1st Partner Plan	San Diego
		Community Health Group Partnership Plan	San Diego
		Health Net Community Solutions, Inc.	Sacramento
		Health Net Community Solutions, Inc.	San Diego
		Kaiser—Sacramento County	Sacramento
		Kaiser—San Diego County	San Diego
		Molina Healthcare of California Partner Plan, Inc.	Sacramento
		Molina Healthcare of California Partner Plan, Inc.	San Diego
County-Organized Health System		CalOptima	Orange
		CenCal Health	San Luis Obispo, Santa Barbara
		Central California Alliance for Health	Merced, Monterey, Santa Cruz
		Gold Coast Health Plan	Ventura
		Health Plan of San Mateo	San Mateo
		Partnership HealthPlan of California	Marin, Mendocino, Napa, Solano, Sonoma, Yolo

Table 2.1—Medi-Cal Managed Care Plans by Model Type as of December 31, 2012

Model Type	MCP Name	County
Specialty MCPs	AIDS Healthcare Foundation	Los Angeles
	Family Mosaic Project	San Francisco
	Senior Care Action Network (SCAN) Health Plan	Los Angeles, Riverside, San Bernardino

Note: HEDIS 2013, reflecting CY 2012, is the first year the following MCPs reported rates; therefore, HEDIS 2012 data, reflecting CY 2011, were not available for comparisons:

- Anthem Blue Cross Partnership Plan—Fresno County
- Anthem BlueCross Partnership Plan—Kings County
- Anthem Blue Cross Partnership Plan—Madera County
- CalViva Health—Fresno County
- CalViva Health—Kings County
- CalViva Health—Madera County
- Gold Coast Health Plan—Ventura County
- Partnership HealthPlan of California—Marin County
- Partnership HealthPlan of California—Mendocino County

How DHCS Uses Performance Measures

DHCS's overall goal is to preserve and improve the health status of all Californians. MCMC provides comprehensive health care services to a large population of low-income children and families, as well as to an expanding population of SPDs. Since MCMC serves some of California's most vulnerable populations, evaluating and monitoring the quality of health care has remained a key objective for supporting DHCS in meeting its overall goal.

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

DHCS expects its MCPs 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. DHCS satisfies this federal requirement by contracting with HSAG, an EQRO, to conduct performance measure validation. HSAG follows the Centers for Medicare & Medicaid Services (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 MCPs report accurate and complete information.

DHCS shares MCP-specific and aggregate HEDIS results with the MCPs and CMS and releases the results publicly. DHCS also incorporates these results into its consumer guides for new

beneficiaries and uses the data as part of its annual performance assessment of MCPs and MCMC as a whole.

In addition, DHCS gives annual quality awards to MCPs in recognition of their accomplishments. The criteria for these awards are based on MCPs' HEDIS results for exceptional performance or marked improvement. HEDIS awards were presented to MCPs at the 2013 Annual Quality Conference, *Care Coordination—Conquering the Challenges,* held in Sacramento, CA, on April 17, 2013. These awards were based on HEDIS 2012 performance results. The awards were presented as follows:

- Gold Quality Award—San Francisco Health Plan (San Francisco County)
- Silver Quality Award—Kaiser—Sacramento County
- Bronze Quality Award—Central California Alliance for Health (Monterey and Santa Cruz counties)
- Honorable Mention Quality Award—Kaiser—San Diego County
- Most Improved Award—Anthem Blue Cross Partnership Plan (Stanislaus County)

Minimum Performance Levels and High Performance Levels

DHCS annually establishes an MPL and HPL for each required performance measure. To establish the MPLs and HPLs for the 2013 rates, DHCS used the *HEDIS 2012 Audit Means, Percentiles, and Ratios*, which reflect the previous year's benchmarks (CY 2011). The MPLs for the 2013 rates were based on the Medicaid national 25th percentiles and the HPLs were based on the national Medicaid 90th percentiles. MCPs are contractually required to perform at or above the established MPLs. MCPs that have rates below the MPLs must submit an improvement plan to DHCS outlining the steps they will take to improve care. MCP performance in relation to 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—HbA1c Poor Control (>9.0 Percent)* 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.

Auto-Assignment Program

Currently, six performance measures selected from the EAS are part of DHCS's auto-assignment program, along with two measures related to MCP use of safety net providers. DHCS awards more default enrollment (i.e., assignment of members who do not choose an MCP) to TPM and GMC model MCPs that perform high on selected measures and that achieve improvement over time. The auto-assignment program encourages MCPs to improve and/or maintain quality of care

and services provided to their members. Previously, the following six performance measures selected from the EAS were part of DHCS's auto-assignment program:

- *Adolescent Well-Care Visits*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combo 3*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Comprehensive Diabetes Care—HbA1c Testing*

The *Adolescent Well-Care Visits* measure was not reported by the MCPs for HEDIS 2013, so only the remaining five measures were used for the auto-assignment program.

In addition to the performance measures selected from the EAS, the following two measures related to MCP use of safety net providers were used in the auto-assignment program:

- Percentage of hospital discharges at Disproportionate Share Hospital facilities for members residing within the county (based on the Office of Statewide Health Planning & Development hospital discharge data)
- Percentage of members assigned to primary care providers (PCPs) who are safety net providers (based on rates provided by the MCPs after safety net provider lists have been validated by MMCD and validation of a sample of screen prints verifying PCP assignments)

Medi-Cal Managed Care's 2013 Performance Measures

DHCS's 2013 EAS for full-scope MCPs, which used 2012 measurement year data, included the following measures:

- *All-Cause Readmissions* (developed as statewide collaborative QIP measure)—SPD stratification required
- *Ambulatory Care*—SPD stratification required
  - *Emergency Department Visits*
  - *Outpatient Visits*
- *Annual Monitoring for Patients on Persistent Medications*—SPD stratification required
  - *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*—SPD stratification required
  - *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*
  - *Adolescents 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*—SPD stratification required
  - *Hemoglobin A1c (HbA1c) Testing*
  - *HbA1c Poor 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)*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 1*

- *Medication Management for People with Asthma*
  - *Medication Compliance 50% Total*
  - *Medication Compliance 75% Total*
- *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*

Measures for the specialty MCPs included the following:

AIDS Healthcare Foundation

- *Colorectal Cancer Screening*
- *Controlling High Blood Pressure*

Family Mosaic Project (Family Mosaic) (non-HEDIS measures)

- *Inpatient Hospitalizations*: The percentage of Medi-Cal managed care members enrolled in Family Mosaic who have a mental health admission to an inpatient hospital facility during the measurement period.
- *Out-of-Home Placements*: The percentage of Medi-Can managed care members enrolled in Family Mosaic who are discharged to an out-of-home placement during the measurement period.

Senior Care Action Network (SCAN) Health Plan

- *Breast Cancer Screening*
- *Osteoporosis Management in Women Who Had a Fracture*

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 five domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Relative Resource Use
- Health Plan Descriptive Information

Performance measures within these domains provide information about a health 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 health 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 health plan.

DHCS uses HEDIS data as one component of its overall quality monitoring strategy. DHCS and MCPs use MCP-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 health plans collect data and calculate and report results consistently to allow for plan comparison.

Methodology

To assist health 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. DHCS's EAS requirements for 2013 indicate that MCPs are responsible for adhering to the *HEDIS 2013 Technical Specifications, Volume 2*.

To ensure that health 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. DHCS requires that MCPs undergo an annual compliance audit conducted by HSAG, DHCS's contracted EQRO.

The HEDIS process begins well in advance of the MCPs reporting their rates. MCPs calculated their 2013 HEDIS rates with measurement data from January 1, 2012, to December 31, 2012. 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)

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

On-site Activity (January through April)

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

[4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013

Post-on-site Activity (May through October)

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

Data Collection Methodology

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

Administrative Method

The administrative method requires health 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.

Following are 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*
- *Medication Management for People with Asthma*
- *Osteoporosis Management in Women Who Had a Fracture**
- *Use of Imaging Studies for Low Back Pain*

*A specialty MCP 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 use 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 of the 10,000 members 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.

Following are the DHCS-selected EAS measures for which NCQA methodology allows hybrid data collection:

- *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 MCP measure

** A full-scope MCP measure and specialty MCP 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 MCMC-contracted MCPs report rates in this manner, Kaiser—Sacramento County and Kaiser—San Diego County. The Kaiser MCPs 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 MCP had already captured administratively.

HEDIS Aggregate Report Data Displays

This report displays 2013 HEDIS results relative to both local and national performance thresholds and benchmarks to compare the quality of services provided to MCMC beneficiaries. A comparison of performance gives both DHCS and MCPs 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 2020* program provide another source of national benchmarks for comparison within this report, as available.[5] Local benchmarks include prior-year MCMC weighted averages. MCPs' submission of HEDIS data provides rates calculated to the sixth decimal place. Unless otherwise noted, results in this report are rounded to the second 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 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 MCP's eligible population for that measure, provides the most representative rate for the overall MCMC population. Weighting the MCMC average by each MCP's eligible population size ensures that the rate for an MCP with 125,000 members, for example, has a greater impact on the overall MCMC weighted average than the rate for an MCP with only 10,000 members.

HSAG computed the 2013 MCMC weighted average for each measure using MCP-reported rates and weighted these by each MCP'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 beneficiaries than a straight average of MCMC MCPs' performance.

[5] *Healthy People 2020* is managed by the U.S. Department of Health and Human Services' Office of Prevention and Health Promotion. *Healthy People 2020* provides a framework for prevention for the nation by establishing national health objectives and setting national goals to reduce threats. Available at http://www.healthypeople.gov/2020/default.aspx. Accessed on: September 9, 2013.

Significance Testing

HSAG used a Chi-square test to determine if MCP-specific differences between 2013 and 2012 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).

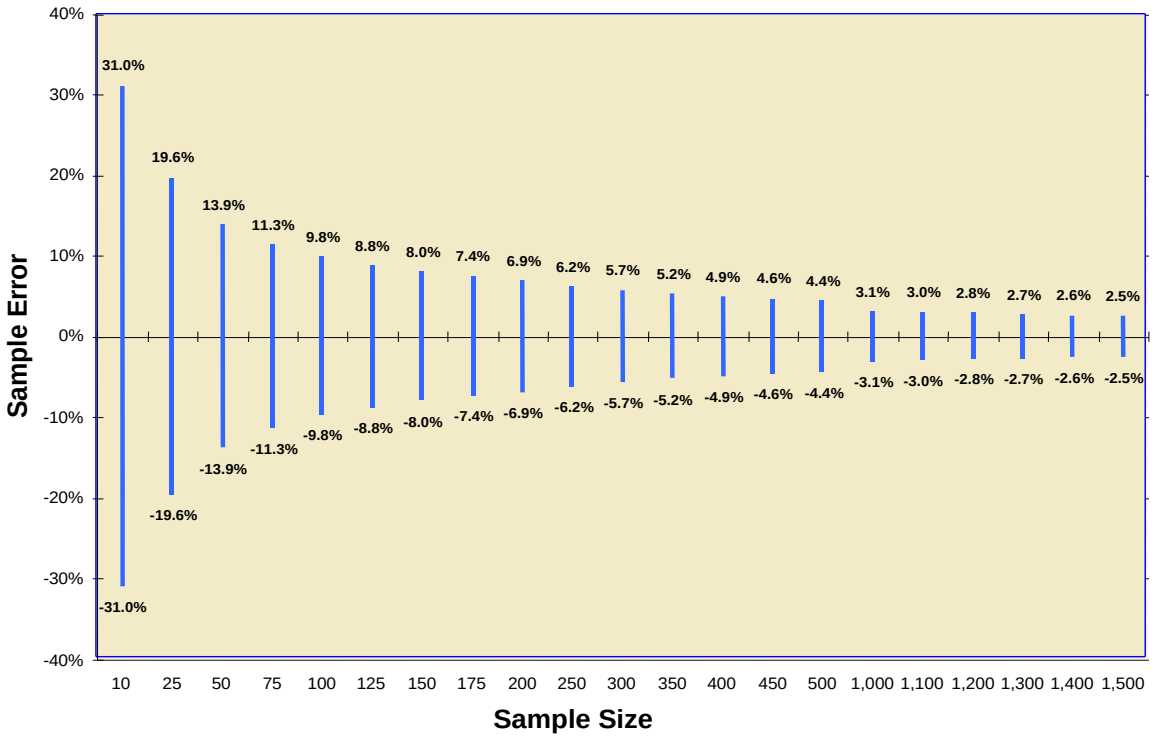
Understanding Sampling Error and Effect Size

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 2013 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 = 0.5, 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 MCPs performing overall?

Results Accuracy

DHCS requires all MCMC MCPs 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, MCPs should understand and consider the issue of sampling error when implementing interventions.

Comparing Medi-Cal Managed Care Rates to National Percentiles

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

- 2012 National Medicaid Average—The most current available mean rate of all Medicaid plans nationwide that reported rates to NCQA in 2012, which represents calendar year 2011 data.
- 2012 National Commercial Average—The most current available mean rate of all commercial plans nationwide that reported rates to NCQA in 2012, which represents calendar year 2011 data.
- Healthy People 2020—The relevant 2020 goals corresponding to the MCMC's EAS.

Medi-Cal Managed Care Plans' Overall Performance

DHCS establishes performance thresholds annually for minimum performance and high performance. This report displays each MCP'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 2012 Audit Means, Percentiles, and Ratios,* DHCS established its MPLs and HPLs for its HEDIS 2013 EAS. DHCS based the MPLs on the 2012 Medicaid national 25th percentile and the HPLs on the 2012 Medicaid national 90th percentile, which represent the most recent data available from NCQA at the time this report was prepared. Appendix A includes all of the applicable HEDIS 2012 Medicaid national percentiles.

For most measures in this report, the 90th percentile indicates the HPL and the 25th percentile represents the MPL. This means that Medi-Cal MCPs with reported rates above the 90th percentile rank in the top 10 percent of all Medicaid plans nationwide. Similarly, MCPs 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—HbA1c Poor 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.

The *Colorectal Cancer Screening* measure and the *Osteoporosis Management in Women Who Had a Fracture* measure were each reported by one of the specialty MCPs. These measures do not have established national percentiles for the Medicaid population. For comparison purposes, HSAG and DHCS use the established commercial 25th and 90th percentiles for the *Colorectal Cancer Screening* measure and the established Medicare 25th and 90th percentiles for the *Osteoporosis Management in Women Who Had a Fracture* measure.

Performance Trend Analysis

In Appendix B, the column, "2012–13 Rate Difference," shows, by measure, a comparison between the HEDIS 2012 results and the HEDIS 2013 results for each MCP. HSAG used a Chi-square test to calculate the statistical significance between MCP rates in 2012 and 2013. The table shows the rate difference between 2012 and 2013 graphically using the key below:

↑	Rates in 2013 were significantly higher than they were in 2012.
↓	Rates in 2013 were significantly lower than they were in 2012.
↔	Rates in 2013 were not significantly different than they were in 2012.
Not comparable	A 2012–13 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—HbA1c Poor 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 2013 rate from the 2012 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2013 rate from the 2012 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, DHCS contracted with HSAG to conduct validation of the selected EAS performance measures. HSAG conducted audits in accordance with the 2013 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased.

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 audit).
- IS 7.0—Data Integration—Accurate Reporting, Control Procedures That Support HEDIS or Measure Reporting Integrity.

HEDIS Audit Results

Through the audit process, HSAG assigns each measure one of the four audit results. A numeric result, usually accompanied with an "R" *Reportable*, indicates that the MCP complied with all HEDIS specifications to produce an unbiased, reportable rate or rates that can be released for public reporting. Although an MCP may have complied with all applicable specifications, if the MCP's denominator is too small to report (less than 30), the audit result is "*NA,*" denoting *Small Denominator*. An audit result of "*NR"* (*Not Reportable*) 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 MCP chose not to report the measure. An "*NB*" (*Benefit Not Offered*) audit result indicates that the MCP did not offer the benefit required to report the measure.

HEDIS Reporting Capabilities

Key Findings

Twenty-five contracted MCPs underwent performance measure validation. Twenty-four of the MCPs had a HEDIS Compliance Audit. Family Mosaic Project, a specialty MCP, reported non-HEDIS measures; therefore, it 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 25 MCP audits for the 2013 reporting year.

Of the 25 audited MCPs, 22 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 MCPs that did not use a certified software vendor, HSAG reviewed and approved the source code. HSAG also reviewed and approved 23 MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide Collaborative QIP measure since this measure is not certified under software certification for Medicaid.

Strengths

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

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

Challenges

Most of the challenges and opportunities were MCP-specific, and there were few challenges that were applicable to all or most of the MCPs. However, HSAG did note an increase in the use of supplemental databases for HEDIS reporting, which required the MCPs to increase coordination and oversight efforts to ensure that these databases met the HEDIS reporting requirements, including the completion of a separate Section 5 of the HEDIS Roadmap document.

Recommendations

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

- Ensure that the rendering provider detail is included on all submitted claims and encounters, especially for services performed at multispecialty and group practices. Inclusion of the rendering provider is important for measures that require a specific provider specialty, such as the identification of a primary care provider for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, *Weight Assessment and Counseling for Nutrition and Physical Activity*, and *Children and Adolescent's Access to Primary Care Practitioners*; and for the identification of a nephrologist, optometrist, and ophthalmologist for the *Comprehensive Diabetes Care* measures. Improving capture of the rendering provider can decrease the burden of medical record review for measures that allow for hybrid reporting.
- Explore the use of supplemental data with greater coordination and oversight to enhance HEDIS reporting. More stringent requirements will be fully enforced for HEDIS 2014, which could invalidate a database if not properly validated by the MCP.
- Closely monitor timelines, milestones, and deliverables of contracted providers and certified software vendors. MCPs should consider implementing sanctions for vendors that do not meet contractual requirements.
- Work to increase electronic data submission from providers.
- Improve reporting accountability by clearly documenting the data audit process.

All-Cause Readmissions

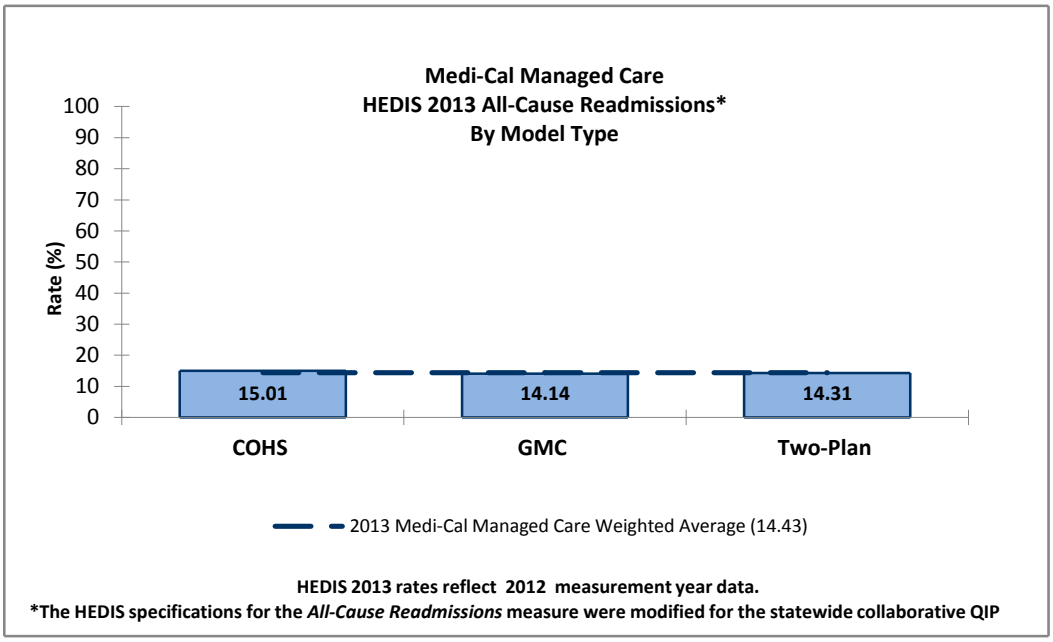
Measure Definition

The *All-Cause Readmissions* measure reports the percentage of acute inpatient hospital stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days for MCMC beneficiaries aged 21 years and older. The HEDIS specifications for the *Plan All-Cause Readmissions* measure were modified to align with the needs of the statewide collaborative QIP.

Importance

Hospital readmissions have been associated with the lack of proper discharge planning and poor care transition. Improving the care transition and coordination after hospital discharge will reduce the high rate of preventable readmissions which will in turn decrease costs and improve overall quality of care, ultimately leading to improved health outcomes for the MCMC population.

Performance Results



Medi-Cal Managed Care
HEDIS 2013 All-Cause Readmissions

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

Note: This measure is a collaborative QIP measure; non-NCQA measure.

Summary of Results

An MPL and HPL are not applied to a measure (1) when 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 DHCS requires the measure. DHCS required its MCPs to report the *All-Cause Readmissions (ACR)* measure in 2013 for the first time; therefore, no HPL and MPL were established for the measure.

The GMC model and TPM types performed similarly and outperformed the COHS model type, since for this measure, a lower rate indicates better performance.

Annual Monitoring for Patients on Persistent Medications (MPM)

Measure Definition

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.

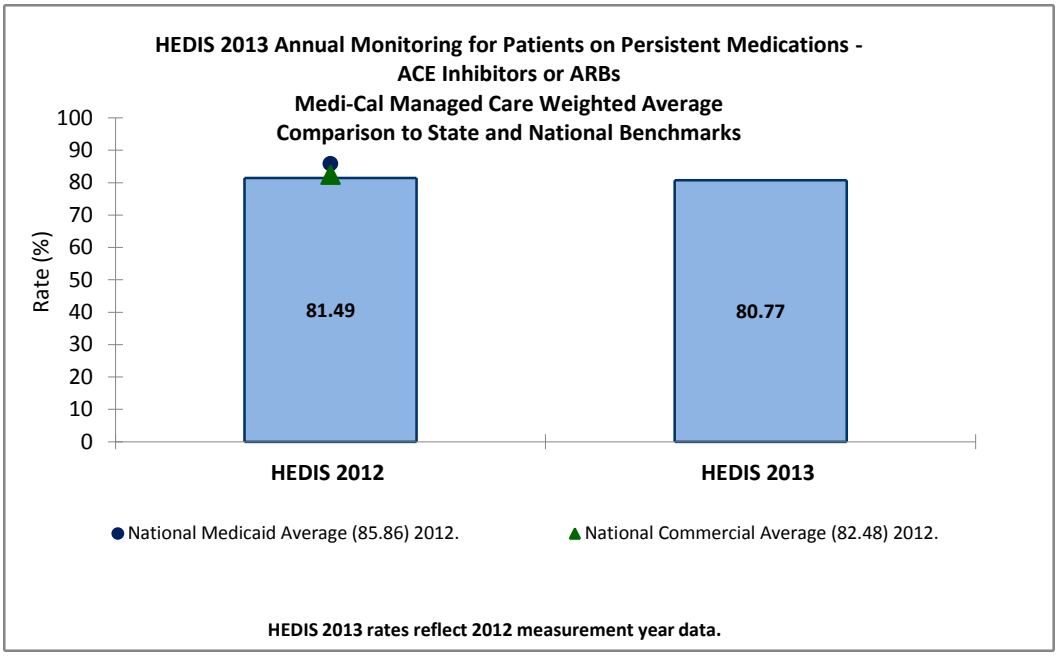
Importance

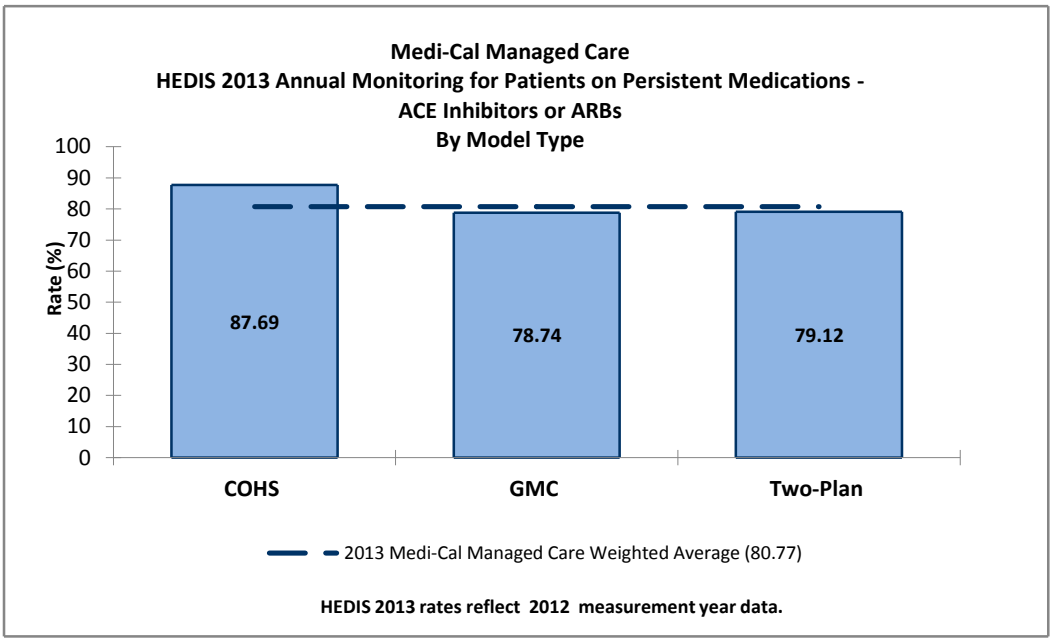
Patient safety is highly important, especially for patients at increased risk of adverse medication events from long-term medication use. Persistent use of these medications warrants monitoring and follow-up by the prescribing provider to assess for side-effects and adjust medication dosage accordingly.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

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.

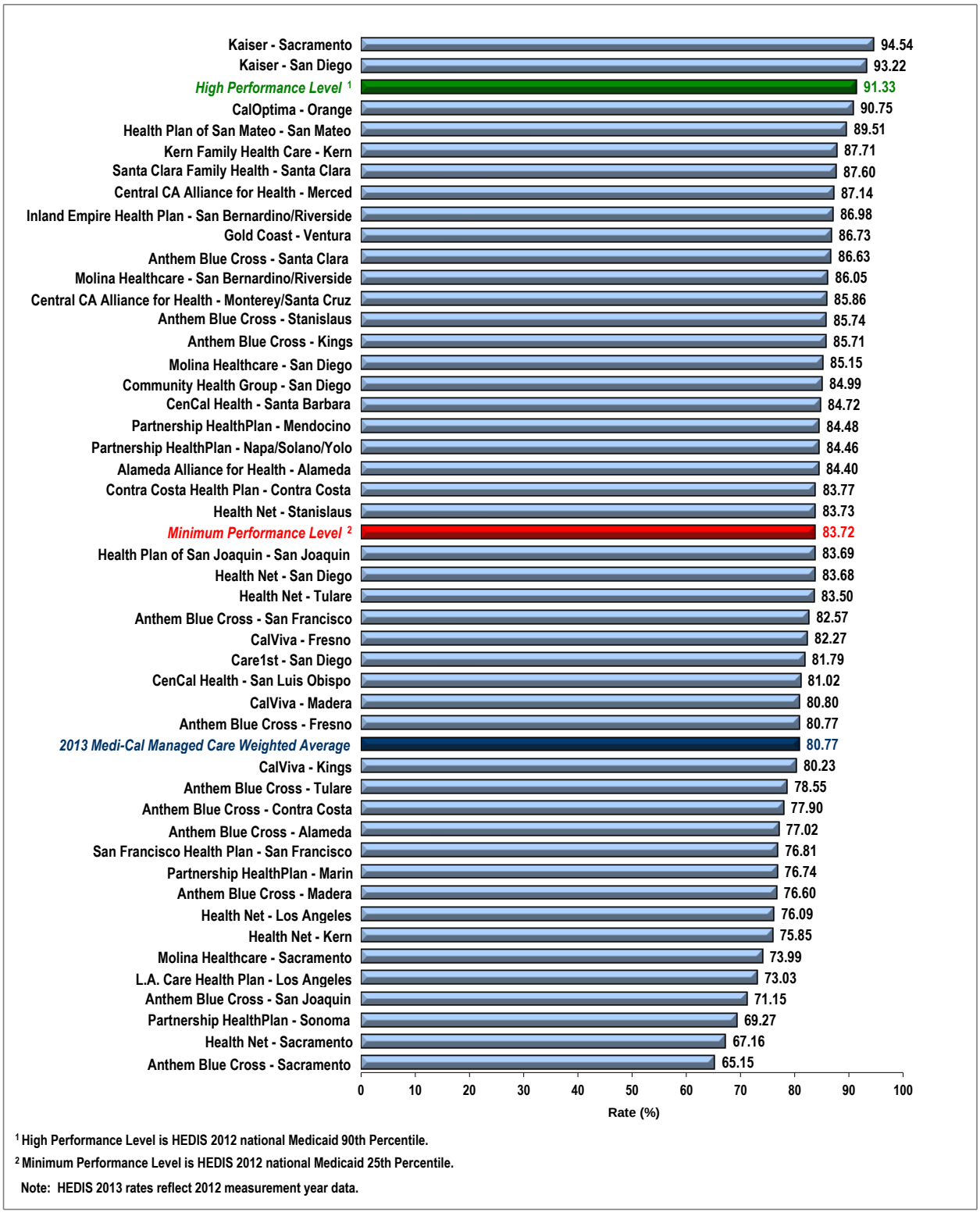
Appropriate monitoring of medication therapy remains a significant issue to guide therapeutic decision making and provides largely unmet opportunities for improvement in care for patients on persistent medications.

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





Medi-Cal Managed Care
HEDIS 2013 Annual Monitoring for Patients on Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB)



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

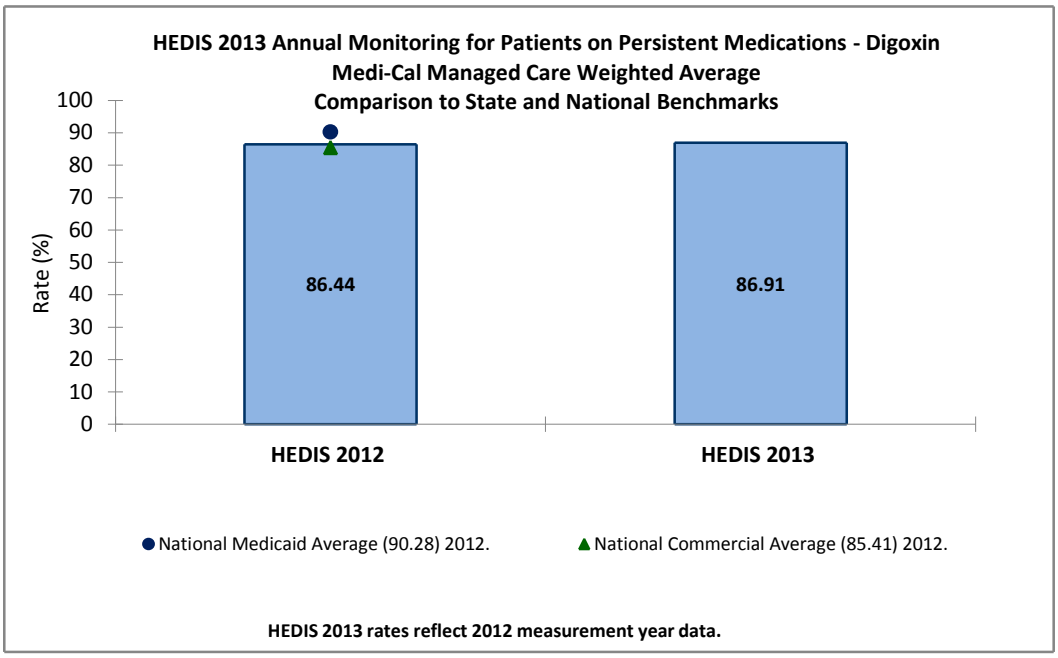
The MCMC 2013 weighted average for the *Annual Monitoring for Patients on Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB)* was below the MPL for this measure. Additionally, the 2013 MCMC performance was lower than the 2012 national Medicaid average and the 2012 national commercial average. The COHS model type performed better than the TPM and GMC model types.

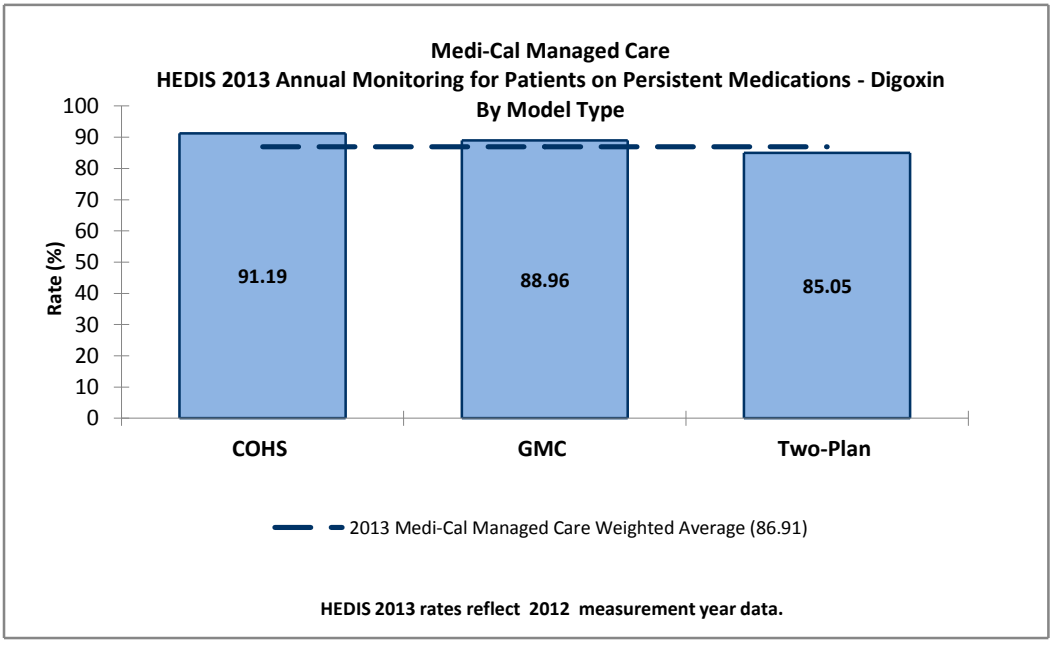
High and Low Performers

Two rates exceeded the 2013 HPL, Kaiser—Sacramento County and Kaiser—San Diego County, compared to 24 rates that were below the MPL.

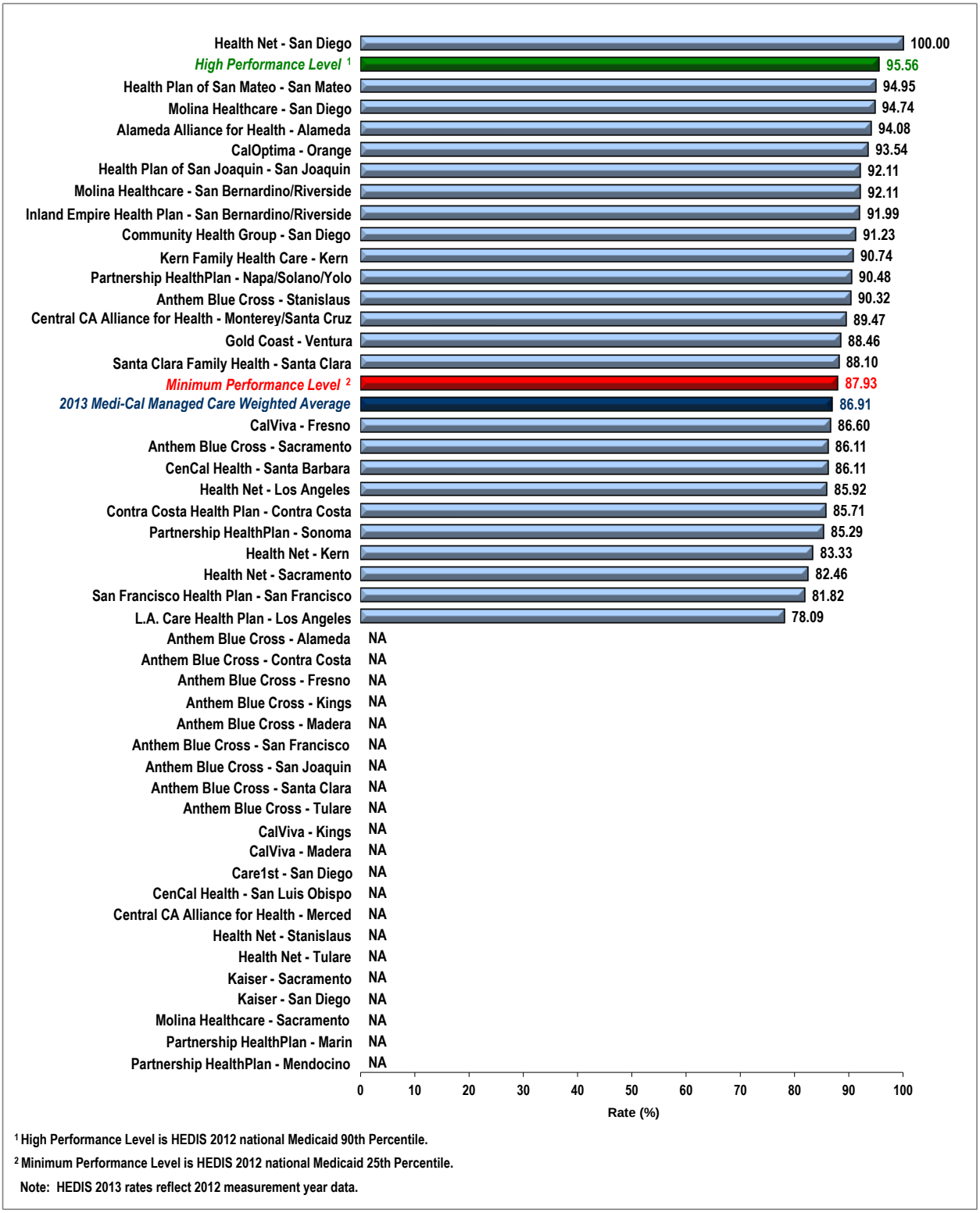
Eleven rates had a statistically significant increase in 2013 compared to 2012 rates, while six rates showed statistically significant declines (refer to Appendix B).

Performance Results—Annual Monitoring for Patients on Digoxin





Medi-Cal Managed Care
HEDIS 2013 Annual Monitoring for Patients on Digoxin



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

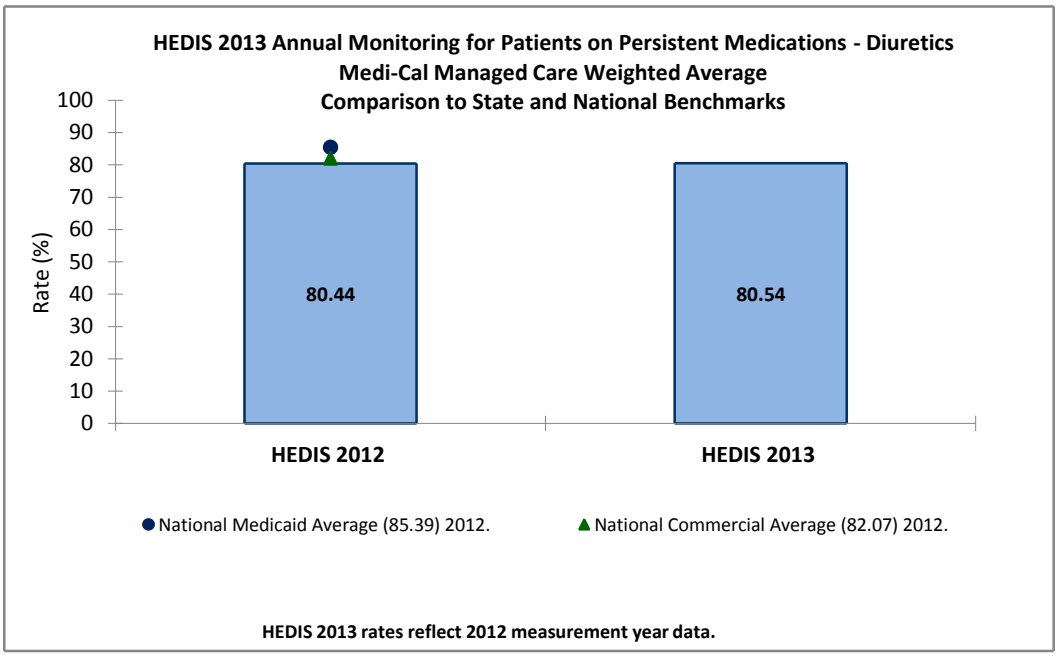
The MCMC 2013 weighted average for the *Annual Monitoring for Patients on Digoxin* was below the MPL for this measure. Additionally, the MCMC's 2013 performance was lower than the 2012 national Medicaid average and higher than the 2012 national commercial average. The COHS model type performed better than the TPM and GMC model types.

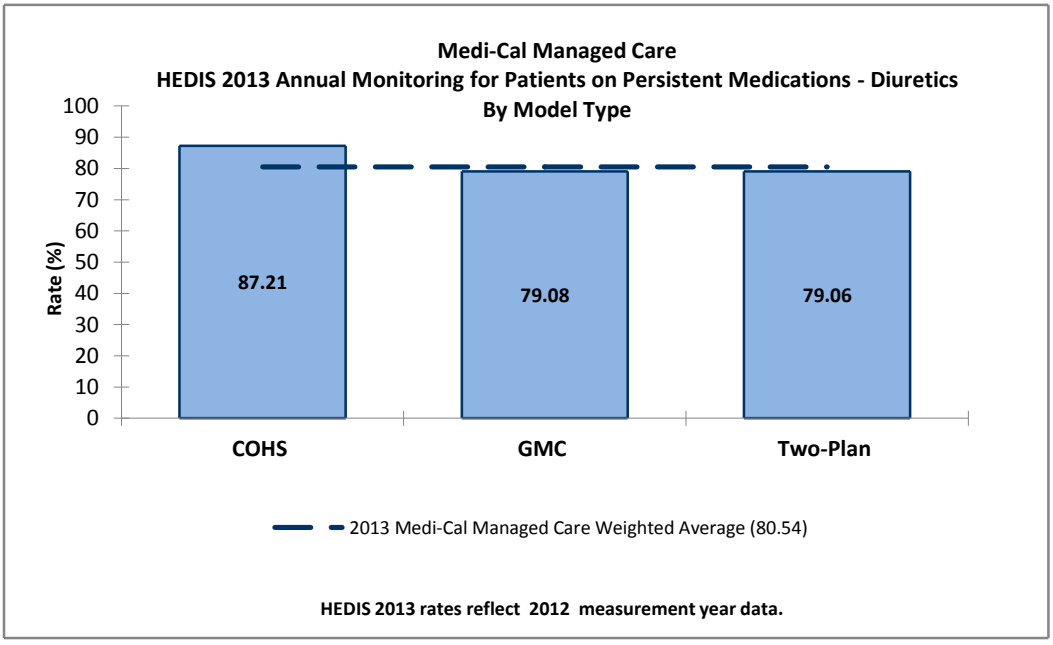
High and Low Performers

Health Net—San Diego County's rate exceeded the 2013 HPL compared to 10 rates that were below the MPL. Two rates had a statistically significant increase in 2013 compared to 2012 rates, while no rates showed statistically significant declines (refer to Appendix B).

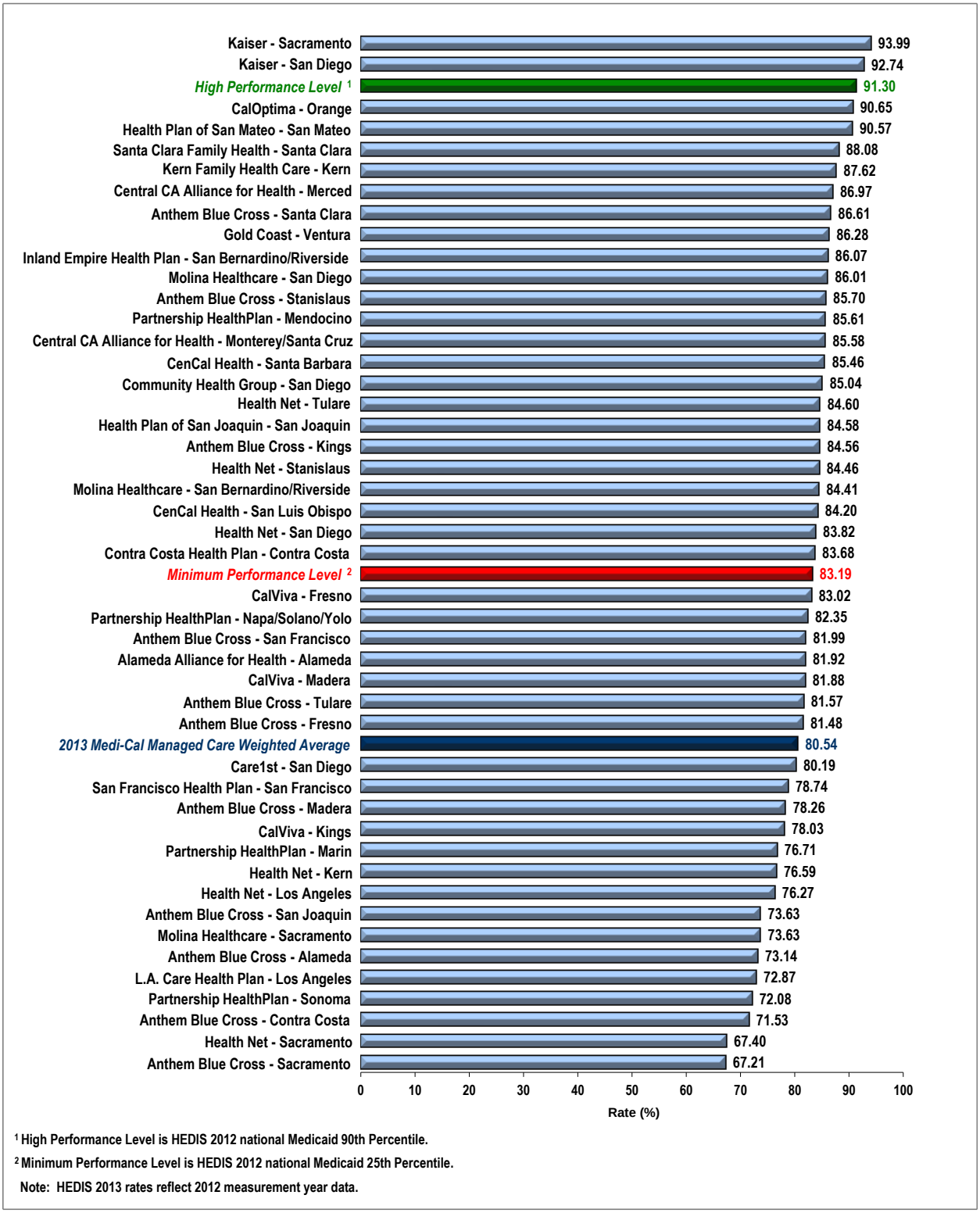
Several MCPs had a denominator less than 30 for this measure, which resulted in an "*NA*" audit result. The MCPs complied with all applicable specifications; however, when the denominator is less than 30, the audit result is "*NA*."

Performance Results—Annual Monitoring for Patients on Diuretics





Medi-Cal Managed Care
HEDIS 2013 Annual Monitoring for Patients on Diuretics



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC 2013 weighted average for the *Annual Monitoring for Patients on Diuretics* was below the MPL for this measure.

Additionally, the MCMC's 2013 performance was lower than the 2012 national Medicaid average and the 2012 national commercial average. The COHS model type performed better than the TPM and GMC model types.

High and Low Performers

Two rates, Kaiser—Sacramento County and Kaiser—San Diego County, exceeded the 2013 HPL compared to 22 rates that were below the MPL. Ten rates had a statistically significant increase in 2013 compared to 2012 rates, while two rates, Alameda Alliance for Health—Alameda County and Central California Alliance for Health—Merced County, showed statistically significant declines (refer to Appendix B).

Annual Monitoring for Patients on Persistent Medications—Best and Emerging Practices

Provider Education

Patients who take medications for chronic conditions may be at increased risk for adverse drug effects or problems relating to nonadherence. While yearly testing for patients on medications such as angiotensin-converting enzyme inhibitors (ACE inhibitors), statins, and anticonvulsants to monitor blood levels and organ functioning is essential, blood tests cannot replace good communication between providers and members. Educational interventions for providers should include prescribing products that simplify the medication regimen or the practice of sending refill reminders; although these interventions are less effective than direct patient contact, they are often more cost-effective.[6]

Computerized Methods to Detect Adverse Drug Events

Use of computerized data to identify adverse drug events (ADEs) is one strategy to monitor the effects prescribed medications are having on patients. The Food and Drug Administration and The Joint Commission emphasize the need for reporting ADEs as important markers of the quality of medical care. Additionally, the American Society for Health-Systems Pharmacists recommends that all health care systems develop ongoing ADE reporting programs. Compared

[6] A. A. Petrilla, J. S. Benner, D. S. Battleman, et al. Evidence-based interventions to improve patient compliance with antihypertensive and lipid-lowering medications. 2005. International Journal of Clinical Practice. 59:12; 1141–1451.

with manual chart review, use of electronic medical records to estimate the rate of ADEs is faster and much less expensive.[7]

Computerized ADE alert monitors use rule sets to search signals that suggest the presence of adverse drug events. The most frequently studied rule sets are those that search for drug names, drug-lab interactions, or lab levels alone that frequently reflect an ADE. Simple versions of an alert monitor can be implemented with pharmacy and laboratory data alone, although the yield and positive predictive value of signals is higher when the two databases are linked. Further refinements include searches for International Classification of Diseases codes and text-searching of electronic outpatient notes for drug-symptom combinations. These refinements increase the number of ADEs identified; however, they require linkage to administrative databases or electronic medical records. The information gathered from the alert monitors can be used by providers to change a patient's medication regimen based on the issue in question.[8]

[7] Honigman B, Lee J, Rothschild J, et al. Using Computerized Data to Identify Adverse Drug Events in Outpatients. J Am Med Inform Assoc. 2001 May–Jun; 8(3): 254–266.

[8] Gandhi TK, Bates DW. Computer Adverse Drug Event (ADE) Detection and Alerts. In*: Making Health Care Safer: A Critical Analysis of Patient Safety Practices.* Evidence Report/Technology Assessment, No. 43. AHRQ Publication No. 01-E058, July 2001. Agency for Healthcare Research and Quality, Rockville, MD. Available at: http://www.ahrq.gov/legacy/clinic/ptsafety/chap8.htm. Accessed on: October 30, 2013.

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.[9] 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.[10] 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.[11]

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.[12] 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.[13] Routine antibiotic treatment of acute bronchitis does not have a consistent impact on the duration, severity of illness, or potential complications.[14]

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

10 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.

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

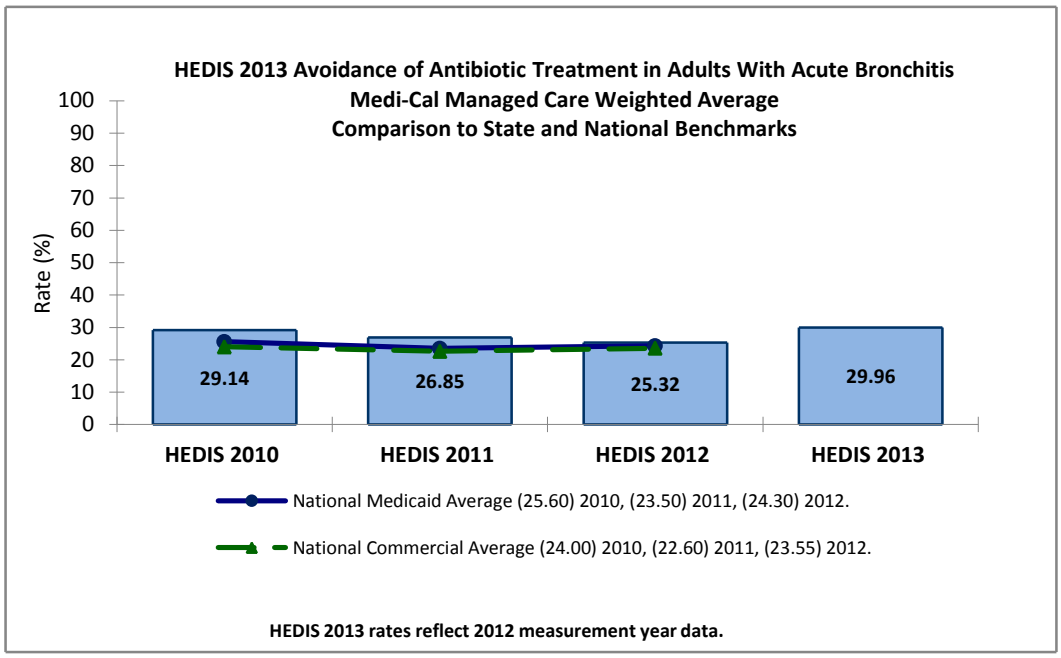
12 Chandran R. Should We Prescribe Antibiotics for Acute Bronchitis? *American Family Physician*. 2001.

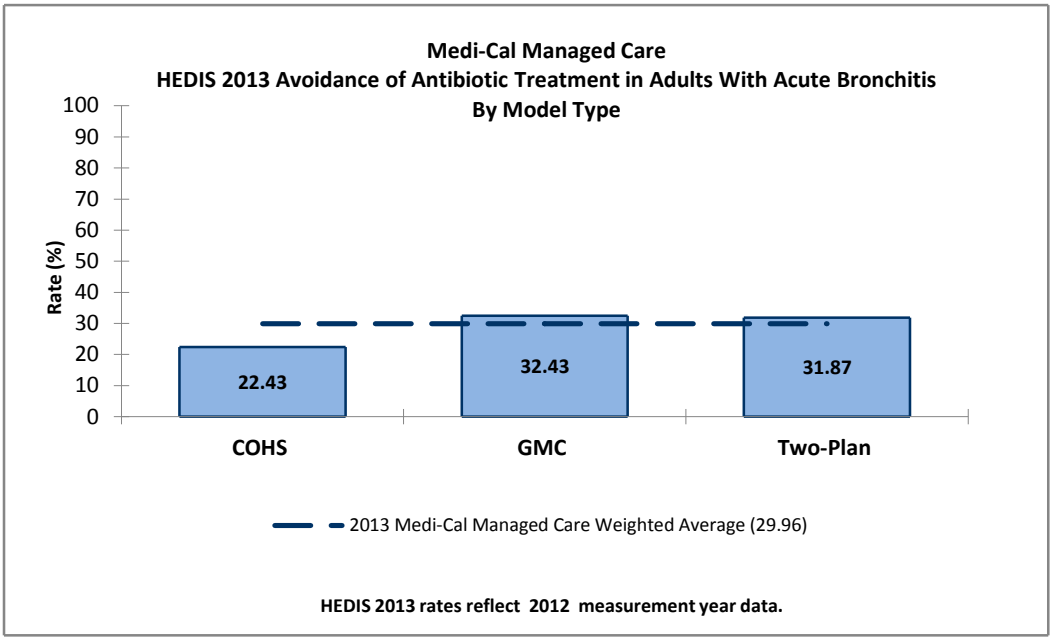
13 Scott JG, Cohen D, DiCicco-Bloom B, et al. Antibiotic Use in Acute Respiratory Infections and the Ways Patients Pressure Physicians for a Prescription. *The Journal of Family Practice*. 2001; 50(10): 853–858.

14 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.[15]

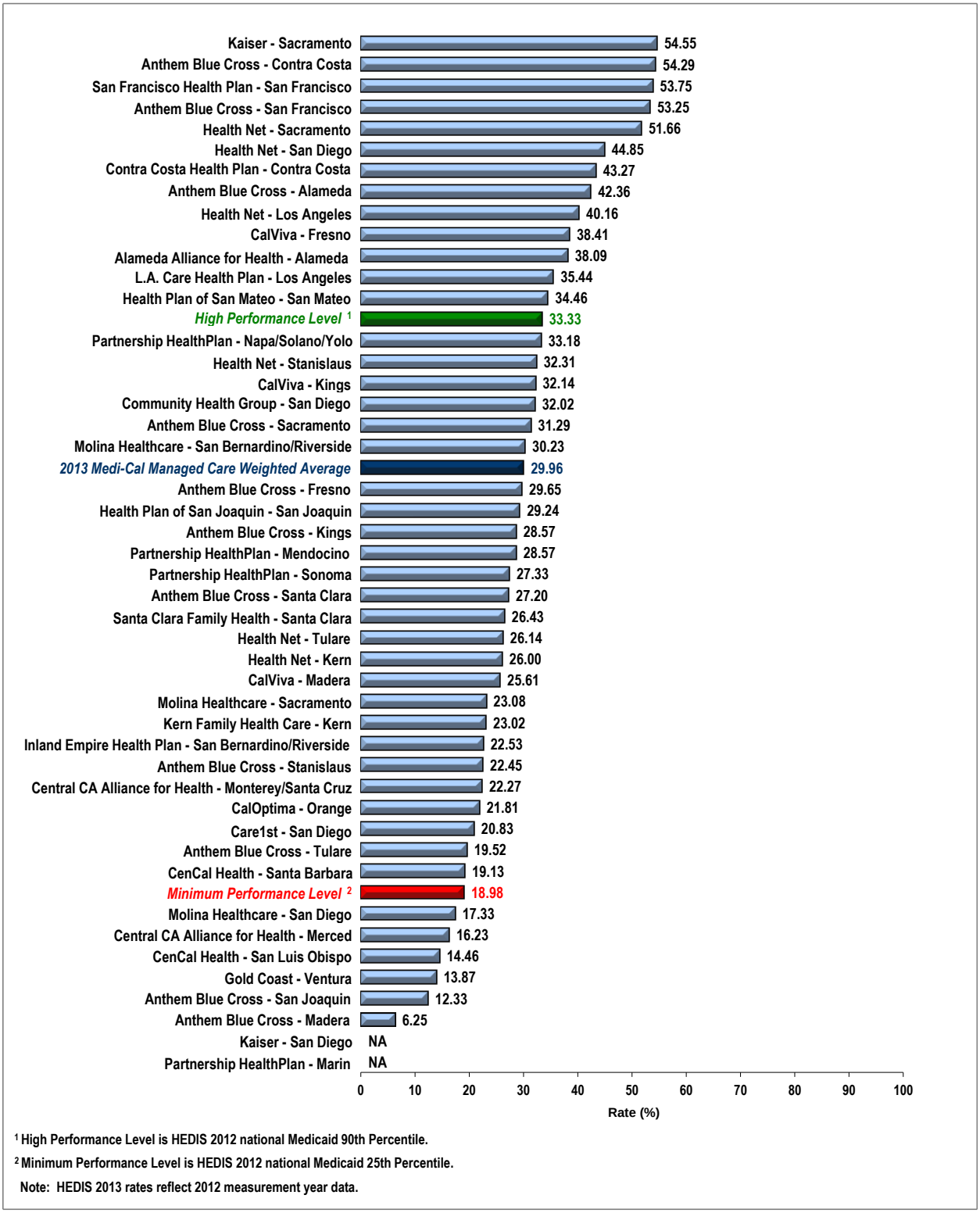
Performance Results





[15] 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 2013 Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC 2013 weighted average for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was 29.96 percent. For 2013, MCMC demonstrated better performance when compared to the 2012 national Medicaid average and the 2012 national commercial average. The TPM and GMC model types performed better than the COHS model type.

High and Low Performers

Thirteen rates exceeded the 2013 HPL compared to six rates that were below the MPL. Twelve rates had a statistically significant increase in 2013 compared to 2012 rates, while five rates showed statistically significant declines (refer to Appendix B).

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 antibiotic 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 advice and tools can help to reduce the symptoms of acute bronchitis caused by smoking.[16] Education provided directly to the patient at the time of the visit is more effective than educational efforts involving pamphlets or newsletters.[17]

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

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

[17] 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.[18]

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 the following:[19]

- 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 antibiotics.

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).[20] Many prescribing applications include information on pathogens, diagnosis, medication, and treatment; therefore, adherence to clinical guidelines is greater.[21,22] NCQA developed a 60-minute Webinar for providers

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

[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] 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.

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

[22] 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: September 10, 2013.

and quality managers, which outlines an algorithm to improve appropriate antibiotic use with acute bronchitis. In the study, both posters and electronic health record (EHR) systems were successful in improving the outcome.[23]

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.[24]

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.[25]

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[23] 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: September 10, 2013.

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

[25] 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.[26] In the United States, Hispanic women are most likely to get cervical cancer, followed by African-Americans, Asians and Pacific Islanders, and Whites.[27]

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.[28]

In March 2012, the U.S. Preventive Services Task Force (USPSTF) updated the screening guidelines for cervical cancer.[29] Consistent with prior recommendations, the 2012 updated guidelines recommend that women ages 21–65 who have a cervix have a Pap smear every three years. The new recommendations provide the alternative of having a combination of Pap smear and human papillomavirus (HPV) testing every five years for women ages 30–65 who want to be screened less frequently. USPSTF did not change its recommendation against cervical cancer screening using HPV testing, alone or with cytology, in women younger than 30.

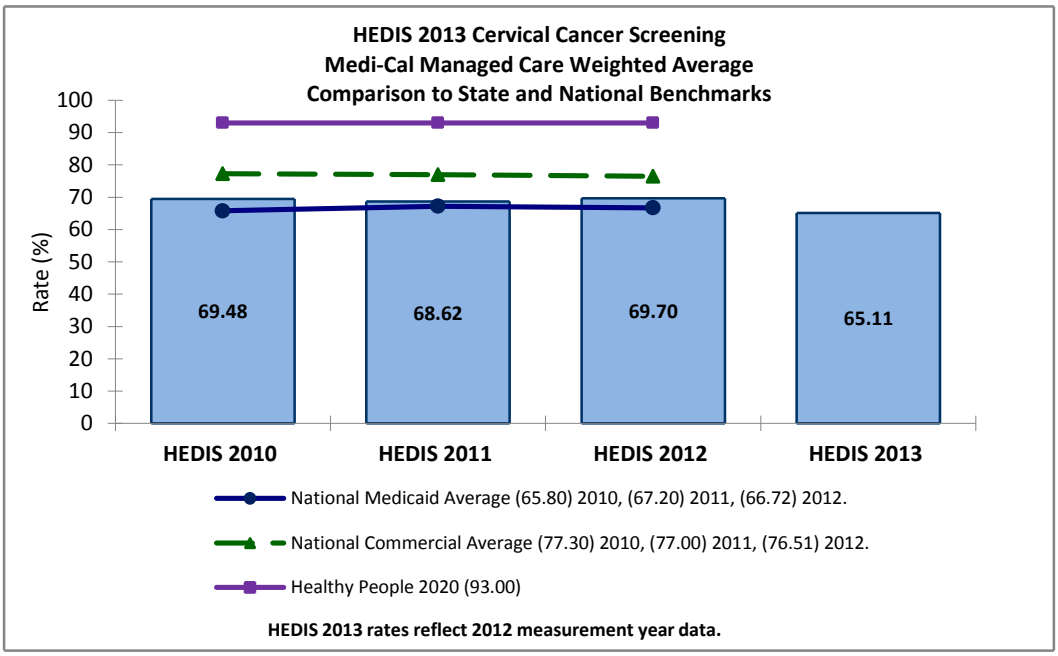
[26] American Cancer Society. Cancer Facts and Figures 2012. Available at: http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-031941.pdf Accessed on: September 10, 2013.

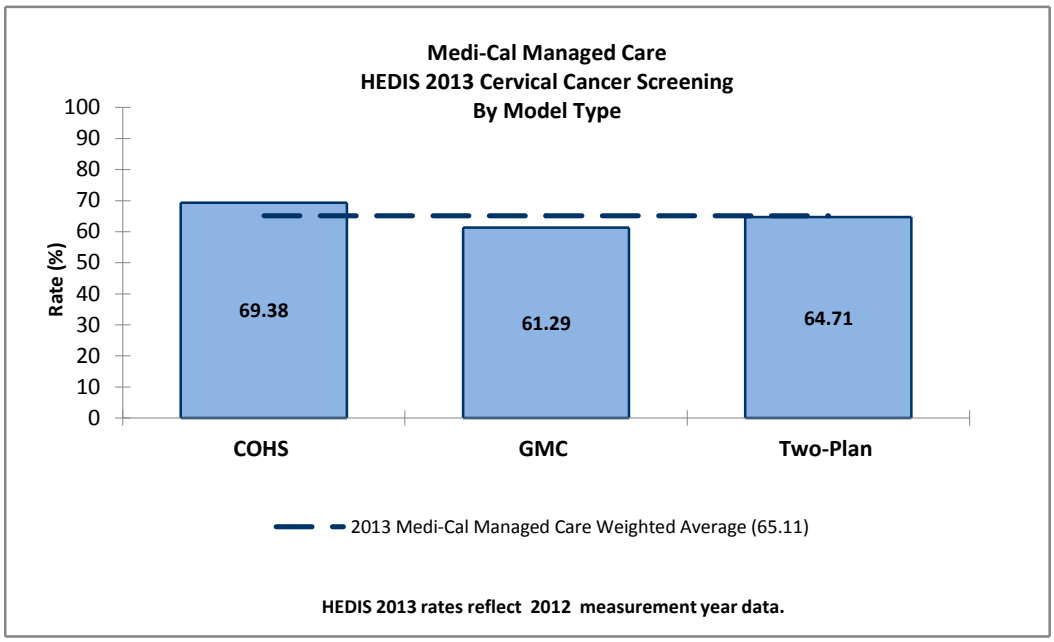
[27] American Cancer Society. Detailed Guide: Cervical Cancer. Updated 2012. Available at: http://www.cancer.org/acs/groups/cid/documents/webcontent/003094-pdf.pdf. Accessed on: September 10, 2013.

[28] Ibid.

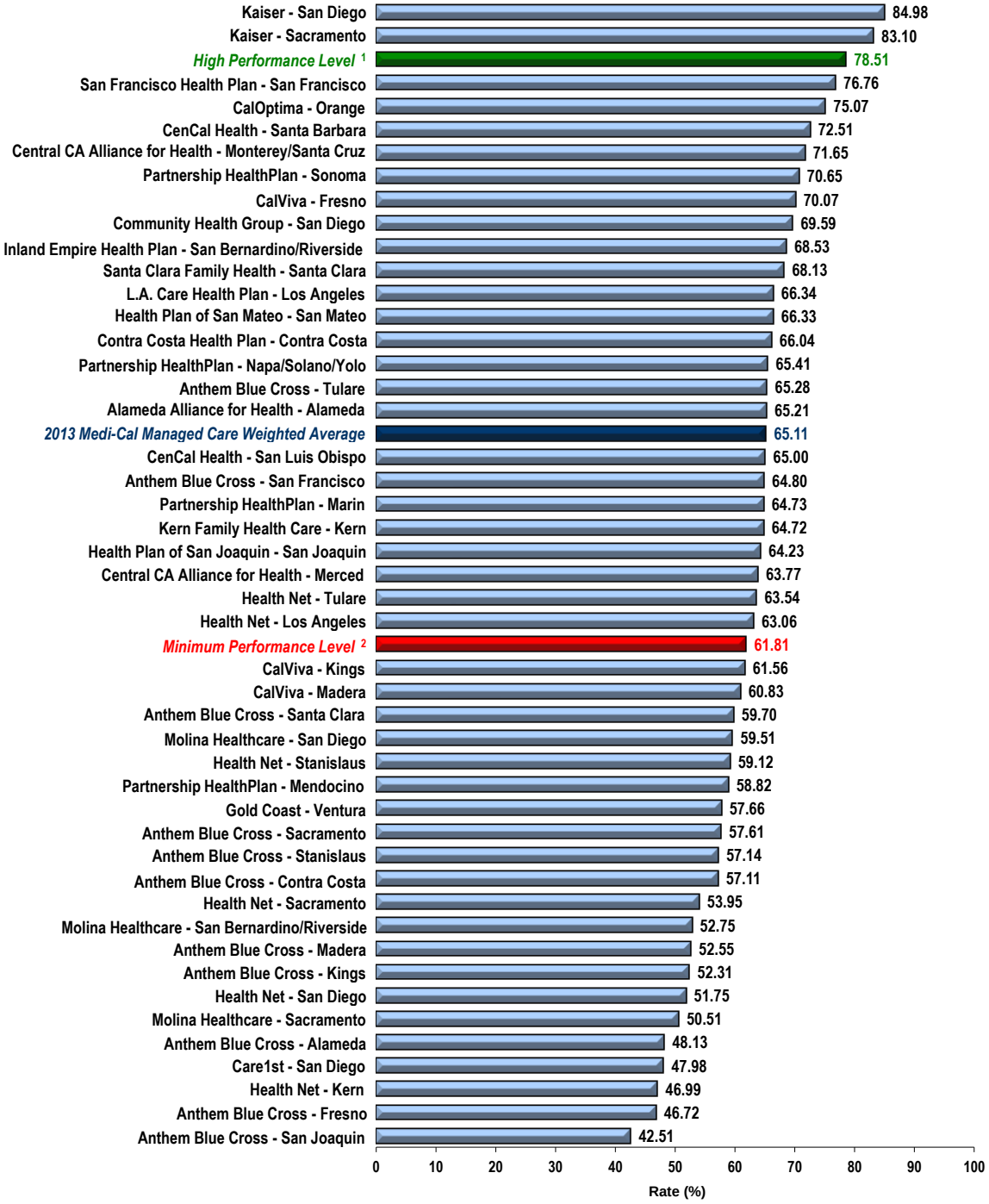
[29] Screening for Cervical Cancer, Topic Page. April 2012. U.S. Preventive Services Task Force. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm. Accessed on: October 30, 2013.

Performance Results





Medi-Cal Managed Care
HEDIS 2013 Cervical Cancer Screening



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC 2013 weighted average for the *Cervical Cancer Screening* measure was 65.11 percent, which was much lower than the Healthy People 2020 objective of 93.0 percent. For 2013, MCMC demonstrated decreased performance compared to both the 2012 national Medicaid average and the 2012 national commercial average. The COHS model MCPs outperformed the GMC model and TPM types in 2013.

High and Low Performers

Kaiser —Sacramento County and Kaiser—San Diego County performed above the HPL in 2013. Twenty-one rates performed below the MPL in 2013, which was more than the nine rates in 2012. No rates showed statistically significant improvement in 2013 compared to 2012 rates, and there were 13 reported rates with a statistically significant decline (refer to Appendix B).

Best and Emerging Practices

Physician and Patient Communication/Patient Education[30]

If a physician is able to properly communicate with his or her patient about various topics such as birth control, sexually transmitted diseases (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.

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

[30] 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.

studies to illustrate the importance of communication and suggest approaches for improving the relationship between the physician and patient.

Health Education Materials[31,32]

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 electronic 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).[33] 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 MCP Example[34]

San Francisco Health Plan—San Francisco County has shown consistently high performance for cervical cancer screening, exceeding the HPL in both 2011 and 2012 and only 1.75 percentage points below the HPL in 2013. The MCP 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.
  - Inform patients of the need for having a Pap test, even when presenting for an urgent care visit.

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[31] 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.

[32] Select Health. HEDIS 2009. Available at: http://selecthealth.org/Static/Files/hedisreport.pdf Accessed on: September 10, 2013.

[33] Ibid.

[34] SFHP 2012 HEDIS Criteria Cervical Cancer Screening. Available at: http://www.sfhp.org/files/PDF/providers/HEDIS/Cervical_Cancer_Screening.pdf Accessed on September 10, 2013.

- 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.[35] 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.[36] 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.[37]

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

[35] 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: September 10, 2013.
[36] National Committee for Quality Assurance. The State of Health Care Quality in 2009. Washington, D.C.: NCQA; 2009.
[37] Centers for Disease Control and Prevention. Mumps Outbreaks. Updated July 2010. Available at: http://www.cdc.gov/mumps/outbreaks.html#e Accessed on: September 10, 2013.

$29 can be saved in direct and indirect costs.[38] 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.[39]

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.[40] In 2007, almost 25 percent of children in the United States 19 to 35 months old did not receive the recommended vaccinations.[41] 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.[42] 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.[43]

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

[39] 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.

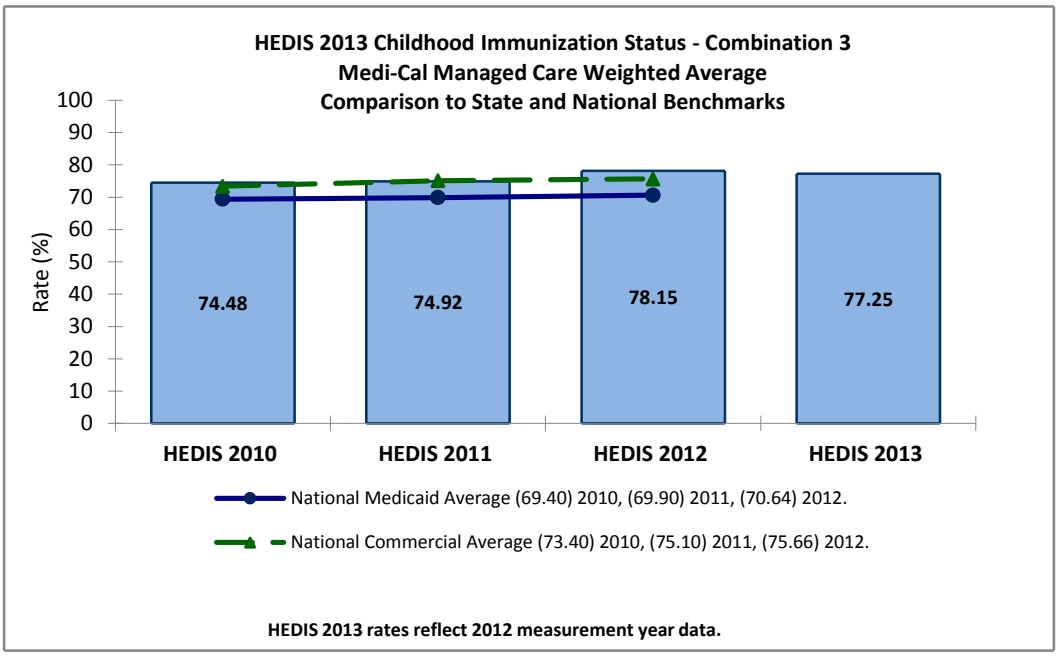
[40] American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine and Council on Community Pediatrics. "Increasing Immunization Coverage." *Pediatrics*. 2003; 112(4): 993–996.

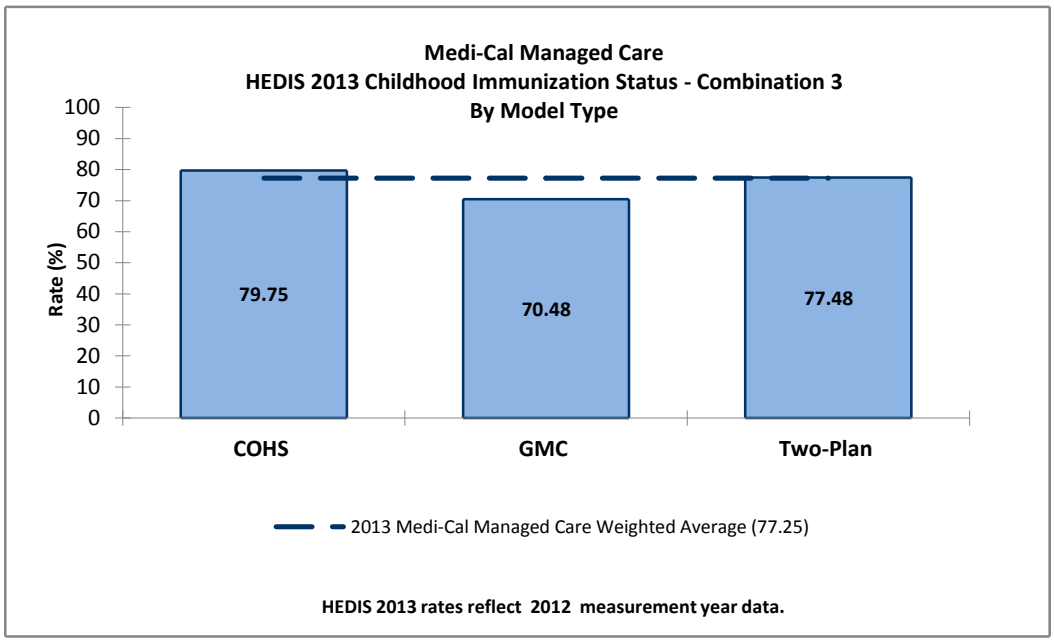
[41] Agency for Healthcare Research and Quality. Childhood immunization status. *National Quality Measures Clearinghouse*. Available at http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?doc_id=14920&string=CIS Accessed on: April 3, 2012.

[42] 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/index.html#chapters. Accessed on: September 10, 2013.

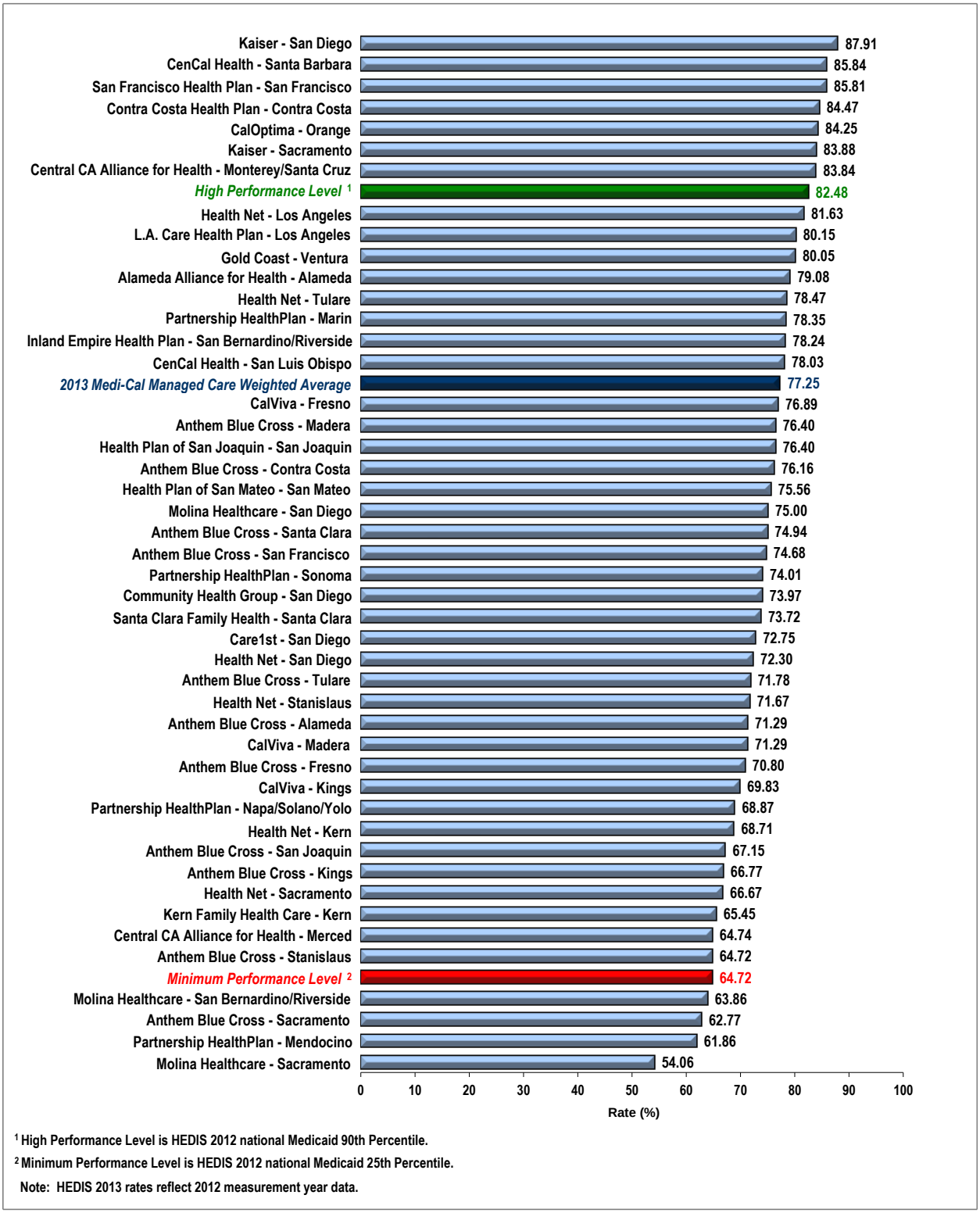
[43] Sugarman, D.E., Barskey, A.E., Delea, M.G., et al. Measles outbreak in a highly vaccinated population, San Diego, 2008: role of the intentionally undervaccinated. 2010. *Pediatrics*. 1653. Available at: http://pediatrics.aappublications.org/content/early/2010/03/22/peds.2009-1653.full.pdf+html Accessed on: September 10, 2013.

Performance Results





Medi-Cal Managed Care
HEDIS 2013 Childhood Immunization Status—Combination 3



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for the *Childhood Immunization Status—Combination 3* measure in 2013 was 77.25 percent. For 2013, MCMC demonstrated better performance when compared to the 2012 national Medicaid average and the 2012 national commercial average. The COHS model and TPM types performed similarly and outperformed the GMC model type in 2013.

High and Low Performers

Seven rates were above the HPL in 2013, which is similar to 2012, and four rates scored below the MPL in 2013 compared to three rates in 2012.

Anthem Blue Cross' rates in Contra Costa, Santa Clara, and Tulare counties showed statistically significant improvement from 2012 to 2013, while only Santa Clara Family Health Plan's rate in Santa Clara County 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.[44] 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 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 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.[45]

[44] 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.
[45] American Academy of Pediatrics. Increasing Immunization Coverage. *Pediatrics*. 2010; 125(6): 1299–1304.

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 the providers can follow up with the patients who are due or past due for these services. 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.[46]

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.[47]

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.[48]

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, and developing "drop-in" clinics or "express-lane" vaccination services, have proven to be effective in increasing childhood immunization rates.[49]

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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[46] 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/index.html#chapters Accessed on: September 10, 2013.

[47] Community Preventive Services Task Force.Increasing Appropriate Vaccination. Available at: http://www.thecommunityguide.org/vaccines/index.html Accessed on: September 14, 2013.

[48] Ibid.

[49] 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.[50] 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.[51]

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.[52] 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 its net for capturing immunization data for its 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.[53]

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.[54] 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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[50] 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.

[51] Nordin J, Anderson R, Anderson R, et al. Institute for Clinical Systems Improvement. Immunizations. Available at: http://www.guideline.gov/content.aspx?id=36813&search=immunizations Updated March 2012. Accessed on: September 10, 2013.

[52] 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: September 10, 2013.

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

[54] 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 of 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. Each MCP reports a separate percentage for each of the four age stratifications.

Importance

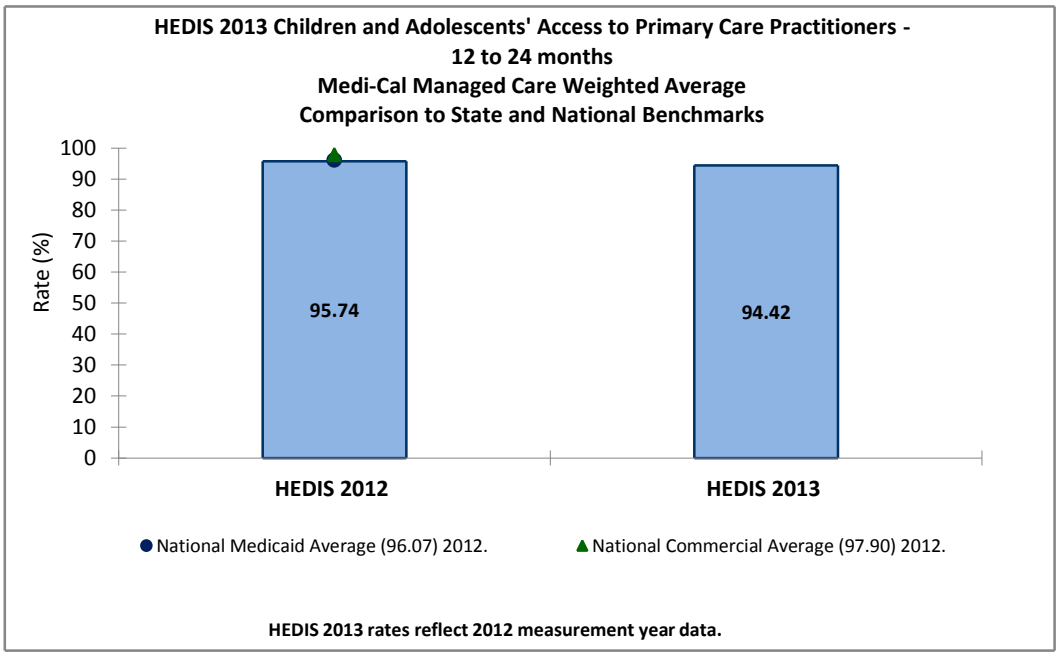
The health of children depends partially on their access to health care services.[55] Theoretical and empirical studies of access to health care have emphasized the importance of having health insurance and a regular source of care to ensure that children have access to health services.[56] Health services 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.[57]

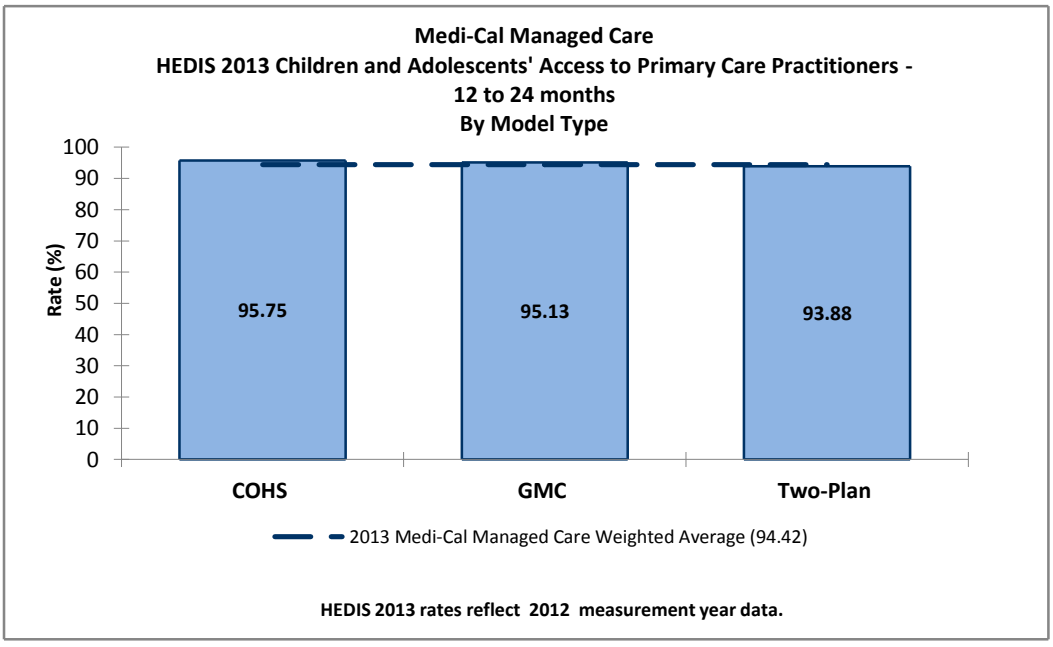
[55] Centers for Disease Control and Prevention. *Vital and Health Statistics: Access to Health Care Part 1: Children.* July 1997. Available at: http://www.cdc.gov/nchs/data/series/sr_10/sr10_196.pdf. Accessed on: September 10, 2013.

[56] 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.

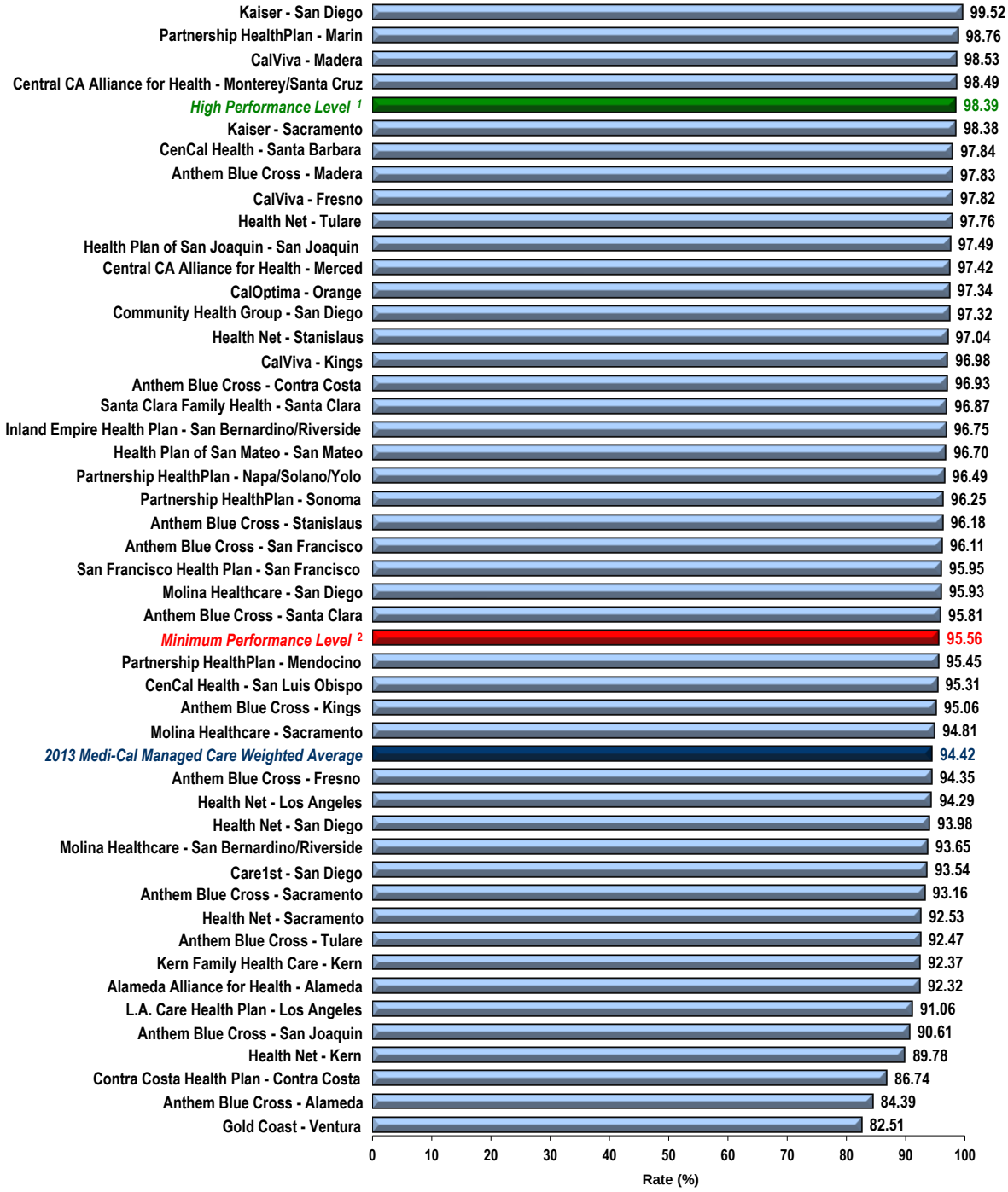
[57] U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. Trends in the well-being of America's children and youth: 1996. Washington. 1996.

Performance Results—12 to 24 Months of Age





Medi-Cal Managed Care
HEDIS 2013 Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

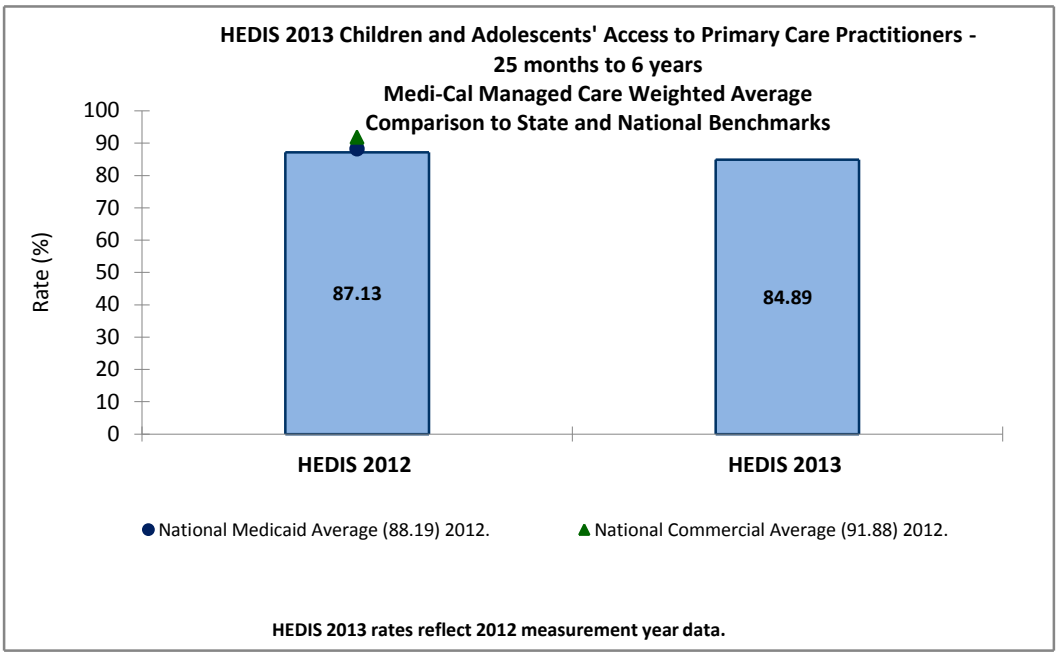
The MCMC weighted average for *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* was 94.42 percent in 2013, which was below the MPL. MCMC demonstrated decreased performance in 2013 when compared to both the 2012 national Medicaid average and the 2012 national commercial average. The COHS model type outperformed both the TPM and GMC model types in 2013, which remained consistent with 2012's performance.

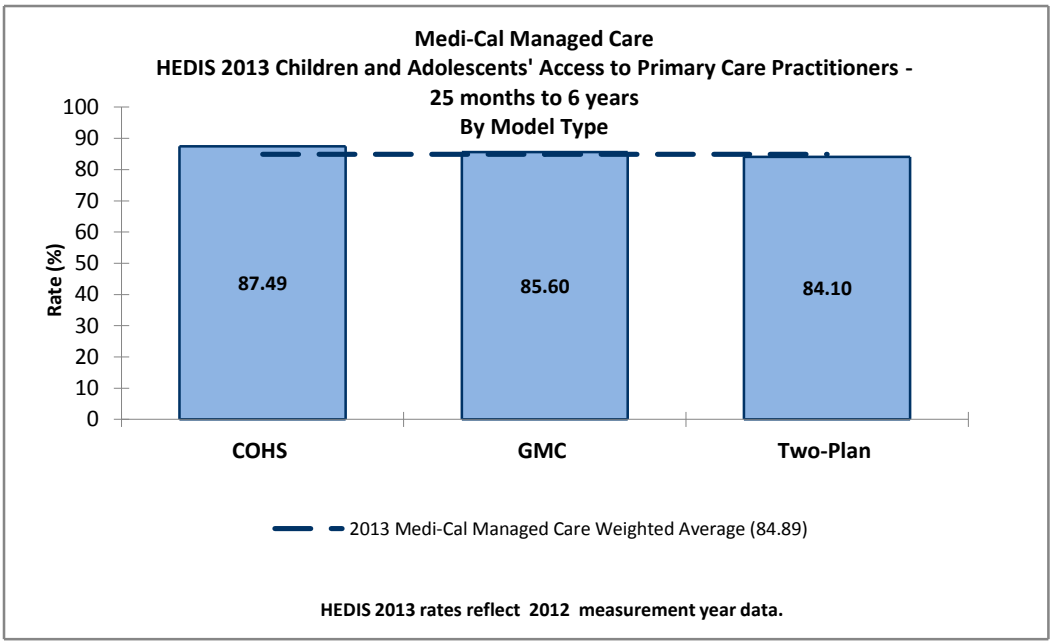
High and Low Performers

Four rates were above the HPL in 2013 while 20 rates scored below the MPL in 2013, compared to only four rates below the MPL in 2012.

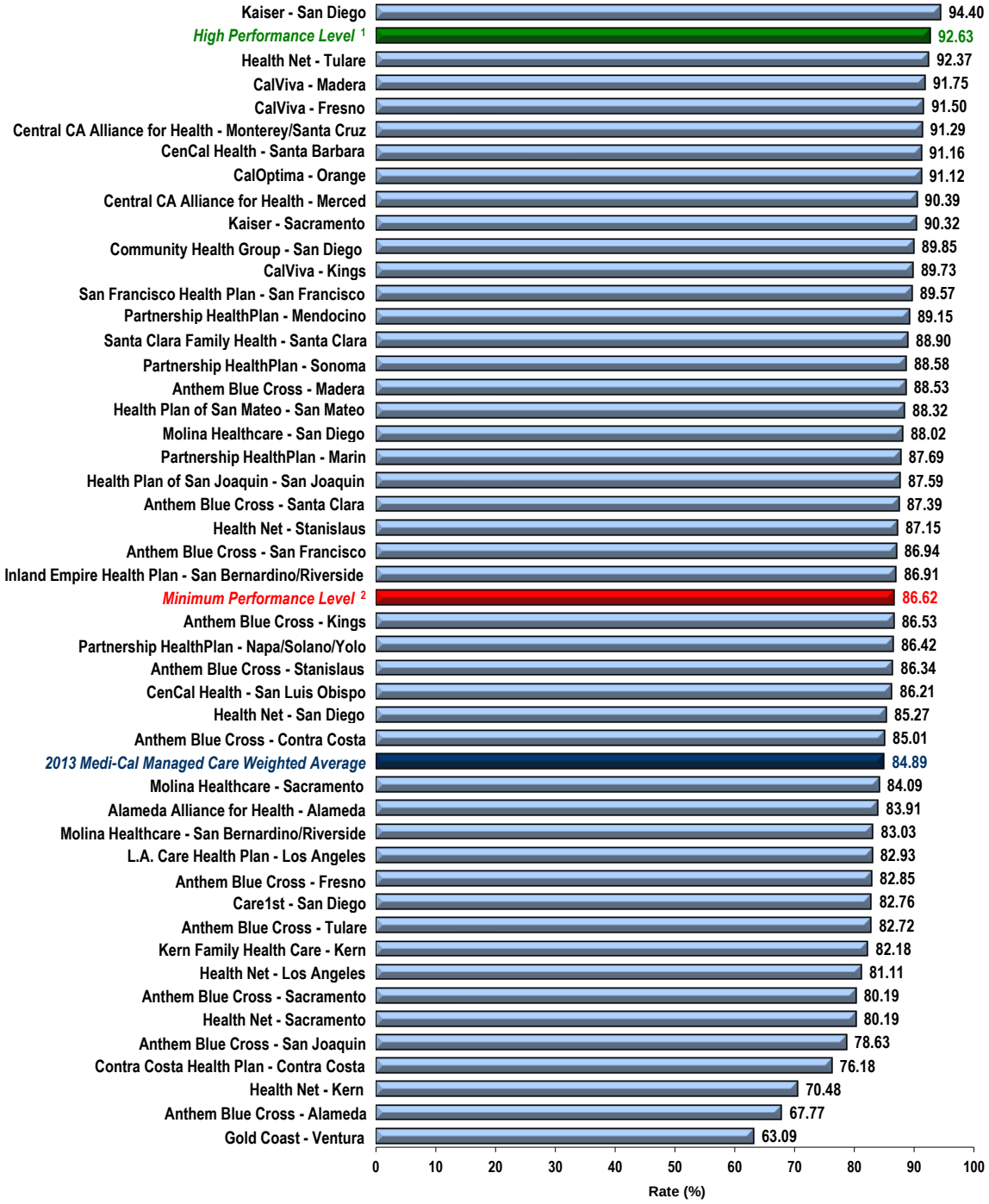
Eight rates showed statistically significant improvement from 2012 to 2013, while 10 rates showed a statistically significant decrease (refer to Appendix B).

Performance Results—25 Months to 6 Years of Age





Medi-Cal Managed Care
HEDIS 2013 Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* was 84.89 percent in 2013, which was below the MPL. For 2013, MCMC demonstrated decreased performance when compared to the 2012 national Medicaid average and the 2012 national commercial average.

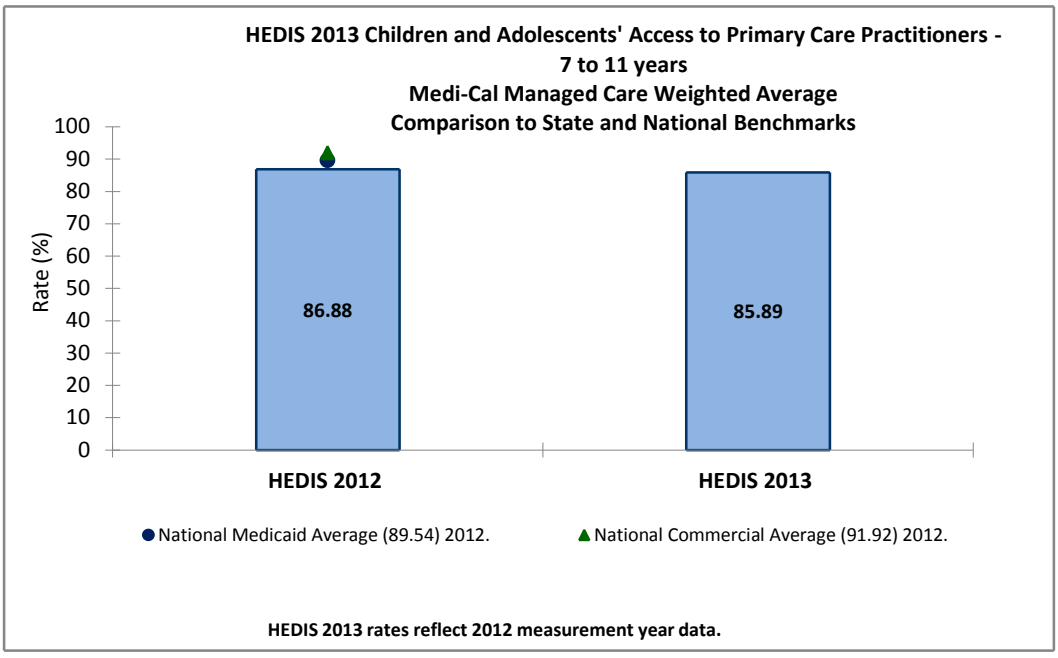
The COHS model type outperformed both the TPM and GMC model types in 2013.

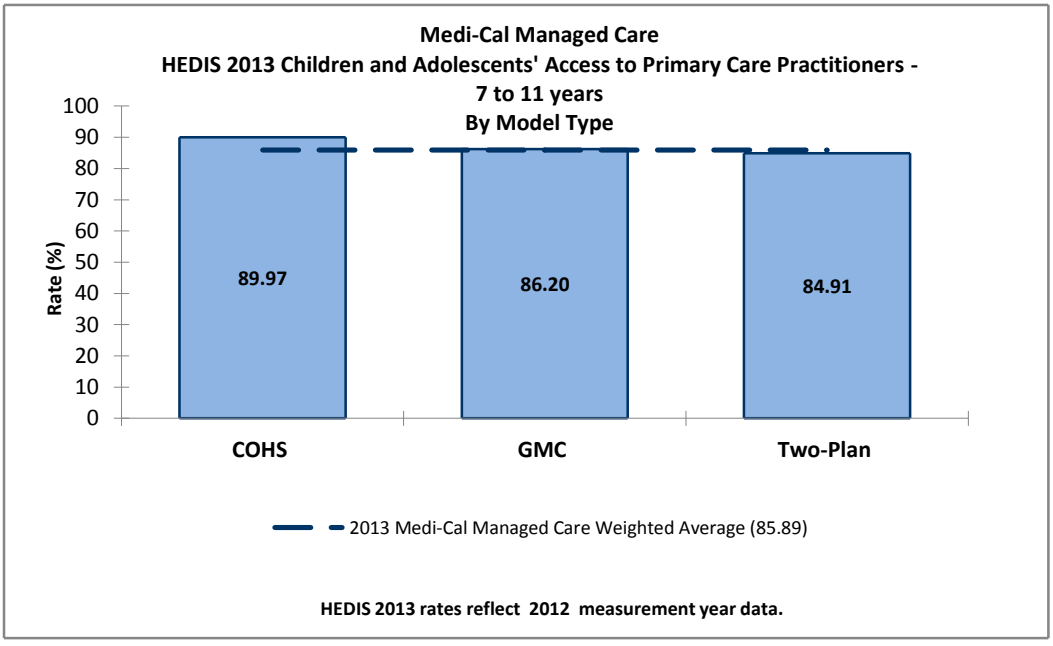
High and Low Performers

Kaiser—San Diego County's rate was above the HPL in 2013, while 22 rates were below the MPL.

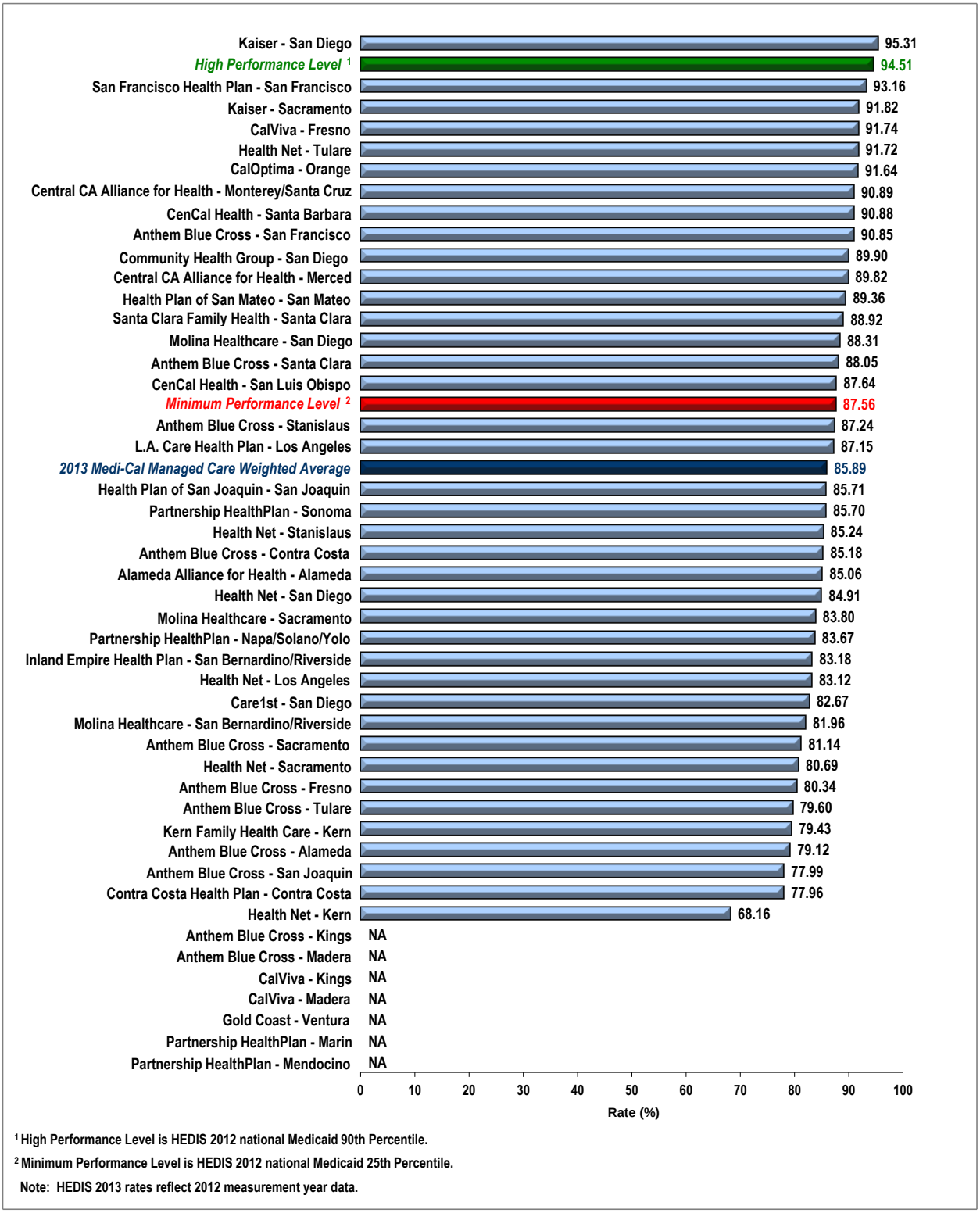
Eight rates showed statistically significant improvement from 2012 to 2013, while 15 rates showed a statistically significant decrease (refer to Appendix B).

Performance Results—7 to 11 Years of Age





Medi-Cal Managed Care
HEDIS 2013 Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* was 85.89 percent, which was below the MPL. In 2013, MCMC demonstrated decreased performance when compared to the 2012 national Medicaid average and the 2012 national commercial average.

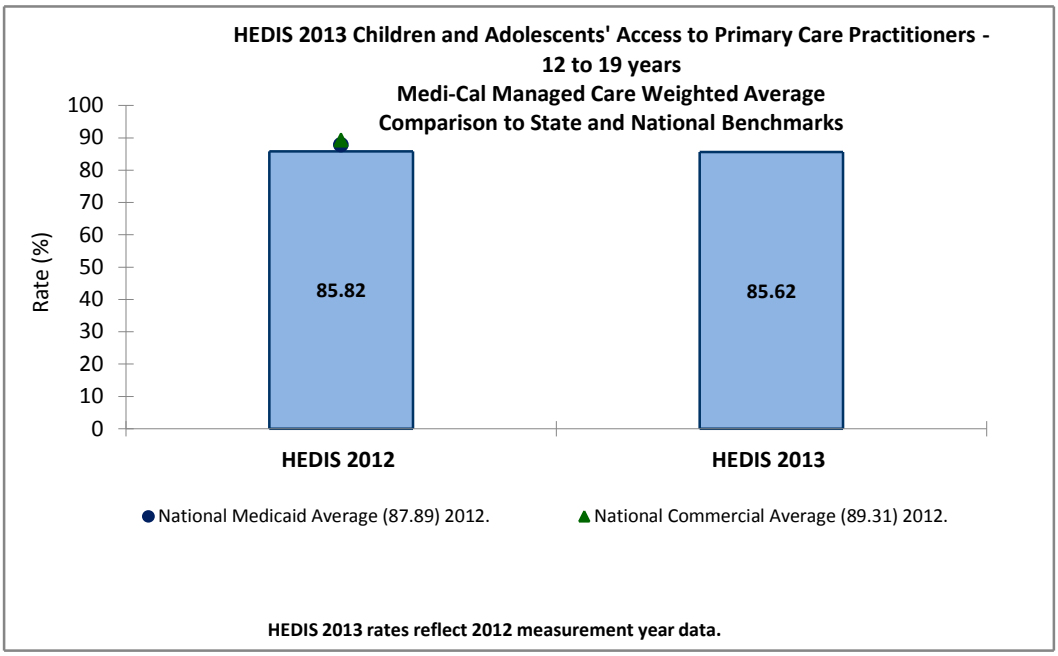
The COHS model type outperformed both the TPM and GMC model types in 2013.

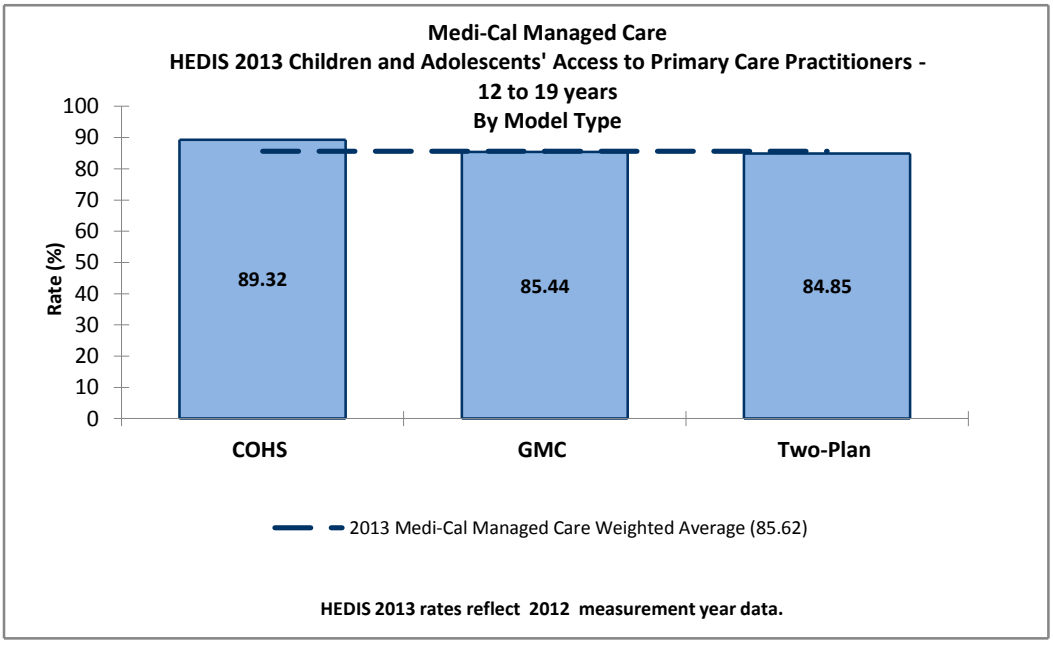
High and Low Performers

Kaiser—San Diego County's rate was above the HPL in 2013, while 23 rates were below the MPL.

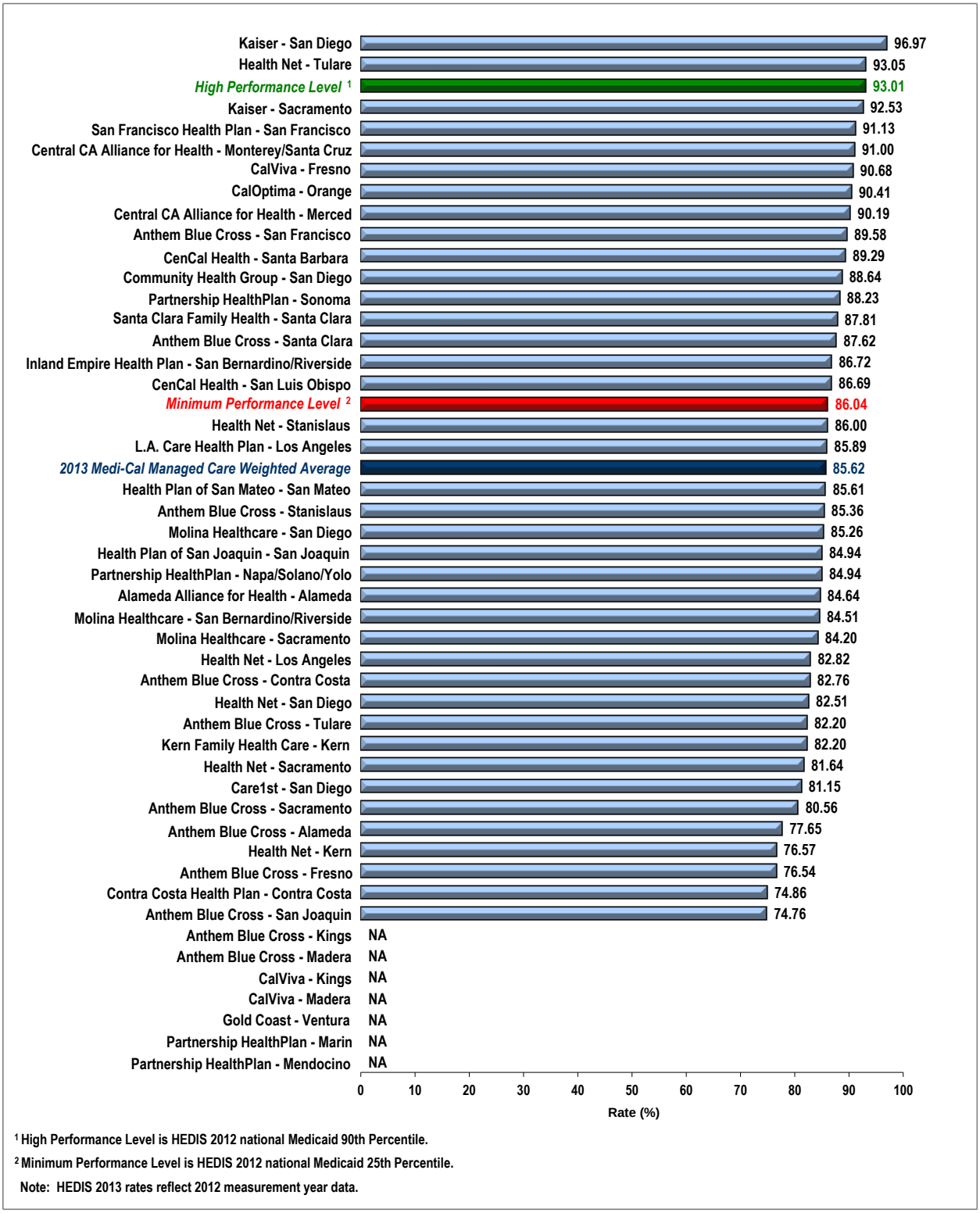
Eight rates showed statistically significant improvement from 2012 to 2013, while 11 rates showed a statistically significant decrease (refer to Appendix B).

Performance Results—12 to 19 Years of Age





Medi-Cal Managed Care
HEDIS 2013 Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* was 85.62 percent in 2013, which was below the MPL. For 2013, MCMC demonstrated lower performance when compared to the 2012 national Medicaid average and the 2012 national commercial average.

The COHS model type outperformed both the TPM and GMC model types in 2013, which remained consistent with 2012's performance.

High and Low Performers

Two rates, Kaiser—San Diego County and Health Net in Tulare County, were above the HPL in 2013, while 23 rates were below the MPL.

Thirteen rates showed statistically significant improvement from 2012 to 2013, while six rates showed a statistically significant decrease (refer to Appendix B).

Best and Emerging Practices

Improve Access

Open-access appointments can increase compliance by expanding provider availability.[58] 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. MCPs 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.[59]

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[58] 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.

[59] 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=79bed26b9c3b786a8e5d9bab9758b851&acdnat=1345747824_b3e26f66640d39dbab97f742e458f57c. Accessed on: September 10, 2013.

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.[60] This best practice would likely result in an increase in primary care visit rates, particularly in rural areas with less public transportation. Another option is to provide bus tokens or taxi vouchers for transportation.

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. MCPs 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.[61] PCPs are essential to the success of this model.[62]

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.[63] Effective interventions may also include

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[60] 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.

[61] 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.

[62] 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 10, 2013.

[63] 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.

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.[64]

Identify Alternative Venues

Identifying alternative settings where children can access a PCP 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.

[64] Nordin J, Anderson R, Anderson R, et al. Institute for Clinical Systems Improvement. Immunizations. Available at: http://www.guideline.gov/content.aspx?id=36813&search=immunizations Updated March 2012. Accessed on September 10, 2013.

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:[65]

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

These risks increase if A1c levels are not controlled.[66] The reduction of A1c level by 1 percent, decreases the risk of:[67]

- 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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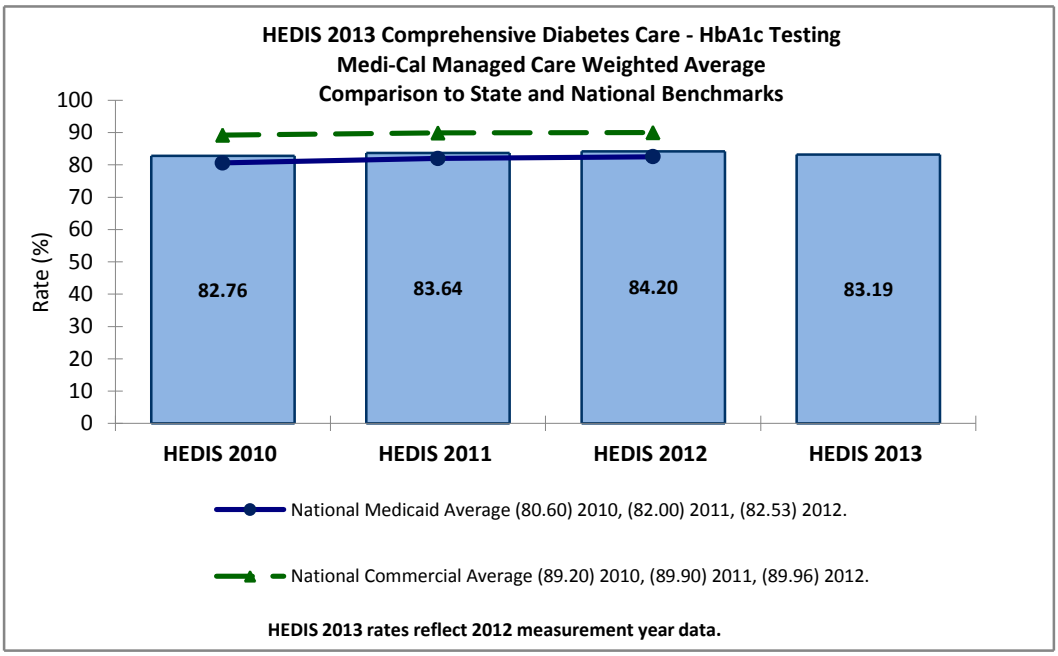
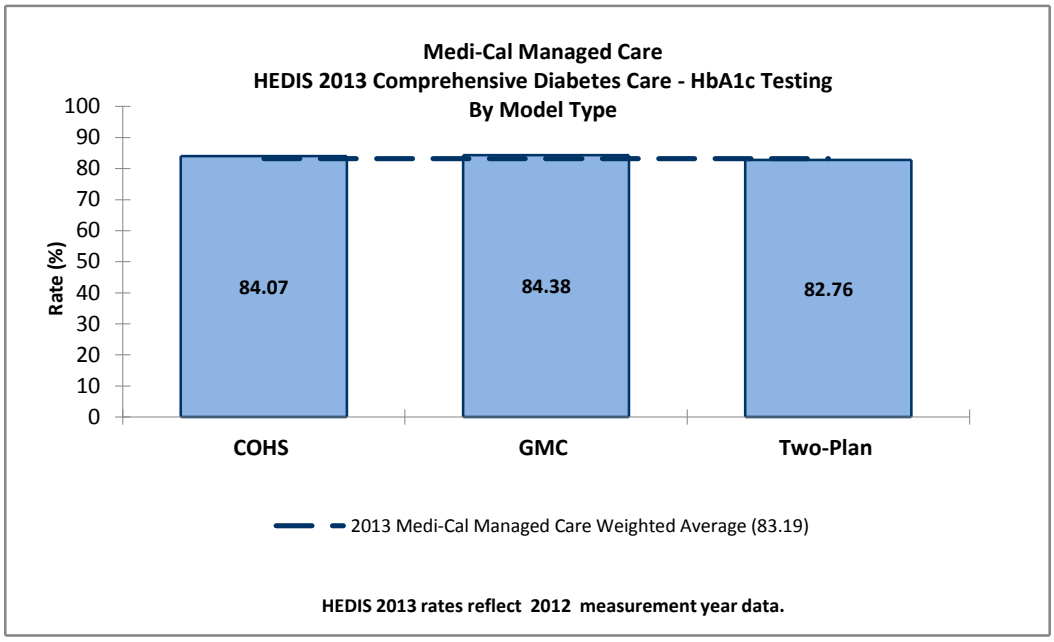
65 American Diabetes Association. A1c. Available at: http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/a1c/ Accessed on: September 11, 2013.

66 Everybody. Diabetes and HbA1c Testing. Available at: http://www.everybody.co.nz/page-46cae434-1bb8-4f84-8d15-76bc9785eae2.aspx Accessed on: September 11, 2013.

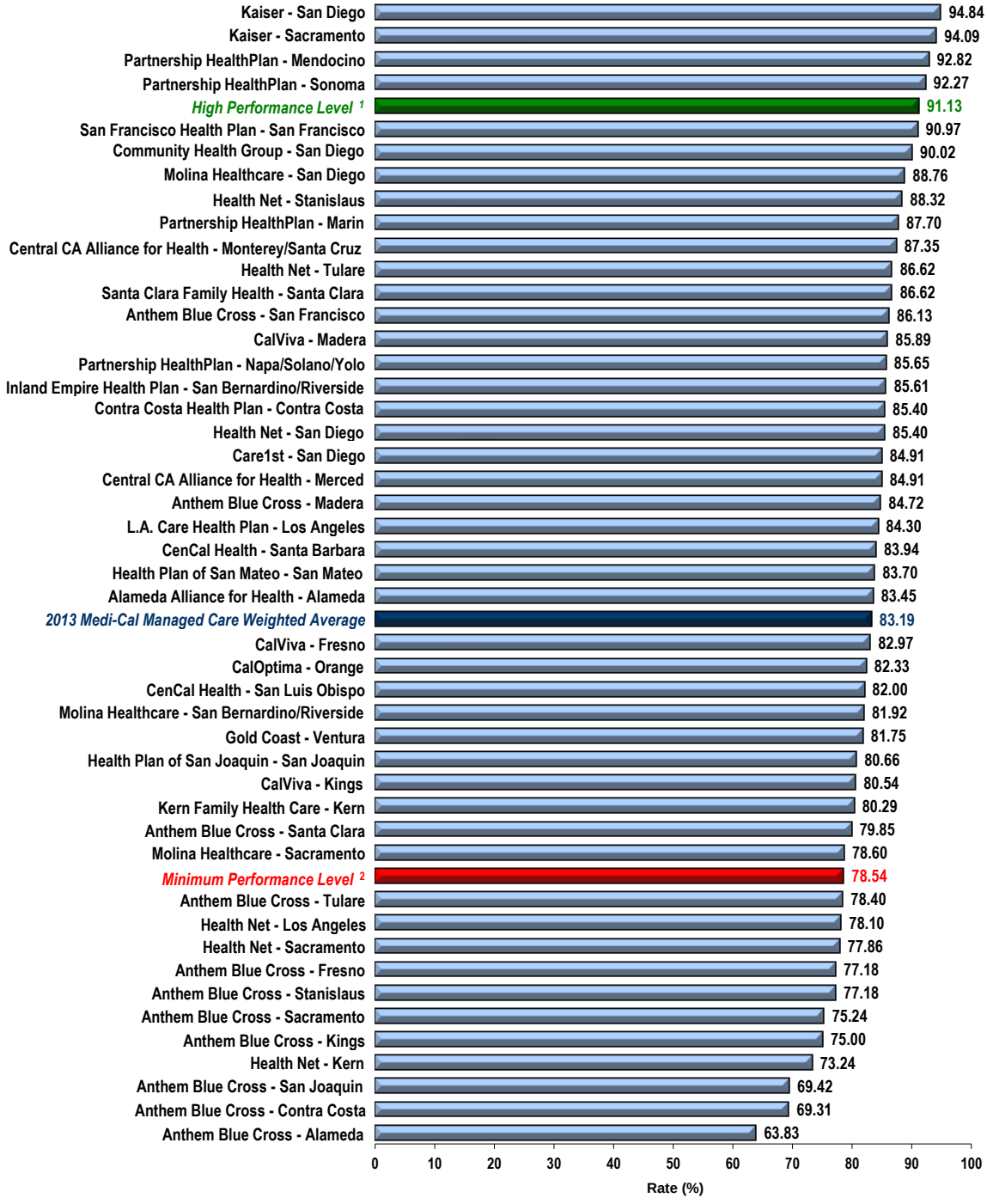
67 Ibid.

Performance Results





Medi-Cal Managed Care
HEDIS 2013 Comprehensive Diabetes Care—HbA1c Testing



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for the *Comprehensive Diabetes Care—HbA1c Testing* measure was 83.19 percent in 2013. The MCMC weighted average for 2013 exceeded the national Medicaid average in 2012; however, the program's weighted average has yet to exceed the national commercial average for any of the reporting years.

COHS model, GMC model, and TPM types performed similarly in 2013.

High and Low Performers

Four reported rates were above the HPL for this measure in 2013. Kaiser—Sacramento County and Kaiser—San Diego County performed above the HPL in 2008–13. Additionally, Partnership HealthPlan of California (Partnership HealthPlan) in Mendocino and Sonoma counties were above the HPL. Eleven MCPs performed below the MPL in 2013 as opposed to six in 2012.

No 2013 reported rates showed statistically significant improvement over 2012 rates, and six rates reported statistically significant declines during the same measurement period (refer to Appendix B).

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

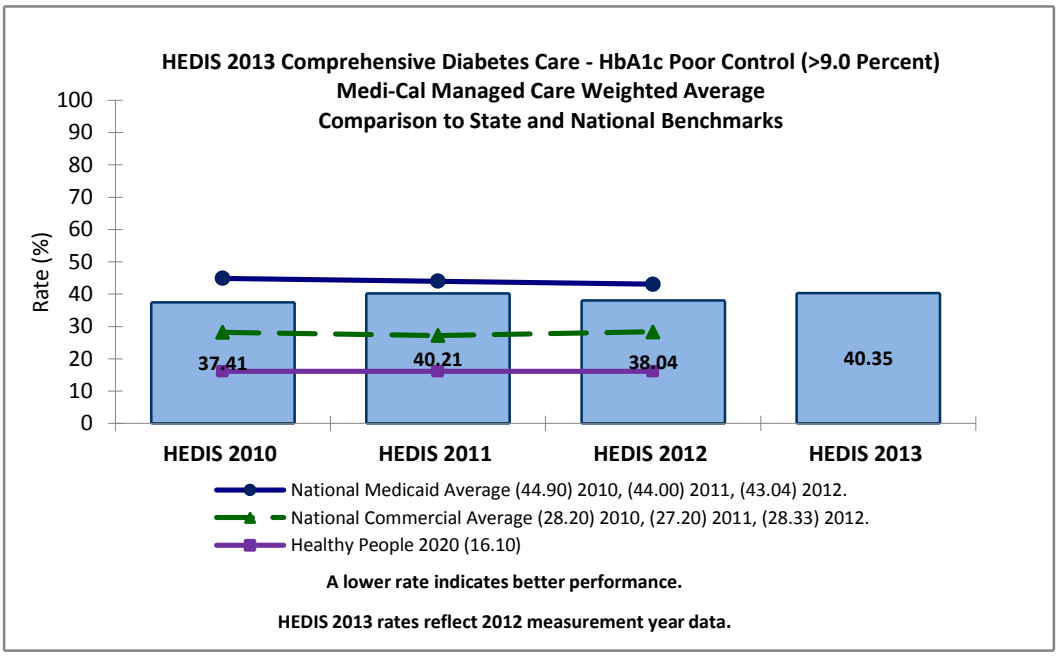
Measure Definition

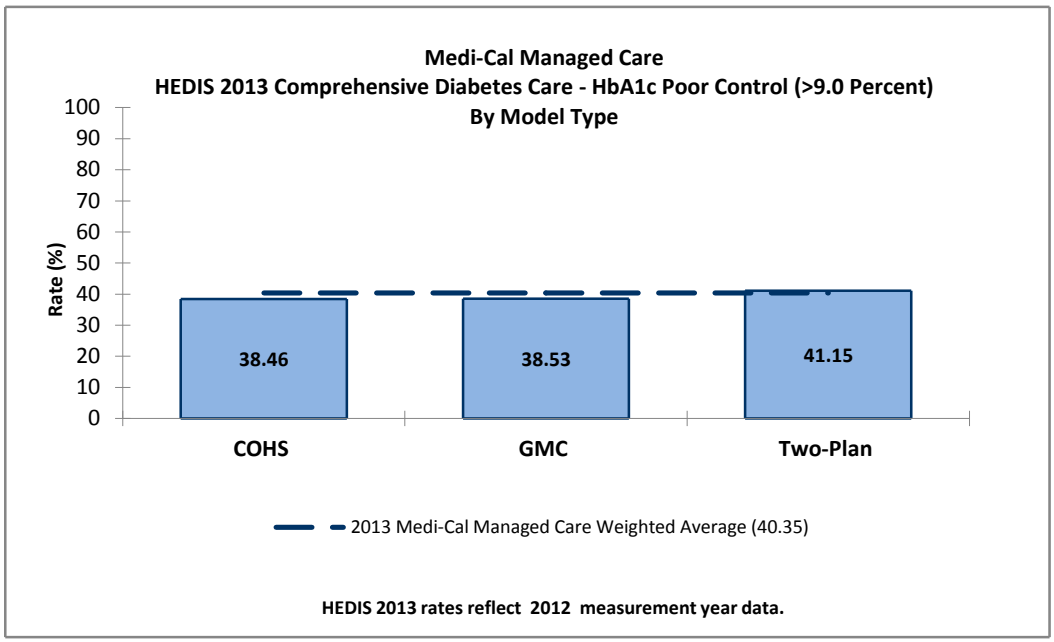
The *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) whose most recent HbA1c test conducted during the measurement year showed a greater than 9 percent HbA1c level, indicating poor control.

Importance

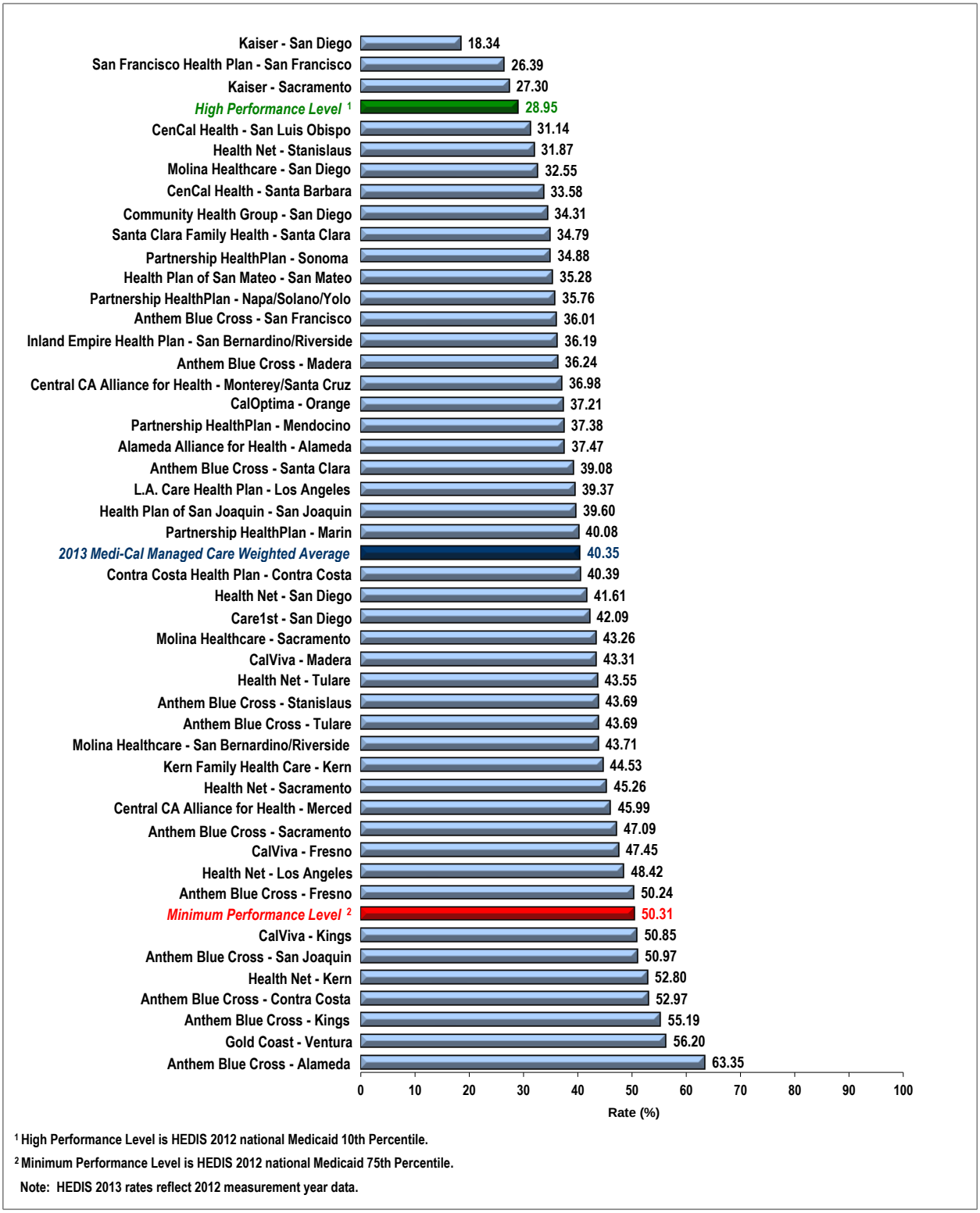
HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Decreasing the HbA1c level lowers the risk of diabetes-related death. Controlling blood glucose levels in people with diabetes significantly reduces the risk for blindness, heart disease, end-stage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

Performance Results





Medi-Cal Managed Care
HEDIS 2013 Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)



[1] High Performance Level is HEDIS 2012 national Medicaid 10th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 75th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

For this measure, a lower rate indicates better performance. The MCMC weighted average was 40.35 percent in 2013, which was below the Healthy People 2020 goal of 16.1 percent. For 2013, MCMC demonstrated better performance when compared to the 2012 national Medicaid average and decreased performance compared to the 2012 national commercial average.

The COHS model performed similarly to the GMC model; both performed better than the TPM type in 2013.

High and Low Performers

Three rates exceeded the 2013 established HPL for this measure. Seven rates did not achieve the MPL.

Three rates showed statistically significant improvement over 2012 rates (i.e., a significant decrease in the rate). Ten rates had statistically significant declines in performance (refer to Appendix B).

Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)

Measure Definition

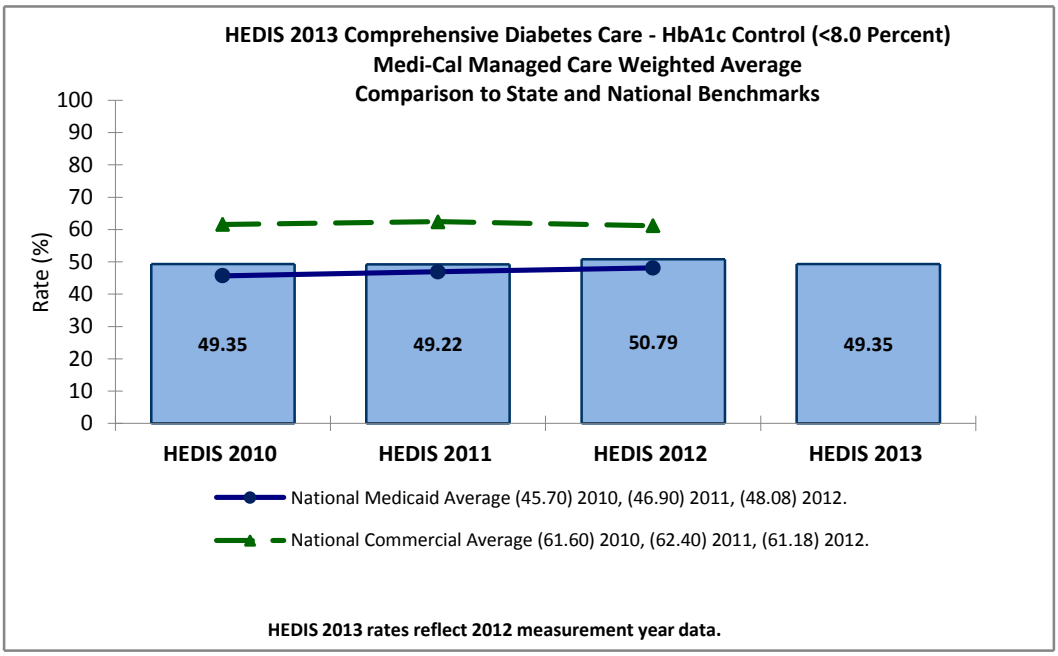
The *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* measure reports the percentage of members 18 through 64 years of age with diabetes (Type 1 and Type 2) whose most recent HbA1c test conducted during the year showed an HbA1c level of less than 8 percent.

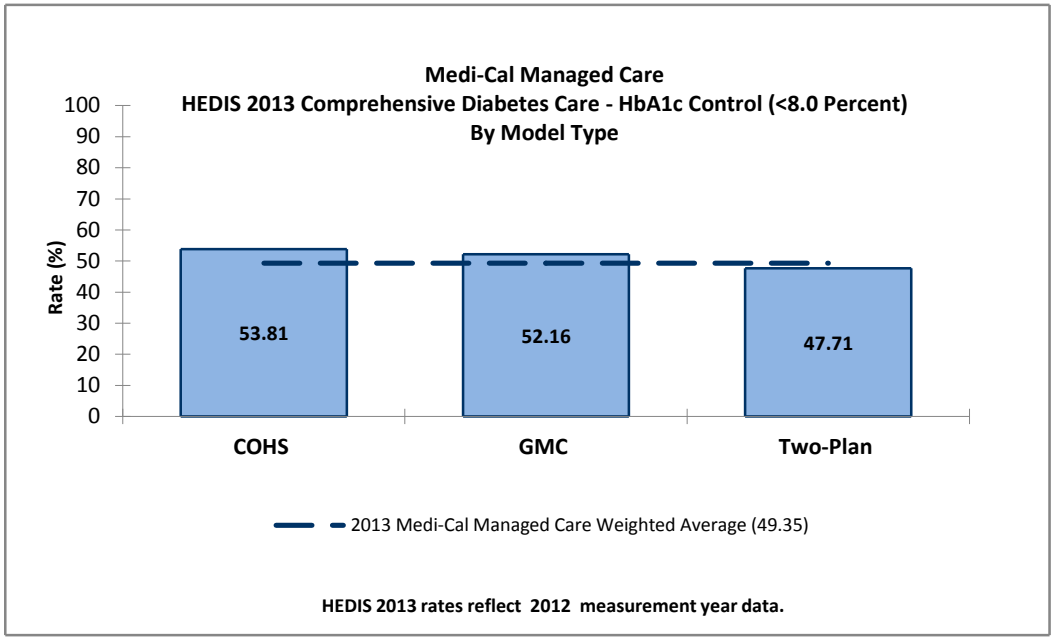
Importance

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.[68]

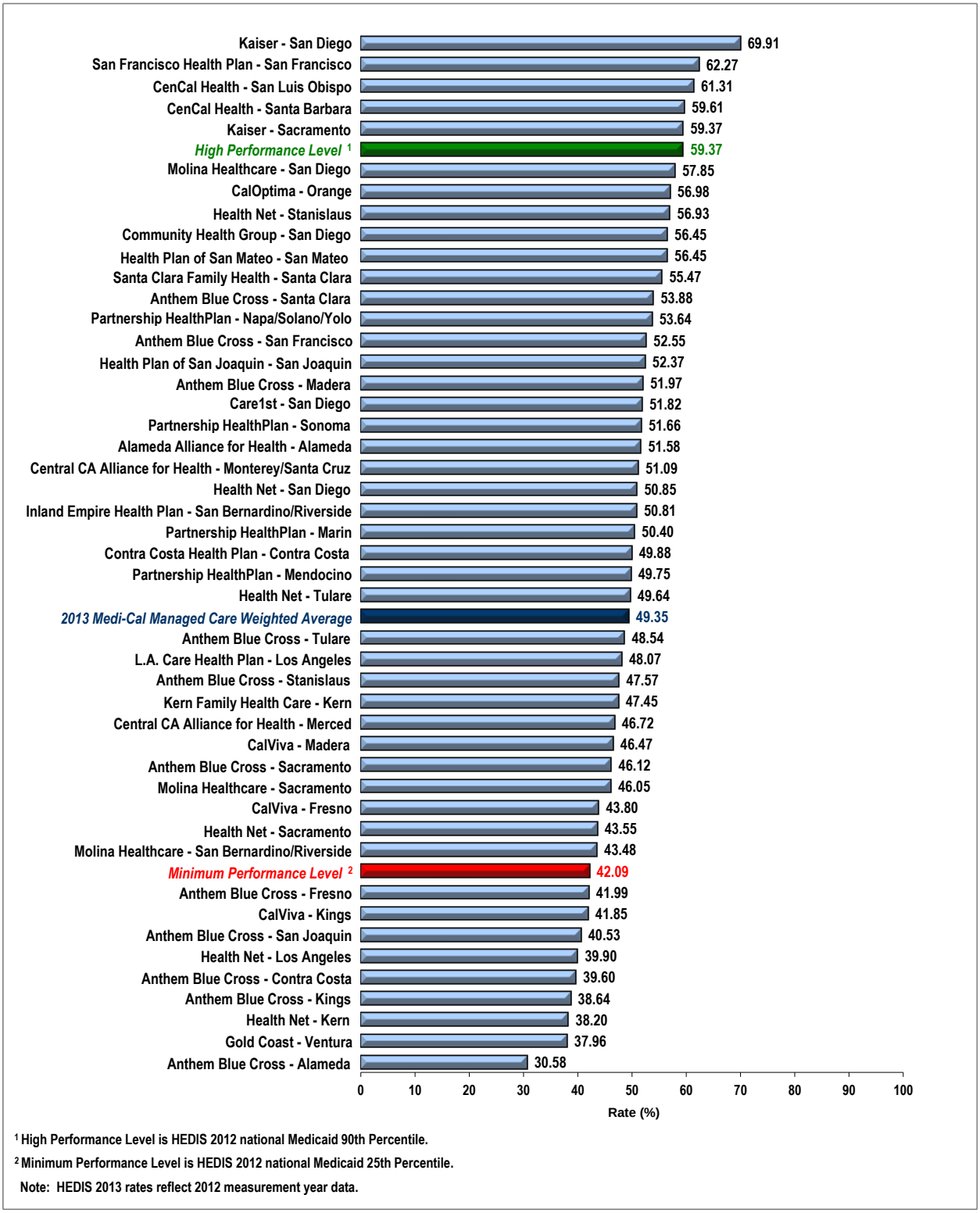
[68] National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.

Performance Results





Medi-Cal Managed Care
HEDIS 2013 Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC 2013 weighted average was 49.35 percent, which was essentially the same as the 2012 weighted average. MCMC demonstrated better performance in 2013 when compared to the 2012 national Medicaid average and decreased performance compared to the 2012 national commercial average.

The COHS model type outperformed the GMC model and TPM types; this result remained consistent with results from 2010 to 2012.

High and Low Performers

Five rates were greater than the HPL in 2013, compared to nine rates in 2012. Nine rates performed below the MPL in 2013, compared to two rates in 2012.

Three rates showed statistically significant improvement over 2012 rates, while eight rates had statistically significant declines in performance (refer to Appendix B).

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.[69,70]

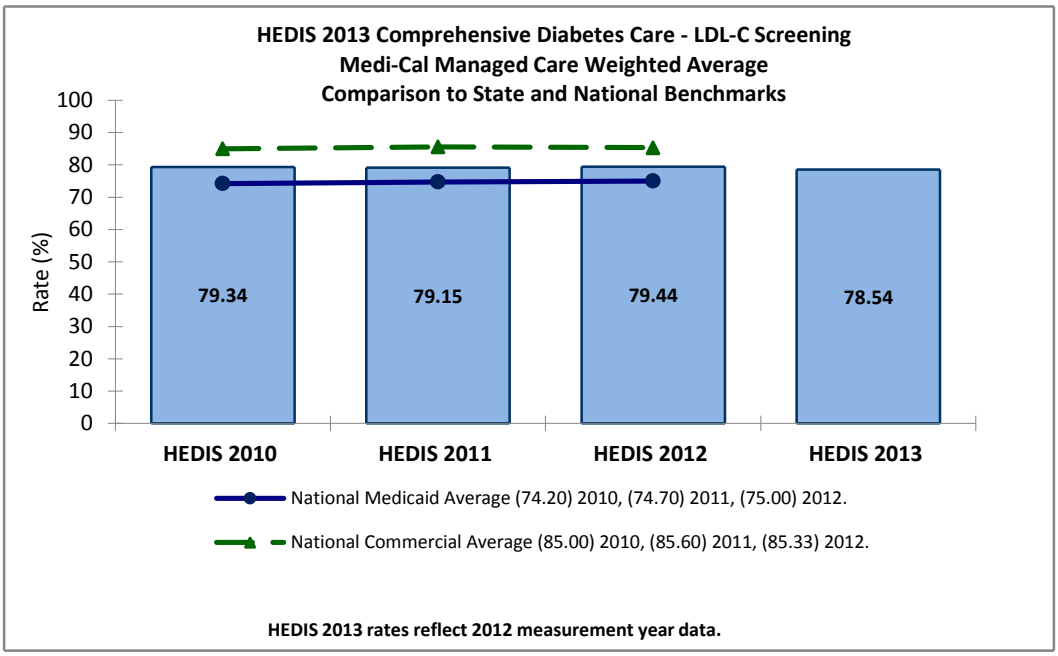
Patients with diabetes are at a two-to-three times greater risk of cardiovascular mortality compared to patients who are non-diabetics. A 30 percent reduction in LDL-C has been shown to reduce major vascular events by approximately 25 percent, regardless of the baseline LDL.[71]

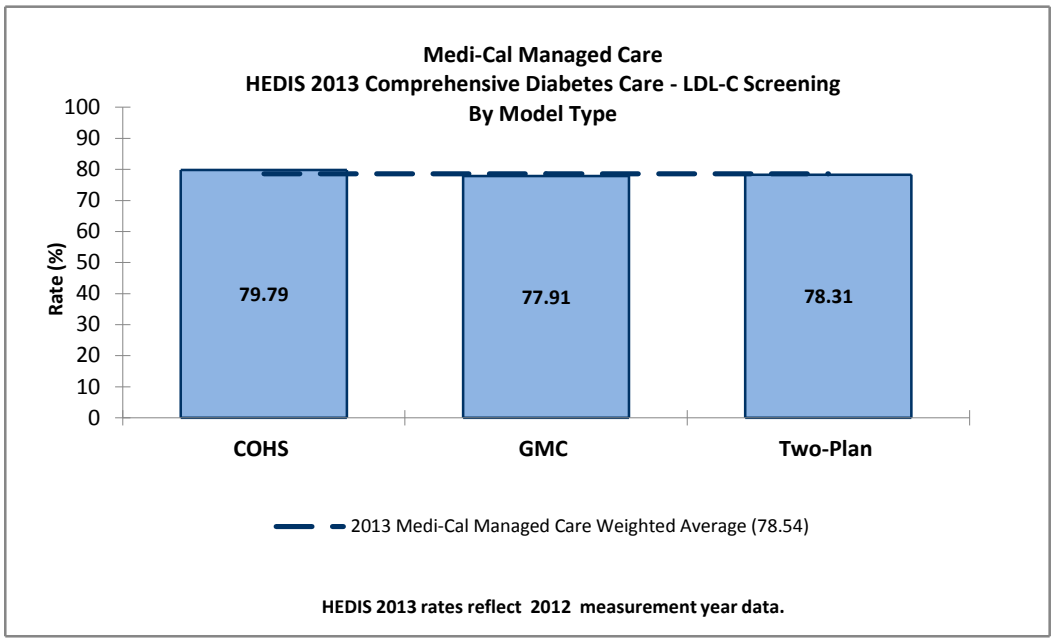
[69] Nesto, R.W. LDL Cholesterol Lowering in Type 2 Diabetes: What Is the Optimum Approach? *Clinical Diabetes*. 2008. Available at: http://clinical.diabetesjournals.org/content/26/1/8.full Accessed on: September 11, 2013.

[70] Lab Tests Online. LDL Cholesterol. Available at: http://www.labtestsonline.org/understanding/analytes/ldl/test.html. Accessed on: September 11, 2013.

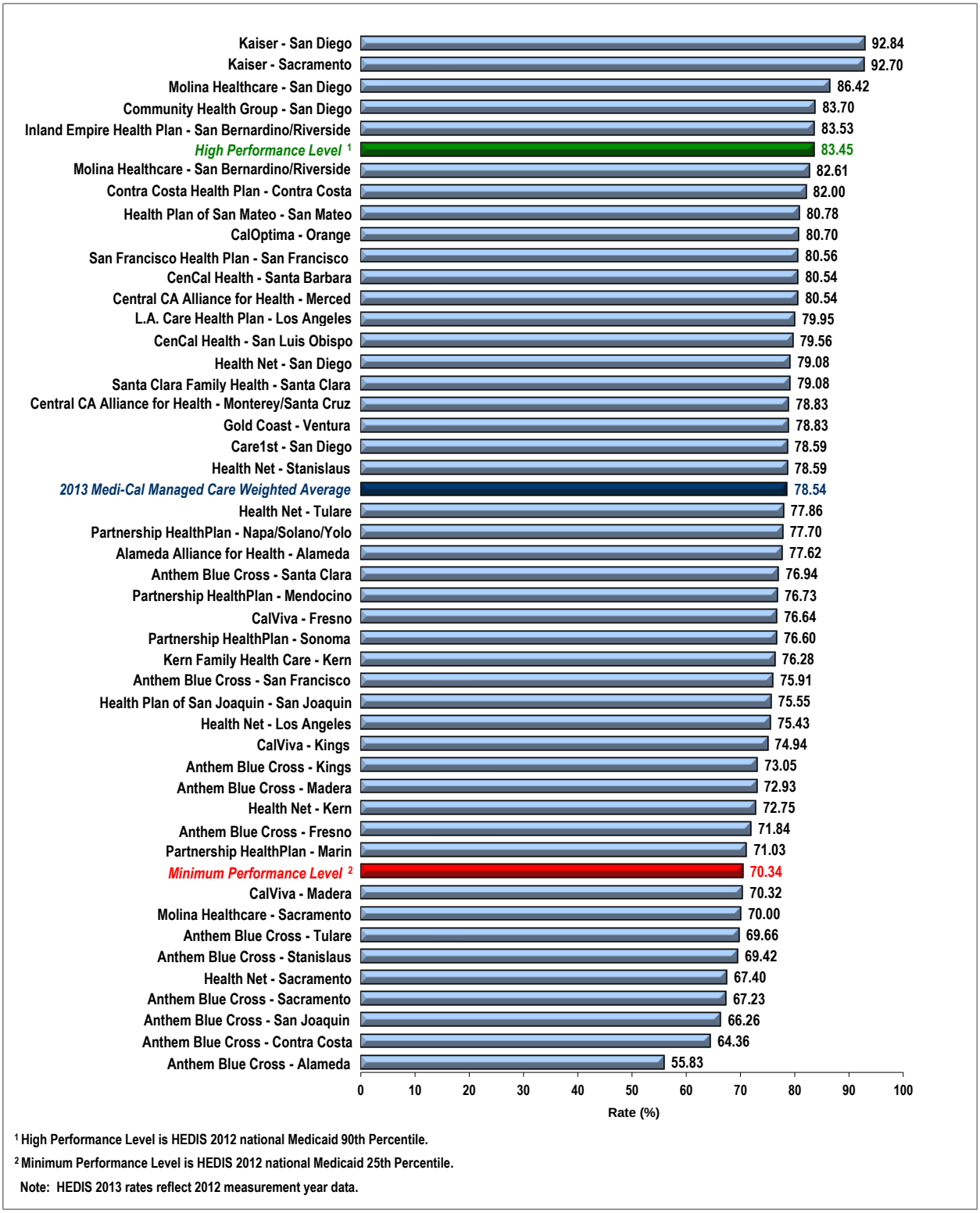
[71] Goliath. LDL in Diabetes: How Low Should They Go? Little Evidence Supports Adding a Statin or Increasing the Dose Once Your Patient Achieves an LDL of <100 mg/dL. Available at: http://business.highbeam.com/413768/article-1G1-168053782/ldl-levels-diabetes-low-should-they-go-little-evidence. Accessed on: September 14, 2013.

Performance Results





Medi-Cal Managed Care
HEDIS 2013 Comprehensive Diabetes Care—LDL-C Screening



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average of 78.54 percent for the *Comprehensive Diabetes Care—LDL-C Screening* had no significant change from 2012 to 2013. MCMC's 2013 weighted average was above the national Medicaid average but below the national commercial average.

The performance between the COHS model, GMC model , and TPM types remained consistent with previous years.

High and Low Performers

Five rates performed above the HPL in 2013. Nine rates were below the MPL in 2013. Eight of the nine rates were for Anthem Blue Cross counties.

Three rates had statistically significant increases from 2012 to 2013. Four rates had significantly significant decreases in 2013, compared to no rates 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

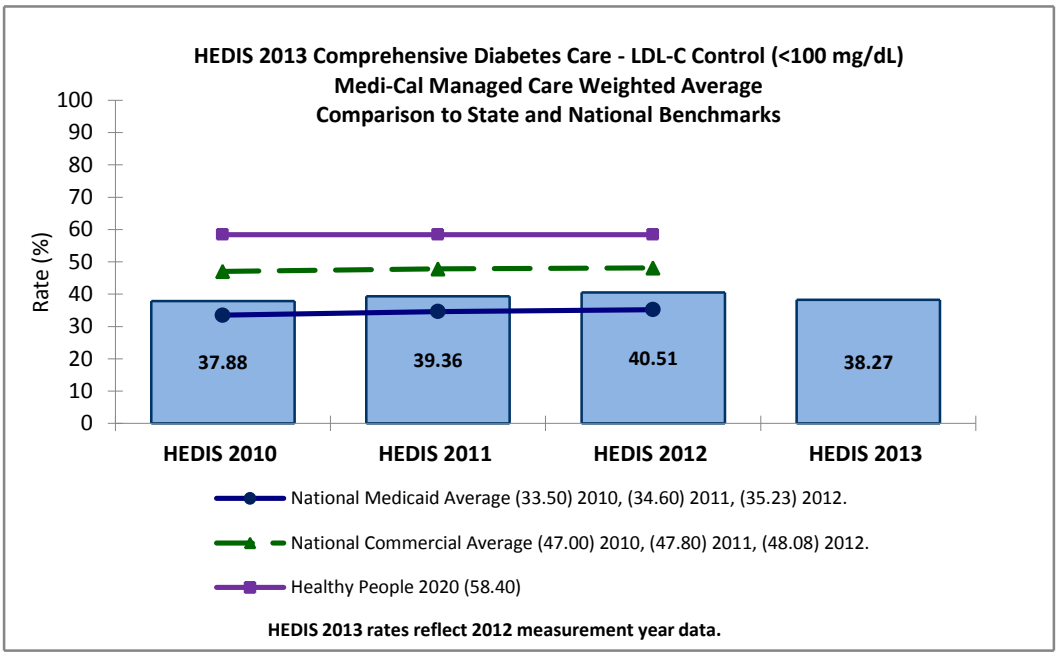
Patients with diabetes have a two-to-three times greater risk of cardiovascular mortality compared to patients who are non-diabetics.[72] Therefore, maintaining a desirable LDL-C level is important because it can decrease the risk of cardiovascular complications in individuals with diabetes.

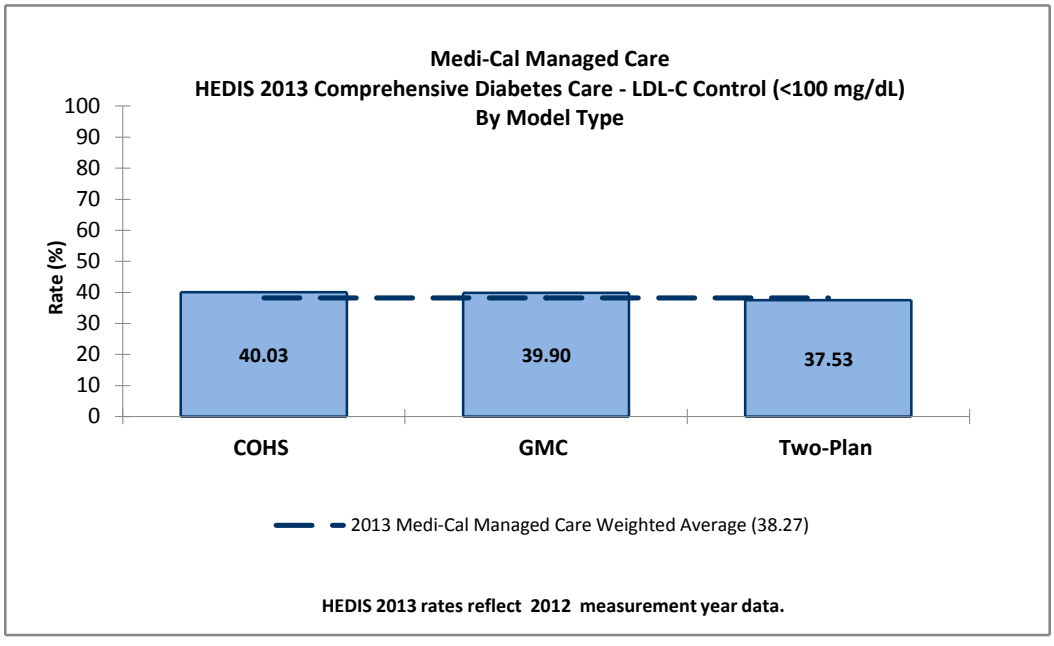
A 30 percent reduction in LDL-C levels has been shown to reduce major vascular events by approximately 25 percent, regardless of the baseline LDL.[73]

[72] 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://business.highbeam.com/413768/article-1G1-168053782/ldl-levels-diabetes-low-should-they-go-little-evidence. Accessed on: September 14, 2013.

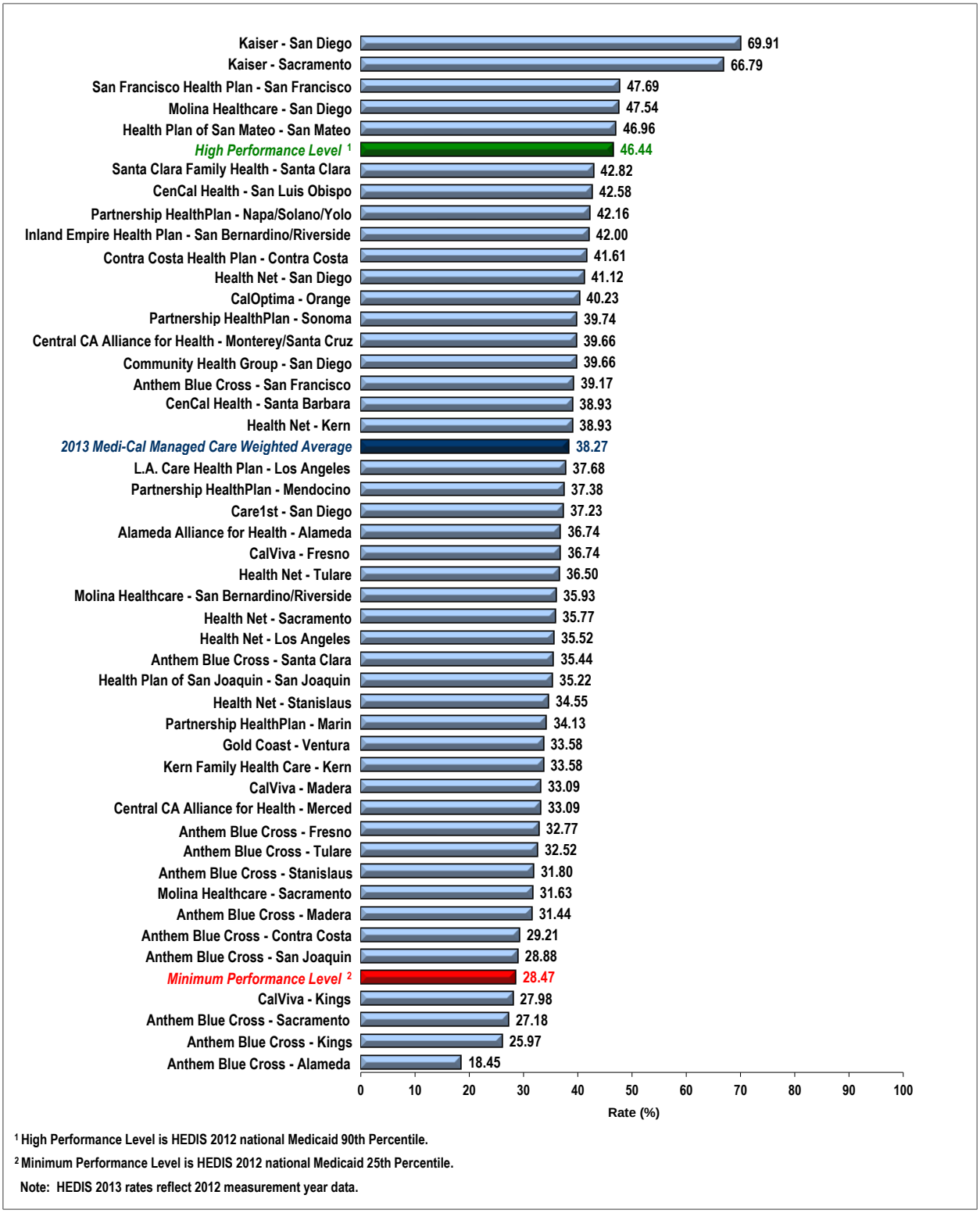
[73] Ibid.

Performance Results





Medi-Cal Managed Care
HEDIS 2013 Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for the *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure decreased to 38.27 percent in 2013 and was below the Healthy People 2020 goal of 58.4 percent. The weighted average in 2013 was above the 2012 national Medicaid average but below the 2012 national commercial average.

The performance between the COHS model, GMC model, and the TPM types was comparable.

High and Low Performers

Five rates performed above the established HPL for this measure in 2013, compared to nine in 2012. Four rates fell below the MPL in 2013, Anthem Blue Cross—Alameda, Kings, and Sacramento counties and CalViva Health (CalViva)—Kings County.

Anthem Blue Cross—Contra Costa County's rate had a statistically significant increase from 2012 to 2013, and six rates demonstrated a statistically significant decrease within the same time frame (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.[74] The three most common eye complications in diabetics are retinopathy, cataracts, and glaucoma.[75] Diabetics have an increased chance of 60 percent of obtaining cataracts over non-diabetics.[76] 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.[77]

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.[78] Diabetes is the leading cause of blindness for adults between 20 and 74 years of age.[79] Diabetic retinopathy accounts for approximately 12,000 to 24,000 new cases of blindness every year.[80]

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74 National Diabetes Information Clearinghouse. *National Diabetes Statistics, 2011*. Available at: http://diabetes.niddk.nih.gov/DM/PUBS/statistics/ Accessed on: September 11, 2013.

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

76 American Diabetes Association. *Eye Complications*. Available at: http://www.diabetes.org/living-with-diabetes/complications/eye-complications. Accessed on: September 11, 2013.

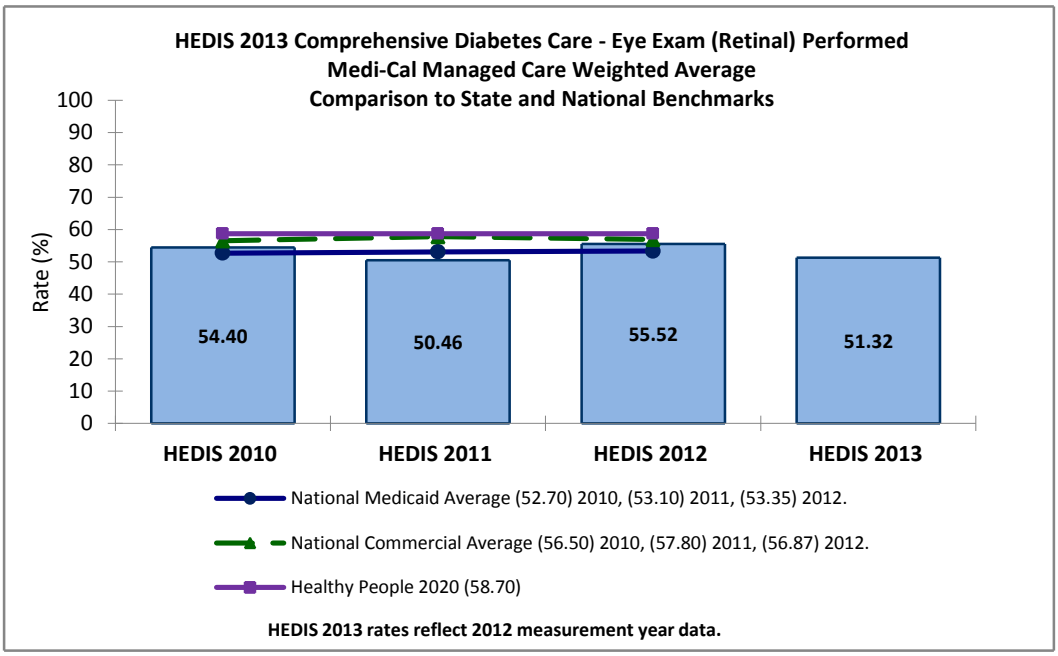
77 WebMD. *Eye Problems and Diabetes*. Available at: http://diabetes.webmd.com/eye-problems. Accessed on: May 1, 2012.

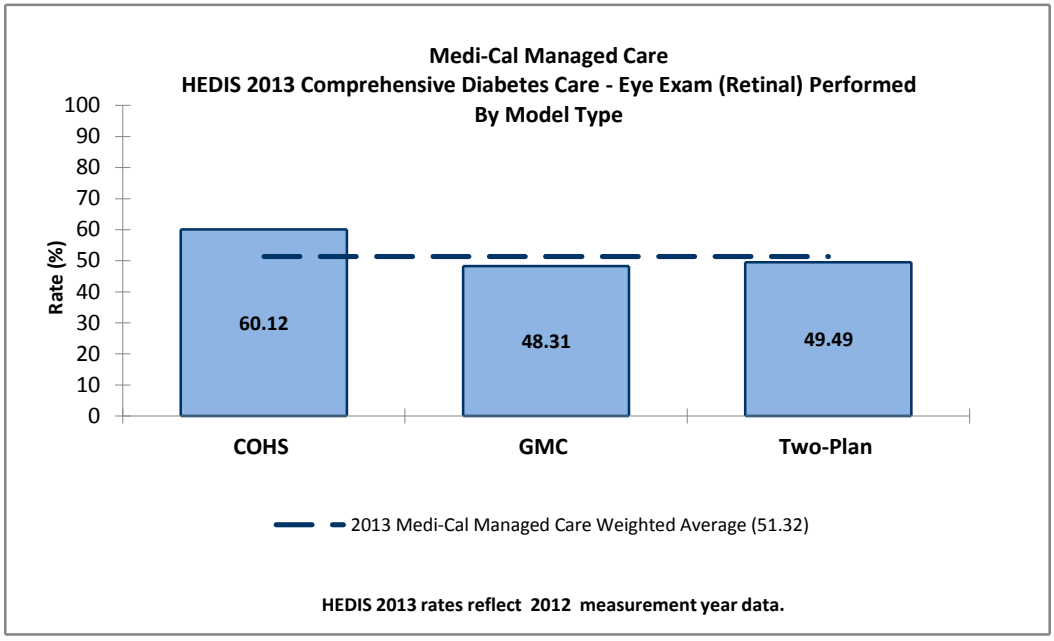
78 2011 National Diabetes Fact Sheet. *Diagnosed and undiagnosed diabetes in the United States, all ages, 2010*. Available at: http://www.cdc.gov/diabetes/pubs/estimates11.htm. Accessed on: September 11, 2013.

79 WebMD. *Eye Problems and Diabetes*. Available at: http://diabetes.webmd.com/eye-problems. Accessed on: September 11, 2013.

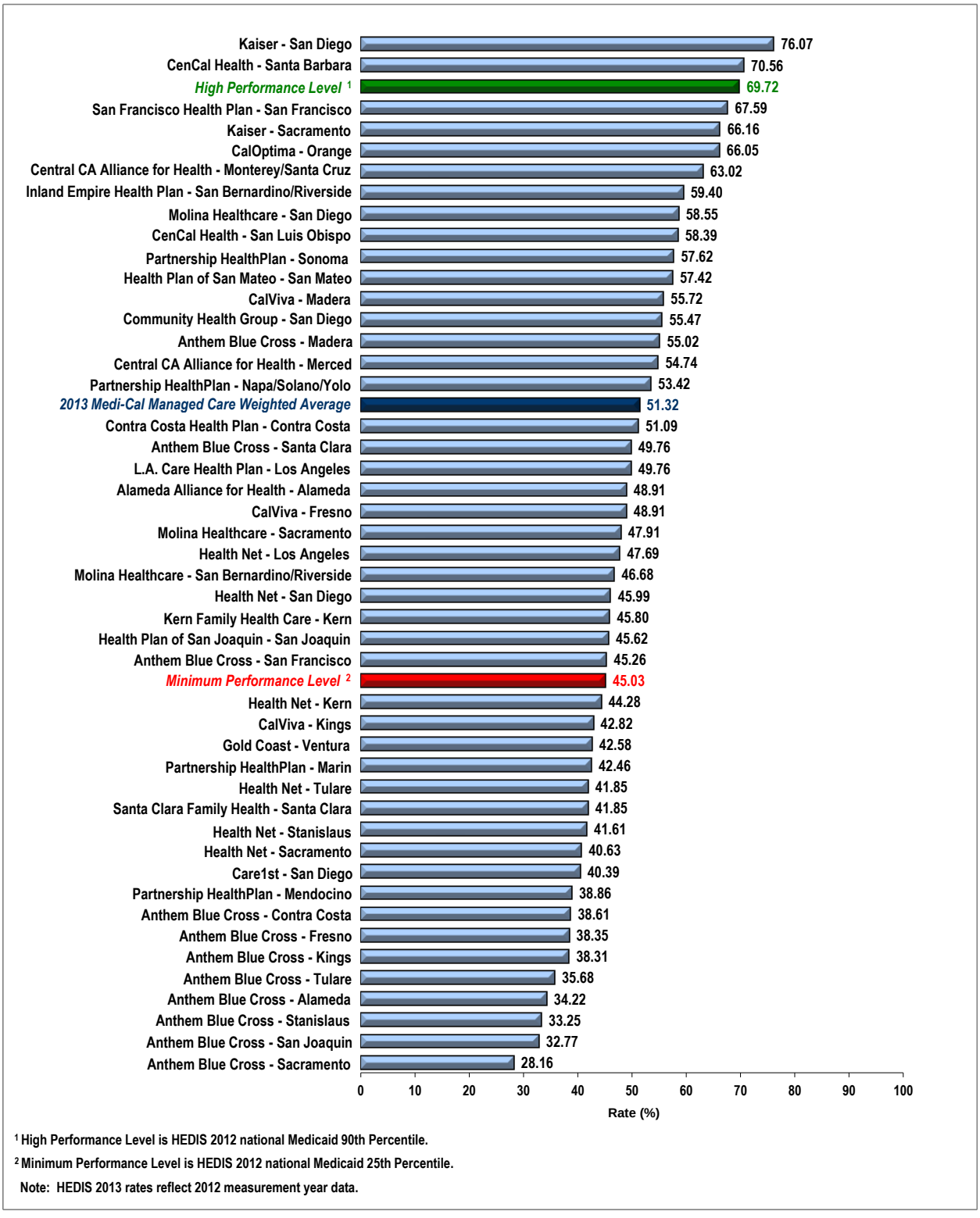
80 National Diabetes Information Clearinghouse. *National Diabetes Statistics, 2007*. Available at: http://diabetes.niddk.nih.gov/DM/PUBS/statistics/. Accessed on: September 11, 2013.

Performance Results





Medi-Cal Managed Care
HEDIS 2013 Comprehensive Diabetes Care—Eye Exam (Retinal) Performed



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure was 51.32 percent in 2013, which was below the Healthy People 2020 goal of 58.7 percent. The 2013 MCMC weighted average was below both the 2012 national Medicaid average and the 2012 national commercial average.

The COHS model type outperformed the GMC model and TPM types in 2013.

High and Low Performers

Two rates reported in 2013, Kaiser—San Diego County and CenCal Health—Santa Barbara County performed above the established HPL, while 18 rates were below the MPL. Eight of Anthem Blue Cross' counties reported the lowest performance in 2013.

Inland Empire Health Plan—San Bernardino/Riverside counties had a statistically significant increase from 2012 to 2013, and 12 rates had a statistically significant decrease during the same time frame (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 ESRD, and 20 to 30 percent of diabetics will develop evidence of nephropathy.[81,82] 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.[83,84] 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.[85]

Furthermore, nephropathy is associated with increased risks for hypertension and high cholesterol.[86] Blood sugar control reduces the risk of microalbuminuria (having small amounts of protein in the

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81 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: September 11, 2013.

82 National Kidney and Urologic Diseases Information Clearinghouse. *IgA Nephropathy*, Available at: http://kidney.niddk.nih.gov/kudiseases/pubs/iganephropathy/. Updated September 2010. Accessed on: September 11, 2013.

83 American Diabetes Association. Nephropathy in Diabetes. *Diabetes Care.* 2004. Available at: http://care.diabetesjournals.org/content/27/suppl_1/s79.full. Accessed on: September 11, 2013.

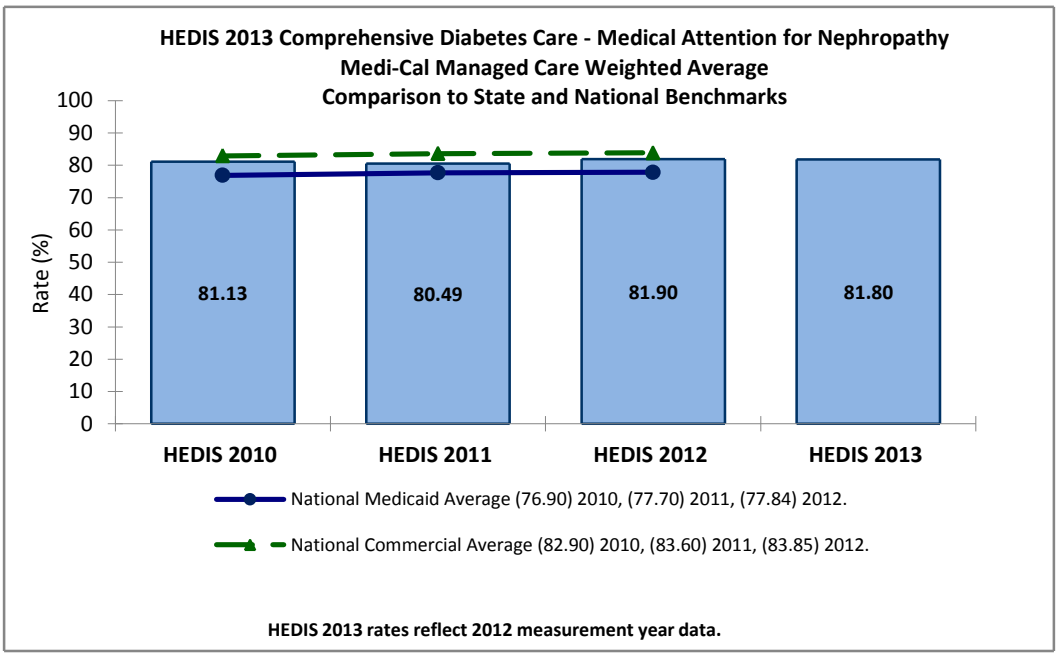
84 National Kidney and Urologic Diseases Information Clearinghouse. *IgA Nephropathy*, Available at: http://kidney.niddk.nih.gov/kudiseases/pubs/iganephropathy/. Updated September 2010. Accessed on: September 11, 2013.

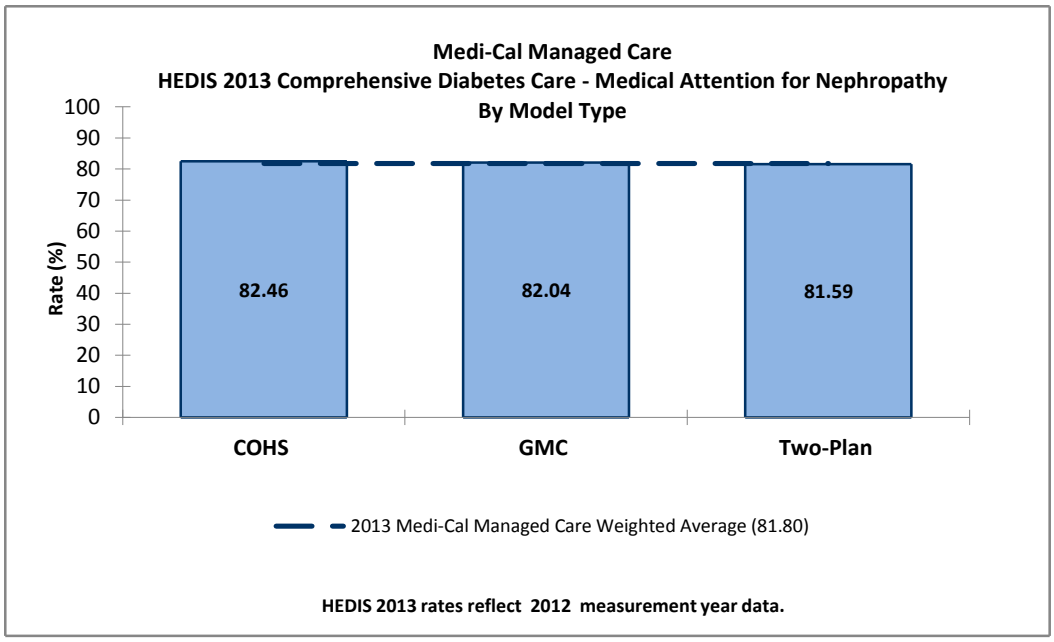
85 American Diabetes Association. Diabetes Statistics. 2011. Available at: http://www.diabetes.org/diabetes-basics/diabetes-statistics/. Accessed on: September 11, 2013.

86 National Kidney and Urologic Diseases Information Clearinghouse. *IgA Nephropathy*, Available at: http://kidney.niddk.nih.gov/kudiseases/pubs/iganephropathy/. Updated September 2010. Accessed on: September 11, 2013.

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.[87]

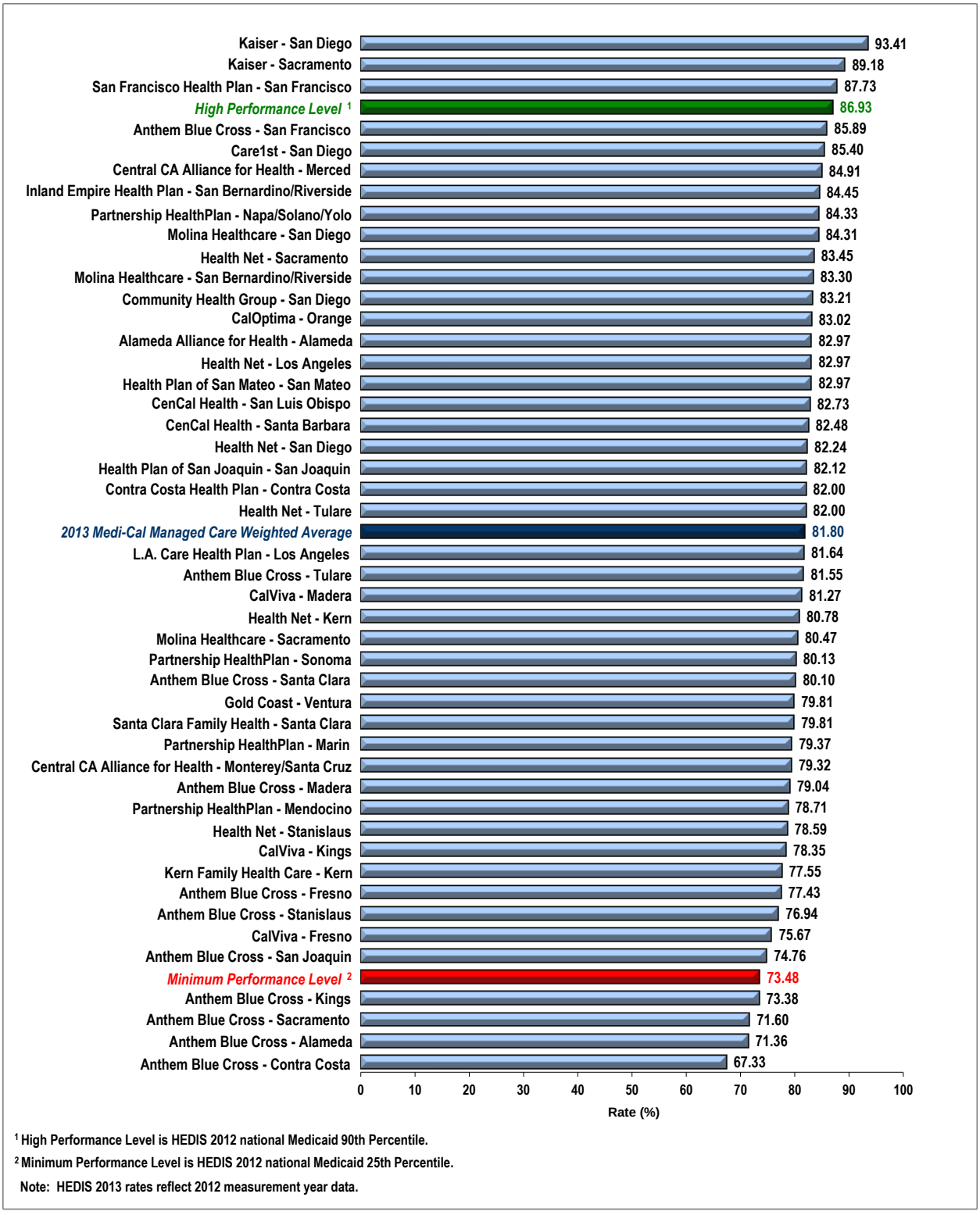
Performance Results





[87] Ibid.

Medi-Cal Managed Care
HEDIS 2013 Comprehensive Diabetes Care—Medical Attention for Nephropathy



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure of 81.80 percent in 2013 was basically unchanged from 2012 results. The program's weighted average has remained above the national Medicaid average and below the national commercial average for the last three years.

The performance was consistent between the COHS model, GMC model and TPM types for 2013.

High and Low Performers

Three rates exceeded the HPL, and four rates fell below the MPL in 2013. Kaiser—Sacramento County, Kaiser—San Diego County, and San Francisco Health Plan—San Francisco County all reported performance rates above the HPL in 2013. Conversely, Anthem Blue Cross—Alameda, Contra Costa, Kings, and Sacramento counties all performed below the MPL. Note that all of the reported rates that fell below the MPL were for Anthem Blue Cross counties.

No rates had a statistically significant increase from 2012 to 2013, and two rates, Contra Costa Health Plan—Contra Costa County and Health Plan of San Mateo—San Mateo County, had statistically significant decreases (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.[88] 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.[89,90] 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.[91,92,93] Furthermore, people with diabetes are two-to-four times 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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88 American Diabetes Association. *High Blood Pressure (Hypertension).* Available at: http://www.diabetes.org/living-with-diabetes/complications/high-blood-pressure-hypertension.html. Accessed on: September 11, 2013.

89 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: September 11, 2013.

90 National Diabetes Information Clearinghouse. *National Diabetes Statistics, 2011.* Available at: http://diabetes.niddk.nih.gov/DM/PUBS/statistics/. Accessed on: September 11, 2013.

91 Ibid.

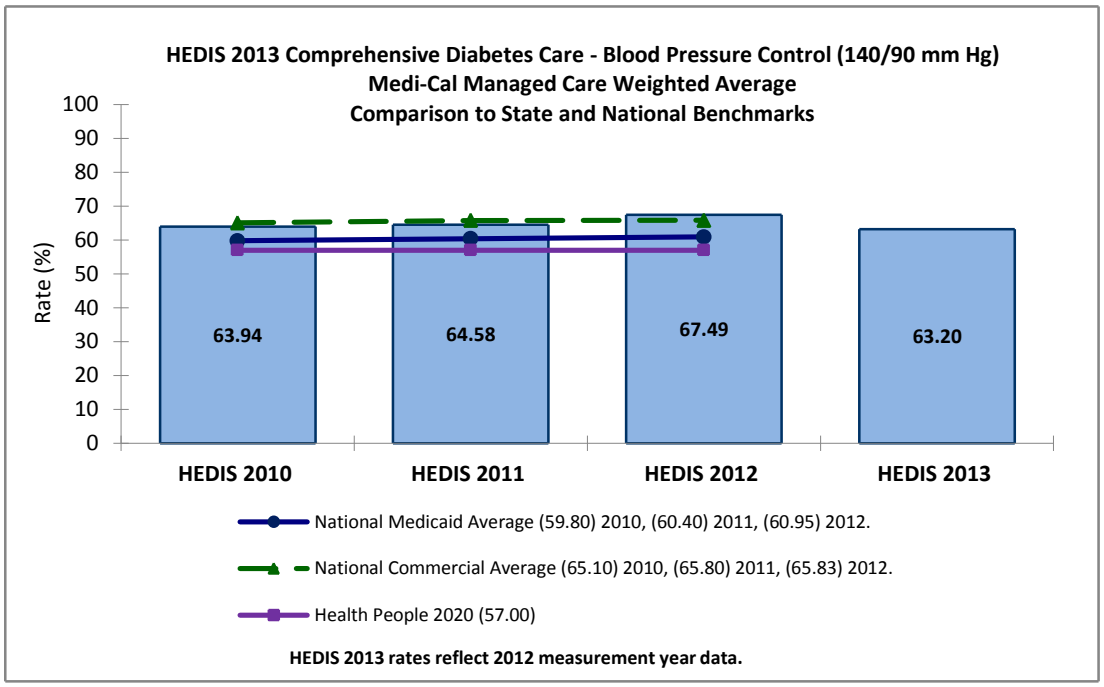
92 American Diabetes Association. *High Blood Pressure (Hypertension).* Available at: http://www.diabetes.org/living-with-diabetes/complications/high-blood-pressure-hypertension.html. Accessed on: September 11, 2013.

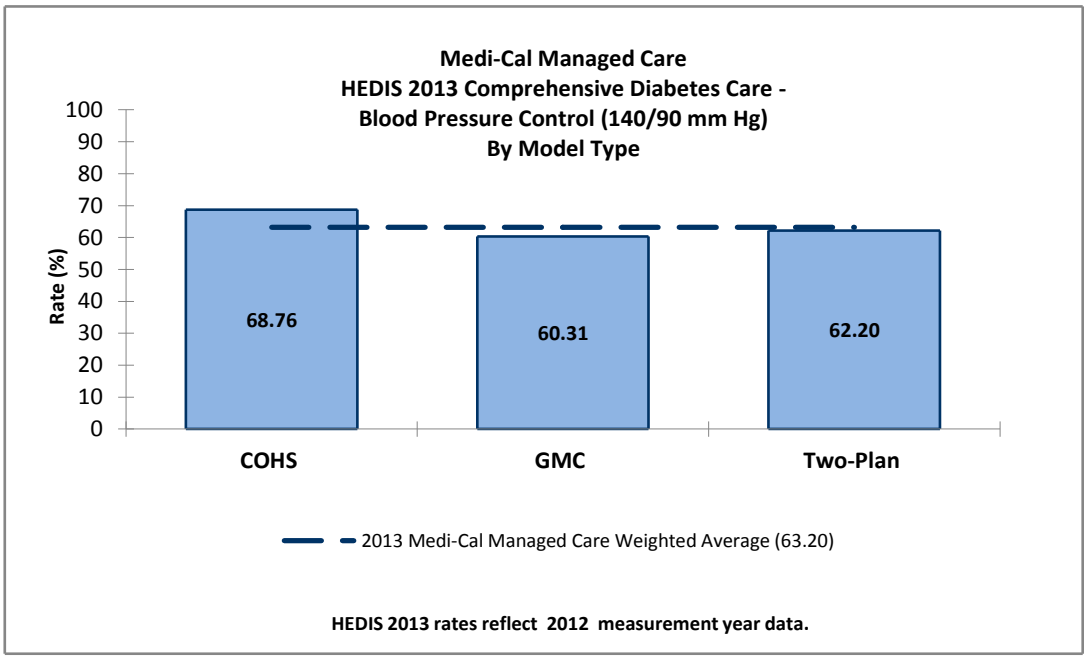
93 New York-Presbyterian. *Diabetes and High Blood Pressure.* 2008. Available at: http://nyp.org/health/diabetes-hpb.html. Accessed on: September 11, 2013.

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.[94]

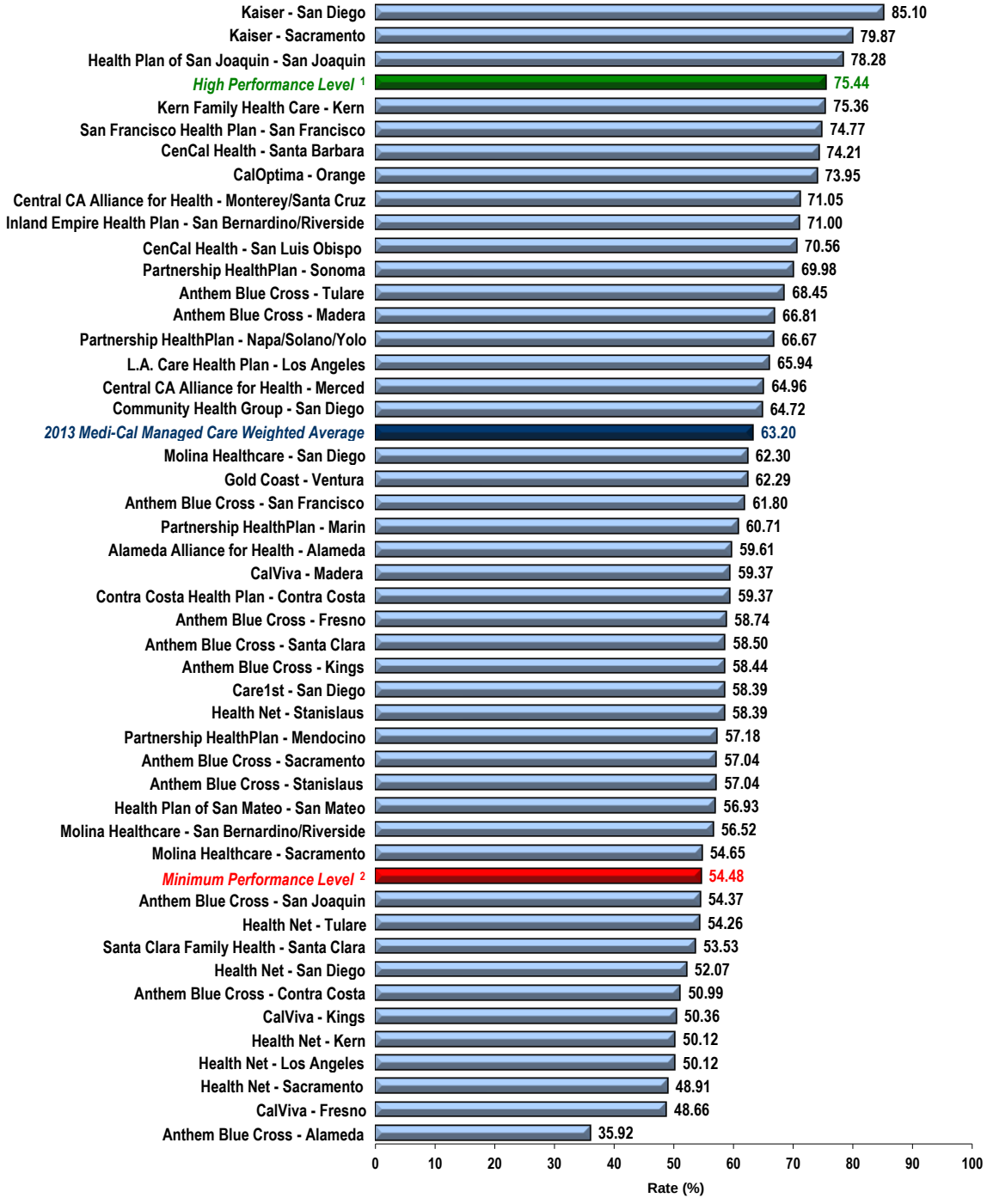
[94] National Diabetes Information Clearinghouse. National Diabetes Statistics, 2011. Available at: http://diabetes.niddk.nih.gov/DM/PUBS/statistics/. Accessed on: September 11, 2013.

Performance Results





Medi-Cal Managed Care
HEDIS 2013 Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure was 63.20 percent in 2013. The weighted average exceeded the Healthy People 2020 goal of 57.0 percent and both the national Medicaid average and the national commercial average in 2012.

The COHS model type outperformed the GMC model and TPM types in 2013.

High and Low Performers

Three rates were higher than the HPL in 2013 (Kaiser—Sacramento County, Kaiser—San Diego County, and Health Plan of San Joaquin—San Joaquin County). Eleven rates fell below the MPL in 2013 as opposed to three in 2012.

Two rates had statistically significant increases in rates from 2012 to 2013, Community Health Group—San Diego County and Santa Clara Family Health Plan—Santa Clara County. Conversely, 13 rates demonstrated a statistically significant decline (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.[95]

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.[96] Healthy eating also reduces the risks of heart disease, high cholesterol, and stroke.[97]

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:[98,99]

- Lowered cholesterol.
- Reduced blood pressure.
- Prevention of angina and chest pain.
- Decreased risk of heart disease and stroke.
- Prevention of acquiring Type 2 diabetes.
- Improved blood sugar levels.

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95 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 June 27, 2012, until new contract awarded.

96 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: September 11, 2013.

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: September 11, 2013.

98 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: September 11, 2013.

99 About.com. *The Health Benefits of Losing Weight*. 2012. Available at: http://weightloss.about.com/library/blhealthbenefits.htm. Accessed on: September 11, 2013.

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.[100] 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.[101]

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.[102]

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.[103]

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

[101] 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: September 11, 2013.

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

[103] Ibid.

Controlling High Blood Pressure

Measure Definition

The *Controlling High Blood Pressure* 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 140/90 mm Hg) during the measurement year.

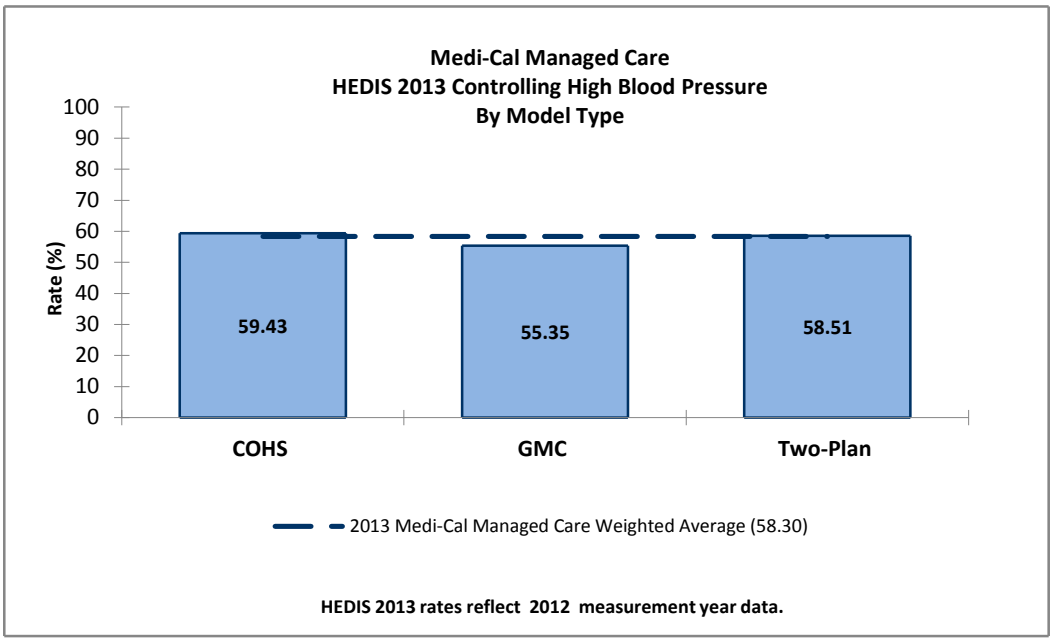
Importance[104]

In 2008, hypertension was identified as a contributing or primary factor for 347,000 deaths in the United States. Specifically, hypertension was a contributing factor for 77 percent of people who had their first stroke, 69 percent of people who had their first heart attack, and 74 percent of people who experienced congestive heart failure. Research indicates that more than 90 percent of U.S. adults will develop hypertension during their lifetime, and as many as 33 percent of U.S. adults currently have high blood pressure. Although high blood pressure is more prevalent with age, approximately 20 percent of adults 24–32 years of age have high blood pressure.

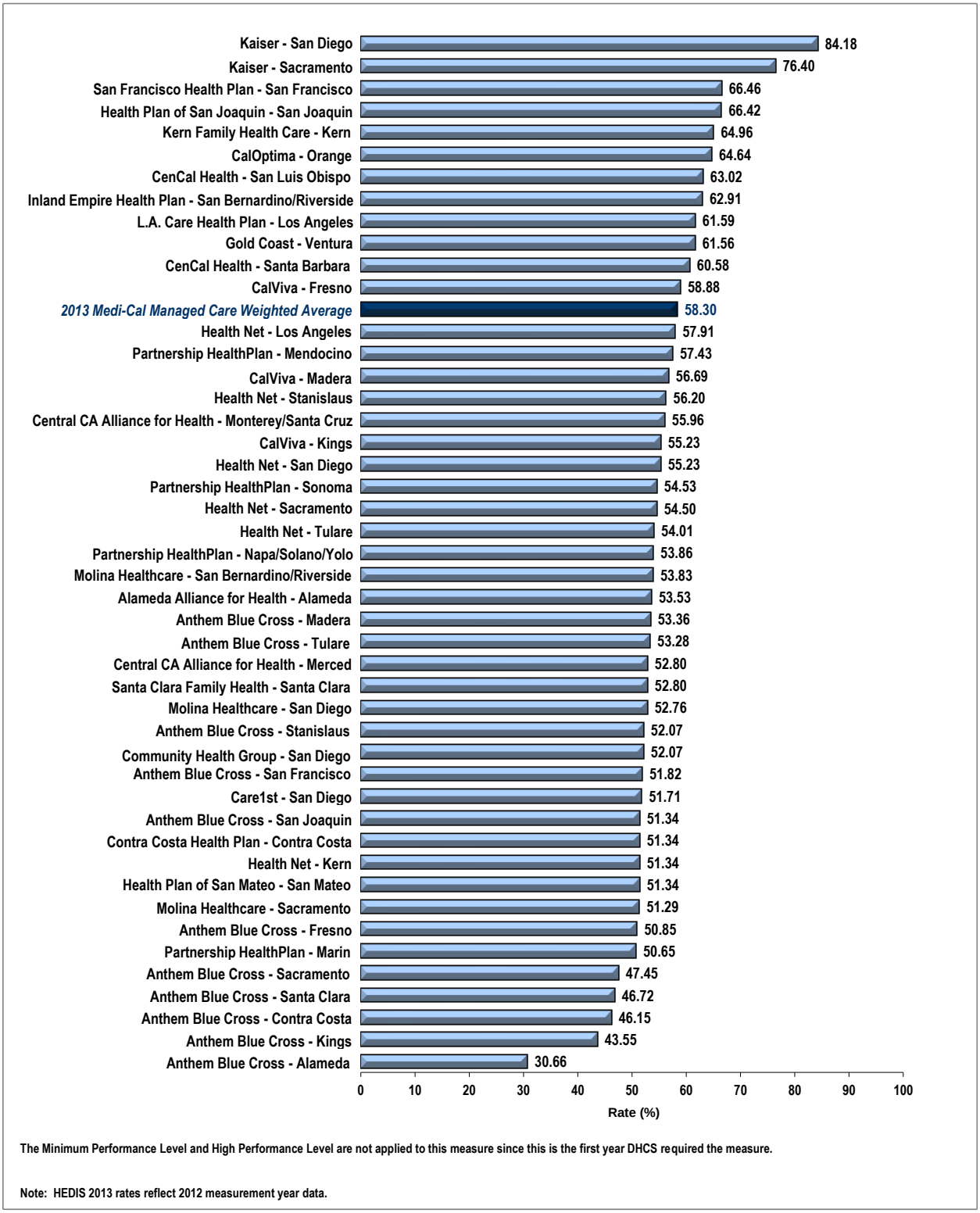
Sixty-nine percent of adults with hypertension require medication to help control their blood pressure. Current estimates are that only 50 percent of adults with high blood pressure have it under control. Costs in 2010 for medical services, prescriptions, and decreased work productivity related to hypertension were estimated to be $93.5 billion.

[104] Agency for Healthcare Research and Quality. *National Quality Measures Clearinghouse.* Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=38869. Accessed on: September 11, 2013.

Performance Results



Medi-Cal Managed Care
HEDIS 2013 Controlling High Blood Pressure



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

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MPL and HPL are not applied to a measure (1) when 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 DHCS requires the measure. The first year that DHCS reported *Controlling High Blood Pressure* was 2013; therefore, there were no established HPLs and MPLs for this measure.

The COHS model, GMC model, and TPM types demonstrated no significant difference in the performance between the three model types.

Immunizations for Adolescents—Combination 1

Measure Definition

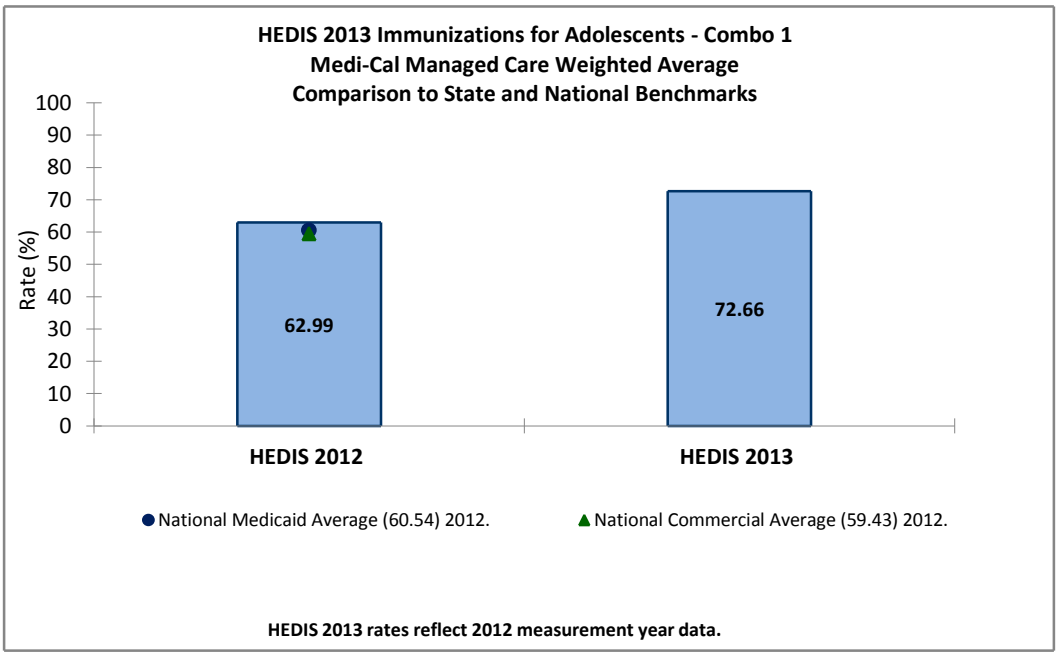
The *Immunizations for Adolescents—Combination 1* measure assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.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

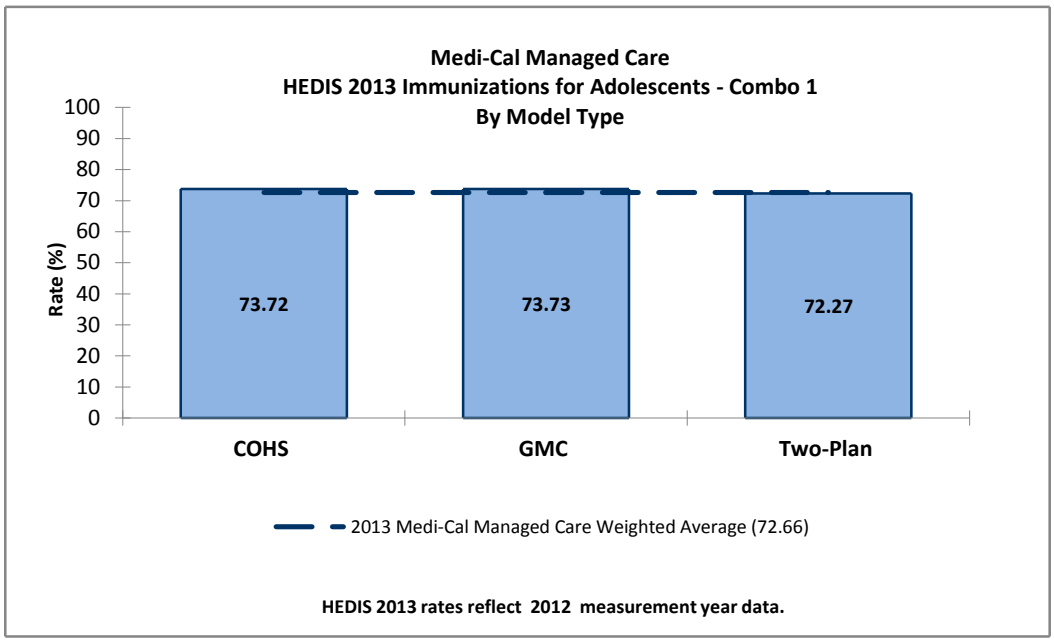
Importance

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.

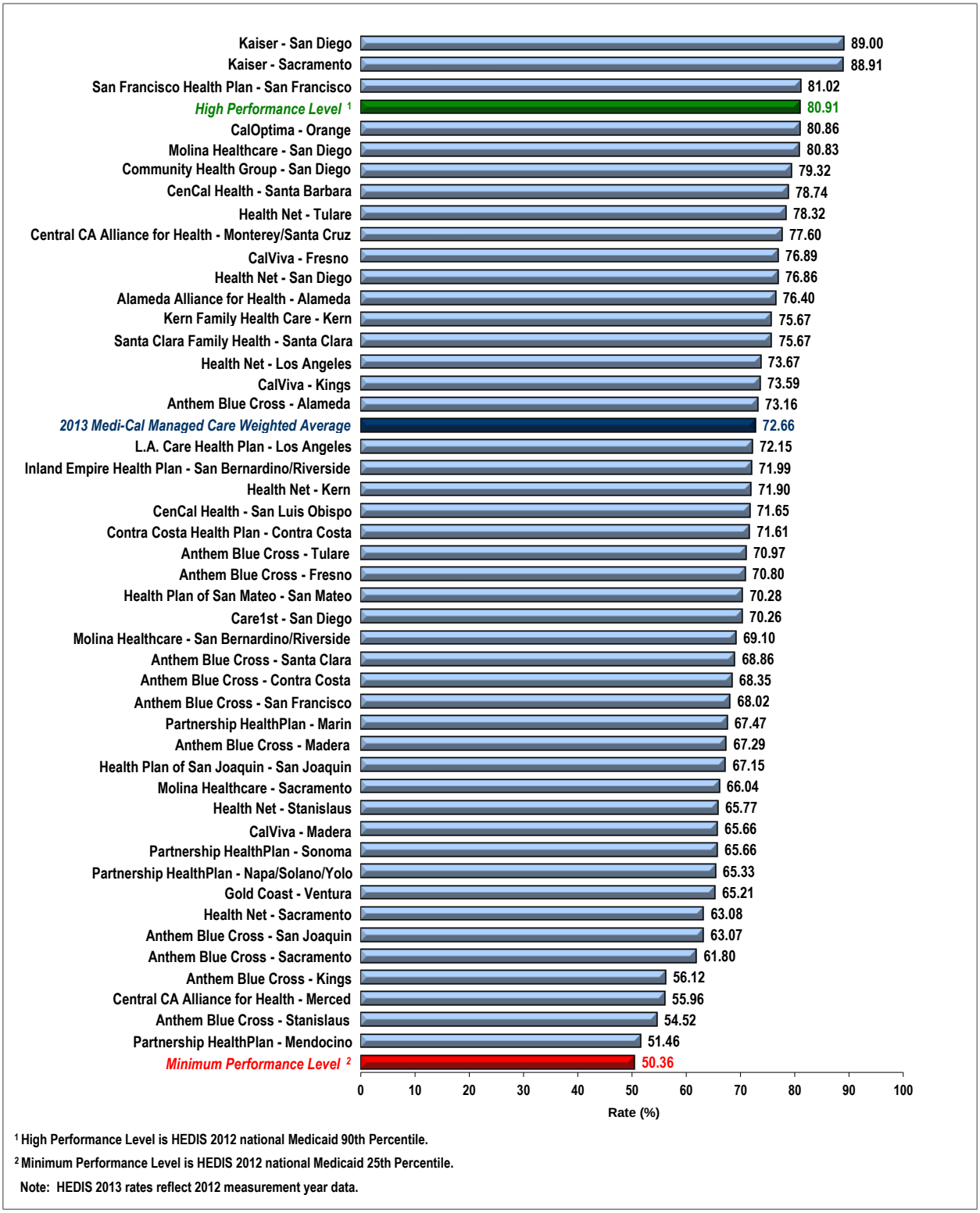
This measure follows the CDC and Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations.

Performance Results





Medi-Cal Managed Care
HEDIS 2013 Immunizations for Adolescents—Combination 1



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for the *Immunizations for Adolescents—Combination 1* measure was 72.66 percent in 2013, an increase over the 2012 average. The rate exceeded the national Medicaid average and the national commercial average.

The COHS, GMC, and TPM types' performance was comparable in 2013.

High and Low Performers

Three rates were above the HPL, Kaiser—Sacramento County, Kaiser—San Diego County, and San Francisco Health Plan—San Francisco County, while no rates were below the MPL.

Twenty-nine rates demonstrated statistically significant improvement from 2012 to 2013, while no rates had a statistically significant decline during the same time frame.

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.[105] 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 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 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.[106]

[105] 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.
[106] American Academy of Pediatrics. Increasing Immunization Coverage. *Pediatrics*. 2010; 125(6): 1299–1304.

Provider Reminders

Studies have shown that provider reminders are helpful in increasing adolescent 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.[107]

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 school-based health clinics and home visits.[108] Referring clients to clinics where they can receive vaccinations, or to provide vaccinations on-site all contributed to improved immunization coverage among adolescents.[109]

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, and developing "drop-in" clinics or "express-lane" vaccination services, have proven to be effective in increasing adolescent immunization rates.[110]

Home health interventions to promote vaccinations increased 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.

Conduct Regular Assessments

Conducting regular assessments of immunization rates is proven to increase vaccination coverage in a range of clinical settings and across populations.[111] 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

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[107] 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/index.html#chapters Accessed on: September 11, 2013.

[108] Community Preventive Services Task Force. Increasing Appropriate Vaccination. Available at: http://www.thecommunityguide.org/vaccines/index.html Accessed on: September 14, 2013.

[109] Ibid.

[110] Ibid.

[111] 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.

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.[112]

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.[113] For example, Columbia United Providers (CUP) in partnership with Washington State developed a registry system called CHILD Profile. In using 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.[114]

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.[115] 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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[112] Nordin J, Anderson R, Anderson R, et al. Institute for Clinical Systems Improvement. Immunizations. Available at: http://www.guideline.gov/content.aspx?id=36813&search=immunizations Updated March 2012. Accessed on: September 10, 2013.

[113] 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: September 11, 2013.

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

[115] Ibid.

Medication Management for People with Asthma

Measure Definition

The *Medication Management for People with Asthma* measure is used to assess the percentage of enrolled members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and who were dispensed an asthma controller medication that they remained on for at least:

- 50 percent of their treatment period.
- 75 percent of their treatment period.

Importance

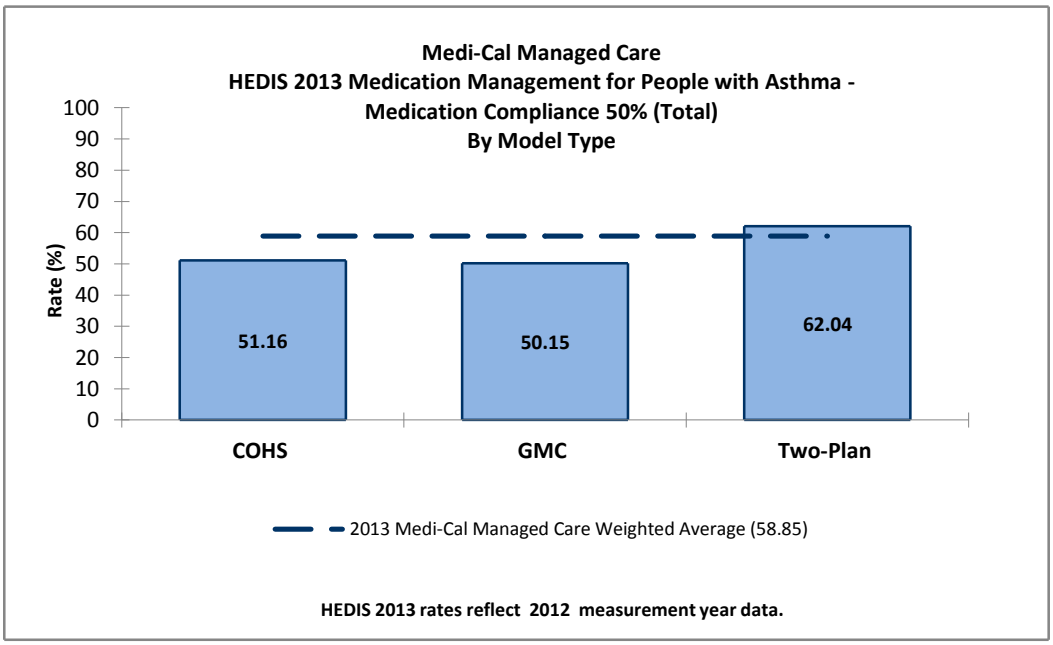
Effective asthma management depends not only on the availability of prescribed medications, but also on their acceptance and regular use by patients. Current adherence rates to controller medications are extremely low, only a third (33.5 percent) of patients who require a prescription for inhaled corticosteroids have such a prescription and only a minority of patients use their preventive medication as directed. [116] According to the Asthma Regional Council, two-thirds of adults and children who display asthma symptoms are considered "not well controlled" or "very poorly controlled" as defined by clinical practice guidelines.

Regular use of controller medications is estimated to reduce hospitalizations by 80 percent and reduce morbidity by more than 20 percent.[117] Appropriate medication adherence can decrease the severity of many asthma-related symptoms. Medication management is used to prevent and control asthma symptoms, improve quality of life, reduce the frequency and severity of asthma exacerbations, and reverse airflow obstruction.

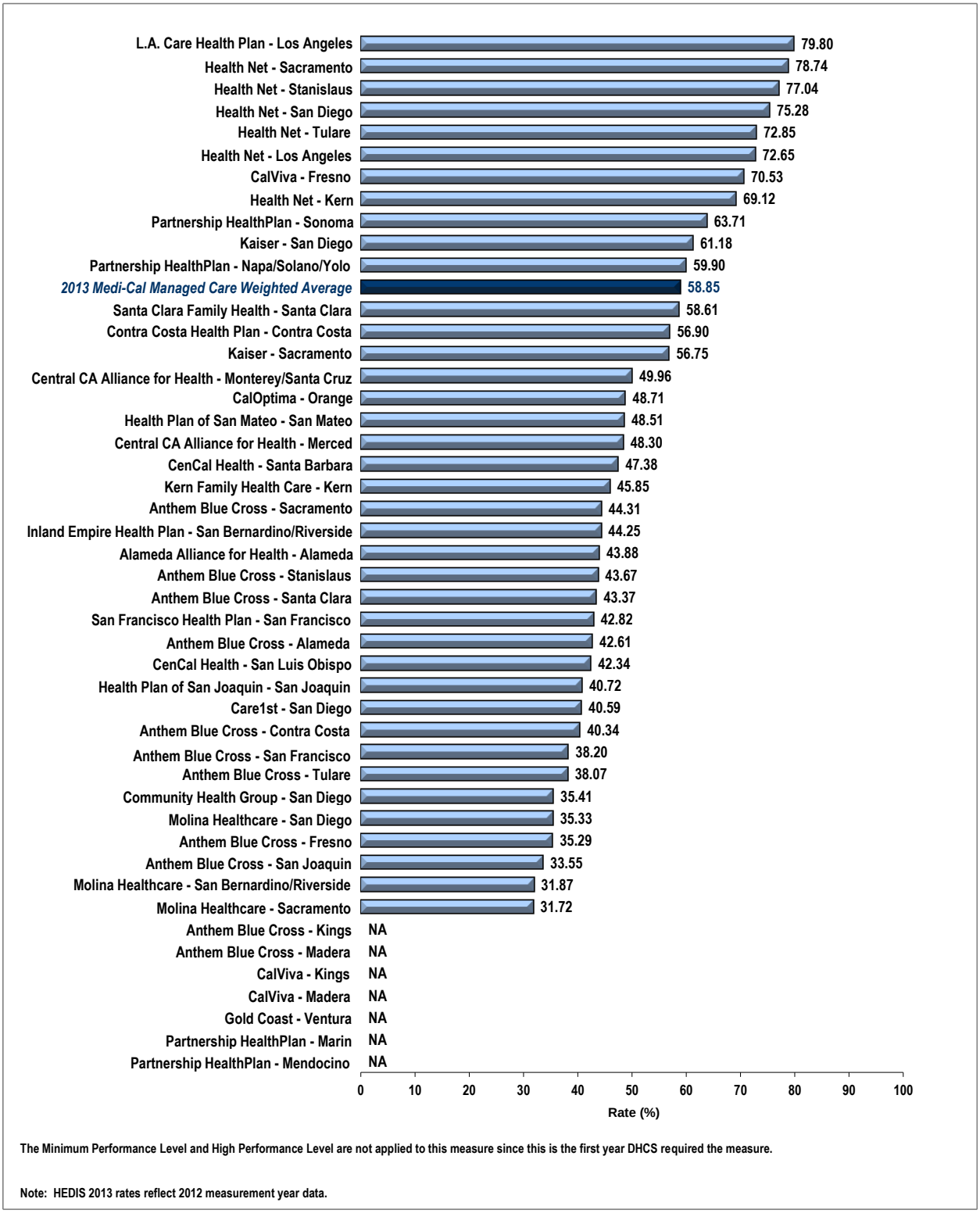
[116] Centers for Disease Control and Prevention, National Center for Health Statistics. Vital Signs: Asthma Prevalence, Disease Characteristics, and Self-Management Education – United States, 2001–2009. 2011.

[117] Roy, A, Battle, K, Lurslurchachai, L, Halm, E, Wisnivesky, J. Inhaler device, administration technique and adherence to inhaled corticosteroids in patients with asthma. 2001. Prim Care Respir J; 20(2): 148–154

Performance Results—Medication Compliance 50% (Total)



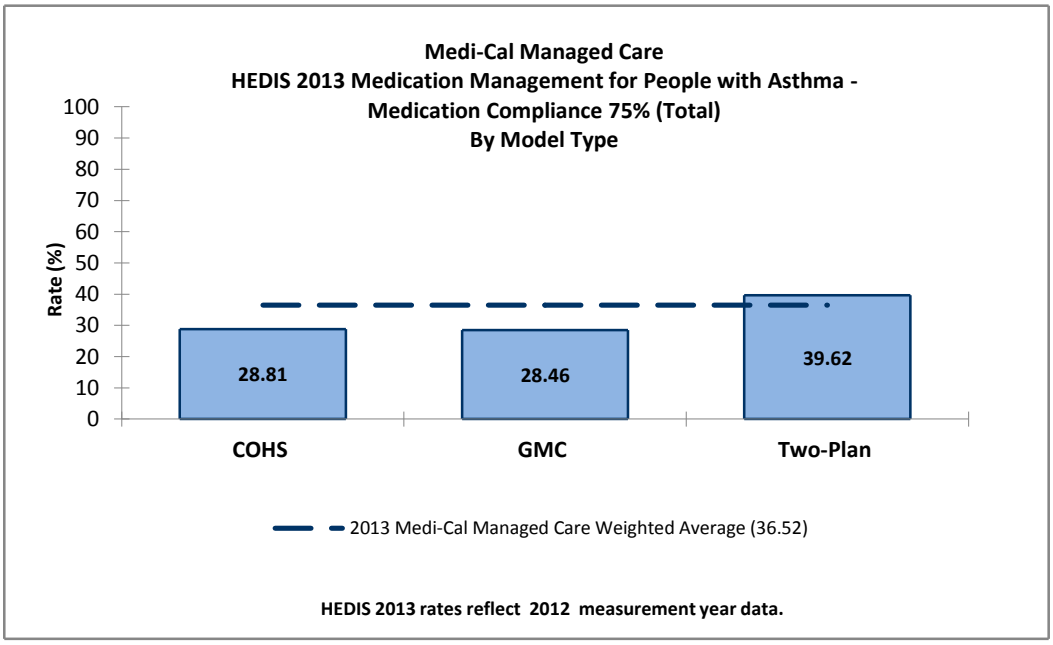
Medi-Cal Managed Care
HEDIS 2013 Medication Management for People with Asthma—Medication Compliance 50% (Total)



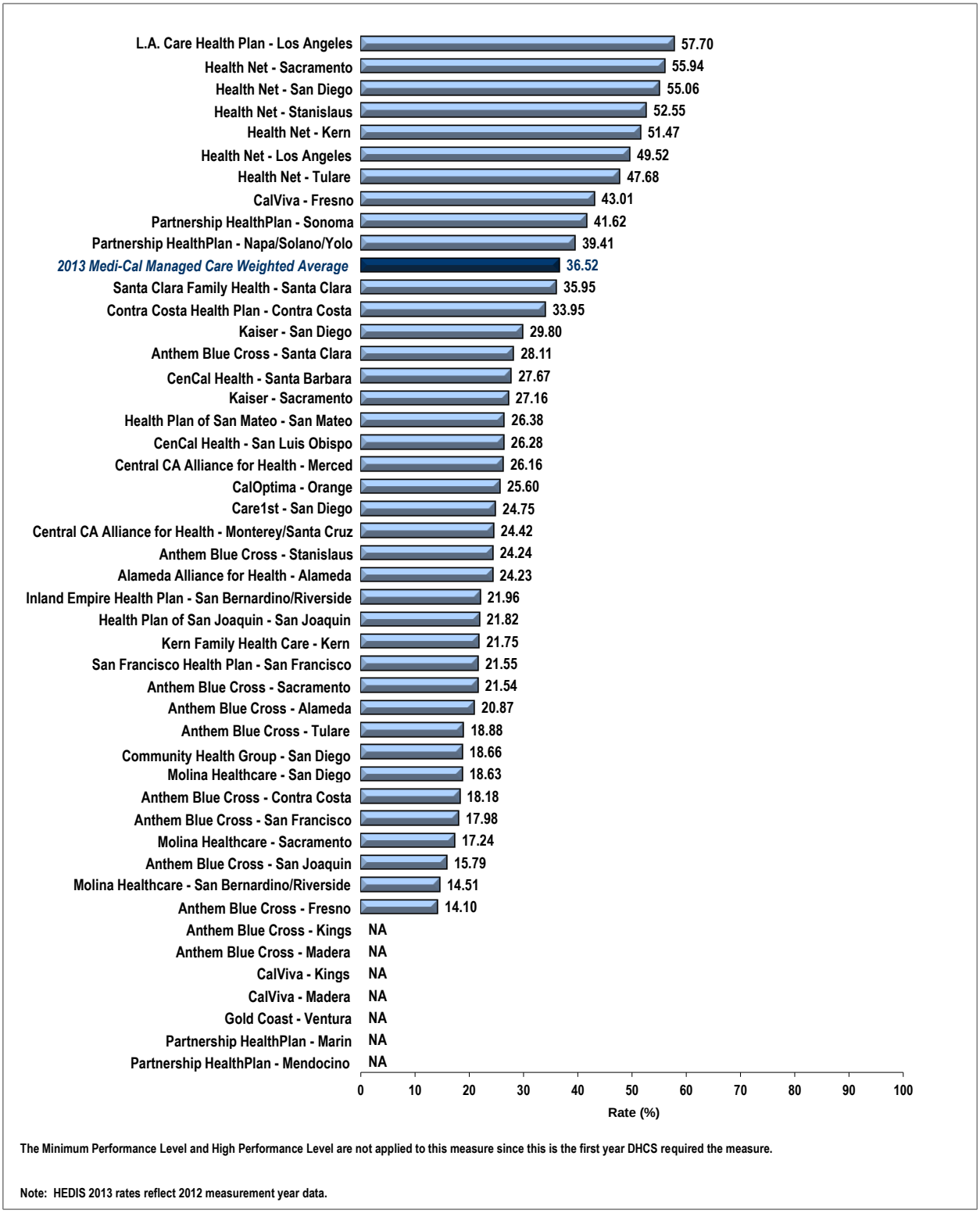
The Minimum Performance Level and High Performance Level are not applied to this measure since this is the first year DHCS required the measure.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Performance Results—Medication Compliance 75% (Total)



Medi-Cal Managed Care
HEDIS 2013 Medication Management for People with Asthma—Medication Compliance 75% (Total)



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

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MPL and HPL are not applied to a measure (1) when 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 DHCS requires the measure. The first year that DHCS reported *Medication Management for People with Asthma* was 2013; therefore, there were no established HPLs and MPLs for the two submeasures.

The MCMC weighted average in 2013 was 58.85 percent for the *Medication Compliance 50%* submeasure and 36.52 percent for the *Medication Compliance 75%* submeasure.

For both *Medication Compliance 50%* and *Medication Compliance 75%*, the TPM type outperformed the GMC and COHS model types.

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.[118] 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.[119] 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.[120] Socioeconomic status is a determinant of health outcomes, including poor birth outcomes.[121] 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.[122] Studies revealed that receiving timely prenatal care is associated with the timing of Medicaid coverage.[123] In 2008, only 82 percent of Medicaid members received timely prenatal care, compared to approximately 92 percent for members in commercial plans.[124]

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 who did not, the infant mortality rate was five times greater for women who did not have timely prenatal care.

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

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.

120 Ibid.

121 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."

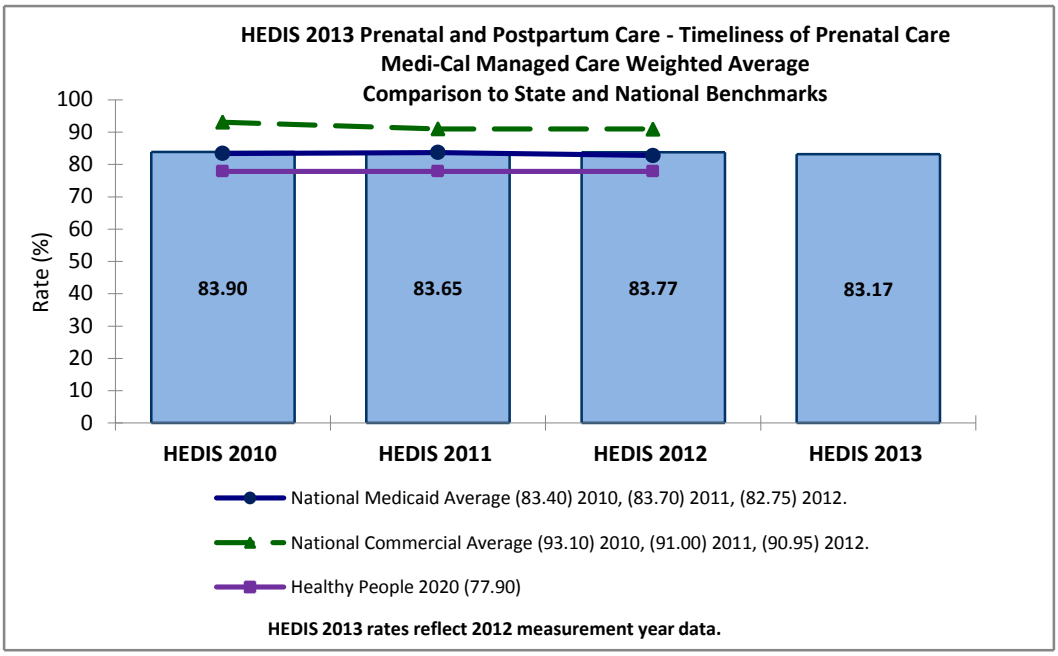
122 Shulman, Shanna. "Poor Preventive Care Achievement and Program Retention Among Low Birth Weight Infant Medicaid Enrollees." *Pediatrics*. Nov 2006. 118(5): e1509-e1515. Available at: http://pediatrics.aappublications.org/cgi/reprint/118/5/e1509 Accessed on: September 11, 2013.

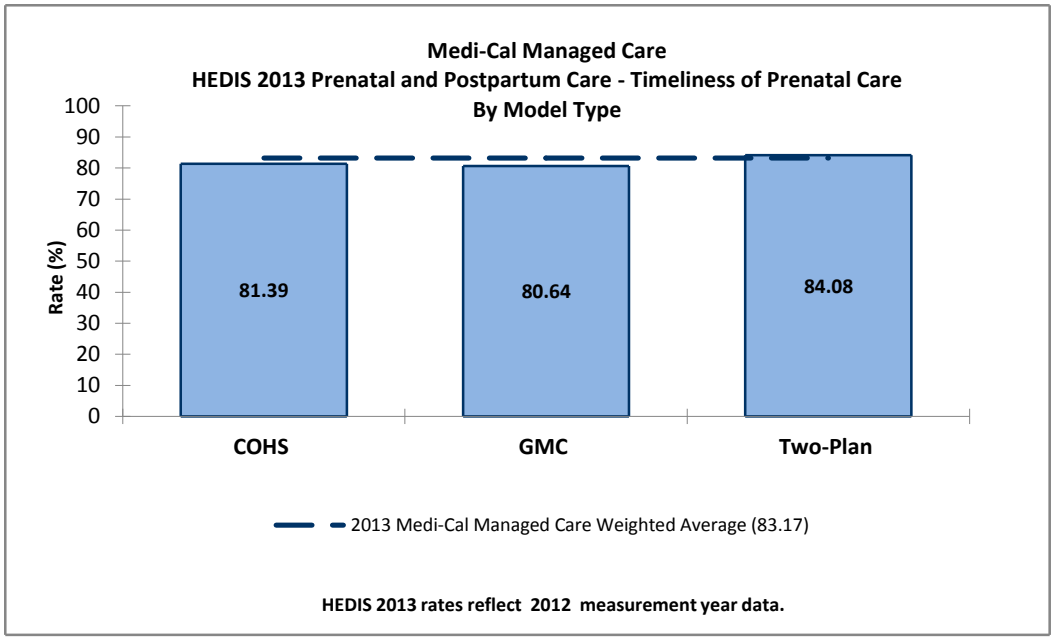
123 Gavin, N., Adams, K., Manning, W., et al. 2007 August. "The Impact of Welfare Reform on Insurance Coverage before Pregnancy and the Timing of Prenatal Care Initiation." *Health Services Research 42(4):* 1564–1588.

124 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.[125] 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.[126]

Performance Results

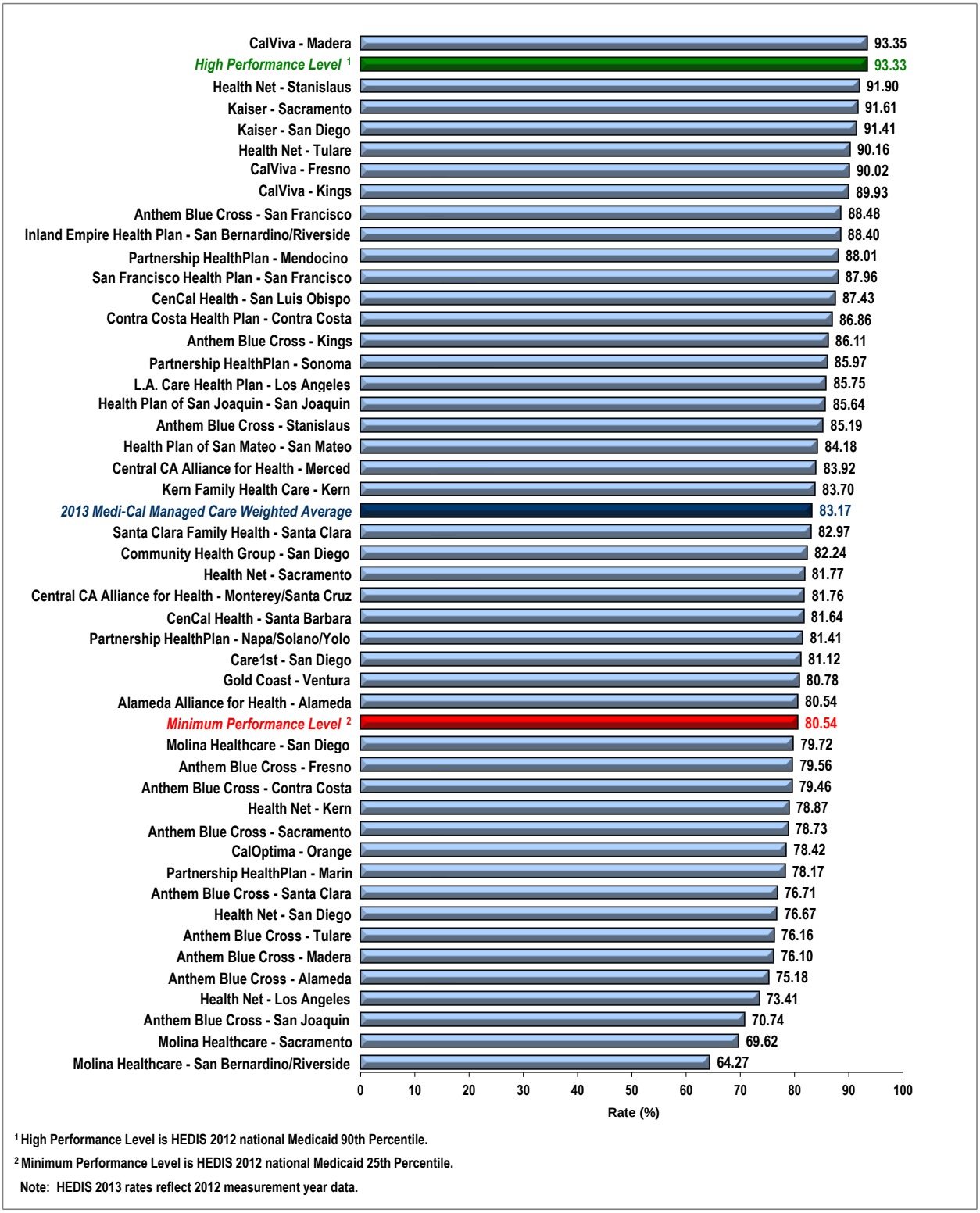




[125] Institute of Medicine. Preterm Birth: Causes, Consequences, and Prevention. Report Brief. July 2006.

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

Medi-Cal Managed Care
HEDIS 2013 Prenatal and Postpartum Care—Timeliness of Prenatal Care



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC 2013 weighted average for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure was 83.17 percent, which exceeded the Healthy People 2020 goal of 77.9 percent. Since 2009, the weighted average has been consistent with the national Medicaid average but below the national commercial average.

The TPM type outperformed both the GMC and COHS model types.

High and Low Performers

Despite this measure being part of the DHCS's auto-assignment program, only one rate, CalViva—Madera County, performed above the HPL in 2013. Sixteen rates fell below the MPL.

L.A. Care Health Plan's rate in Los Angeles County demonstrated statistically significant improvement from 2012 to 2013, while 12 rates had a statistically significant decrease (refer to Appendix B).

Best and Emerging Practices

System and Provider Interventions

An initial improvement strategy is to educate and ensure that providers are accurately capturing prenatal care visits using 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.[127] 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 MCP 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 MCP is performing relative to comparable entities.

[127] 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: September 11, 2013.

Member Incentives

The State or individual MCPs 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. MCPs 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

An effective strategy is to 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

An effective intervention is to 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.[128]

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.

[128] 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.

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.[129] 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

One improvement strategy is to 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.[130] Alternatively, MCPs can use text messaging for members preferring that method of communication.

[129] 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.

[130] 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.[131]

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).[132] An estimated 10 percent of these women suffer from postpartum depression for which a postpartum care visit is needed.[133] This figure increases to 25 percent if the woman has a history of postpartum depression.[134] Postpartum depression has been associated with marital happiness, the mother-child relationship, and infant behavior.[135] If untreated, postpartum depressed usually lasts around seven months.[136] 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

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

132 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: September 11, 2013.

133 Centers for Disease Control and Prevention. *PRAMS and Postpartum Depression.* Atlanta, GA: CDC, June 2004.

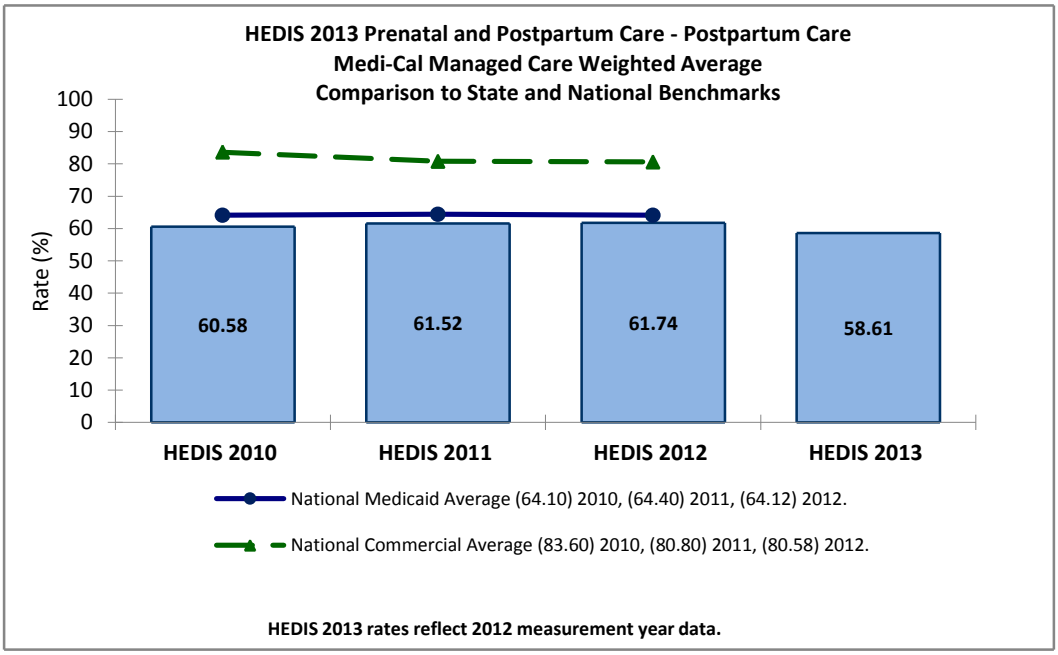
134 Blenning, C., Paladine, H., " An Approach to the Postpartum Office Visit." *Am Fam Physician.* 2005 Dec 15;72(12):2491–2496. Available at: http://www.aafp.org/afp/2005/1215/p2491.html Accessed on: September 11, 2013.

135 Centers for Disease Control and Prevention. *PRAMS and Postpartum Depression.* Atlanta, GA: CDC, June 2004.

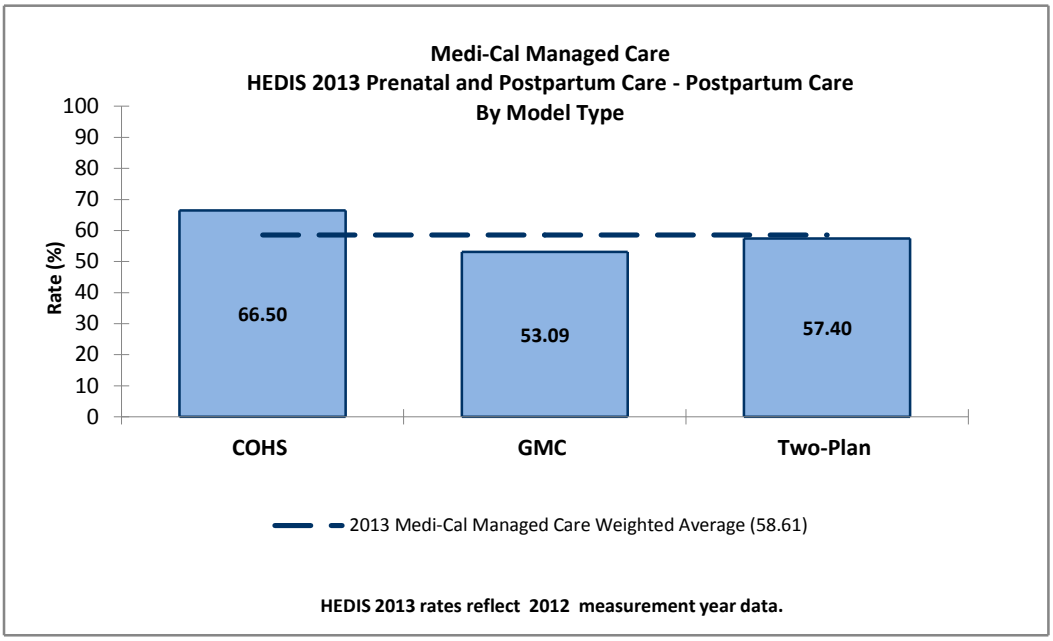
136 Blenning, C., Paladine, H., " An Approach to the Postpartum Office Visit." *Am Fam Physician.* 2005 Dec 15;72(12):2491–2496. Available at: http://www.aafp.org/afp/2005/1215/p2491.html Accessed on: September 11, 2013.

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.[137]

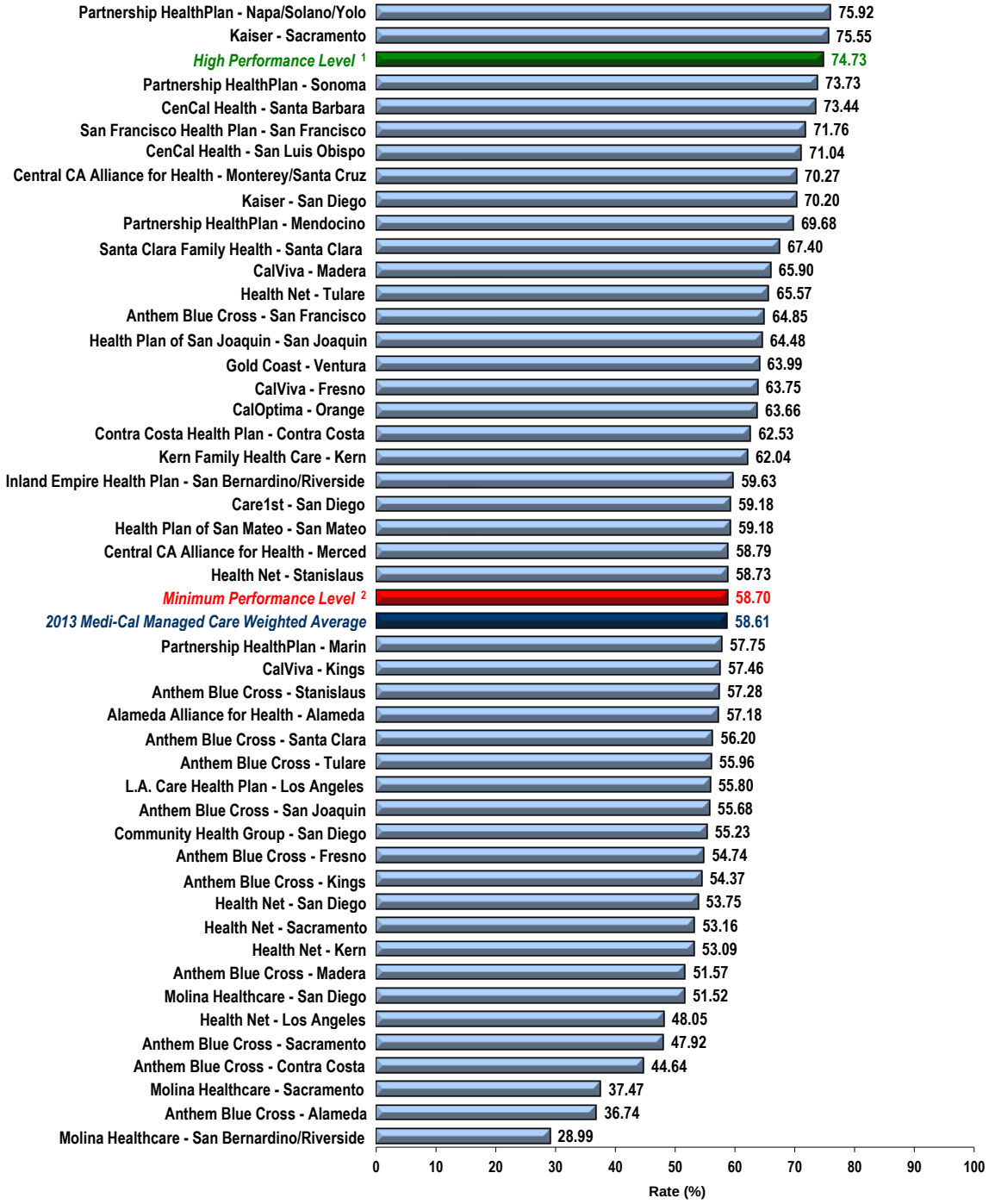
Performance Results



[137] Ibid.


Medi-Cal Managed Care
HEDIS 2013 Prenatal and Postpartum Care - Postpartum Care
By Model Type
Rate (%)
100
90
80
70
60
50
40
30
20
10
0
66.50
53.09
57.40
COHS
GMC
Two-Plan
2013 Medi-Cal Managed Care Weighted Average (58.61)
HEDIS 2013 rates reflect 2012 measurement year data.

Medi-Cal Managed Care
HEDIS 2013 Prenatal and Postpartum Care—Postpartum Care



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for the *Prenatal and Postpartum Care—Postpartum Care* measure remains below both the national Medicaid and national commercial average. Additionally, the 2013 MCMC weighted average fell below the MPL.

The COHS model type outperformed the GMC model and TPM types in 2013.

High and Low Performers

Two rates (Partnership HealthPlan—Napa/Solano/Yolo counties, and Kaiser—Sacramento County) were above the established HPL in 2013. In contrast, 22 rates were below the 2013 established MPL.

Anthem Blue Cross' rate in San Joaquin County and Santa Clara Family Health Plan—Santa Clara County showed a statistically significant increase from 2012 to 2013. Conversely, there were eight 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. MCPs 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

An effective improvement strategy is to 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.[138]

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

An effective improvement strategy is to educate and ensure that providers are accurately capturing postpartum care visits using 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 MCP 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 MCP is performing relative to comparable entities.

Member Incentives

The State or individual MCPs 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.[139] This best practice would likely result in an increase in postpartum visit rates,

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[138] 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.

[139] 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

An effective improvement strategy is to 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.[140] 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.[141] 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.[142] 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.[143] Abnormalities found when imaging patients with and without back pain had similar

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

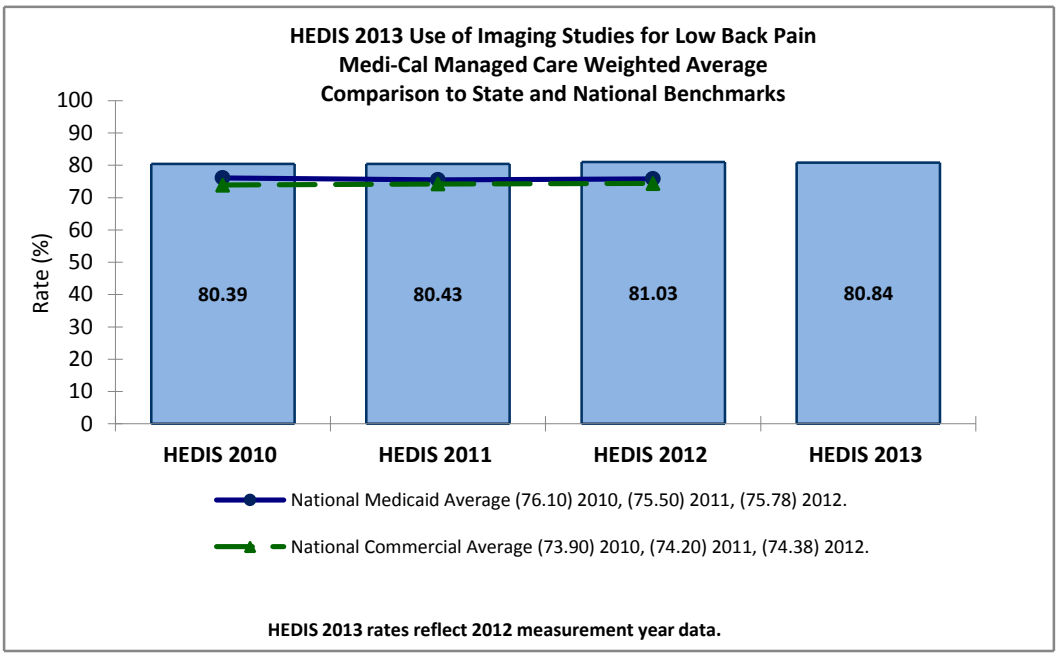
141 Atlas SJ, Deyo RA. Evaluating and Managing Acute Low Back Pain in the Primary Care Setting. *Journal of General Internal Medicine.* 2001; 16: 120–131.

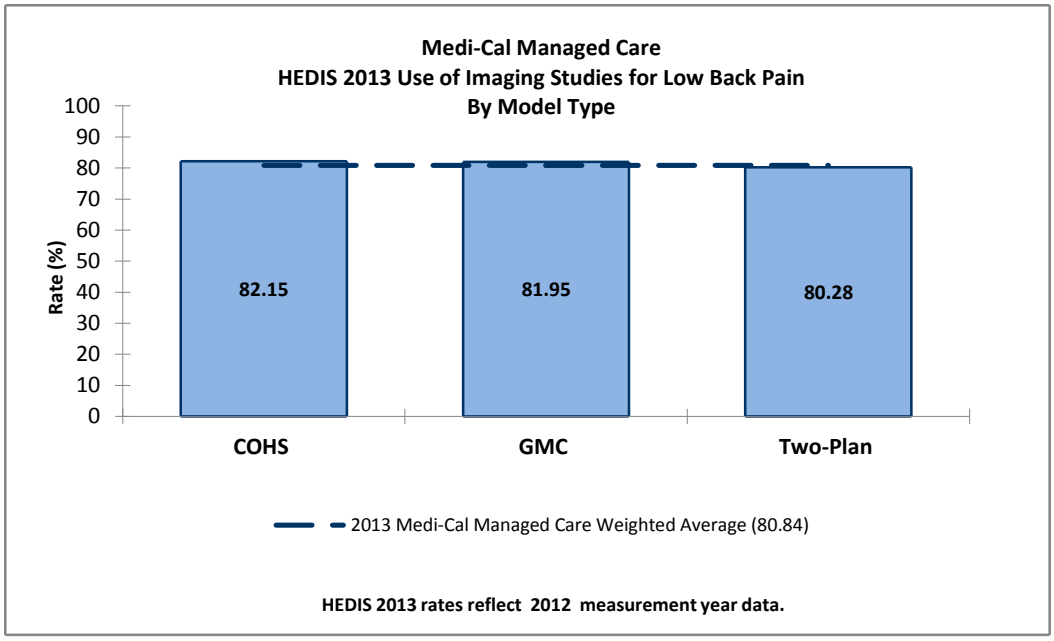
142 Patel AT, Ogle AA. Diagnosis and Management of Acute Low Back Pain. *American Family Physician.* 2000. Available at: http://www.aafp.org/afp/20000315/1779.html. Accessed on: September 11, 2013.

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

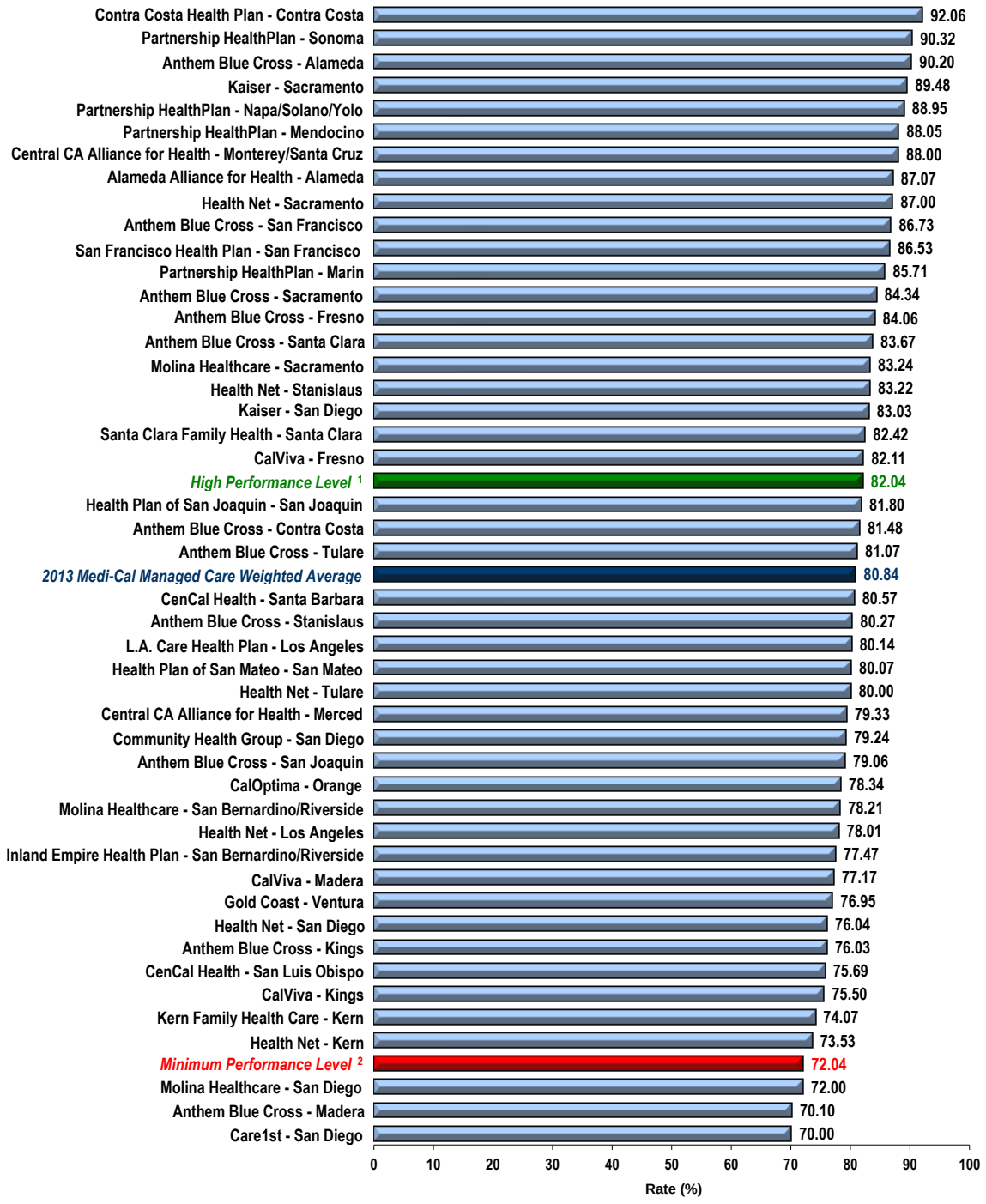
prevalence. Other than patient satisfaction, most patients given standard low back care experienced no difference in health outcomes compared to those given lower back radiographs.

Performance Results





Medi-Cal Managed Care
HEDIS 2013 Use of Imaging Studies for Low Back Pain



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for the *Use of Imaging Studies for Low Back Pain* measure was 80.84 percent in 2013. The 2013 rate exceeded the 2012 national Medicaid average and the national commercial average.

The COHS model, GMC model, and TPM types performed similarly in 2013.

High and Low Performers

Twenty rates met or exceeded the HPL in 2013, while three rates, Molina Health Care—San Diego County, Anthem Blue Cross—Madera County, and Care1st—San Diego County, fell below the MPL in 2013.

Two rates showed statistically significant increases from the 2012 rates, Community Health Group—San Diego County and Contra Costa Health Plan—Contra Costa County. Conversely, three rates had statistically significant declines during the same time frame, Care1st—San Diego County, Central California Alliance for Health—Merced County, and Health Net in Los Angeles County (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.[144] 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.[145]

[144] 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.

[145] Ibid.

Meet Patient Expectations through Education

Information about why an imaging test is not indicated is generally sufficient for most patients.[146] 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.

[146] 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. 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 2007–08 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.

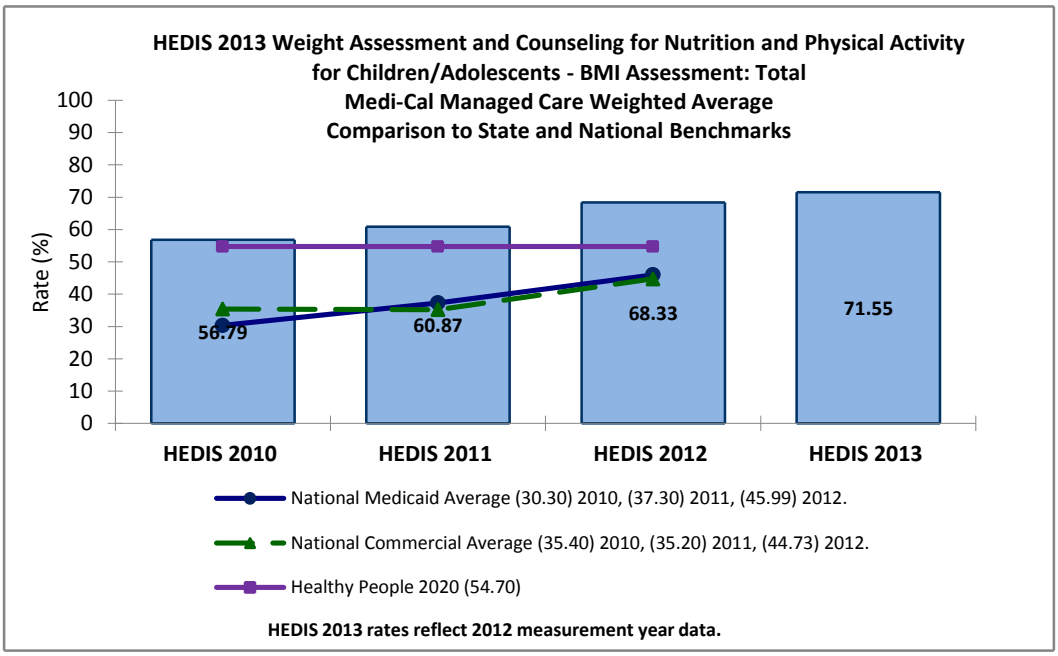
Additionally, according to a study conducted by the CDC, it was reported that almost 25 percent of children ages 9 to 13 did not engage in any free-time physical activity.[147] For young people in grades 9 through 12, the level of physical activity decreases drastically. Almost two-thirds of young people 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.[148]

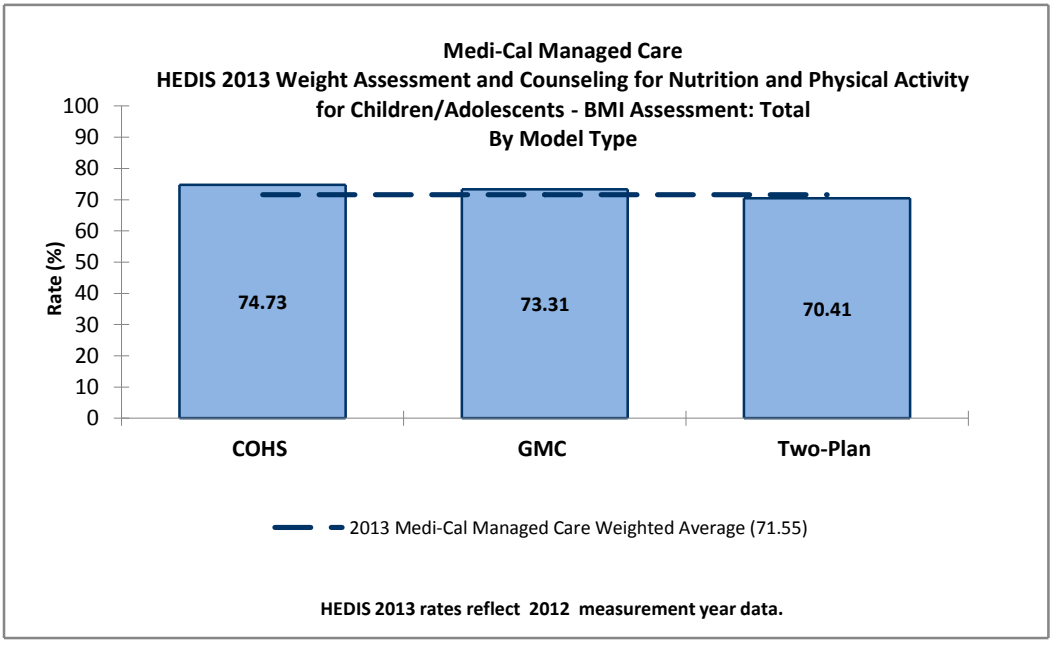
[147] Physical Activity Levels Among Children 9–13 Years—United States, 2002. *Morbidity and Mortality Weekly Report*. 2003; 52(33): 785–788. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5233a1.htm. Accessed on: September 11, 2013.

[148] 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: September 11, 2013.

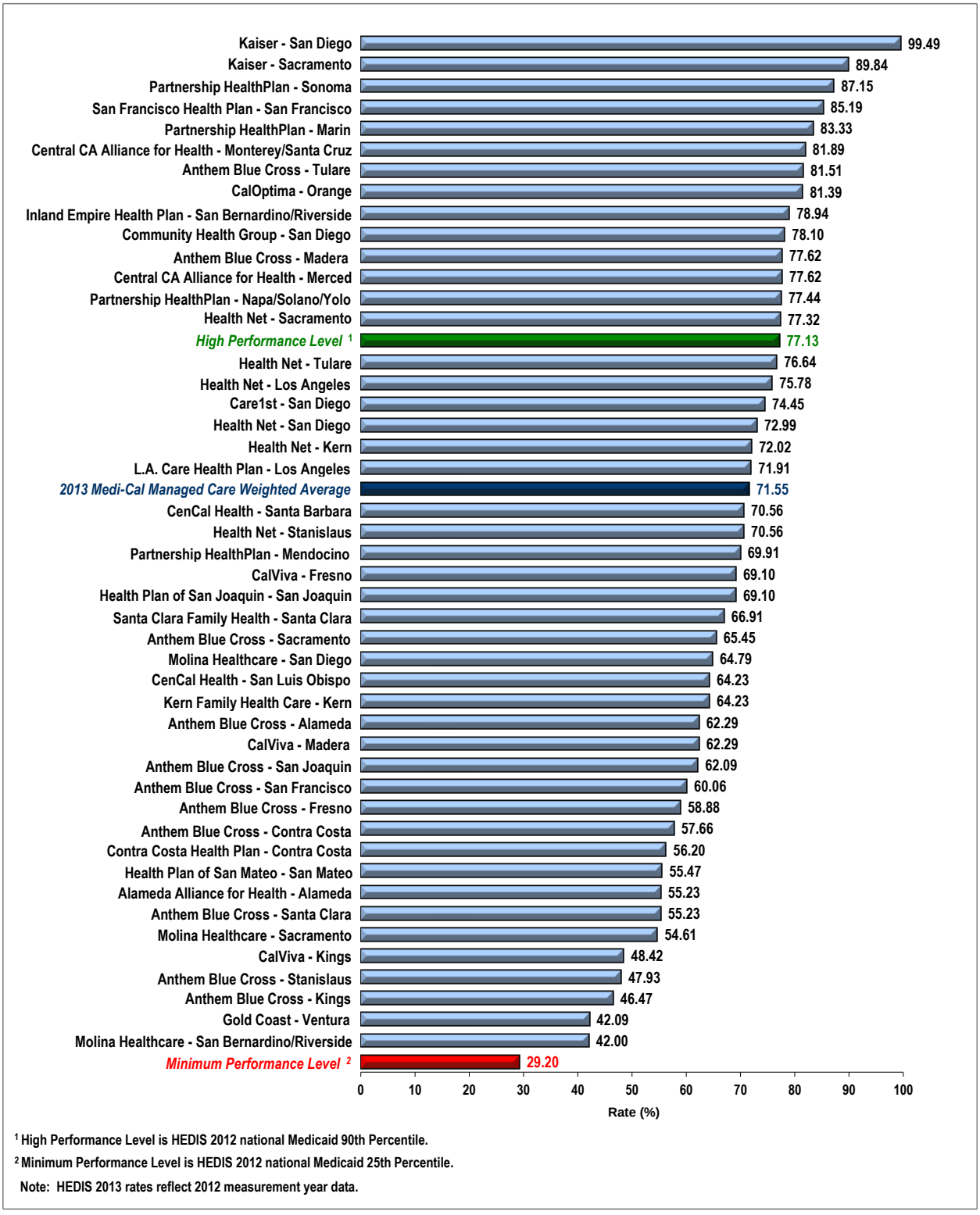
For these reasons, it is essential that children and adolescents in the United States receive adequate weight assessment and counseling for nutrition and physical activity. The first step involves screening for overweight and obesity in the physician's office with the calculation of BMI. With this tool, 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—BMI Assessment





Medi-Cal Managed Care
HEDIS 2013 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for the BMI Assessment indicator of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure was 71.55 percent in 2013, which exceeded the Healthy People 2020 goal of 54.7 percent. The weighted average was higher than the 2012 national Medicaid average and the national commercial average.

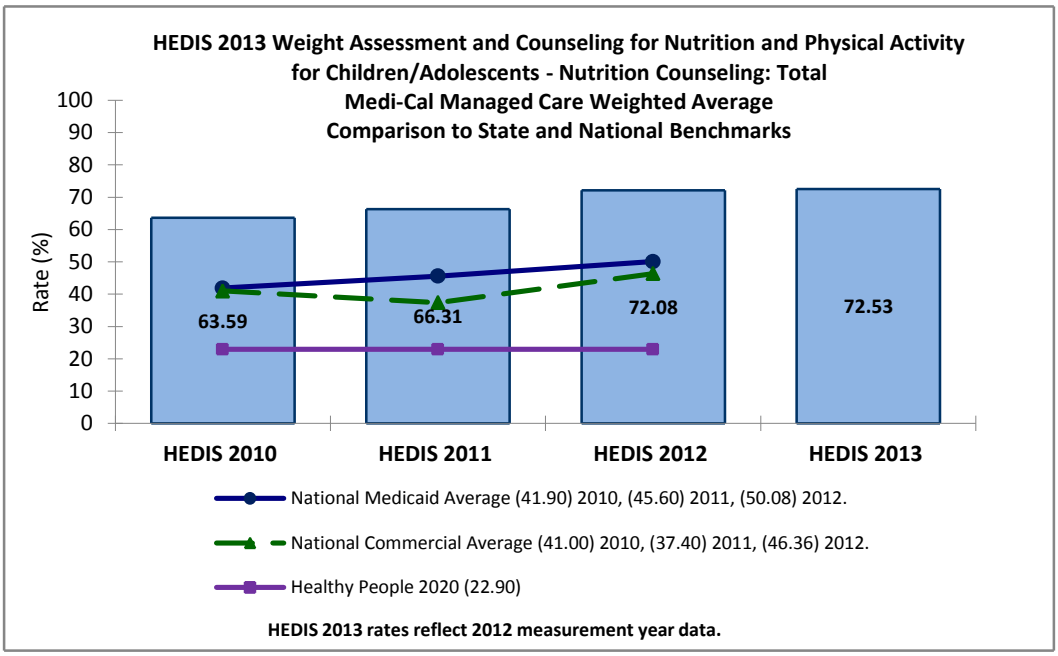
The COHS model type performed better than the GMC model and TPM types.

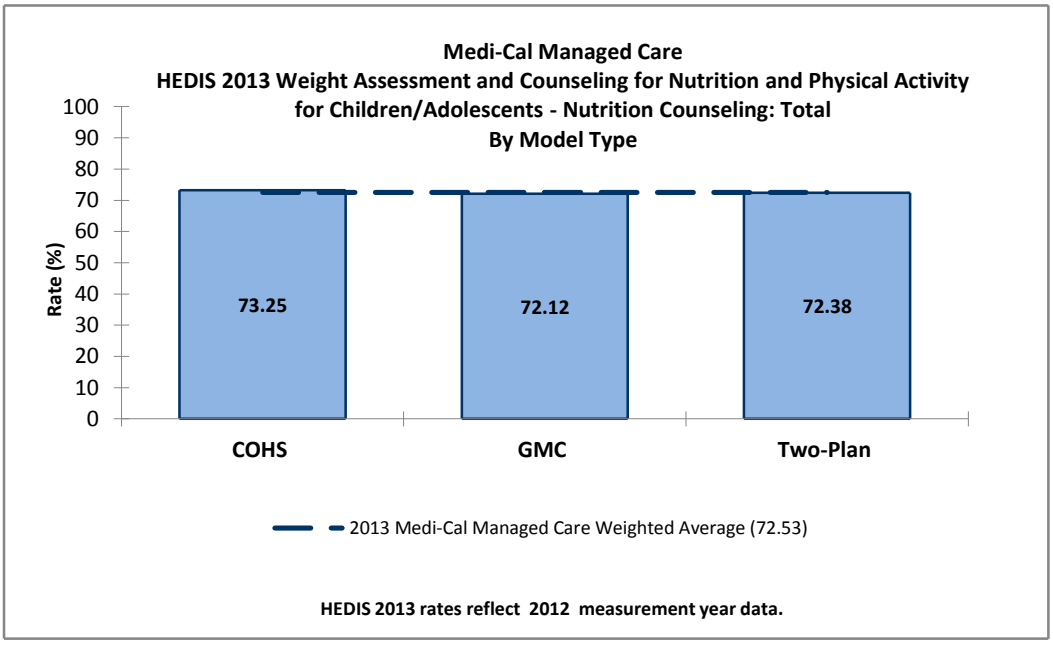
High and Low Performers

Fourteen rates surpassed the HPL, while for the third consecutive year, no rates fell below the MPL.

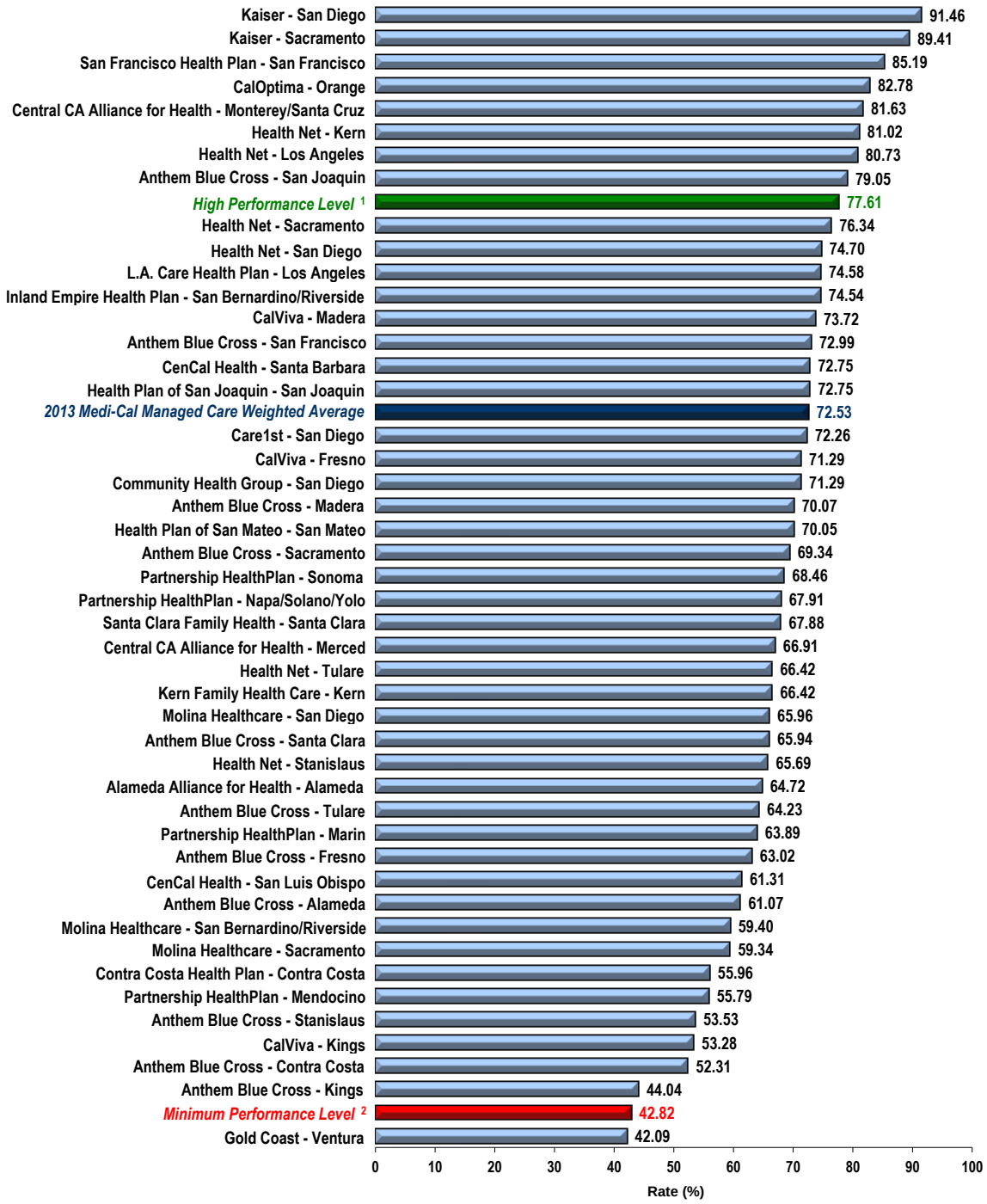
Twelve rates showed statistically significant increases over 2012 rates, and only three rates had a statistically significant decline during the same time frame (refer to Appendix B).

Performance Results—Nutrition Counseling





Medi-Cal Managed Care
HEDIS 2013 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC 2013 weighted average for the Nutritional Counseling indicator of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure was 72.53 percent, which was basically unchanged from the 2012 rate and exceeded the Healthy People 2020 goal of 22.90 percent. The MCMC's weighted average in 2013 exceeded both the national Medicaid average as well as the national commercial average for the third consecutive year.

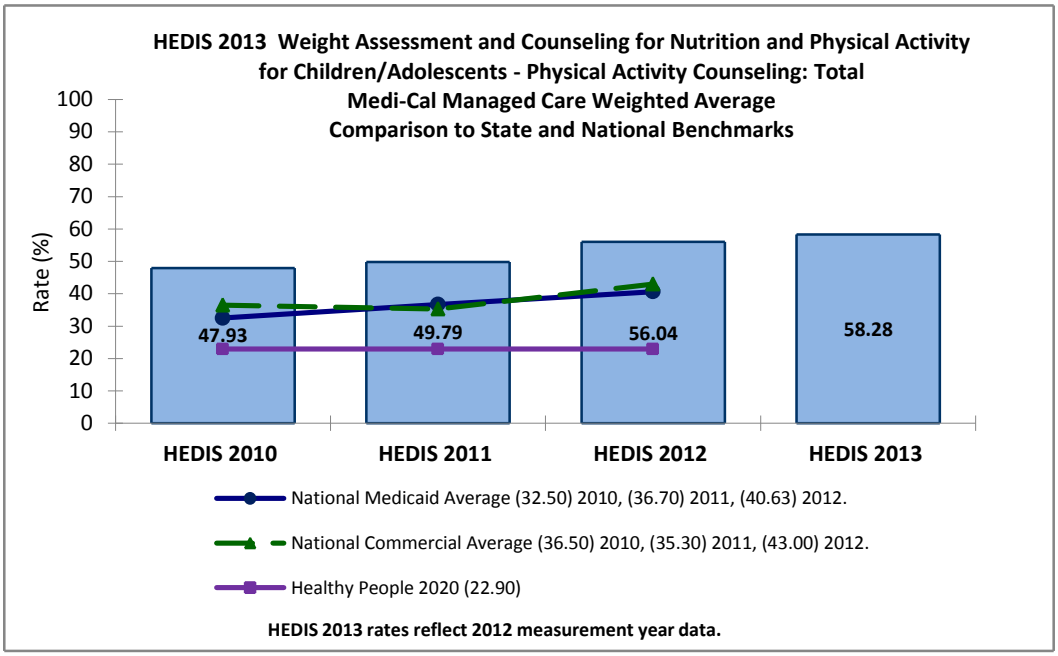
The COHS model type outperformed the GMC model and TPM types.

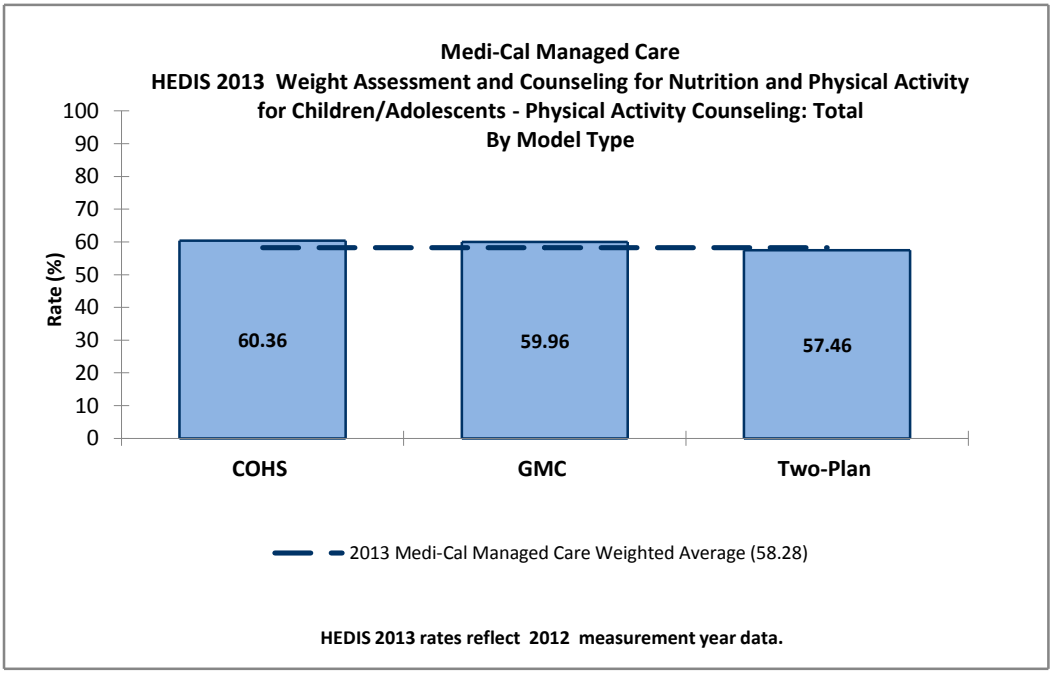
High and Low Performers

Eight rates exceeded the HPL in 2013, and only one MCP, Gold Coast—Ventura County failed to meet the MPL.

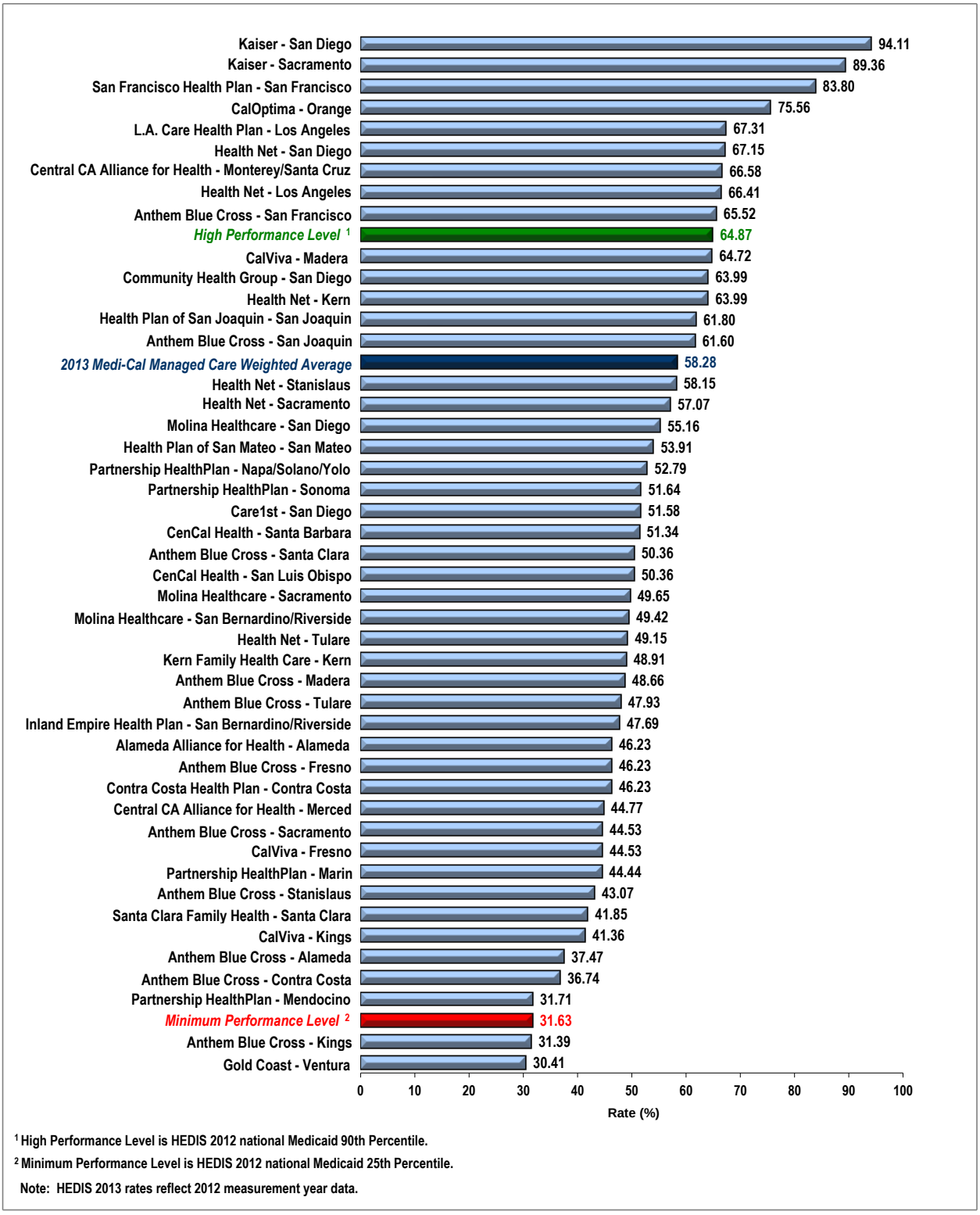
Five rates showed statistically significant increases over the 2012 rates, and three rates had statistically significant decreases in 2013 (refer to Appendix B).

Performance Results—Physical Activity Counseling





Medi-Cal Managed Care
HEDIS 2013 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for the Physical Activity Counseling indicator of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure was 58.28 percent in 2013 and exceeded the Healthy People 2020 goal of 22.9 percent. The MCMC's 2013 weighted average was also higher than both the 2012 national Medicaid average and the national commercial average.

The COHS model type outperformed the GMC model and TPM types in 2013.

High and Low Performers

Nine rates surpassed the HPL, and only two MCPs, Anthem Blue Cross—Kings County and Gold Coast—Ventura County, failed to meet the MPL in 2013.

Eleven rates showed statistically significant increases over the 2012 rates, and three rates had statistically significant decreases in 2013 (refer to Appendix B).

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—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.[149]

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

[149] 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: September 11, 2013.

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.[150]

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.[151] 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.[152]

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. 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.[153]

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. To combat obesity in rural areas, the Steps Program implemented a walking program called BC Walks. More

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150 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: September 11, 2013.

151 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: September 11, 2013.

152 Ibid.

153 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: September 11, 2013.

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.[154]

Community-Wide Wellness Campaign

The Steps 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, 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.[155]

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.[156]

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154 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: September 11, 2013.

155 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: September 11, 2013.

156 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: September 11, 2013.

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.[157]

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.[158] 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.[159]

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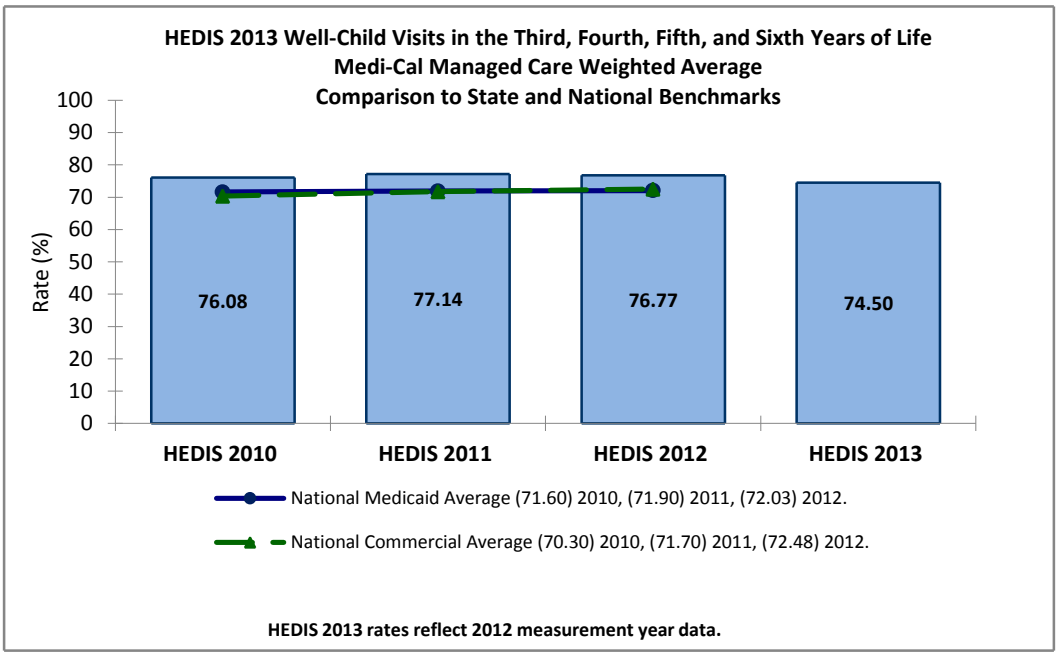
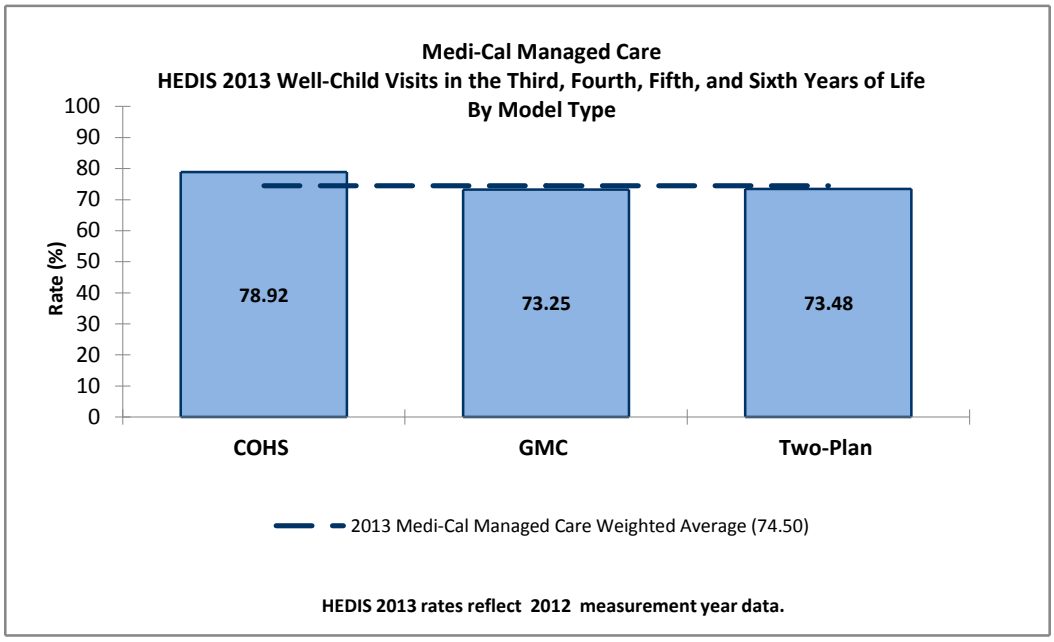
157 Medicaid Managed Care Services. *Components of Well Child Screenings*. Available at: http://mmcs.afmc.org/HealthCareProfessionals/ProviderRelations/WellChildEPSDT/ComponentsofWellChildScreenings.aspx Accessed on: September 11, 2013.

158 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: September 11, 2013.

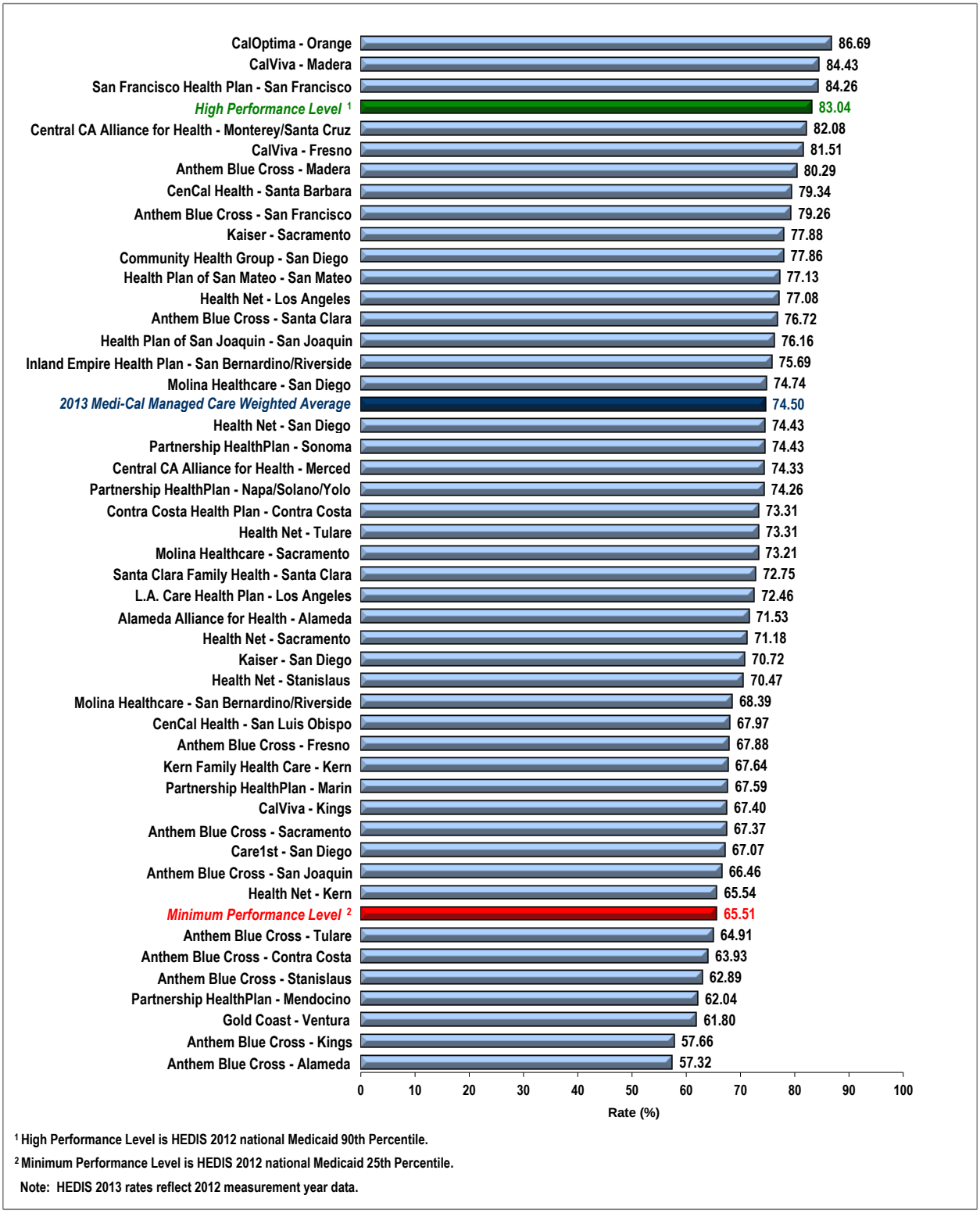
159 Selden TM. Compliance with Well-Child Visit Recommendations: Evidence from the Medical Expenditure Panel Survey, 2000-2002. 2006. *Pediatrics* 118(6):1766-1778. Available at: http://pediatrics.aappublications.org/cgi/content/full/118/6/e1766. Accessed on: September 11, 2013.

Performance Results





Medi-Cal Managed Care
HEDIS 2013 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life



[1] High Performance Level is HEDIS 2012 national Medicaid 90th Percentile.

[2] Minimum Performance Level is HEDIS 2012 national Medicaid 25th Percentile.

Note: HEDIS 2013 rates reflect 2012 measurement year data.

Summary of Results

The MCMC weighted average for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure dropped slightly from 76.8 percent in 2012 to 74.50 percent in 2013. The MCMC 2013 weighted average was also higher than both the 2012 national Medicaid average and the national commercial average.

The COHS model type outperformed the GMC model and TPM types.

High and Low Performers

Three rates (CalOptima—Orange County, CalViva—Madera County, and San Francisco Health Plan—San Francisco County) exceeded the established HPL. Six Anthem Blue Cross counties (Alameda, Contra Costa, Kings, Stanislaus, Tulare, and Ventura) as well as Partnership HealthPlan—Mendocino County and Gold Coast—Ventura County reported rates below the MPL in 2013.

Kaiser—Sacramento County demonstrated statistically significant improvement over its 2012 rate, while three rates, Anthem Blue Cross in Alameda and San Joaquin counties and Alameda Alliance for Health—Alameda County, showed a statistically significant decline from 2012 to 2013 (refer to Appendix B).

Best and Emerging Practices

Access

Open access reduces well-child visit no-shows.[160] 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.

[160] 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.

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 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.

DHCS contracts with three specialty MCPs. These MCPs are required to report annual scores for two performance measures. DHCS chooses these performance measures in collaboration with each MCP as appropriate for each MCP's Medi-Cal managed care population. This section includes results from the specialty MCPs' 2013 performance measures, which reflect data from January 1, 2012, to December 31, 2012. As each specialty MCP provides unique services relevant to its population, HSAG includes local and national benchmarks as available.

AIDS Healthcare Foundation

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

AHF's 2013 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.[161]

[161] 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 11, 2013.

Controlling high blood pressure is important since it can lead to many further complications. Complications due to high blood pressure include:[162]

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

Performance Results

Table 6.1—Controlling High Blood Pressure Rates for AHF

Year	2012*	2013*
Rate	**68.2%**	**62.20%**
HPL	67.6%	69.11%
MPL	47.9%	50.00%
Healthy People 2020 Goal	61.2%	61.20%

* Rates in 2012 were reported to one decimal place. To be consistent with how NCQA is reporting rates for 2013, two decimal places are used for the 2013 rates. Comparison between the 2012 and 2013 rates for the measure was calculated based on rates reported with two decimal places for both years.

Summary of Results

Although the *Controlling High Blood Pressure* measure did not display a statistically significant decrease from 2012 to 2013, AHF's rate no longer exceeded the HPL. However, the 2013 rate did exceed the Healthy People 2020 goal for the second year in a row.

[162] 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 11, 2013.

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[163]

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 declining for more than 20 years. One reason is that there are fewer cases and with preventive colorectal cancer screening, polyps can be found and removed before they become cancerous.

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—Colorectal Cancer Screening Rates for AHF

Year	2012**	2013
Rate	**64.2%**	**63.07%**
HPL*	74.2%	73.72%
MPL*	57.3%	55.99%
Healthy People 2020 Goal	70.5%	70.50%

* MPLs/HPLs for COL were based on NCQA's commercial HEDIS 2011 and 2012 Audit Means, Percentiles, and Ratios as there are no Medicaid benchmarks available for this measure. MPLs and HPLs are established using the National commercial 25th and 90th percentiles.

** Rates in 2012 were reported to one decimal place. To be consistent with how NCQA is reporting rates for 2013, two decimal places are used for the 2013 rates. Comparison between the 2012 and 2013 rates for the measure was calculated based on rates reported with two decimal places for both years.

[163] 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: September 11, 2013.

Summary of Results

AHF performed above the MPL for this measure in 2013 without a statistically significant change in its rate from 2012. The MCP did not meet the Healthy People 2020 goal of 70.5 percent. DHCS based the MPL and HPL on the 2012 national commercial 25th and 90th percentiles, respectively, since no Medicaid benchmark exists for this measure.

Family Mosaic Project

Family Mosaic Project (FMP), operated by the City and County of San Francisco Department of Public Health, is a specialty MCP in San Francisco County. FMP became operational with MCMC 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 DHCS for approval to be enrolled in FMP's Medi-Cal managed care program. Once a client is approved and under FMP's contract with 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 2013 reporting.

Inpatient Hospitalizations

Measure Definition

The percentage of members enrolled into FMP 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—Inpatient Hospitalization Admissions for FMP

Number of Admissions*			
Year	1**	2**	3+**
2012	1.5%	0.5%	0%
2013	2.9%	0%	0%

* There is no MPL or HPL for this measure.

** The *Inpatient Hospitalization Admissions* measure was developed by FMP. Since comparisons cannot be made to HEDIS measure rates, which are reported to two decimal places in 2013, the rates for FMP's measure are reported to one decimal place for consistency with how the rates for this measure are reported.

Summary of Results

Differences between the 2013 and 2012 rates were not statistically significant. Although, for two and three admissions, the 2013 rates reached the maximum performance level since both rates were 0.0 percent.

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.[164] 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.

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

Performance Results

Table 6.4—Out-of-Home Placements Rates* for FMP

Year	2012**	2013**
Rate	6.3%	4.1%

* There is no MPL or HPL for this measure.

** The *Out-of-Home Placements* measure was developed by FMP. Since comparisons cannot be made to HEDIS measure rates, which are reported to two decimal places in 2013, the rates for FMP's measure are reported to one decimal place for consistency with how the rates for this measure are reported.

Summary of Results

The rate of *Out-of-Home Placements* dropped from 6.3 percent in 2012 to 6.3 percent in 2013. 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 (SCAN) Health Plan is a Fully-Integrated Dual-Eligible Special Needs Plan (FIDE-SNP) that contracts with DHCS as a specialty MCP to provide 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, including comprehensive medical coverage, prescription benefits, and support services specifically designed to enhance the ability of its members to manage their health and remain independent. SCAN became operational in Los Angeles County with MCMC in 1985 and expanded into Riverside and San Bernardino counties in 1997.

SCAN's 2013 performance measures were the HEDIS measures *Breast Cancer Screening* and *Osteoporosis Management in Women Who Had a Fracture*. Since SCAN participates in the *All-Cause Readmissions* statewide collaborative QIP, the MCP also reported a rate for the *All-Cause Readmissions* measure, which is a non-HEDIS measure.

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.[165] There is a one-in-eight lifetime risk that a woman in the United States will develop breast cancer.[166] The risk factors and mortality rate vary across age and racial/ethnic groups. For example, breast cancer mortality rates tend to be higher in Hispanic and African American women.[167,168] Older women are more at risk for breast cancer than younger women. While women aged 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.[169]

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.[170] 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.[171,172] For women 50 to 69 years of age, mammogram screenings decrease breast cancer mortality by up to 35 percent.[173]

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.[174] It is estimated

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165 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.

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

167 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: September 11, 2013.

168 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.

169 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.

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

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

172 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.

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

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

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.[175]

Performance Results

Table 6.5—Breast Cancer Screening Rates for SCAN Health Plan

Year	2012*	2013
Rate	**79.9%**	**81.42%**
HPL	62.9%	62.76%
MPL	45.3%	44.82%
Healthy People 2020 Goal	81.1%	81.10%

* Rates in 2012 were reported to one decimal place. To be consistent with how NCQA is reporting rates for 2013, two decimal places are used for the 2013 rates. Comparison between the 2012 and 2013 rates for the measure was calculated based on rates reported with two decimal places for both years.

Summary of Results

SCAN performance did not demonstrate a statistically significant change from 2012 to 2013. The MCP continued to perform above the HPL in 2013 and its rate on this measure was higher than the Healthy People 2020 goal of 81.10 percent.

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.[176]

Treatment of osteoporotic fractures is estimated at $10–$15 billion annually in the U.S. In 1995, osteoporotic fractures caused 432,000 hospital admissions, 2.5 million physician visits, and

[175] National Committee for Quality Assurance. *The State of Health Care Quality 2009*: NCQA; 2009.
[176] Ibid.

180,000 nursing home admissions.[177] The aging U.S. population is likely to increase the future financial cost of osteoporosis care.

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—Osteoporosis Management in Women Who Had a Fracture Rates for SCAN Health Plan

Year	2012**	2013
Rate	**27.7%**	**28.40%**
HPL*	29.8%	37.96%
MPL*	15.6%	14.87%

* MPLs/HPLs for OMW were based on NCQA's Medicare HEDIS 2011 and 2012 Audit Means, Percentiles, and Ratios since there are no Medicaid benchmarks available for this measure. MPLs and HPLs are established using the National Medicare 25th and 90th percentiles.

** Rates in 2012 were reported to one decimal place. To be consistent with how NCQA is reporting rates for 2013, two decimal places are used for the 2013 rates. Comparison between the 2012 and 2013 rates for the measure was calculated based on rates reported with two decimal places for both years.

Summary of Results

In 2013, SCAN reported a rate for the *Osteoporosis Management in Women Who Had a Fracture* measure that was 1.3 percentage points lower than the 2012 rate. The 2013 rate remained below the HPL.

All-Cause Readmissions

Measure Definition

The *All-Cause Readmissions* measure reports the percentage of acute inpatient hospital stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days for MCMC beneficiaries aged 21 years and older. The HEDIS specifications for the *Plan All-Cause Readmissions* measure were modified to align with the needs of the statewide collaborative QIP.

Importance

Hospital readmissions have been associated with the lack of proper discharge planning and poor care transition. Improving the care transition and coordination after hospital discharge will reduce

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

the high rate of preventable readmissions which will in turn decrease costs and improve overall quality of care, ultimately leading to improved health outcomes for the MCMC population.

Performance Results

Plans were required to report a separate rate for their SPD population for this measure and to use a stratification methodology provided by DHCS. SCAN submitted its rates according to DHCS's required methodology via a Microsoft Excel reporting template.

Table 6.7—All Cause Readmissions Rates for SCAN Health Plan

Year	2013
SPD Rate	14.10%
Non-SPD Rate	0.00%
Total (SPD and Non-SPD) Rate	14.06%

No MPL or HPL was applied to this measure since 2013 was the first year DHCS required its MCPs to report the *All-Cause Readmissions (ACR)* measure.

Utilization information can be helpful to MCPs 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, 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.[178]

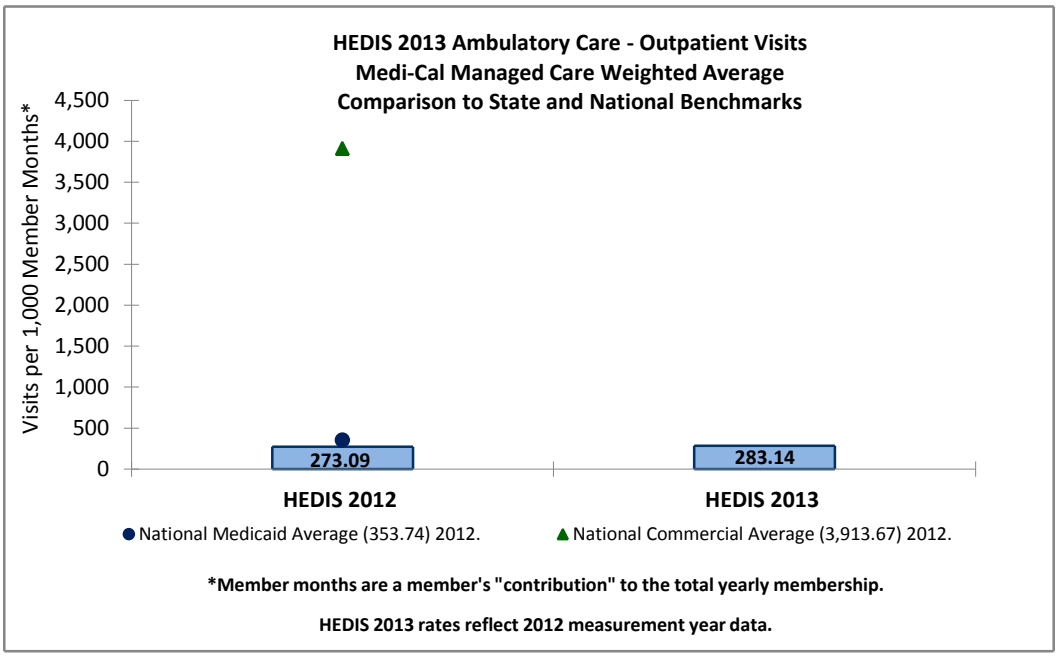
Importance

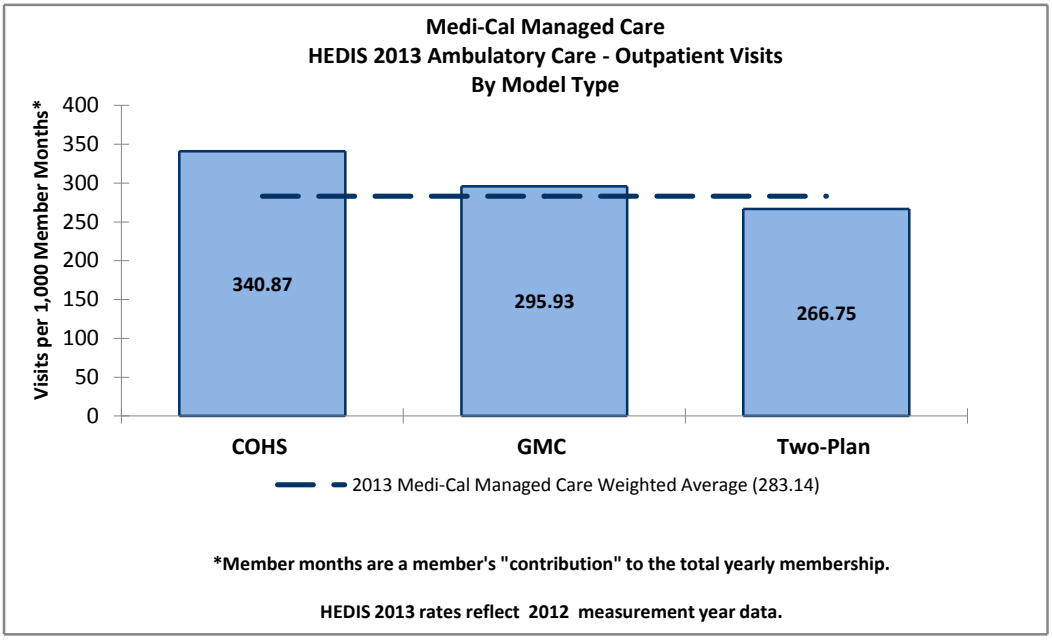
Use of services measures provide information about how MCPs manage the provision of care to their members and use and manage resources. However, use of services measures are not totally controlled by the MCPs and are affected by many member characteristics, which can vary greatly among MCPs, and include 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.[179]

[178] 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: September 11, 2013.

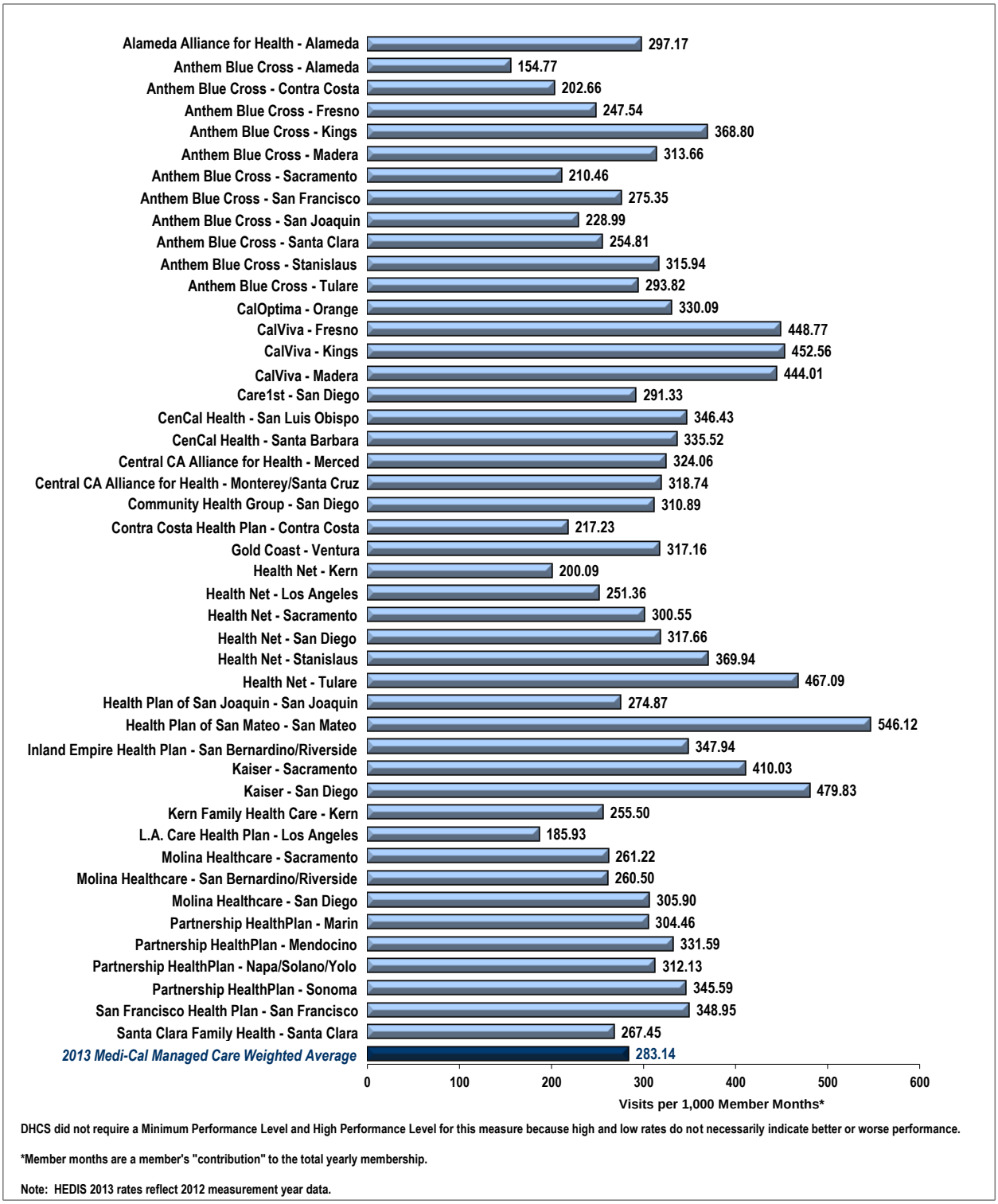
[179] Ibid.

Performance Results—Outpatient Visits





Medi-Cal Managed Care
HEDIS 2013 Ambulatory Care—Outpatient Visits

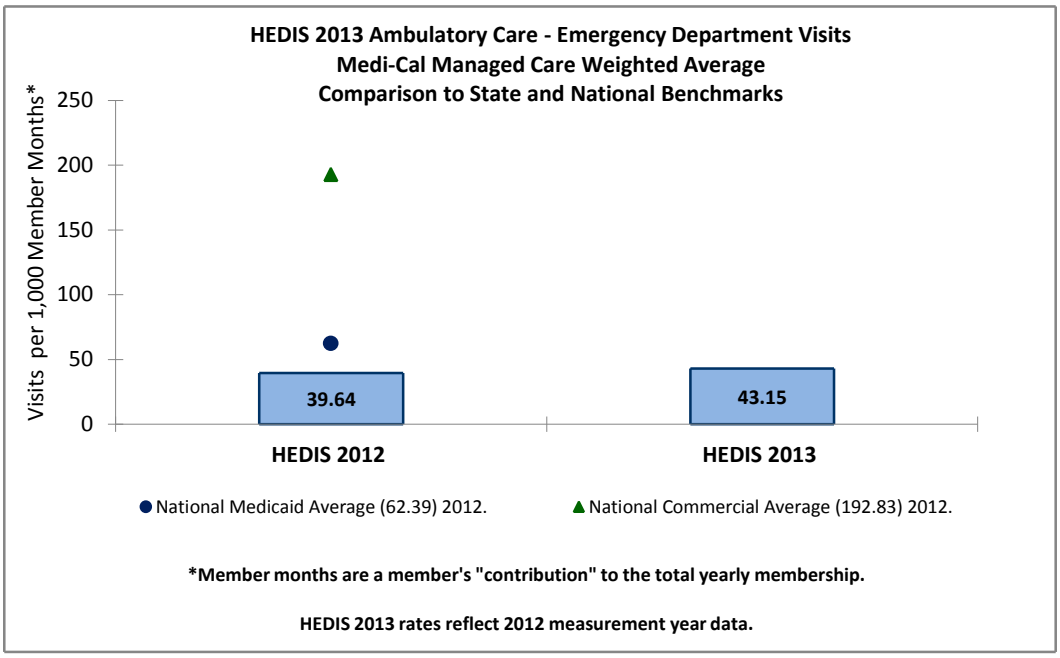


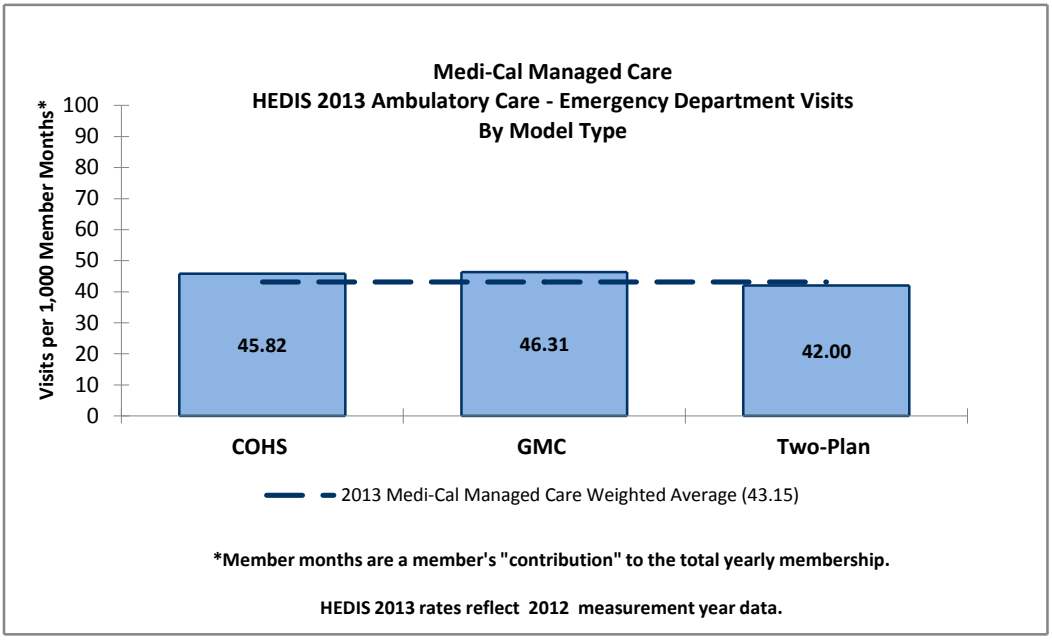
DHCS did not require a Minimum Performance Level and High Performance Level for this measure because high and low rates do not necessarily indicate better or worse performance.

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

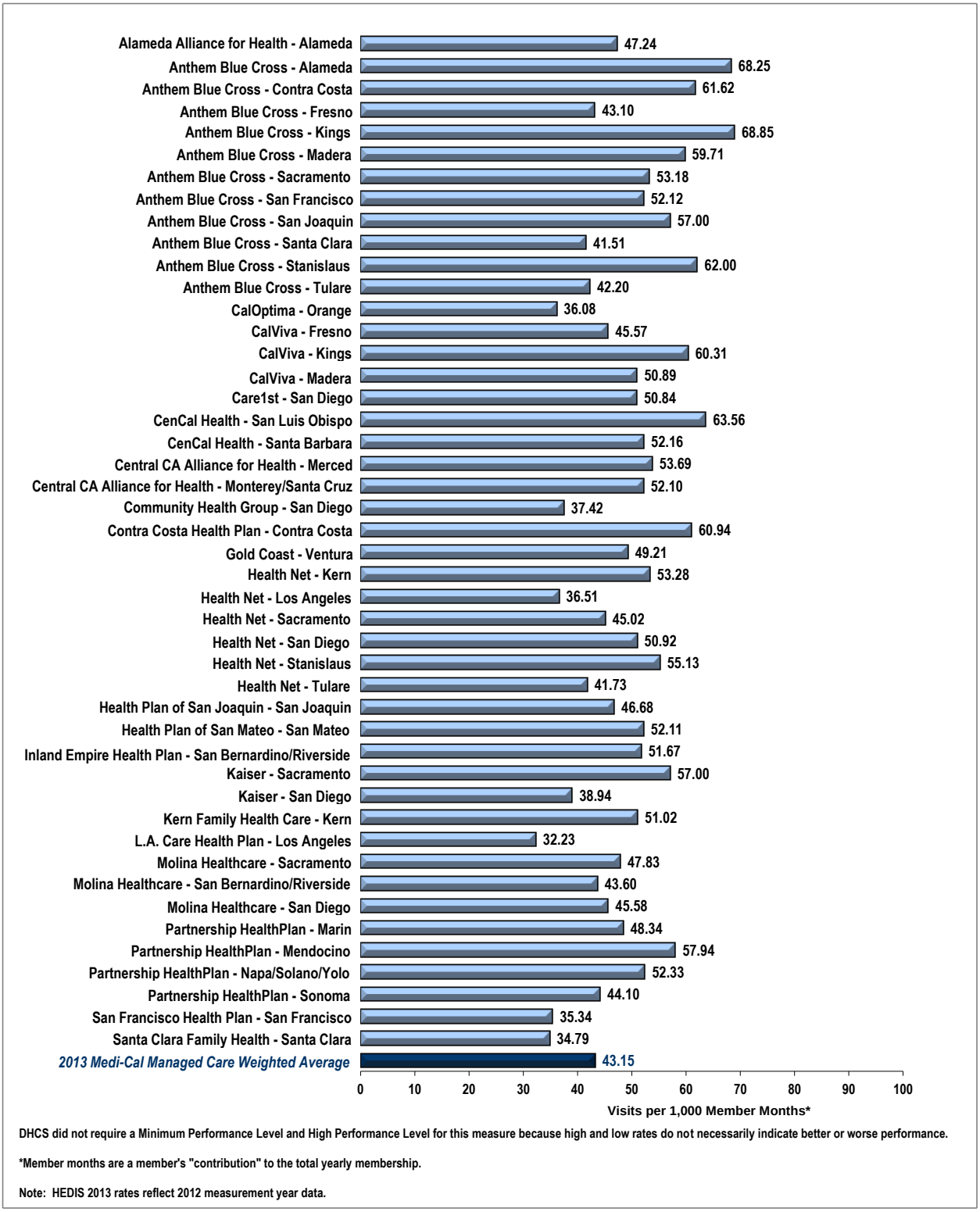
Note: HEDIS 2013 rates reflect 2012 measurement year data.

Performance Results—Emergency Department Visits





Medi-Cal Managed Care
HEDIS 2013 Ambulatory Care—Emergency Department Visits



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.

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

Note: HEDIS 2013 rates reflect 2012 measurement year data.

7.1—HEDIS 2013 Medi-Cal Managed Care Ambulatory Care Measure

MCP Name	County	Outpatient Visits	ED Visits
Alameda Alliance for Health	Alameda	297.17	47.24
Anthem Blue Cross	Alameda	154.77	68.25
Anthem Blue Cross	Contra Costa	202.66	61.62
Anthem Blue Cross	Fresno	247.54	43.10
Anthem Blue Cross	Kings	368.80	68.85
Anthem Blue Cross	Madera	313.66	59.71
Anthem Blue Cross	Sacramento	210.46	53.18
Anthem Blue Cross	San Francisco	275.35	52.12
Anthem Blue Cross	San Joaquin	228.99	57.00
Anthem Blue Cross	Santa Clara	254.81	41.51
Anthem Blue Cross	Stanislaus	315.94	62.00
Anthem Blue Cross	Tulare	293.82	42.20
CalOptima	Orange	330.09	36.08
CalViva Health	Fresno	448.77	45.57
CalViva Health	Kings	452.56	60.31
CalViva Health	Madera	444.01	50.89
Care1st Partner Plan	San Diego	291.33	50.84
CenCal Health	Santa Barbara	335.52	52.16
CenCal Health	San Luis Obispo	346.43	63.56
Central CA Alliance for Health	Merced	324.06	53.69
Central CA Alliance for Health	Monterey/Santa Cruz	318.74	52.10
Community Health Group Partnership Plan	San Diego	310.89	37.42
Contra Costa Health Plan	Contra Costa	217.23	60.94
Gold Coast Health Plan	Ventura	317.16	49.21
Health Net Community Solutions, Inc.	Kern	200.09	53.28
Health Net Community Solutions, Inc.	Los Angeles	251.36	36.51
Health Net Community Solutions, Inc.	Sacramento	300.55	45.02
Health Net Community Solutions, Inc.	San Diego	317.66	50.92
Health Net Community Solutions, Inc.	Stanislaus	369.94	55.13
Health Net Community Solutions, Inc.	Tulare	467.09	41.73
Health Plan of San Joaquin	San Joaquin	274.87	46.68
Health Plan of San Mateo	San Mateo	546.12	52.11
Inland Empire Health Plan	San Bernardino/ Riverside	347.94	51.67
Kaiser—Sacramento County	Sacramento	410.03	57.00
Kaiser—San Diego County	San Diego	479.83	38.94
Kern Family Health Care	Kern	255.50	51.02
L.A. Care Health Plan	Los Angeles	185.93	32.23
Molina Healthcare of California Partner Plan, Inc.	San Bernardino/ Riverside	260.50	43.60
Molina Healthcare of California Partner Plan, Inc.	Sacramento	261.22	47.83
Molina Healthcare of California Partner Plan, Inc.	San Diego	305.90	45.58
Partnership HealthPlan	Marin	304.46	48.34
Partnership HealthPlan	Mendocino	331.59	57.94
Partnership HealthPlan	Napa/Solano/Yolo	312.13	52.33
Partnership HealthPlan	Sonoma	345.59	44.10
San Francisco Health Plan	San Francisco	348.95	35.34
Santa Clara Family Health Plan	Santa Clara	267.45	34.79

In addition to reporting the EAS in 2013, full-scope MCPs were required to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of measures. DHCS provided the stratification methodology for the MCPs to use, and MCPs reported the rates for the SPD population separately via a Microsoft Excel reporting template. The SPD rates were compared to the non-SPD rates to identify statistically significant differences between the two populations.

Performance Measure Results

Within the SPD tables, HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test and displayed this information within the "SPD Compared to Non-SPD" column. The following symbols are used to show statistically significant changes:

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

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

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

Different symbols (▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate. An upward triangle (▲) denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

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

All-Cause Readmissions

Summary of Results

The SPD population had significantly higher rates of readmissions than non-SPDs for 36 of the 46 reported rates, which represented lower performance. Only the SPD rate for Health Plan of San Mateo—San Mateo County demonstrated a statistically significant lower readmission rate for the SPDs, when compared to non-SPDs.

8.1—Medi-Cal Managed Care All-Cause Readmissions (Non-HEDIS Measure)
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name	County	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Alameda Alliance for Health	Alameda	10.47%	15.86%	▼	14.66%
Anthem Blue Cross	Alameda	9.84%	15.98%	▼	14.67%
Anthem Blue Cross	Contra Costa	8.89%	23.00%	↔	18.62%
Anthem Blue Cross	Fresno	10.55%	16.79%	▼	13.83%
Anthem Blue Cross	Kings	11.84%	19.82%	↔	16.58%
Anthem Blue Cross	Madera	2.50%	17.31%	▼	10.87%
Anthem Blue Cross	Sacramento	7.85%	15.52%	▼	12.63%
Anthem Blue Cross	San Francisco	6.56%	15.35%	↔	14.19%
Anthem Blue Cross	San Joaquin	8.63%	21.22%	▼	16.00%
Anthem Blue Cross	Santa Clara	12.43%	14.47%	↔	13.74%
Anthem Blue Cross	Stanislaus	8.21%	18.34%	▼	14.07%
Anthem Blue Cross	Tulare	7.83%	15.70%	▼	11.70%
CalOptima	Orange	11.35%	18.82%	▼	16.69%
CalViva Health	Fresno	7.69%	12.30%	▼	10.64%
CalViva Health	Kings	5.00%	12.69%	↔	10.31%
CalViva Health	Madera	7.41%	14.04%	↔	10.81%
Care1st Health	San Diego	8.65%	17.35%	▼	15.64%
CenCal Health	Santa Barbara	5.54%	13.88%	▼	11.13%
CenCal Health	San Luis Obispo	6.70%	16.54%	▼	13.49%
Central CA Alliance for Health	Merced	9.86%	14.40%	▼	12.73%
Central CA Alliance for Health	Monterey/Santa Cruz	7.78%	14.47%	▼	12.06%
Community Health Group Partnership Plan	San Diego	10.79%	17.03%	▼	14.37%
Contra Costa Health Plan	Contra Costa	12.72%	19.48%	▼	16.99%
Gold Coast Health Plan	Ventura	11.32%	23.16%	▼	19.17%
Health Net Community Solutions, Inc.	Kern	7.36%	11.72%	▼	10.40%
Health Net Community Solutions, Inc.	Los Angeles	7.58%	14.16%	▼	11.93%
Health Net Community Solutions, Inc.	Sacramento	6.02%	14.03%	▼	12.15%
Health Net Community Solutions, Inc.	San Diego	9.38%	17.88%	▼	15.96%
Health Net Community Solutions, Inc.	Stanislaus	5.66%	10.12%	↔	8.71%
Health Net Community Solutions, Inc.	Tulare	5.79%	15.86%	▼	11.86%
Health Plan of San Joaquin	San Joaquin	6.27%	13.75%	▼	7.07%
Health Plan of San Mateo	San Mateo	19.24%	13.28%	▲	14.52%

8.1—Medi-Cal Managed Care All-Cause Readmissions (Non-HEDIS Measure)
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name	County	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Inland Empire Health Plan	San Bernardino/Riverside	9.82%	16.95%	▼	14.24%
Kaiser—Sacramento County	Sacramento	11.63%	17.05%	↔	15.71%
Kaiser—San Diego County	San Diego	6.67%	20.74%	▼	17.51%
Kern Family Health Care	Kern	6.27%	17.07%	▼	8.77%
L.A. Care Health Plan	Los Angeles	10.99%	19.69%	▼	17.05%
Molina Healthcare of California Partner Plan, Inc.	San Bernardino/Riverside	9.17%	18.15%	▼	14.65%
Molina Healthcare of California Partner Plan, Inc.	Sacramento	9.02%	14.68%	▼	13.20%
Molina Healthcare of California Partner Plan, Inc.	San Diego	9.37%	17.65%	▼	14.45%
Partnership HealthPlan	Marin	3.70%	18.83%	▼	16.04%
Partnership HealthPlan	Mendocino	8.03%	10.68%	↔	9.81%
Partnership HealthPlan	Napa/Solano/Yolo	6.84%	15.67%	▼	13.25%
Partnership HealthPlan	Sonoma	7.01%	15.38%	▼	13.05%
San Francisco Health Plan	San Francisco	7.59%	18.08%	▼	15.81%
Santa Clara Family Health	Santa Clara	8.26%	16.54%	▼	13.77%

Children and Adolescents' Access to Primary Care Practitioners

Summary of Results

For the 12 to 24 month age group, eight of the SPD rates were significantly lower than the non-SPD rates, demonstrating lower performance. Conversely, none of the SPD rates showed statistically significant higher performance.

For the population 25 months to 6 years of age, 10 SPD rates were significantly lower than the non-SPD rates. However, for this age group, there were two SPD rates, Kaiser—Sacramento County and Partnership HealthPlan—Sonoma County, that were significantly higher than the rates for the non-SPD population.

For the age group 7 to 11 years, six of the SPD rates were significantly higher than the non-SPD rates, and only three SPD rates were significantly lower than the non-SPD rates.

For the population 12 to 19 years of age, 10 SPD rates were significantly lower than the non-SPD rates. Four SPD rates were significantly higher than the rates for the non-SPD population.

8.2—Medi-Cal Managed Care Children and Adolescents' Access to Primary Care Practitioners
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Alameda Alliance for Health—Alameda	12 to 24 months	92.41%	85.71%	↔	92.32%
	25 months to 6 years	83.84%	85.99%	↔	83.91%
	7 to 11 years	85.00%	86.15%	↔	85.06%
	12 to 19 years	84.99%	80.59%	↓	84.64%
Anthem Blue Cross—Alameda	12 to 24 months	84.31%	NA	Not Comparable	84.39%
	25 months to 6 years	67.90%	63.92%	↔	67.77%
	7 to 11 years	78.76%	84.46%	↔	79.12%
	12 to 19 years	77.69%	77.30%	↔	77.65%
Anthem Blue Cross—Contra Costa	12 to 24 months	96.88%	NA	Not Comparable	96.93%
	25 months to 6 years	84.85%	89.33%	↔	85.01%
	7 to 11 years	85.69%	77.78%	↓	85.18%
	12 to 19 years	82.84%	82.10%	↔	82.76%

8.2—Medi-Cal Managed Care Children and Adolescents' Access to Primary Care Practitioners
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Anthem Blue Cross—Fresno	12 to 24 months	94.28%	NA	Not Comparable	94.35%
	25 months to 6 years	82.89%	80.80%	↔	82.85%
	7 to 11 years	80.30%	81.52%	↔	80.34%
	12 to 19 years	76.57%	75.98%	↔	76.54%
Anthem Blue Cross—Kings	12 to 24 months	95.01%	NA	Not Comparable	95.06%
	25 months to 6 years	86.69%	80.00%	↔	86.53%
	7 to 11 years	NA	NA	Not Comparable	NA
	12 to 19 years	NA	NA	Not Comparable	NA
Anthem Blue Cross—Madera	12 to 24 months	98.05%	NA	Not Comparable	97.83%
	25 months to 6 years	88.48%	90.48%	↔	88.53%
	7 to 11 years	NA	NA	Not Comparable	NA
	12 to 19 years	NA	NA	Not Comparable	NA
Anthem Blue Cross—Sacramento	12 to 24 months	93.23%	88.37%	↔	93.16%
	25 months to 6 years	80.26%	77.94%	↔	80.19%
	7 to 11 years	81.02%	83.54%	↔	81.14%
	12 to 19 years	80.47%	81.66%	↔	80.56%
Anthem Blue Cross—San Francisco	12 to 24 months	96.08%	NA	Not Comparable	96.11%
	25 months to 6 years	87.28%	NA	Not Comparable	86.94%
	7 to 11 years	90.74%	94.12%	↔	90.85%
	12 to 19 years	89.69%	87.78%	↔	89.58%
Anthem Blue Cross—San Joaquin	12 to 24 months	90.82%	NA	Not Comparable	90.61%
	25 months to 6 years	78.97%	70.07%	↓	78.63%
	7 to 11 years	78.02%	77.40%	↔	77.99%
	12 to 19 years	74.75%	74.76%	↔	74.76%
Anthem Blue Cross—Santa Clara	12 to 24 months	96.07%	NA	Not Comparable	95.81%
	25 months to 6 years	87.40%	87.16%	↔	87.39%
	7 to 11 years	88.02%	88.81%	↔	88.05%
	12 to 19 years	87.64%	87.01%	↔	87.62%
Anthem Blue Cross—Stanislaus	12 to 24 months	96.14%	NA	Not Comparable	96.18%
	25 months to 6 years	86.40%	84.62%	↔	86.34%
	7 to 11 years	87.02%	91.35%	↑	87.24%
	12 to 19 years	85.38%	85.12%	↔	85.36%

8.2—Medi-Cal Managed Care Children and Adolescents' Access to Primary Care Practitioners
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Anthem Blue Cross—Tulare	12 to 24 months	92.49%	NA	Not Comparable	92.47%
	25 months to 6 years	82.70%	83.87%	↔	82.72%
	7 to 11 years	79.53%	81.43%	↔	79.60%
	12 to 19 years	82.13%	83.68%	↔	82.20%
CalOptima—Orange	12 to 24 months	97.45%	85.60%	↓	97.34%
	25 months to 6 years	91.29%	86.36%	↓	91.12%
	7 to 11 years	92.03%	85.40%	↓	91.64%
	12 to 19 years	90.99%	81.99%	↓	90.41%
CalViva—Fresno	12 to 24 months	97.90%	91.46%	↓	97.82%
	25 months to 6 years	91.52%	90.62%	↔	91.50%
	7 to 11 years	91.65%	93.76%	↔	91.74%
	12 to 19 years	90.67%	90.79%	↔	90.68%
CalViva—Kings	12 to 24 months	96.94%	NA	Not Comparable	96.98%
	25 months to 6 years	89.73%	89.47%	↔	89.73%
	7 to 11 years	NA	NA	Not Comparable	NA
	12 to 19 years	NA	NA	Not Comparable	NA
CalViva—Madera	12 to 24 months	98.67%	NA	Not Comparable	98.53%
	25 months to 6 years	91.77%	90.79%	↔	91.75%
	7 to 11 years	NA	NA	Not Comparable	NA
	12 to 19 years	NA	NA	Not Comparable	NA
Care1st—San Diego	12 to 24 months	93.78%	NA	Not Comparable	93.54%
	25 months to 6 years	83.10%	70.83%	↓	82.76%
	7 to 11 years	82.68%	82.50%	↔	82.67%
	12 to 19 years	81.22%	78.13%	↔	81.15%
CenCal Health—Santa Barbara	12 to 24 months	97.87%	NA	Not Comparable	97.84%
	25 months to 6 years	91.26%	86.40%	↓	91.16%
	7 to 11 years	91.01%	87.97%	↔	90.88%
	12 to 19 years	89.25%	89.83%	↔	89.29%

8.2—Medi-Cal Managed Care Children and Adolescents' Access to Primary Care Practitioners
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
CenCal Health—San Luis Obispo	12 to 24 months	95.37%	NA	Not Comparable	95.31%
	25 months to 6 years	86.59%	73.87%	↓	86.21%
	7 to 11 years	87.92%	83.22%	↔	87.64%
	12 to 19 years	87.58%	76.61%	↓	86.69%
Central CA Alliance for Health—Merced	12 to 24 months	97.51%	90.32%	↓	97.42%
	25 months to 6 years	90.37%	91.17%	↔	90.39%
	7 to 11 years	89.76%	90.89%	↔	89.82%
	12 to 19 years	90.30%	88.74%	↔	90.19%
Central CA Alliance for Health—Monterey/Santa Cruz	12 to 24 months	98.50%	96.67%	↔	98.49%
	25 months to 6 years	91.26%	92.76%	↔	91.29%
	7 to 11 years	90.86%	91.46%	↔	90.89%
	12 to 19 years	91.17%	88.47%	↓	91.00%
Community Health Group—San Diego	12 to 24 months	97.34%	NA	Not Comparable	97.32%
	25 months to 6 years	89.87%	88.46%	↔	89.85%
	7 to 11 years	89.76%	94.09%	↑	89.90%
	12 to 19 years	88.70%	87.12%	↔	88.64%
Contra Costa Health Plan—Contra Costa	12 to 24 months	86.81%	NA	Not Comparable	86.74%
	25 months to 6 years	76.24%	74.13%	↔	76.18%
	7 to 11 years	77.74%	82.34%	↑	77.96%
	12 to 19 years	74.46%	79.63%	↑	74.86%
Gold Coast—Ventura	12 to 24 months	82.60%	75.00%	↔	82.51%
	25 months to 6 years	63.12%	61.92%	↔	63.09%
	7 to 11 years	NA	NA	Not Comparable	NA
	12 to 19 years	NA	NA	Not Comparable	NA
Health Net—Kern	12 to 24 months	89.99%	NA	Not Comparable	89.78%
	25 months to 6 years	70.52%	68.83%	↔	70.48%
	7 to 11 years	68.00%	72.27%	↔	68.16%
	12 to 19 years	76.72%	73.89%	↔	76.57%
Health Net—Los Angeles	12 to 24 months	94.35%	86.07%	↓	94.29%
	25 months to 6 years	81.21%	76.93%	↓	81.11%
	7 to 11 years	83.10%	83.57%	↔	83.12%
	12 to 19 years	83.01%	78.40%	↓	82.82%

8.2—Medi-Cal Managed Care Children and Adolescents' Access to Primary Care Practitioners
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Health Net—Sacramento	12 to 24 months	92.71%	NA	Not Comparable	92.53%
	25 months to 6 years	80.23%	78.66%	↔	80.19%
	7 to 11 years	80.41%	86.48%	↑	80.69%
	12 to 19 years	81.67%	81.16%	↔	81.64%
Health Net—San Diego	12 to 24 months	94.45%	NA	Not Comparable	93.98%
	25 months to 6 years	85.41%	81.31%	↔	85.27%
	7 to 11 years	84.87%	85.96%	↔	84.91%
	12 to 19 years	82.60%	80.42%	↔	82.51%
Health Net—Stanislaus	12 to 24 months	97.12%	NA	Not Comparable	97.04%
	25 months to 6 years	87.18%	86.27%	↔	87.15%
	7 to 11 years	84.96%	90.98%	↔	85.24%
	12 to 19 years	85.74%	94.25%	↑	86.00%
Health Net—Tulare	12 to 24 months	97.78%	NA	Not Comparable	97.76%
	25 months to 6 years	92.30%	94.74%	↔	92.37%
	7 to 11 years	91.58%	94.50%	↔	91.72%
	12 to 19 years	93.09%	92.00%	↔	93.05%
Health Plan of San Joaquin—San Joaquin	12 to 24 months	97.51%	96.30%	↔	97.49%
	25 months to 6 years	87.52%	89.90%	↔	87.59%
	7 to 11 years	85.55%	88.53%	↔	85.71%
	12 to 19 years	84.77%	87.69%	↑	84.94%
Health Plan of San Mateo—San Mateo	12 to 24 months	96.98%	79.41%	↓	96.70%
	25 months to 6 years	88.77%	74.72%	↓	88.32%
	7 to 11 years	90.72%	72.19%	↓	89.36%
	12 to 19 years	87.60%	65.03%	↓	85.61%
Inland Empire Health Plan—San Bernardino/Riverside	12 to 24 months	96.76%	96.12%	↔	96.75%
	25 months to 6 years	86.92%	86.54%	↔	86.91%
	7 to 11 years	82.97%	87.66%	↑	83.18%
	12 to 19 years	86.73%	86.60%	↔	86.72%
Kaiser—Sacramento County	12 to 24 months	98.34%	NA	Not Comparable	98.38%
	25 months to 6 years	90.10%	95.58%	↑	90.32%
	7 to 11 years	91.52%	95.56%	↑	91.82%
	12 to 19 years	92.23%	94.80%	↑	92.53%

8.2—Medi-Cal Managed Care Children and Adolescents' Access to Primary Care Practitioners
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Kaiser—San Diego County	12 to 24 months	99.51%	NA	Not Comparable	99.52%
	25 months to 6 years	94.23%	98.70%	↔	94.40%
	7 to 11 years	95.14%	97.80%	↔	95.31%
	12 to 19 years	97.23%	93.57%	↓	96.97%
Kern Family Health Care—Kern	12 to 24 months	92.43%	87.76%	↔	92.37%
	25 months to 6 years	82.13%	86.32%	↔	82.18%
	7 to 11 years	79.38%	85.00%	↔	79.43%
	12 to 19 years	82.19%	85.37%	↔	82.20%
L.A. Care Health Plan—Los Angeles	12 to 24 months	91.20%	77.40%	↓	91.06%
	25 months to 6 years	82.97%	81.54%	↓	82.93%
	7 to 11 years	87.12%	87.85%	↔	87.15%
	12 to 19 years	85.96%	84.37%	↓	85.89%
Molina Health Care—San Bernardino/Riverside	12 to 24 months	93.77%	NA	Not Comparable	93.65%
	25 months to 6 years	83.13%	79.18%	↔	83.03%
	7 to 11 years	81.88%	84.52%	↔	81.96%
	12 to 19 years	84.55%	83.44%	↔	84.51%
Molina Healthcare—Sacramento	12 to 24 months	94.90%	NA	Not Comparable	94.81%
	25 months to 6 years	84.18%	79.27%	↔	84.09%
	7 to 11 years	83.64%	87.88%	↔	83.80%
	12 to 19 years	84.55%	79.40%	↓	84.20%
Molina Healthcare—San Diego	12 to 24 months	96.16%	80.65%	↓	95.93%
	25 months to 6 years	88.11%	84.13%	↔	88.02%
	7 to 11 years	88.25%	89.63%	↔	88.31%
	12 to 19 years	85.32%	84.01%	↔	85.26%
Partnership HealthPlan—Marin	12 to 24 months	98.75%	NA	Not Comparable	98.76%
	25 months to 6 years	87.92%	77.97%	↓	87.69%
	7 to 11 years	NA	NA	Not Comparable	NA
	12 to 19 years	NA	NA	Not Comparable	NA
Partnership HealthPlan—Mendocino	12 to 24 months	95.44%	NA	Not Comparable	95.45%
	25 months to 6 years	89.08%	NA	Not Comparable	89.15%
	7 to 11 years	NA	NA	Not Comparable	NA
	12 to 19 years	NA	NA	Not Comparable	NA

8.2—Medi-Cal Managed Care Children and Adolescents' Access to Primary Care Practitioners
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Partnership HealthPlan—Napa/Solano/Yolo	12 to 24 months	96.69%	86.79%	↓	96.49%
	25 months to 6 years	86.57%	82.56%	↓	86.42%
	7 to 11 years	83.59%	84.64%	↔	83.67%
	12 to 19 years	85.36%	81.91%	↓	84.94%
Partnership HealthPlan—Sonoma	12 to 24 months	96.29%	NA	Not Comparable	96.25%
	25 months to 6 years	88.48%	94.74%	↑	88.58%
	7 to 11 years	85.78%	84.06%	↔	85.70%
	12 to 19 years	88.24%	88.04%	↔	88.23%
San Francisco Health Plan—San Francisco	12 to 24 months	95.91%	NA	Not Comparable	95.95%
	25 months to 6 years	89.65%	83.67%	↔	89.57%
	7 to 11 years	93.25%	90.85%	↔	93.16%
	12 to 19 years	91.27%	87.06%	↔	91.13%
Santa Clara Family Health—Santa Clara	12 to 24 months	96.87%	96.30%	↔	96.87%
	25 months to 6 years	88.91%	88.74%	↔	88.90%
	7 to 11 years	88.91%	89.16%	↔	88.92%
	12 to 19 years	87.74%	89.55%	↔	87.81%

Comprehensive Diabetes Care

Summary of Results

Overall, the SPD rates were better than the non-SPD rates for the *Comprehensive Diabetes Care* measures. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. The statistically significant differences in the rates for the SPDs with diabetes compared to the non-SPDs with diabetes are as follows:

- Blood Pressure Control (<140/90 mm Hg)
  - One single-county MCP had an SPD rate that was statistically significantly higher than the non-SPD rate.
  - Eight counties, representing seven MCPs, had SPD rates that were statistically significantly lower than the non-SPD rates.
- Eye Exam (Retinal) Performed
  - Eight counties, representing eight MCPs, had SPD rates that were statistically significantly higher than the non-SPD rates.
  - One county in a multi-county MCP had an SPD rate that was statistically significantly lower than the non-SPD rate.
- HbA1c Testing
  - Fifteen counties, representing ten MCPs, had SPD rates that were statistically significantly higher than the non-SPD rates.
- HbA1c Control (<8.0 Percent)
  - Twenty counties, representing thirteen MCPs, had SPD rates that were statistically significantly higher than the non-SPD rates.
- LDL-C Control (<100 mg/dL)
  - Twenty-two counties, representing seventeen MCPs, had SPD rates that were statistically significantly higher than the non-SPD rates.
- LDL-C Screening
  - Sixteen counties, representing thirteen MCPs, had SPD rates that were statistically significantly higher than the non-SPD rates.
  - One county in a multi-county MCP had an SPD rate that was significantly lower than the non-SPD rate.

- Medical Attention for Nephropathy
  - Thirty-three counties, representing eighteen MCPs, had SPD rates that were statistically significantly higher than the non-SPD rates.
- HbA1c Poor Control (>9.0 Percent)
  - Eighteen counties, representing twelve MCPs, had SPD rates that were statistically significantly better than the non-SPD rates.
  - One single-county MCP's SPD rate was statistically significantly worse than the non-SPD rate.

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Alameda Alliance for Health—Alameda	Blood Pressure Control (<140/90 mm Hg)	59.37%	62.29%	↔	59.61%
	Eye Exam (Retinal) Performed	48.91%	52.07%	↔	48.91%
	HbA1c Testing	83.45%	84.43%	↔	83.45%
	HbA1c Control (<8.0 Percent)	51.58%	53.53%	↔	51.58%
	LDL-C Control (<100 mg/dL)	36.74%	38.20%	↔	36.74%
	LDL-C Screening	77.62%	78.10%	↔	77.62%
	Medical Attention for Nephropathy	82.97%	83.21%	↔	82.97%
	HbA1c Poor Control (>9.0 Percent)*	37.47%	34.55%	↔	37.47%
Anthem Blue Cross—Alameda	Blood Pressure Control (<140/90 mm Hg)	39.62%	35.04%	↔	35.92%
	Eye Exam (Retinal) Performed	33.46%	32.12%	↔	34.22%
	HbA1c Testing	63.08%	65.45%	↔	63.83%
	HbA1c Control (<8.0 Percent)	27.31%	31.14%	↔	30.58%
	LDL-C Control (<100 mg/dL)	16.92%	19.71%	↔	18.45%
	LDL-C Screening	50.38%	55.72%	↔	55.83%
	Medical Attention for Nephropathy	62.69%	76.40%	↑	71.36%
	HbA1c Poor Control (>9.0 Percent)*	65.77%	63.26%	↔	63.35%

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Anthem Blue Cross—Contra Costa	Blood Pressure Control (<140/90 mm Hg)	42.68%	56.67%	↔	50.99%
	Eye Exam (Retinal) Performed	41.46%	36.67%	↔	38.61%
	HbA1c Testing	60.98%	75.00%	↑	69.31%
	HbA1c Control (<8.0 Percent)	34.15%	43.33%	↔	39.60%
	LDL-C Control (<100 mg/dL)	21.95%	34.17%	↔	29.21%
	LDL-C Screening	59.76%	67.50%	↔	64.36%
	Medical Attention for Nephropathy	53.66%	76.67%	↑	67.33%
	HbA1c Poor Control (>9.0 Percent)*	60.98%	47.50%	↔	52.97%
Anthem Blue Cross—Fresno	Blood Pressure Control (<140/90 mm Hg)	59.61%	56.20%	↔	58.74%
	Eye Exam (Retinal) Performed	40.63%	37.71%	↔	38.35%
	HbA1c Testing	71.53%	82.24%	↑	77.18%
	HbA1c Control (<8.0 Percent)	38.69%	43.31%	↔	41.99%
	LDL-C Control (<100 mg/dL)	29.20%	35.52%	↔	32.77%
	LDL-C Screening	66.42%	75.67%	↑	71.84%
	Medical Attention for Nephropathy	73.24%	84.91%	↑	77.43%
	HbA1c Poor Control (>9.0 Percent)*	54.74%	46.47%	▲	50.24%
Anthem Blue Cross—Kings	Blood Pressure Control (<140/90 mm Hg)	59.63%	57.14%	↔	58.44%
	Eye Exam (Retinal) Performed	41.61%	34.69%	↔	38.31%
	HbA1c Testing	75.78%	74.15%	↔	75.00%
	HbA1c Control (<8.0 Percent)	37.89%	39.46%	↔	38.64%
	LDL-C Control (<100 mg/dL)	26.09%	25.85%	↔	25.97%
	LDL-C Screening	72.67%	73.47%	↔	73.05%
	Medical Attention for Nephropathy	68.94%	78.23%	↔	73.38%
	HbA1c Poor Control (>9.0 Percent)*	55.28%	55.10%	↔	55.19%

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Anthem Blue Cross—Madera	Blood Pressure Control (<140/90 mm Hg)	68.70%	64.29%	↔	66.81%
	Eye Exam (Retinal) Performed	51.91%	59.18%	↔	55.02%
	HbA1c Testing	79.39%	91.84%	↑	84.72%
	HbA1c Control (<8.0 Percent)	49.62%	55.10%	↔	51.97%
	LDL-C Control (<100 mg/dL)	29.77%	33.67%	↔	31.44%
	LDL-C Screening	70.23%	76.53%	↔	72.93%
	Medical Attention for Nephropathy	74.05%	85.71%	↑	79.04%
	HbA1c Poor Control (>9.0 Percent)*	37.40%	34.69%	↔	36.24%
Anthem Blue Cross—Sacramento	Blood Pressure Control (<140/90 mm Hg)	55.96%	57.18%	↔	57.04%
	Eye Exam (Retinal) Performed	29.20%	31.14%	↔	28.16%
	HbA1c Testing	67.40%	81.02%	↑	75.24%
	HbA1c Control (<8.0 Percent)	37.71%	53.04%	↑	46.12%
	LDL-C Control (<100 mg/dL)	22.63%	34.06%	↑	27.18%
	LDL-C Screening	58.15%	71.53%	↑	67.23%
	Medical Attention for Nephropathy	61.07%	80.54%	↑	71.60%
	HbA1c Poor Control (>9.0 Percent)*	53.53%	39.90%	▲	47.09%
Anthem Blue Cross—San Francisco	Blood Pressure Control (<140/90 mm Hg)	60.19%	62.97%	↔	61.80%
	Eye Exam (Retinal) Performed	39.81%	47.52%	↔	45.26%
	HbA1c Testing	84.47%	87.17%	↔	86.13%
	HbA1c Control (<8.0 Percent)	48.54%	55.10%	↔	52.55%
	LDL-C Control (<100 mg/dL)	31.07%	41.11%	↔	39.17%
	LDL-C Screening	73.79%	76.68%	↔	75.91%
	Medical Attention for Nephropathy	82.52%	86.88%	↔	85.89%
	HbA1c Poor Control (>9.0 Percent)*	37.86%	34.40%	↔	36.01%

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Anthem Blue Cross—San Joaquin	Blood Pressure Control (<140/90 mm Hg)	55.43%	56.36%	↔	54.37%
	Eye Exam (Retinal) Performed	33.33%	36.36%	↔	32.77%
	HbA1c Testing	72.09%	67.58%	↔	69.42%
	HbA1c Control (<8.0 Percent)	36.05%	42.42%	↔	40.53%
	LDL-C Control (<100 mg/dL)	30.62%	30.61%	↔	28.88%
	LDL-C Screening	68.60%	66.36%	↔	66.26%
	Medical Attention for Nephropathy	69.38%	78.79%	↑	74.76%
	HbA1c Poor Control (>9.0 Percent)*	53.88%	50.30%	↔	50.97%
Anthem Blue Cross—Santa Clara	Blood Pressure Control (<140/90 mm Hg)	66.42%	54.26%	↓	58.50%
	Eye Exam (Retinal) Performed	51.82%	50.61%	↔	49.76%
	HbA1c Testing	83.21%	81.51%	↔	79.85%
	HbA1c Control (<8.0 Percent)	52.31%	49.39%	↔	53.88%
	LDL-C Control (<100 mg/dL)	39.90%	41.61%	↔	35.44%
	LDL-C Screening	79.32%	79.32%	↔	76.94%
	Medical Attention for Nephropathy	79.81%	86.37%	↑	80.10%
	HbA1c Poor Control (>9.0 Percent)*	38.93%	41.36%	↔	39.08%
Anthem Blue Cross—Stanislaus	Blood Pressure Control (<140/90 mm Hg)	60.34%	58.15%	↔	57.04%
	Eye Exam (Retinal) Performed	29.20%	32.36%	↔	33.25%
	HbA1c Testing	74.94%	79.56%	↔	77.18%
	HbA1c Control (<8.0 Percent)	46.96%	48.18%	↔	47.57%
	LDL-C Control (<100 mg/dL)	33.33%	33.09%	↔	31.80%
	LDL-C Screening	70.32%	73.24%	↔	69.42%
	Medical Attention for Nephropathy	70.56%	78.35%	↑	76.94%
	HbA1c Poor Control (>9.0 Percent)*	47.20%	44.04%	↔	43.69%

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Anthem Blue Cross—Tulare	Blood Pressure Control (<140/90 mm Hg)	67.88%	63.02%	↔	68.45%
	Eye Exam (Retinal) Performed	35.52%	36.01%	↔	35.68%
	HbA1c Testing	79.08%	80.78%	↔	78.40%
	HbA1c Control (<8.0 Percent)	46.47%	46.96%	↔	48.54%
	LDL-C Control (<100 mg/dL)	33.33%	35.77%	↔	32.52%
	LDL-C Screening	70.80%	74.70%	↔	69.66%
	Medical Attention for Nephropathy	79.56%	84.18%	↔	81.55%
	HbA1c Poor Control (>9.0 Percent)*	44.28%	42.09%	↔	43.69%
CalOptima—Orange	Blood Pressure Control (<140/90 mm Hg)	75.12%	70.23%	↔	73.95%
	Eye Exam (Retinal) Performed	62.09%	70.47%	↑	66.05%
	HbA1c Testing	81.86%	85.58%	↔	82.33%
	HbA1c Control (<8.0 Percent)	48.60%	65.58%	↑	56.98%
	LDL-C Control (<100 mg/dL)	36.28%	46.74%	↑	40.23%
	LDL-C Screening	79.07%	84.42%	↑	80.70%
	Medical Attention for Nephropathy	77.67%	85.81%	↑	83.02%
	HbA1c Poor Control (>9.0 Percent)*	42.33%	29.53%	▲	37.21%
CalViva—Fresno	Blood Pressure Control (<140/90 mm Hg)	53.16%	49.39%	↔	48.66%
	Eye Exam (Retinal) Performed	43.20%	50.12%	↑	48.91%
	HbA1c Testing	78.64%	86.62%	↑	82.97%
	HbA1c Control (<8.0 Percent)	44.17%	45.50%	↔	43.80%
	LDL-C Control (<100 mg/dL)	33.98%	38.20%	↔	36.74%
	LDL-C Screening	71.60%	82.00%	↑	76.64%
	Medical Attention for Nephropathy	68.20%	81.27%	↑	75.67%
	HbA1c Poor Control (>9.0 Percent)*	49.76%	42.09%	▲	47.45%
CalViva—Kings	Blood Pressure Control (<140/90 mm Hg)	48.28%	49.53%	↔	50.36%
	Eye Exam (Retinal) Performed	41.87%	41.59%	↔	42.82%
	HbA1c Testing	55.17%	49.07%	↔	80.54%
	HbA1c Control (<8.0 Percent)	32.02%	37.85%	↔	41.85%
	LDL-C Control (<100 mg/dL)	16.75%	28.50%	↑	27.98%
	LDL-C Screening	53.69%	49.07%	↔	74.94%
	Medical Attention for Nephropathy	72.41%	82.24%	↑	78.35%
	HbA1c Poor Control (>9.0 Percent)*	40.89%	34.11%	↔	50.85%

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
CalViva—Madera	Blood Pressure Control (<140/90 mm Hg)	62.78%	51.85%	↓	59.37%
	Eye Exam (Retinal) Performed	50.81%	59.26%	↔	55.72%
	HbA1c Testing	82.52%	89.35%	↑	85.89%
	HbA1c Control (<8.0 Percent)	44.98%	48.61%	↔	46.47%
	LDL-C Control (<100 mg/dL)	33.66%	32.87%	↔	33.09%
	LDL-C Screening	69.26%	74.54%	↔	70.32%
	Medical Attention for Nephropathy	77.35%	84.26%	↔	81.27%
	HbA1c Poor Control (>9.0 Percent)*	44.01%	43.98%	↔	43.31%
Care1st—San Diego	Blood Pressure Control (<140/90 mm Hg)	63.36%	57.00%	↔	58.39%
	Eye Exam (Retinal) Performed	40.46%	38.40%	↔	40.39%
	HbA1c Testing	83.21%	82.80%	↔	84.91%
	HbA1c Control (<8.0 Percent)	38.17%	45.20%	↔	51.82%
	LDL-C Control (<100 mg/dL)	35.11%	38.60%	↔	37.23%
	LDL-C Screening	74.81%	79.40%	↔	78.59%
	Medical Attention for Nephropathy	80.92%	88.40%	↑	85.40%
	HbA1c Poor Control (>9.0 Percent)*	52.67%	48.00%	↔	42.09%
CenCal Health—Santa Barbara	Blood Pressure Control (<140/90 mm Hg)	71.78%	68.61%	↔	74.21%
	Eye Exam (Retinal) Performed	64.96%	68.37%	↔	70.56%
	HbA1c Testing	81.51%	84.91%	↔	83.94%
	HbA1c Control (<8.0 Percent)	56.45%	61.07%	↔	59.61%
	LDL-C Control (<100 mg/dL)	36.25%	42.09%	↔	38.93%
	LDL-C Screening	76.16%	81.27%	↔	80.54%
	Medical Attention for Nephropathy	80.54%	85.89%	↑	82.48%
	HbA1c Poor Control (>9.0 Percent)*	38.69%	31.39%	▲	33.58%
CenCal Health—San Luis Obispo	Blood Pressure Control (<140/90 mm Hg)	70.23%	72.67%	↔	70.56%
	Eye Exam (Retinal) Performed	47.91%	57.27%	↑	58.39%
	HbA1c Testing	75.81%	83.14%	↑	82.00%
	HbA1c Control (<8.0 Percent)	47.44%	60.47%	↑	61.31%
	LDL-C Control (<100 mg/dL)	32.56%	45.35%	↑	42.58%
	LDL-C Screening	73.95%	81.69%	↑	79.56%
	Medical Attention for Nephropathy	72.09%	88.08%	↑	82.73%
	HbA1c Poor Control (>9.0 Percent)*	48.37%	34.01%	▲	31.14%

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Central CA Alliance for Health—Merced	Blood Pressure Control (<140/90 mm Hg)	69.34%	61.80%	↓	64.96%
	Eye Exam (Retinal) Performed	49.88%	53.28%	↔	54.74%
	HbA1c Testing	84.18%	84.67%	↔	84.91%
	HbA1c Control (<8.0 Percent)	45.26%	48.66%	↔	46.72%
	LDL-C Control (<100 mg/dL)	33.58%	33.33%	↔	33.09%
	LDL-C Screening	81.75%	79.32%	↔	80.54%
	Medical Attention for Nephropathy	82.00%	86.13%	↔	84.91%
	HbA1c Poor Control (>9.0 Percent)*	45.50%	43.80%	↔	45.99%
Central CA Alliance for Health—Monterey/Santa Cruz	Blood Pressure Control (<140/90 mm Hg)	76.16%	65.21%	↓	71.05%
	Eye Exam (Retinal) Performed	61.56%	63.99%	↔	63.02%
	HbA1c Testing	85.64%	86.37%	↔	87.35%
	HbA1c Control (<8.0 Percent)	48.42%	51.58%	↔	51.09%
	LDL-C Control (<100 mg/dL)	38.20%	40.88%	↔	39.66%
	LDL-C Screening	79.81%	76.16%	↔	78.83%
	Medical Attention for Nephropathy	76.16%	81.02%	↔	79.32%
	HbA1c Poor Control (>9.0 Percent)*	39.90%	36.98%	↔	36.98%
Community Health Group—San Diego	Blood Pressure Control (<140/90 mm Hg)	65.69%	62.53%	↔	64.72%
	Eye Exam (Retinal) Performed	53.77%	60.58%	↑	55.47%
	HbA1c Testing	86.86%	90.27%	↔	90.02%
	HbA1c Control (<8.0 Percent)	56.69%	58.88%	↔	56.45%
	LDL-C Control (<100 mg/dL)	38.69%	46.47%	↑	39.66%
	LDL-C Screening	82.24%	86.62%	↔	83.70%
	Medical Attention for Nephropathy	80.05%	88.08%	↑	83.21%
	HbA1c Poor Control (>9.0 Percent)*	34.55%	30.66%	↔	34.31%
Contra Costa Health Plan—Contra Costa	Blood Pressure Control (<140/90 mm Hg)	59.85%	56.20%	↔	59.37%
	Eye Exam (Retinal) Performed	49.88%	54.50%	↔	51.09%
	HbA1c Testing	81.27%	88.56%	↑	85.40%
	HbA1c Control (<8.0 Percent)	40.88%	55.96%	↑	49.88%
	LDL-C Control (<100 mg/dL)	33.58%	43.55%	↑	41.61%
	LDL-C Screening	76.16%	84.43%	↑	82.00%
	Medical Attention for Nephropathy	75.91%	86.13%	↑	82.00%
	HbA1c Poor Control (>9.0 Percent)*	51.34%	33.82%	▲	40.39%

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Gold Coast—Ventura	Blood Pressure Control (<140/90 mm Hg)	65.69%	57.66%	↓	62.29%
	Eye Exam (Retinal) Performed	44.04%	44.53%	↔	42.58%
	HbA1c Testing	82.73%	85.16%	↔	81.75%
	HbA1c Control (<8.0 Percent)	37.71%	35.04%	↔	37.96%
	LDL-C Control (<100 mg/dL)	33.82%	36.25%	↔	33.58%
	LDL-C Screening	77.37%	79.08%	↔	78.83%
	Medical Attention for Nephropathy	80.78%	86.13%	↑	79.81%
	HbA1c Poor Control (>9.0 Percent)*	54.99%	58.64%	↔	56.20%
Health Net—Kern	Blood Pressure Control (<140/90 mm Hg)	49.14%	48.66%	↔	50.12%
	Eye Exam (Retinal) Performed	49.88%	43.55%	↔	44.28%
	HbA1c Testing	68.64%	73.24%	↔	73.24%
	HbA1c Control (<8.0 Percent)	32.84%	40.15%	↑	38.20%
	LDL-C Control (<100 mg/dL)	28.89%	40.88%	↑	38.93%
	LDL-C Screening	64.20%	75.91%	↑	72.75%
	Medical Attention for Nephropathy	75.56%	83.21%	↑	80.78%
	HbA1c Poor Control (>9.0 Percent)*	59.01%	49.15%	▲	52.80%
Health Net—Los Angeles	Blood Pressure Control (<140/90 mm Hg)	53.04%	50.36%	↔	50.12%
	Eye Exam (Retinal) Performed	51.09%	43.55%	↓	47.69%
	HbA1c Testing	78.83%	78.83%	↔	78.10%
	HbA1c Control (<8.0 Percent)	35.04%	45.50%	↑	39.90%
	LDL-C Control (<100 mg/dL)	31.63%	38.20%	↑	35.52%
	LDL-C Screening	75.91%	78.10%	↔	75.43%
	Medical Attention for Nephropathy	81.27%	84.43%	↔	82.97%
	HbA1c Poor Control (>9.0 Percent)*	51.34%	44.28%	▲	48.42%
Health Net—Sacramento	Blood Pressure Control (<140/90 mm Hg)	50.12%	48.91%	↔	48.91%
	Eye Exam (Retinal) Performed	36.98%	37.71%	↔	40.63%
	HbA1c Testing	72.51%	80.78%	↑	77.86%
	HbA1c Control (<8.0 Percent)	39.66%	49.64%	↑	43.55%
	LDL-C Control (<100 mg/dL)	23.60%	37.96%	↑	35.77%
	LDL-C Screening	59.61%	71.78%	↑	67.40%
	Medical Attention for Nephropathy	72.51%	85.64%	↑	83.45%
	HbA1c Poor Control (>9.0 Percent)*	51.34%	39.42%	▲	45.26%

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Health Net—San Diego	Blood Pressure Control (<140/90 mm Hg)	50.18%	53.28%	↔	52.07%
	Eye Exam (Retinal) Performed	47.67%	43.31%	↔	45.99%
	HbA1c Testing	78.49%	86.37%	↑	85.40%
	HbA1c Control (<8.0 Percent)	43.01%	51.82%	↑	50.85%
	LDL-C Control (<100 mg/dL)	28.32%	43.80%	↑	41.12%
	LDL-C Screening	68.82%	81.75%	↑	79.08%
	Medical Attention for Nephropathy	70.97%	87.59%	↑	82.24%
	HbA1c Poor Control (>9.0 Percent)*	48.75%	37.71%	▲	41.61%
Health Net—Stanislaus	Blood Pressure Control (<140/90 mm Hg)	58.30%	60.58%	↔	58.39%
	Eye Exam (Retinal) Performed	45.56%	41.12%	↔	41.61%
	HbA1c Testing	85.33%	89.78%	↔	88.32%
	HbA1c Control (<8.0 Percent)	50.19%	60.10%	↑	56.93%
	LDL-C Control (<100 mg/dL)	29.34%	42.82%	↑	34.55%
	LDL-C Screening	76.83%	81.27%	↔	78.59%
	Medical Attention for Nephropathy	74.13%	82.97%	↑	78.59%
	HbA1c Poor Control (>9.0 Percent)*	36.29%	30.17%	↔	31.87%
Health Net—Tulare	Blood Pressure Control (<140/90 mm Hg)	58.64%	49.39%	↓	54.26%
	Eye Exam (Retinal) Performed	43.55%	45.01%	↔	41.85%
	HbA1c Testing	84.43%	87.59%	↔	86.62%
	HbA1c Control (<8.0 Percent)	44.53%	53.77%	↑	49.64%
	LDL-C Control (<100 mg/dL)	30.90%	38.20%	↑	36.50%
	LDL-C Screening	73.97%	76.64%	↔	77.86%
	Medical Attention for Nephropathy	79.81%	82.73%	↔	82.00%
	HbA1c Poor Control (>9.0 Percent)*	45.50%	38.93%	↔	43.55%
Health Plan of San Joaquin—San Joaquin	Blood Pressure Control (<140/90 mm Hg)	60.34%	63.26%	↔	78.28%
	Eye Exam (Retinal) Performed	42.58%	45.01%	↔	45.62%
	HbA1c Testing	77.62%	82.00%	↔	80.66%
	HbA1c Control (<8.0 Percent)	45.99%	51.09%	↔	52.37%
	LDL-C Control (<100 mg/dL)	27.74%	34.79%	↑	35.22%
	LDL-C Screening	71.29%	77.86%	↑	75.55%
	Medical Attention for Nephropathy	76.40%	82.24%	↑	82.12%
	HbA1c Poor Control (>9.0 Percent)*	47.20%	43.55%	↔	39.60%

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Health Plan of San Mateo—San Mateo	Blood Pressure Control (<140/90 mm Hg)	13.38%	48.18%	↑	56.93%
	Eye Exam (Retinal) Performed	32.36%	57.42%	↑	57.42%
	HbA1c Testing	78.35%	83.94%	↑	83.70%
	HbA1c Control (<8.0 Percent)	46.47%	55.72%	↑	56.45%
	LDL-C Control (<100 mg/dL)	30.90%	48.18%	↑	46.96%
	LDL-C Screening	69.34%	83.21%	↑	80.78%
	Medical Attention for Nephropathy	73.97%	85.16%	↑	82.97%
	HbA1c Poor Control (>9.0 Percent)*	35.52%	46.72%	▼	35.28%
Inland Empire Health Plan—San Bernardino/Riverside	Blood Pressure Control (<140/90 mm Hg)	68.19%	67.12%	↔	71.00%
	Eye Exam (Retinal) Performed	52.94%	60.59%	↑	59.40%
	HbA1c Testing	79.74%	86.49%	↑	85.61%
	HbA1c Control (<8.0 Percent)	42.70%	57.43%	↑	50.81%
	LDL-C Control (<100 mg/dL)	34.64%	48.65%	↑	42.00%
	LDL-C Screening	76.03%	86.49%	↑	83.53%
	Medical Attention for Nephropathy	75.60%	86.71%	↑	84.45%
	HbA1c Poor Control (>9.0 Percent)*	46.19%	31.31%	▲	36.19%
Kaiser—Sacramento County	Blood Pressure Control (<140/90 mm Hg)	82.01%	80.69%	↔	79.87%
	Eye Exam (Retinal) Performed	65.24%	70.60%	↔	66.16%
	HbA1c Testing	91.46%	96.19%	↑	94.09%
	HbA1c Control (<8.0 Percent)	50.61%	66.30%	↑	59.37%
	LDL-C Control (<100 mg/dL)	57.62%	73.68%	↑	66.79%
	LDL-C Screening	89.94%	95.20%	↑	92.70%
	Medical Attention for Nephropathy	85.67%	92.87%	↑	89.18%
	HbA1c Poor Control (>9.0 Percent)*	34.45%	20.05%	▲	27.30%
Kaiser—San Diego County	Blood Pressure Control (<140/90 mm Hg)	87.01%	84.15%	↔	85.10%
	Eye Exam (Retinal) Performed	71.43%	78.37%	↑	76.07%
	HbA1c Testing	94.81%	94.86%	↔	94.84%
	HbA1c Control (<8.0 Percent)	63.64%	73.02%	↑	69.91%
	LDL-C Control (<100 mg/dL)	60.61%	74.52%	↑	69.91%
	LDL-C Screening	90.91%	93.79%	↔	92.84%
	Medical Attention for Nephropathy	90.91%	94.65%	↔	93.41%
	HbA1c Poor Control (>9.0 Percent)*	23.38%	15.85%	▲	18.34%

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Kern Family Health Care—Kern	Blood Pressure Control (<140/90 mm Hg)	75.73%	73.72%	↔	75.36%
	Eye Exam (Retinal) Performed	43.98%	48.18%	↔	45.80%
	HbA1c Testing	77.37%	83.21%	↑	80.29%
	HbA1c Control (<8.0 Percent)	46.53%	56.57%	↑	47.45%
	LDL-C Control (<100 mg/dL)	31.39%	40.69%	↑	33.58%
	LDL-C Screening	72.99%	83.76%	↑	76.28%
	Medical Attention for Nephropathy	76.09%	84.85%	↑	77.55%
	HbA1c Poor Control (>9.0 Percent)*	46.35%	36.31%	▲	44.53%
L.A. Care Health Plan—Los Angeles	Blood Pressure Control (<140/90 mm Hg)	57.66%	54.01%	↔	65.94%
	Eye Exam (Retinal) Performed	43.55%	47.69%	↔	49.76%
	HbA1c Testing	79.56%	81.51%	↔	84.30%
	HbA1c Control (<8.0 Percent)	41.61%	43.80%	↔	48.07%
	LDL-C Control (<100 mg/dL)	29.68%	36.98%	↑	37.68%
	LDL-C Screening	75.67%	78.83%	↔	79.95%
	Medical Attention for Nephropathy	76.64%	82.97%	↑	81.64%
	HbA1c Poor Control (>9.0 Percent)*	48.42%	45.26%	↔	39.37%
Molina Healthcare—San Bernardino/Riverside	Blood Pressure Control (<140/90 mm Hg)	67.63%	56.25%	↓	56.52%
	Eye Exam (Retinal) Performed	46.89%	46.88%	↔	46.68%
	HbA1c Testing	84.23%	80.21%	↔	81.92%
	HbA1c Control (<8.0 Percent)	42.32%	47.40%	↔	43.48%
	LDL-C Control (<100 mg/dL)	37.76%	42.19%	↔	35.93%
	LDL-C Screening	84.65%	76.56%	↓	82.61%
	Medical Attention for Nephropathy	83.40%	88.02%	↔	83.30%
	HbA1c Poor Control (>9.0 Percent)*	46.06%	44.79%	↔	43.71%
Molina Healthcare—Sacramento	Blood Pressure Control (<140/90 mm Hg)	57.40%	55.80%	↔	54.65%
	Eye Exam (Retinal) Performed	44.84%	47.83%	↔	47.91%
	HbA1c Testing	74.44%	73.91%	↔	78.60%
	HbA1c Control (<8.0 Percent)	38.12%	52.17%	↑	46.05%
	LDL-C Control (<100 mg/dL)	27.35%	34.06%	↔	31.63%
	LDL-C Screening	64.13%	63.77%	↔	70.00%
	Medical Attention for Nephropathy	71.30%	81.88%	↑	80.47%
	HbA1c Poor Control (>9.0 Percent)*	50.22%	44.20%	↔	43.26%

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Molina Healthcare—San Diego	Blood Pressure Control (<140/90 mm Hg)	60.21%	58.45%	↔	62.30%
	Eye Exam (Retinal) Performed	45.42%	52.11%	↔	58.55%
	HbA1c Testing	81.69%	85.21%	↔	88.76%
	HbA1c Control (<8.0 Percent)	46.83%	57.75%	↑	57.85%
	LDL-C Control (<100 mg/dL)	33.80%	51.41%	↑	47.54%
	LDL-C Screening	72.18%	83.80%	↑	86.42%
	Medical Attention for Nephropathy	71.13%	90.14%	↑	84.31%
	HbA1c Poor Control (>9.0 Percent)*	42.25%	37.32%	↔	32.55%
Partnership HealthPlan—Marin	Blood Pressure Control (<140/90 mm Hg)	62.82%	59.77%	↔	60.71%
	Eye Exam (Retinal) Performed	41.03%	43.10%	↔	42.46%
	HbA1c Testing	84.62%	89.08%	↔	87.70%
	HbA1c Control (<8.0 Percent)	39.74%	55.17%	↑	50.40%
	LDL-C Control (<100 mg/dL)	30.77%	35.63%	↔	34.13%
	LDL-C Screening	65.38%	73.56%	↔	71.03%
	Medical Attention for Nephropathy	70.51%	83.33%	↑	79.37%
	HbA1c Poor Control (>9.0 Percent)*	50.00%	35.63%	▲	40.08%
Partnership HealthPlan—Mendocino	Blood Pressure Control (<140/90 mm Hg)	61.25%	54.51%	↔	57.18%
	Eye Exam (Retinal) Performed	31.88%	43.44%	↑	38.86%
	HbA1c Testing	95.63%	90.98%	↔	92.82%
	HbA1c Control (<8.0 Percent)	45.00%	52.87%	↔	49.75%
	LDL-C Control (<100 mg/dL)	32.50%	40.57%	↔	37.38%
	LDL-C Screening	75.00%	77.87%	↔	76.73%
	Medical Attention for Nephropathy	71.25%	83.61%	↑	78.71%
	HbA1c Poor Control (>9.0 Percent)*	40.00%	35.66%	↔	37.38%
Partnership HealthPlan—Napa/Solano/Yolo	Blood Pressure Control (<140/90 mm Hg)	69.54%	61.95%	↓	66.67%
	Eye Exam (Retinal) Performed	52.54%	53.54%	↔	53.42%
	HbA1c Testing	87.64%	85.62%	↔	85.65%
	HbA1c Control (<8.0 Percent)	49.67%	54.65%	↔	53.64%
	LDL-C Control (<100 mg/dL)	37.75%	43.81%	↔	42.16%
	LDL-C Screening	78.15%	77.88%	↔	77.70%
	Medical Attention for Nephropathy	82.12%	88.72%	↑	84.33%
	HbA1c Poor Control (>9.0 Percent)*	37.75%	33.19%	↔	35.76%

8.3—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Partnership HealthPlan—Sonoma	Blood Pressure Control (<140/90 mm Hg)	73.95%	67.77%	↔	69.98%
	Eye Exam (Retinal) Performed	52.99%	59.60%	↔	57.62%
	HbA1c Testing	90.12%	93.38%	↔	92.27%
	HbA1c Control (<8.0 Percent)	48.50%	56.07%	↑	51.66%
	LDL-C Control (<100 mg/dL)	37.43%	46.58%	↑	39.74%
	LDL-C Screening	78.14%	77.04%	↔	76.60%
	Medical Attention for Nephropathy	79.04%	84.33%	↔	80.13%
	HbA1c Poor Control (>9.0 Percent)*	37.72%	30.91%	▲	34.88%
San Francisco Health Plan—San Francisco	Blood Pressure Control (<140/90 mm Hg)	76.39%	73.38%	↔	74.77%
	Eye Exam (Retinal) Performed	69.68%	63.43%	↔	67.59%
	HbA1c Testing	90.97%	90.51%	↔	90.97%
	HbA1c Control (<8.0 Percent)	61.11%	65.97%	↔	62.27%
	LDL-C Control (<100 mg/dL)	48.61%	50.69%	↔	47.69%
	LDL-C Screening	81.25%	81.48%	↔	80.56%
	Medical Attention for Nephropathy	85.88%	87.27%	↔	87.73%
	HbA1c Poor Control (>9.0 Percent)*	27.78%	24.54%	↔	26.39%
Santa Clara Family Health—Santa Clara	Blood Pressure Control (<140/90 mm Hg)	55.72%	53.53%	↔	53.53%
	Eye Exam (Retinal) Performed	38.20%	40.15%	↔	41.85%
	HbA1c Testing	82.73%	89.05%	↑	86.62%
	HbA1c Control (<8.0 Percent)	48.18%	61.07%	↑	55.47%
	LDL-C Control (<100 mg/dL)	35.77%	47.93%	↑	42.82%
	LDL-C Screening	73.72%	84.67%	↑	79.08%
	Medical Attention for Nephropathy	74.94%	87.83%	↑	79.81%
	HbA1c Poor Control (>9.0 Percent)*	41.61%	29.20%	▲	34.79%

Annual Monitoring for Patients on Persistent Medications

Summary of Results

Overall, the rates for the SPD population represented better performance than the rates for the non-SPD population for both the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Annual Monitoring for Patients on Persistent Medications—Diuretics* measures.

8.4—Medi-Cal Managed Care Annual Monitoring for Patients on Persistent Medications
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Alameda Alliance for Health—Alameda	ACE Inhibitors or ARBs	77.54%	85.99%	↑	84.40%
	Digoxin	NA	94.30%	Not Comparable	94.08%
	Diuretics	73.16%	84.07%	↑	81.92%
Anthem Blue Cross—Alameda	ACE Inhibitors or ARBs	66.07%	79.85%	↑	77.02%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	62.94%	75.70%	↑	73.14%
Anthem Blue Cross—Contra Costa	ACE Inhibitors or ARBs	72.41%	80.49%	↔	77.90%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	58.00%	78.72%	↑	71.53%
Anthem Blue Cross—Fresno	ACE Inhibitors or ARBs	79.15%	82.19%	↔	80.77%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	78.81%	83.44%	↔	81.48%
Anthem Blue Cross—Kings	ACE Inhibitors or ARBs	84.82%	86.55%	↔	85.71%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	78.13%	90.28%	↔	84.56%
Anthem Blue Cross—Madera	ACE Inhibitors or ARBs	74.47%	78.72%	↔	76.60%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	65.79%	87.04%	↑	78.26%
Anthem Blue Cross—Sacramento	ACE Inhibitors or ARBs	60.90%	67.13%	↑	65.15%
	Digoxin	NA	NA	Not Comparable	86.11%
	Diuretics	59.22%	70.32%	↑	67.21%
Anthem Blue Cross—San Francisco	ACE Inhibitors or ARBs	77.78%	83.49%	↔	82.57%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	81.13%	82.14%	↔	81.99%

8.4—Medi-Cal Managed Care Annual Monitoring for Patients on Persistent Medications
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Anthem Blue Cross—San Joaquin	ACE Inhibitors or ARBs	64.94%	74.91%	↑	71.15%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	66.33%	77.32%	↑	73.63%
Anthem Blue Cross—Santa Clara	ACE Inhibitors or ARBs	84.37%	88.02%	↔	86.63%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	85.21%	87.38%	↔	86.61%
Anthem Blue Cross—Stanislaus	ACE Inhibitors or ARBs	84.99%	86.26%	↔	85.74%
	Digoxin	NA	NA	Not Comparable	90.32%
	Diuretics	85.29%	85.91%	↔	85.70%
Anthem Blue Cross—Tulare	ACE Inhibitors or ARBs	75.69%	82.10%	↑	78.55%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	77.22%	86.27%	↑	81.57%
CalOptima—Orange	ACE Inhibitors or ARBs	87.58%	91.78%	↑	90.75%
	Digoxin	91.18%	93.77%	↔	93.54%
	Diuretics	86.39%	91.88%	↑	90.65%
CalViva—Fresno	ACE Inhibitors or ARBs	80.26%	83.76%	↑	82.27%
	Digoxin	NA	89.61%	Not Comparable	86.60%
	Diuretics	79.47%	85.44%	↑	83.02%
CalViva—Kings	ACE Inhibitors or ARBs	74.65%	85.71%	↑	80.23%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	71.18%	86.11%	↑	78.03%
CalViva—Madera	ACE Inhibitors or ARBs	76.08%	87.11%	↑	80.80%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	75.86%	88.55%	↑	81.88%
Care1st—San Diego	ACE Inhibitors or ARBs	84.85%	81.13%	↔	81.79%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	75.23%	81.24%	↔	80.19%
CenCal Health—Santa Barbara	ACE Inhibitors or ARBs	80.90%	86.86%	↑	84.72%
	Digoxin	NA	87.10%	Not Comparable	86.11%
	Diuretics	78.97%	88.10%	↑	85.46%
CenCal Health—San Luis Obispo	ACE Inhibitors or ARBs	74.84%	83.88%	↑	81.02%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	78.57%	86.25%	↔	84.20%

8.4—Medi-Cal Managed Care Annual Monitoring for Patients on Persistent Medications
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Central CA Alliance for Health—Merced	ACE Inhibitors or ARBs	86.26%	87.83%	↔	87.14%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	84.96%	88.28%	↔	86.97%
Central CA Alliance for Health—Monterey/Santa Cruz	ACE Inhibitors or ARBs	80.15%	89.32%	↑	85.86%
	Digoxin	NA	89.13%	Not Comparable	89.47%
	Diuretics	78.84%	88.86%	↑	85.58%
Community Health Group—San Diego	ACE Inhibitors or ARBs	84.91%	85.05%	↔	84.99%
	Digoxin	NA	90.24%	Not Comparable	91.23%
	Diuretics	84.06%	85.76%	↔	85.04%
Contra Costa Health Plan—Contra Costa	ACE Inhibitors or ARBs	78.37%	85.68%	↑	83.77%
	Digoxin	NA	86.54%	Not Comparable	85.71%
	Diuretics	77.84%	85.83%	↑	83.68%
Gold Coast—Ventura	ACE Inhibitors or ARBs	84.26%	88.46%	↑	86.73%
	Digoxin	NA	88.37%	Not Comparable	88.46%
	Diuretics	85.15%	86.97%	↔	86.28%
Health Net—Kern	ACE Inhibitors or ARBs	70.82%	78.34%	↑	75.85%
	Digoxin	NA	NA	Not Comparable	83.33%
	Diuretics	70.73%	78.90%	↑	76.59%
Health Net—Los Angeles	ACE Inhibitors or ARBs	74.64%	77.01%	↑	76.09%
	Digoxin	83.33%	86.48%	↔	85.92%
	Diuretics	72.64%	78.39%	↑	76.27%
Health Net—Sacramento	ACE Inhibitors or ARBs	61.52%	69.20%	↑	67.16%
	Digoxin	NA	83.93%	Not Comparable	82.46%
	Diuretics	56.74%	71.03%	↑	67.40%
Health Net—San Diego	ACE Inhibitors or ARBs	76.98%	86.17%	↑	83.68%
	Digoxin	NA	NA	Not Comparable	100.0%
	Diuretics	75.42%	86.79%	↑	83.82%
Health Net—Stanislaus	ACE Inhibitors or ARBs	84.65%	83.26%	↔	83.73%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	80.25%	86.47%	↔	84.46%
Health Net—Tulare	ACE Inhibitors or ARBs	83.16%	83.74%	↔	83.50%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	79.55%	87.50%	↑	84.60%

8.4—Medi-Cal Managed Care Annual Monitoring for Patients on Persistent Medications
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Health Plan of San Joaquin—San Joaquin	ACE Inhibitors or ARBs	80.70%	85.44%	↑	83.69%
	Digoxin	NA	90.91%	Not Comparable	92.11%
	Diuretics	81.44%	86.39%	↑	84.58%
Health Plan of San Mateo—San Mateo	ACE Inhibitors or ARBs	85.52%	89.95%	↑	89.51%
	Digoxin	NA	94.79%	Not Comparable	94.95%
	Diuretics	84.70%	91.23%	↑	90.57%
Inland Empire Health Plan—San Bernardino/Riverside	ACE Inhibitors or ARBs	83.14%	89.22%	↑	86.98%
	Digoxin	96.23%	91.32%	↔	91.99%
	Diuretics	81.24%	88.78%	↑	86.07%
Kaiser—Sacramento County	ACE Inhibitors or ARBs	89.80%	96.27%	↑	94.54%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	90.72%	95.25%	↑	93.99%
Kaiser—San Diego County	ACE Inhibitors or ARBs	91.74%	94.76%	↔	93.22%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	91.46%	94.24%	↔	92.74%
Kern Family Health Care—Kern	ACE Inhibitors or ARBs	85.38%	92.05%	↑	87.71%
	Digoxin	NA	NA	Not Comparable	90.74%
	Diuretics	85.34%	91.17%	↑	87.62%
L.A. Care Health Plan—Los Angeles	ACE Inhibitors or ARBs	72.80%	73.17%	↔	73.03%
	Digoxin	75.57%	78.75%	↔	78.09%
	Diuretics	71.64%	73.59%	↑	72.87%
Molina Healthcare—San Bernardino/Riverside	ACE Inhibitors or ARBs	83.14%	87.80%	↑	86.05%
	Digoxin	NA	90.63%	Not Comparable	92.11%
	Diuretics	80.14%	87.06%	↑	84.41%
Molina Healthcare—Sacramento	ACE Inhibitors or ARBs	71.60%	74.59%	↔	73.99%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	70.51%	74.40%	↔	73.63%
Molina Healthcare—San Diego	ACE Inhibitors or ARBs	83.63%	85.79%	↔	85.15%
	Digoxin	NA	94.12%	Not Comparable	94.74%
	Diuretics	81.40%	88.10%	↑	86.01%
Partnership HealthPlan—Marin	ACE Inhibitors or ARBs	67.24%	79.13%	↔	76.74%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	65.91%	79.43%	↔	76.71%

8.4—Medi-Cal Managed Care Annual Monitoring for Patients on Persistent Medications
SPD versus Non-SPD
HEDIS Reporting Year 2013

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Partnership HealthPlan—Mendocino	ACE Inhibitors or ARBs	79.55%	86.52%	↔	84.48%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	78.57%	88.14%	↔	85.61%
Partnership HealthPlan—Napa/Solano/Yolo	ACE Inhibitors or ARBs	78.93%	86.70%	↑	84.46%
	Digoxin	NA	91.07%	Not Comparable	90.48%
	Diuretics	74.90%	85.26%	↑	82.35%
Partnership HealthPlan—Sonoma	ACE Inhibitors or ARBs	68.61%	69.54%	↔	69.27%
	Digoxin	NA	84.38%	Not Comparable	85.29%
	Diuretics	62.90%	75.51%	↑	72.08%
San Francisco Health Plan—San Francisco	ACE Inhibitors or ARBs	73.62%	77.85%	↑	76.81%
	Digoxin	NA	80.56%	Not Comparable	81.82%
	Diuretics	74.36%	79.97%	↑	78.74%
Santa Clara Family Health—Santa Clara	ACE Inhibitors or ARBs	84.67%	88.79%	↑	87.60%
	Digoxin	NA	89.33%	Not Comparable	88.10%
	Diuretics	83.20%	90.07%	↑	88.08%

Ambulatory Care

Utilization information can be helpful to MCPs 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, DHCS does not establish performance thresholds for these measures and HSAG does not provide comparative analysis.

8.5—HEDIS 2013 Medi-Cal Managed Care Ambulatory Care Measure SPD versus Non-SPD

		Non-SPD Visits/1,000 Member Months		SPD Visits/1,000 Member Months	
MCP Name	County	Outpatient Visits	ED Visits	Outpatient Visits	ED Visits
Alameda Alliance for Health	Alameda	240.90	40.42	481.81	69.61
Anthem Blue Cross	Alameda	144.94	55.23	189.35	114.02
Anthem Blue Cross	Contra Costa	202.82	56.21	201.70	93.77
Anthem Blue Cross	Fresno	231.05	40.31	401.81	69.24
Anthem Blue Cross	Kings	337.12	61.10	662.36	140.74
Anthem Blue Cross	Madera	293.16	56.55	542.71	95.08
Anthem Blue Cross	Sacramento	190.39	47.88	331.70	85.17
Anthem Blue Cross	San Francisco	237.72	32.91	349.50	89.99
Anthem Blue Cross	San Joaquin	211.40	52.00	335.61	87.32
Anthem Blue Cross	Santa Clara	234.32	37.66	364.03	62.01
Anthem Blue Cross	Stanislaus	283.46	57.44	553.38	95.33
Anthem Blue Cross	Tulare	278.32	38.85	494.61	85.58
CalOptima	Orange	288.81	34.15	559.23	46.80
CalViva Health	Fresno	435.84	42.99	551.16	66.02
CalViva Health	Kings	419.16	53.80	737.46	115.90
CalViva Health	Madera	425.90	48.98	648.89	72.47
Care1st Partner Plan	San Diego	249.97	43.32	415.00	73.34
CenCal Health	Santa Barbara	308.44	46.35	566.20	101.65
CenCal Health	San Luis Obispo	303.89	57.42	599.51	100.09
Central CA Alliance for Health	Merced	299.06	51.12	536.12	75.54
Central CA Alliance for Health	Monterey/Santa Cruz	293.93	49.10	543.55	79.25
Community Health Group Partnership Plan	San Diego	287.97	34.30	495.48	62.49
Community Health Group Partnership Plan	Contra Costa	199.28	55.98	299.06	83.56
Gold Coast Health Plan	Ventura	294.22	46.49	493.66	70.16

8.5—HEDIS 2013 Medi-Cal Managed Care Ambulatory Care Measure
SPD versus Non-SPD

		Non-SPD Visits/1,000 Member Months		SPD Visits/1,000 Member Months	
MCP Name	County	Outpatient Visits	ED Visits	Outpatient Visits	ED Visits
Health Net Community Solutions, Inc.	Kern	196.35	47.99	219.48	80.74
Health Net Community Solutions, Inc.	Los Angeles	248.68	33.35	267.73	55.77
Health Net Community Solutions, Inc.	Sacramento	274.99	39.84	399.51	65.06
Health Net Community Solutions, Inc.	San Diego	296.72	46.14	406.58	71.22
Health Net Community Solutions, Inc.	Stanislaus	350.80	50.77	491.16	82.73
Health Net Community Solutions, Inc.	Tulare	449.45	37.86	602.84	71.55
Health Plan of San Joaquin	San Joaquin	246.24	43.01	474.21	72.22
Health Plan of San Mateo	San Mateo	405.92	49.86	924.90	58.21
Inland Empire Health Plan	San Bernardino/Riverside	308.23	48.29	630.72	75.75
Kaiser—Sacramento County	Sacramento	347.03	49.88	671.49	86.57
Kaiser—San Diego County	San Diego	415.75	35.60	737.64	52.40
Kern Family Health Care	Kern	240.89	48.21	487.16	95.53
L.A. Care Health Plan	Los Angeles	169.83	27.42	284.56	61.70
Molina Healthcare of California Partner Plan, Inc.	San Bernardino/Riverside	247.94	40.14	346.49	67.24
Molina Healthcare of California Partner Plan, Inc.	Sacramento	218.18	42.97	415.90	65.28
Molina Healthcare of California Partner Plan, Inc.	San Diego	273.91	43.19	512.86	61.02
Partnership HealthPlan	Marin	275.93	45.40	441.02	62.43
Partnership HealthPlan	Mendocino	289.83	51.97	589.67	94.82
Partnership HealthPlan	Napa/Solano/Yolo	274.50	47.01	503.87	79.44
Partnership HealthPlan	Sonoma	306.38	38.92	577.11	74.66
San Francisco Health Plan	San Francisco	300.16	24.57	527.95	74.89
Santa Clara Family Health Plan	Santa Clara	244.89	33.44	403.89	42.92

Table A.1—NCQA's 2012 National Percentiles

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months^*	42.03	52.45	63.15	72.77	80.04
*Ambulatory Care—Outpatient Visits per 1,000 Member Months^*	261.52	301.57	347.76	388.71	436.59
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.15%	83.72%	86.89%	89.18%	91.33%
Annual Monitoring for Patients on Persistent Medications—Digoxin	83.33%	87.93%	90.95%	93.41%	95.56%
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.52%	83.19%	86.40%	88.93%	91.30%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	16.45%	18.98%	22.14%	26.67%	33.33%
Breast Cancer Screening	36.80%	44.82%	50.46%	56.58%	62.76%
Cervical Cancer Screening	51.85%	61.81%	69.10%	73.24%	78.51%
Childhood Immunization Status—Combination 3	58.88%	64.72%	71.93%	77.49%	82.48%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	93.06%	95.56%	97.02%	97.88%	98.39%
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	83.16%	86.62%	89.19%	91.40%	92.63%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	83.37%	87.56%	90.58%	92.88%	94.51%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	81.78%	86.04%	89.21%	91.59%	93.01%
*Colorectal Cancer Screening**	49.88%	55.99%	63.29%	68.86%	73.72%
Comprehensive Diabetes Care—HbA1c Testing	74.90%	78.54%	82.38%	87.01%	91.13%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	28.95%	34.33%	41.68%	50.31%	58.24%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	35.04%	42.09%	48.72%	55.70%	59.37%
Comprehensive Diabetes Care—LDL-C Screening	64.38%	70.34%	76.16%	80.88%	83.45%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	23.06%	28.47%	35.86%	41.02%	46.44%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	36.25%	45.03%	52.88%	61.75%	69.72%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.43%	73.48%	78.71%	83.03%	86.93%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	47.02%	54.48%	63.50%	69.82%	75.44%
Controlling High Blood Pressure	42.22%	50.00%	57.52%	63.65%	69.11%

Table A.1—NCQA's 2012 National Percentiles

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Immunizations for Adolescents—Combination 1	39.77%	50.36%	62.29%	70.83%	80.91%
Medication Management for People with Asthma—Medication Compliance 50% Total	42.87%	47.31%	52.31%	56.98%	62.39%
Medication Management for People with Asthma—Medication Compliance 75% Total	20.39%	24.62%	29.14%	33.71%	40.17%
*Osteoporosis Management in Women Who Had A Fracture****	11.97%	14.87%	19.2%	25.53%	37.96%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	72.02%	80.54%	86.13%	90.39%	93.33%
Prenatal and Postpartum Care—Postpartum Care	52.43%	58.70%	64.98%	71.05%	74.73%
Use of Imaging Studies for Low Back Pain	69.52%	72.04%	75.67%	79.38%	82.04%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	1.55%	29.20%	47.45%	66.67%	77.13%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	0.82%	42.82%	54.88%	67.15%	77.61%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	0.16%	31.63%	43.29%	56.20%	64.87%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.07%	65.51%	72.26%	79.32%	83.04%

^Member months are a member's "contribution" to the total yearly membership.
*For this measure, NCQA's national commercial percentiles are displayed since no Medicaid benchmarks exist for this measure.
**For this measure, a lower rate indicates better performance.
***For this measure, NCQA's national Medicare percentiles are displayed since no Medicaid benchmarks exist for this measure.
Source: NCQA. Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios.

Tables B.1 through B.46 provide three-year trending information for each MCP across the reported measures. The following audit findings are provided within the table:

– = A year that data were not collected.
NR = A *Not Report* audit finding. The rate could not be publically reported because it was either materially biased or the MCP chose not to report the result.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

Within Tables B.1 through B.46, HSAG calculated statistical significance testing between the 2012 and 2013 rates for each measure using a Chi-square test and displayed this information within the "2012–2013 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2013 were significantly higher than they were in 2012.
↓ = Rates in 2013 were significantly lower than they were in 2012.
↔ = Rates in 2013 were not significantly different than they were in 2012.

Different symbols (▲ ▽) are used to indicate a performance change for *All-Cause Readmissions* and *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 2013 rate from the 2012 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2013 rate from the 2012 rate.

Not comparable = A 2012–13 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 2013 Trend Table for Alameda Alliance for Health—Alameda County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.66%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	42.02	47.24	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	315.03	297.17	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	86.41%	94.08%	↑
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	87.05%	84.40%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	84.78%	81.92%	↓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	35.61%	31.53%	38.09%	↑
Cervical Cancer Screening	67.65%	68.37%	65.21%	↔
Childhood Immunization Status—Combination 3	47.92%	78.10%	79.08%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.63%	92.32%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	85.48%	83.91%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	85.61%	85.06%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	82.03%	84.64%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	55.65%	59.85%	59.61%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	40.00%	52.55%	48.91%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.00%	83.21%	83.45%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	40.00%	58.88%	51.58%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.09%	43.55%	36.74%	↓
Comprehensive Diabetes Care—LDL-C Screening	74.26%	76.89%	77.62%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.74%	82.97%	82.97%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	49.91%	28.47%	37.47%	▼
Controlling High Blood Pressure	—	—	53.53%	Not Comparable
Immunizations for Adolescents—Combination 1	—	66.67%	76.40%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	43.88%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	24.23%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	58.84%	61.07%	57.18%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	64.65%	88.56%	80.54%	↓
Use of Imaging Studies for Low Back Pain	84.26%	84.76%	87.07%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	39.58%	55.23%	55.23%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	80.09%	58.64%	64.72%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	55.79%	41.61%	46.23%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.75%	77.62%	71.53%	↓

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

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

Table B.2—HEDIS 2013 Trend Table for Anthem Blue Cross Partnership Plan—Alameda County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.67%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	55.63	68.25	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	215.86	154.77	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	79.35%	77.02%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	72.88%	73.14%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	34.31%	39.13%	42.36%	↔
Cervical Cancer Screening	54.01%	58.15%	48.13%	↓
Childhood Immunization Status—Combination 3	66.91%	70.56%	71.29%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	93.51%	84.39%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	82.89%	67.77%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	84.12%	79.12%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	79.44%	77.65%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	50.61%	47.45%	35.92%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	27.98%	35.28%	34.22%	↔
Comprehensive Diabetes Care—HbA1c Testing	72.75%	73.48%	63.83%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	37.71%	32.36%	30.58%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.20%	22.38%	18.45%	↔
Comprehensive Diabetes Care—LDL-C Screening	68.37%	66.91%	55.83%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.86%	68.86%	71.36%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	53.53%	60.58%	63.35%	↔
Controlling High Blood Pressure	—	—	30.66%	Not Comparable
Immunizations for Adolescents—Combination 1	—	64.96%	73.16%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	42.61%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	20.87%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	51.09%	50.61%	36.74%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	65.94%	72.99%	75.18%	↔
Use of Imaging Studies for Low Back Pain	86.88%	91.46%	90.20%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	46.96%	44.04%	62.29%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	55.23%	62.04%	61.07%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	28.47%	31.14%	37.47%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	62.04%	73.71%	57.32%	↓

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

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

Table B.3—HEDIS 2013 Trend Table for Anthem Blue Cross Partnership Plan—Contra Costa County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	18.62%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	52.20	61.62	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	213.84	202.66	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	76.67%	77.90%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	67.86%	71.53%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	30.00%	NA	54.29%	Not Comparable
Cervical Cancer Screening	53.04%	58.15%	57.11%	↔
Childhood Immunization Status—Combination 3	68.61%	68.37%	76.16%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	93.04%	96.93%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	82.73%	85.01%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	80.01%	85.18%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	80.28%	82.76%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	55.20%	46.72%	50.99%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	26.40%	36.50%	38.61%	↔
Comprehensive Diabetes Care—HbA1c Testing	69.60%	67.15%	69.31%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	35.20%	29.20%	39.60%	↑
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	26.40%	16.79%	29.21%	↑
Comprehensive Diabetes Care—LDL-C Screening	61.60%	57.66%	64.36%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	66.40%	64.96%	67.33%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	58.40%	65.69%	52.97%	▲
Controlling High Blood Pressure	—	—	46.15%	Not Comparable
Immunizations for Adolescents—Combination 1	—	65.02%	68.35%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	40.34%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	18.18%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	43.55%	48.15%	44.64%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	69.35%	76.30%	79.46%	↔
Use of Imaging Studies for Low Back Pain	85.92%	92.59%	81.48%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	49.15%	42.58%	57.66%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	52.80%	53.77%	52.31%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	35.28%	25.55%	36.74%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	63.26%	67.45%	63.93%	↔

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

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

Table B.4—HEDIS 2013 Trend Table for Anthem Blue Cross Partnership Plan—Fresno County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.83%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	—	43.10	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	—	247.54	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	80.77%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	81.48%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	29.65%	Not Comparable
Cervical Cancer Screening	—	—	46.72%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	70.80%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	94.35%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	82.85%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	80.34%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	76.54%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	58.74%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	38.35%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	—	77.18%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	41.99%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	32.77%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	—	71.84%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	77.43%	Not Comparable
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	—	—	50.24%	Not Comparable
Controlling High Blood Pressure	—	—	50.85%	Not Comparable
Immunizations for Adolescents—Combination 1	—	—	70.80%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	35.29%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	14.10%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	54.74%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	79.56%	Not Comparable
Use of Imaging Studies for Low Back Pain	—	—	84.06%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	58.88%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	63.02%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	46.23%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	67.88%	Not Comparable

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

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

Table B.5—HEDIS 2013 Trend Table for Anthem Blue Cross Partnership Plan—Kings County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	16.58%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	—	68.85	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	—	368.80	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	85.71%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	84.56%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	28.57%	Not Comparable
Cervical Cancer Screening	—	—	52.31%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	66.77%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	95.06%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	86.53%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	58.44%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	38.31%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	—	75.00%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	38.64%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	25.97%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	—	73.05%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	73.38%	Not Comparable
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	—	—	55.19%	Not Comparable
Controlling High Blood Pressure	—	—	43.55%	Not Comparable
Immunizations for Adolescents—Combination 1	—	—	56.12%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	54.37%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	86.11%	Not Comparable
Use of Imaging Studies for Low Back Pain	—	—	76.03%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	46.47%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	44.04%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	31.39%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	57.66%	Not Comparable

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

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

Table B.6—HEDIS 2013 Trend Table for Anthem Blue Cross Partnership Plan—Madera County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	10.87%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	—	59.71	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	—	313.66	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	76.60%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	78.26%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	6.25%	Not Comparable
Cervical Cancer Screening	—	—	52.55%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	76.40%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	97.83%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	88.53%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	66.81%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	55.02%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	—	84.72%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	51.97%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	31.44%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	—	72.93%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	79.04%	Not Comparable
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	—	—	36.24%	Not Comparable
Controlling High Blood Pressure	—	—	53.36%	Not Comparable
Immunizations for Adolescents—Combination 1	—	—	67.29%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	51.57%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	76.10%	Not Comparable
Use of Imaging Studies for Low Back Pain	—	—	70.10%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	77.62%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	70.07%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	48.66%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	80.29%	Not Comparable

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

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

Table B.7—HEDIS 2013 Trend Table for Anthem Blue Cross Partnership Plan—Sacramento County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	12.63%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	41.30	53.18	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	210.80	210.46	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	86.11%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	61.68%	65.15%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	61.75%	67.21%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.10%	24.14%	31.29%	↑
Cervical Cancer Screening	61.80%	58.93%	57.61%	↔
Childhood Immunization Status—Combination 3	57.66%	57.42%	62.77%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.51%	93.16%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	81.91%	80.19%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	81.22%	81.14%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	80.23%	80.56%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	54.99%	56.20%	57.04%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	28.22%	32.36%	28.16%	↔
Comprehensive Diabetes Care—HbA1c Testing	76.40%	76.16%	75.24%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	43.55%	49.15%	46.12%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.68%	25.79%	27.18%	↔
Comprehensive Diabetes Care—LDL-C Screening	64.48%	62.04%	67.23%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.02%	71.53%	71.60%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	47.93%	42.58%	47.09%	↔
Controlling High Blood Pressure	—	—	47.45%	Not Comparable
Immunizations for Adolescents—Combination 1	—	51.58%	61.80%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	44.31%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	21.54%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	49.88%	54.26%	47.92%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	70.32%	76.89%	78.73%	↔
Use of Imaging Studies for Low Back Pain	83.69%	84.94%	84.34%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	49.88%	63.02%	65.45%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	59.61%	71.29%	69.34%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	27.74%	39.42%	44.53%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.72%	64.33%	67.37%	↔

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

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

Table B.8—HEDIS 2013 Trend Table for Anthem Blue Cross Partnership Plan—San Francisco County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.19%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	38.76	52.12	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	250.78	275.35	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	80.10%	82.57%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	79.10%	81.99%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	50.00%	50.53%	53.25%	↔
Cervical Cancer Screening	74.45%	74.14%	64.80%	↓
Childhood Immunization Status—Combination 3	79.08%	72.41%	74.68%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.41%	96.11%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	90.78%	86.94%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	91.67%	90.85%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	89.56%	89.58%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	75.37%	62.33%	61.80%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	46.31%	51.63%	45.26%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.24%	83.72%	86.13%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	55.67%	53.49%	52.55%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	35.96%	37.67%	39.17%	↔
Comprehensive Diabetes Care—LDL-C Screening	75.37%	69.77%	75.91%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.77%	80.00%	85.89%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	32.51%	33.95%	36.01%	↔
Controlling High Blood Pressure	—	—	51.82%	Not Comparable
Immunizations for Adolescents—Combination 1	—	69.42%	68.02%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	38.20%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	17.98%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	55.50%	64.02%	64.85%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.96%	85.71%	88.48%	↔
Use of Imaging Studies for Low Back Pain	85.37%	80.39%	86.73%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	53.53%	73.24%	60.06%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	70.80%	79.32%	72.99%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	56.20%	71.78%	65.52%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.40%	80.00%	79.26%	↔

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

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

Table B.9—HEDIS 2013 Trend Table for Anthem Blue Cross Partnership Plan—San Joaquin County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	16.00%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	39.78	57.00	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	214.38	228.99	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	80.07%	71.15%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	79.10%	73.63%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	8.80%	11.56%	12.33%	↔
Cervical Cancer Screening	61.56%	55.36%	42.51%	↓
Childhood Immunization Status—Combination 3	64.48%	67.88%	67.15%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	90.71%	90.61%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	74.02%	78.63%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	79.97%	77.99%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	77.97%	74.76%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	56.69%	61.56%	54.37%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	37.71%	36.50%	32.77%	↔
Comprehensive Diabetes Care—HbA1c Testing	77.86%	73.48%	69.42%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	35.52%	43.07%	40.53%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.71%	30.66%	28.88%	↔
Comprehensive Diabetes Care—LDL-C Screening	72.51%	68.13%	66.26%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.89%	74.70%	74.76%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	57.42%	50.12%	50.97%	↔
Controlling High Blood Pressure	—	—	51.34%	Not Comparable
Immunizations for Adolescents—Combination 1	—	59.37%	63.07%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	33.55%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	15.79%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	51.34%	48.18%	55.68%	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.32%	78.59%	70.74%	↓
Use of Imaging Studies for Low Back Pain	76.39%	78.06%	79.06%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	49.88%	63.50%	62.09%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	70.56%	81.51%	79.05%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	28.71%	60.34%	61.60%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.94%	73.83%	66.46%	↓

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

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

Table B.10—HEDIS 2013 Trend Table for Anthem Blue Cross Partnership Plan—Santa Clara County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.74%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	37.89	41.51	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	232.42	254.81	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	84.95%	86.63%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	84.21%	86.61%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	28.83%	20.00%	27.20%	↔
Cervical Cancer Screening	72.02%	72.24%	59.70%	↓
Childhood Immunization Status—Combination 3	70.56%	66.91%	74.94%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.63%	95.81%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	86.67%	87.39%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	87.63%	88.05%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	86.34%	87.62%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	72.51%	65.69%	58.50%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.77%	64.48%	49.76%	↓
Comprehensive Diabetes Care—HbA1c Testing	87.35%	85.89%	79.85%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	60.10%	61.31%	53.88%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.72%	47.20%	35.44%	↓
Comprehensive Diabetes Care—LDL-C Screening	84.67%	82.73%	76.94%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.97%	79.56%	80.10%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	31.87%	29.44%	39.08%	▼
Controlling High Blood Pressure	—	—	46.72%	Not Comparable
Immunizations for Adolescents—Combination 1	—	60.10%	68.86%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	43.37%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	28.11%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	65.69%	60.64%	56.20%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.45%	79.52%	76.71%	↔
Use of Imaging Studies for Low Back Pain	83.92%	82.43%	83.67%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	65.69%	53.28%	55.23%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	63.50%	70.56%	65.94%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	35.52%	38.44%	50.36%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.07%	76.72%	76.72%	↔

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

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

Table B.11—HEDIS 2013 Trend Table for Anthem Blue Cross Partnership Plan—Stanislaus County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.07%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	55.76	62.00	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	311.24	315.94	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	90.32%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	83.04%	85.74%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	83.22%	85.70%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.93%	24.96%	22.45%	↔
Cervical Cancer Screening	67.15%	61.20%	57.14%	↔
Childhood Immunization Status—Combination 3	58.88%	65.69%	64.72%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.00%	96.18%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	89.23%	86.34%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	88.47%	87.24%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	85.76%	85.36%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	57.66%	65.21%	57.04%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	22.38%	40.63%	33.25%	↓
Comprehensive Diabetes Care—HbA1c Testing	76.16%	76.16%	77.18%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	34.06%	49.64%	47.57%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	24.82%	32.12%	31.80%	↔
Comprehensive Diabetes Care—LDL-C Screening	72.26%	70.56%	69.42%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	71.29%	72.75%	76.94%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	58.39%	44.04%	43.69%	↔
Controlling High Blood Pressure	—	—	52.07%	Not Comparable
Immunizations for Adolescents—Combination 1	—	54.26%	54.52%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	43.67%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	24.24%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	53.66%	56.69%	57.28%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.63%	88.56%	85.19%	↔
Use of Imaging Studies for Low Back Pain	79.51%	80.52%	80.27%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	33.09%	49.64%	47.93%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	45.01%	63.02%	53.53%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	23.11%	37.23%	43.07%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.34%	64.41%	62.89%	↔

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

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

Table B.12—HEDIS 2013 Trend Table for Anthem Blue Cross Partnership Plan—Tulare County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	11.70%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	25.62	42.20	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	194.99	293.82	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	70.48%	78.55%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	69.03%	81.57%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	15.85%	20.19%	19.52%	↔
Cervical Cancer Screening	67.15%	68.85%	65.28%	↔
Childhood Immunization Status—Combination 3	69.10%	64.96%	71.78%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	92.51%	92.47%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	71.01%	82.72%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	81.80%	79.60%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	82.21%	82.20%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	64.96%	68.13%	68.45%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	29.20%	33.09%	35.68%	↔
Comprehensive Diabetes Care—HbA1c Testing	77.13%	77.13%	78.40%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	42.09%	45.26%	48.54%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	31.87%	33.09%	32.52%	↔
Comprehensive Diabetes Care—LDL-C Screening	69.83%	68.61%	69.66%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.89%	77.62%	81.55%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	49.64%	45.74%	43.69%	↔
Controlling High Blood Pressure	—	—	53.28%	Not Comparable
Immunizations for Adolescents—Combination 1	—	57.91%	70.97%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	38.07%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	18.88%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	63.99%	53.13%	55.96%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.73%	83.07%	76.16%	↓
Use of Imaging Studies for Low Back Pain	79.56%	80.85%	81.07%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	32.60%	83.94%	81.51%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	48.91%	68.13%	64.23%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	30.17%	50.36%	47.93%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.24%	71.95%	64.91%	↔

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

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

Table B.13—HEDIS 2013 Trend Table for CalOptima—Orange County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	16.69%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	36.79	36.08	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	351.89	330.09	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	90.38%	93.54%	↔
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	90.25%	90.75%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	89.29%	90.65%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	21.77%	20.73%	21.81%	↔
Cervical Cancer Screening	75.43%	72.00%	75.07%	↔
Childhood Immunization Status—Combination 3	84.52%	81.30%	84.25%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	97.67%	97.34%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	92.55%	91.12%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	92.05%	91.64%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	90.37%	90.41%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	70.37%	73.76%	73.95%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	61.66%	69.25%	66.05%	↔
Comprehensive Diabetes Care—HbA1c Testing	86.06%	86.45%	82.33%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	61.22%	58.71%	56.98%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	48.15%	50.75%	40.23%	↓
Comprehensive Diabetes Care—LDL-C Screening	84.53%	85.59%	80.70%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.22%	85.38%	83.02%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	28.54%	30.97%	37.21%	▼
Controlling High Blood Pressure	—	—	64.64%	Not Comparable
Immunizations for Adolescents—Combination 1	—	69.21%	80.86%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	48.71%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	25.60%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	72.37%	69.38%	63.66%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.79%	84.82%	78.42%	↓
Use of Imaging Studies for Low Back Pain	77.18%	79.00%	78.34%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	72.35%	76.92%	81.39%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	76.30%	81.43%	82.78%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	68.15%	71.62%	75.56%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	82.52%	82.54%	86.69%	↔

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

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

Table B.14—HEDIS 2013 Trend Table for CalViva Health—Fresno County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	10.64%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	—	45.57	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	—	448.77	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	86.60%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	82.27%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	83.02%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	38.41%	Not Comparable
Cervical Cancer Screening	—	—	70.07%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	76.89%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	97.82%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	91.50%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	91.74%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	90.68%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	48.66%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	48.91%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	—	82.97%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	43.80%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	36.74%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	—	76.64%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	75.67%	Not Comparable
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	—	—	47.45%	Not Comparable
Controlling High Blood Pressure	—	—	58.88%	Not Comparable
Immunizations for Adolescents—Combination 1	—	—	76.89%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	70.53%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	43.01%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	63.75%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	90.02%	Not Comparable
Use of Imaging Studies for Low Back Pain	—	—	82.11%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	69.10%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	71.29%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	44.53%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	81.51%	Not Comparable

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

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

Table B.15—HEDIS 2013 Trend Table for CalViva Health—Kings County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	10.31%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	—	60.31	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	—	452.56	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	80.23%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	78.03%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	32.14%	Not Comparable
Cervical Cancer Screening	—	—	61.56%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	69.83%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	96.98%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	89.73%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	50.36%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	42.82%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	—	80.54%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	41.85%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	27.98%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	—	74.94%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	78.35%	Not Comparable
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	—	—	50.85%	Not Comparable
Controlling High Blood Pressure	—	—	55.23%	Not Comparable
Immunizations for Adolescents—Combination 1	—	—	73.59%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	57.46%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	89.93%	Not Comparable
Use of Imaging Studies for Low Back Pain	—	—	75.50%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	48.42%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	53.28%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	41.36%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	67.40%	Not Comparable

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

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

Table B.16—HEDIS 2013 Trend Table for CalViva Health—Madera County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	10.81%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	—	50.89	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	—	444.01	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	80.80%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	81.88%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	25.61%	Not Comparable
Cervical Cancer Screening	—	—	60.83%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	71.29%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	98.53%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	91.75%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	59.37%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	55.72%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	—	85.89%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	46.47%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	33.09%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	—	70.32%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	81.27%	Not Comparable
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	—	—	43.31%	Not Comparable
Controlling High Blood Pressure	—	—	56.69%	Not Comparable
Immunizations for Adolescents—Combination 1	—	—	65.66%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	65.90%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	93.35%	Not Comparable
Use of Imaging Studies for Low Back Pain	—	—	77.17%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	62.29%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	73.72%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	64.72%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	84.43%	Not Comparable

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

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

Table B.17—HEDIS 2013 Trend Table for Care1st Partner Plan—San Diego County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	15.64%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	48.06	50.84	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	239.46	291.33	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	89.19%	81.79%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	86.76%	80.19%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	28.00%	15.38%	20.83%	↔
Cervical Cancer Screening	64.52%	66.91%	47.98%	↓
Childhood Immunization Status—Combination 3	79.81%	73.24%	72.75%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	90.56%	93.54%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	78.47%	82.76%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	81.48%	82.67%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	77.75%	81.15%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	66.06%	73.90%	58.39%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.82%	47.39%	40.39%	↔
Comprehensive Diabetes Care—HbA1c Testing	83.64%	88.76%	84.91%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	52.73%	49.00%	51.82%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.06%	38.15%	37.23%	↔
Comprehensive Diabetes Care—LDL-C Screening	80.61%	81.53%	78.59%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	87.27%	88.35%	85.40%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	30.91%	36.95%	42.09%	↔
Controlling High Blood Pressure	—	—	51.71%	Not Comparable
Immunizations for Adolescents—Combination 1	—	62.13%	70.26%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	40.59%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	24.75%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	60.45%	67.06%	59.18%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.00%	85.00%	81.12%	↔
Use of Imaging Studies for Low Back Pain	61.02%	82.72%	70.00%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	57.18%	65.94%	74.45%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	63.26%	68.37%	72.26%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	36.25%	46.72%	51.58%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.79%	73.44%	67.07%	↔

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

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

Table B.18—HEDIS 2013 Trend Table for CenCal Health—Santa Barbara County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	11.13%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	48.37	52.16	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	346.64	335.52	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	86.11%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	86.89%	84.72%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	87.25%	85.46%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	31.61%	29.55%	19.13%	↓
Cervical Cancer Screening	73.89%	71.65%	72.51%	↔
Childhood Immunization Status—Combination 3	82.31%	85.20%	85.84%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	97.31%	97.84%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	90.42%	91.16%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	89.69%	90.88%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	87.69%	89.29%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	69.59%	69.10%	74.21%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.32%	71.29%	70.56%	↔
Comprehensive Diabetes Care—HbA1c Testing	81.75%	92.21%	83.94%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	61.56%	69.34%	59.61%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	45.74%	50.12%	38.93%	↓
Comprehensive Diabetes Care—LDL-C Screening	76.89%	85.16%	80.54%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.56%	87.35%	82.48%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	28.95%	22.63%	33.58%	▼
Controlling High Blood Pressure	—	—	60.58%	Not Comparable
Immunizations for Adolescents—Combination 1	—	70.07%	78.74%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	47.38%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	27.67%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	77.57%	76.35%	73.44%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.49%	80.74%	81.64%	↔
Use of Imaging Studies for Low Back Pain	80.67%	80.46%	80.57%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	59.12%	66.42%	70.56%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	72.51%	67.88%	72.75%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	39.17%	44.77%	51.34%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.39%	76.01%	79.34%	↔

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

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

Table B.19—HEDIS 2013 Trend Table for CenCal Health—San Luis Obispo County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.49%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	65.82	63.56	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	343.58	346.43	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	82.95%	81.02%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	82.35%	84.20%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	34.44%	33.33%	14.46%	↓
Cervical Cancer Screening	58.52%	64.84%	65.00%	↔
Childhood Immunization Status—Combination 3	76.32%	76.39%	78.03%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.17%	95.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	87.31%	86.21%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	88.32%	87.64%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	86.08%	86.69%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	66.91%	67.64%	70.56%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	60.83%	61.56%	58.39%	↔
Comprehensive Diabetes Care—HbA1c Testing	73.72%	81.02%	82.00%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	51.34%	59.37%	61.31%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.69%	41.36%	42.58%	↔
Comprehensive Diabetes Care—LDL-C Screening	75.43%	78.59%	79.56%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.32%	84.67%	82.73%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	41.12%	32.60%	31.14%	↔
Controlling High Blood Pressure	—	—	63.02%	Not Comparable
Immunizations for Adolescents—Combination 1	—	60.10%	71.65%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	42.34%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	26.28%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	70.42%	70.11%	71.04%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.51%	82.76%	87.43%	↔
Use of Imaging Studies for Low Back Pain	78.38%	77.86%	75.69%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	46.96%	62.29%	64.23%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	57.91%	59.61%	61.31%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	34.79%	47.69%	50.36%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	63.66%	69.79%	67.97%	↔

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

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

Table B.20—HEDIS 2013 Trend Table for Central California Alliance for Health—Merced County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	12.73%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	49.09	53.69	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	320.62	324.06	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	86.41%	87.14%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	87.31%	86.97%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	15.09%	11.61%	16.23%	↑
Cervical Cancer Screening	53.04%	57.91%	63.77%	↔
Childhood Immunization Status—Combination 3	55.23%	64.72%	64.74%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.92%	97.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	91.25%	90.39%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	89.54%	89.82%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	87.63%	90.19%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	67.15%	64.48%	64.96%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.61%	56.20%	54.74%	↔
Comprehensive Diabetes Care—HbA1c Testing	86.13%	87.83%	84.91%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.72%	51.34%	46.72%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.01%	37.96%	33.09%	↔
Comprehensive Diabetes Care—LDL-C Screening	80.05%	80.29%	80.54%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.37%	82.48%	84.91%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)***	44.04%	37.23%	45.99%	▼
Controlling High Blood Pressure	—	—	52.80%	Not Comparable
Immunizations for Adolescents—Combination 1	—	50.12%	55.96%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	48.30%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	26.16%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	63.02%	59.61%	58.79%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.32%	85.40%	83.92%	↔
Use of Imaging Studies for Low Back Pain	79.87%	84.15%	79.33%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	46.72%	58.88%	77.62%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	62.29%	64.23%	66.91%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	40.39%	44.28%	44.77%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.97%	72.51%	74.33%	↔

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

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

Table B.21—HEDIS 2013 Trend Table for Central California Alliance for Health—Monterey/Santa Cruz Counties

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	12.06%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	51.95	52.10	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	320.58	318.74	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	88.31%	85.86%	↓
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	87.93%	89.47%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	88.95%	85.58%	↓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.36%	27.95%	22.27%	↓
Cervical Cancer Screening	71.29%	73.24%	71.65%	↔
Childhood Immunization Status—Combination 3	82.73%	84.18%	83.84%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	97.42%	98.49%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	91.05%	91.29%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	89.57%	90.89%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	88.93%	91.00%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	71.78%	76.64%	71.05%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	65.94%	67.40%	63.02%	↔
Comprehensive Diabetes Care—HbA1c Testing	89.05%	91.97%	87.35%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.45%	61.80%	51.09%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	45.74%	47.20%	39.66%	↓
Comprehensive Diabetes Care—LDL-C Screening	84.43%	84.91%	78.83%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.48%	79.81%	79.32%	↔
*Comprehensive Diabetes Care—Poor HbA1c Control (>9.0 Percent)***	33.33%	28.22%	36.98%	▼
Controlling High Blood Pressure	—	—	55.96%	Not Comparable
Immunizations for Adolescents—Combination 1	—	63.99%	77.60%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	49.96%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	24.42%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	75.43%	77.62%	70.27%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.43%	86.13%	81.76%	↔
Use of Imaging Studies for Low Back Pain	86.06%	85.12%	88.00%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	69.83%	79.08%	81.89%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	72.26%	80.29%	81.63%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	61.31%	61.31%	66.58%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	83.45%	83.21%	82.08%	↔

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

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

Table B.22—HEDIS 2013 Trend Table for Community Health Group Partnership Plan—San Diego County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.37%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	32.73	37.42	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	329.00	310.89	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	91.23%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	87.07%	84.99%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	85.01%	85.04%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	17.31%	14.08%	32.02%	↑
Cervical Cancer Screening	65.21%	69.10%	69.59%	↔
Childhood Immunization Status—Combination 3	78.10%	73.97%	73.97%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.21%	97.32%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	90.27%	89.85%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	89.61%	89.90%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	88.45%	88.64%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	65.69%	57.18%	64.72%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	61.07%	53.28%	55.47%	↔
Comprehensive Diabetes Care—HbA1c Testing	88.32%	87.35%	90.02%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	52.31%	47.69%	56.45%	↑
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	40.63%	35.04%	39.66%	↔
Comprehensive Diabetes Care—LDL-C Screening	84.67%	82.24%	83.70%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.21%	79.08%	83.21%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	37.71%	43.80%	34.31%	▲
Controlling High Blood Pressure	—	—	52.07%	Not Comparable
Immunizations for Adolescents—Combination 1	—	73.48%	79.32%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	35.41%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	18.66%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	57.18%	60.10%	55.23%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.08%	77.86%	82.24%	↔
Use of Imaging Studies for Low Back Pain	77.75%	75.03%	79.24%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	63.26%	73.48%	78.10%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	69.83%	71.53%	71.29%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	40.39%	55.96%	63.99%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.95%	77.13%	77.86%	↔

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

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

Table B.23—HEDIS 2013 Trend Table for Contra Costa Health Plan—Contra Costa County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	16.99%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	59.47	60.94	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	274.88	217.23	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	85.71%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	85.62%	83.77%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	80.95%	83.68%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	29.56%	26.52%	43.27%	↑
Cervical Cancer Screening	70.62%	66.67%	66.04%	↔
Childhood Immunization Status—Combination 3	87.16%	85.40%	84.47%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	93.97%	86.74%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	84.54%	76.18%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	84.07%	77.96%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	83.25%	74.86%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	55.11%	54.99%	59.37%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	49.09%	52.80%	51.09%	↔
Comprehensive Diabetes Care—HbA1c Testing	86.86%	84.91%	85.40%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.57%	53.04%	49.88%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	40.69%	36.25%	41.61%	↔
Comprehensive Diabetes Care—LDL-C Screening	77.74%	75.43%	82.00%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	89.23%	87.35%	82.00%	↓
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	33.94%	36.98%	40.39%	↔
Controlling High Blood Pressure	—	—	51.34%	Not Comparable
Immunizations for Adolescents—Combination 1	—	59.85%	71.61%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	56.90%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	33.95%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	67.40%	64.96%	62.53%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	81.75%	83.21%	86.86%	↔
Use of Imaging Studies for Low Back Pain	88.64%	88.58%	92.06%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	61.07%	59.37%	56.20%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	58.88%	55.72%	55.96%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	46.47%	46.47%	46.23%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.82%	77.86%	73.31%	↔

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

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

Table B.24—HEDIS 2013 Trend Table for Gold Coast Health Plan—Ventura County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	19.17%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	—	49.21	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	—	317.16	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	88.46%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	86.73%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	86.28%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	13.87%	Not Comparable
Cervical Cancer Screening	—	—	57.66%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	80.05%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	82.51%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	63.09%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	62.29%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	42.58%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	—	81.75%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	37.96%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	33.58%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	—	78.83%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	79.81%	Not Comparable
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	—	—	56.20%	Not Comparable
Controlling High Blood Pressure	—	—	61.56%	Not Comparable
Immunizations for Adolescents—Combination 1	—	—	65.21%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	63.99%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	80.78%	Not Comparable
Use of Imaging Studies for Low Back Pain	—	—	76.95%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	42.09%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	42.09%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	30.41%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	61.80%	Not Comparable

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

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

Table B.25—HEDIS 2013 Trend Table for Health Net Community Solutions, Inc.—Kern County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	10.40%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	47.52	53.28	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	269.41	200.09	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	83.33%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	77.67%	75.85%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	79.57%	76.59%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	18.18%	17.23%	26.00%	↑
Cervical Cancer Screening	63.73%	67.16%	46.99%	↓
Childhood Immunization Status—Combination 3	70.44%	71.35%	68.71%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	93.78%	89.78%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	80.79%	70.48%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	78.17%	68.16%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	81.18%	76.57%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58.41%	65.82%	50.12%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.24%	54.04%	44.28%	↓
Comprehensive Diabetes Care—HbA1c Testing	79.09%	78.52%	73.24%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	40.63%	40.88%	38.20%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.54%	35.57%	38.93%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.44%	73.21%	72.75%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.69%	83.14%	80.78%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	48.80%	50.58%	52.80%	↔
Controlling High Blood Pressure	—	—	51.34%	Not Comparable
Immunizations for Adolescents—Combination 1	—	60.58%	71.90%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	69.12%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	51.47%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	62.41%	62.41%	53.09%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.29%	89.47%	78.87%	↓
Use of Imaging Studies for Low Back Pain	73.50%	75.26%	73.53%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	53.16%	55.28%	72.02%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	69.66%	71.24%	81.02%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	41.75%	51.24%	63.99%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.02%	69.21%	65.54%	↔

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

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

Table B.26—HEDIS 2013 Trend Table for Health Net Community Solutions, Inc.—Los Angeles County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	11.93%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	33.03	36.51	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	241.22	251.36	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	76.99%	85.92%	↑
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	74.03%	76.09%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	74.07%	76.27%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	20.18%	21.40%	40.16%	↑
Cervical Cancer Screening	69.50%	68.41%	63.06%	↔
Childhood Immunization Status—Combination 3	77.10%	87.62%	81.63%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.13%	94.29%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	88.17%	81.11%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	87.98%	83.12%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	85.90%	82.82%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.89%	67.53%	50.12%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	55.32%	58.82%	47.69%	↓
Comprehensive Diabetes Care—HbA1c Testing	84.03%	83.53%	78.10%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.30%	48.47%	39.90%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.27%	37.41%	35.52%	↔
Comprehensive Diabetes Care—LDL-C Screening	80.79%	76.47%	75.43%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.57%	82.35%	82.97%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	40.74%	39.76%	48.42%	▼
Controlling High Blood Pressure	—	—	57.91%	Not Comparable
Immunizations for Adolescents—Combination 1	—	65.02%	73.67%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	72.65%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	49.52%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	58.21%	52.34%	48.05%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.57%	83.64%	73.41%	↓
Use of Imaging Studies for Low Back Pain	80.02%	81.09%	78.01%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	63.61%	71.53%	75.78%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	71.33%	79.86%	80.73%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	53.73%	63.66%	66.41%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	79.10%	83.10%	77.08%	↔

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

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

Table B.27—HEDIS 2013 Trend Table for Health Net Community Solutions, Inc.—Sacramento County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	12.15%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	38.10	45.02	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	241.00	300.55	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	82.46%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	59.33%	67.16%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	55.59%	67.40%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	28.48%	20.21%	51.66%	↑
Cervical Cancer Screening	59.48%	69.34%	53.95%	↓
Childhood Immunization Status—Combination 3	67.33%	69.55%	66.67%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.41%	92.53%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	84.73%	80.19%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	84.22%	80.69%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	83.57%	81.64%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.55%	62.91%	48.91%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	45.62%	48.36%	40.63%	↓
Comprehensive Diabetes Care—HbA1c Testing	83.82%	83.57%	77.86%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	49.21%	52.82%	43.55%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.75%	33.57%	35.77%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.40%	73.94%	67.40%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.57%	82.63%	83.45%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	40.00%	35.92%	45.26%	▼
Controlling High Blood Pressure	—	—	54.50%	Not Comparable
Immunizations for Adolescents—Combination 1	—	54.61%	63.08%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	78.74%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	55.94%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	60.57%	60.78%	53.16%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.89%	83.58%	81.77%	↔
Use of Imaging Studies for Low Back Pain	87.78%	87.52%	87.00%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	67.88%	69.51%	77.32%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	73.48%	77.58%	76.34%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	41.61%	52.69%	57.07%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.85%	78.20%	71.18%	↔

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

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

Table B.28—HEDIS 2013 Trend Table for Health Net Community Solutions, Inc.—San Diego County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	15.96%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	44.10	50.92	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	258.60	317.66	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	100.0%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	78.12%	83.68%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	77.56%	83.82%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	18.12%	18.46%	44.85%	↑
Cervical Cancer Screening	58.12%	66.28%	51.75%	↓
Childhood Immunization Status—Combination 3	69.82%	77.30%	72.30%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.01%	93.98%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	85.83%	85.27%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	85.38%	84.91%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	82.99%	82.51%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	53.78%	64.38%	52.07%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.43%	51.91%	45.99%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.59%	84.48%	85.40%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	41.99%	48.35%	50.85%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	31.42%	35.62%	41.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	73.41%	76.34%	79.08%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.18%	78.63%	82.24%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	46.53%	41.48%	41.61%	↔
Controlling High Blood Pressure	—	—	55.23%	Not Comparable
Immunizations for Adolescents—Combination 1	—	65.29%	76.86%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	75.28%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	55.06%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	62.47%	54.77%	53.75%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.84%	83.38%	76.67%	↓
Use of Imaging Studies for Low Back Pain	74.07%	77.40%	76.04%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	51.34%	67.56%	72.99%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	61.31%	67.78%	74.70%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	43.07%	49.56%	67.15%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.80%	70.00%	74.43%	↔

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

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

Table B.29—HEDIS 2013 Trend Table for Health Net Community Solutions, Inc.—Stanislaus County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	8.71%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	49.38	55.13	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	349.91	369.94	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	75.91%	83.73%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	79.78%	84.46%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.51%	29.55%	32.31%	↔
Cervical Cancer Screening	64.03%	77.28%	59.12%	↓
Childhood Immunization Status—Combination 3	67.80%	68.52%	71.67%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	97.18%	97.04%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	88.90%	87.15%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	87.88%	85.24%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	85.93%	86.00%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	67.83%	67.30%	58.39%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.70%	50.00%	41.61%	↓
Comprehensive Diabetes Care—HbA1c Testing	82.03%	84.60%	88.32%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	52.75%	53.08%	56.93%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.39%	39.34%	34.55%	↔
Comprehensive Diabetes Care—LDL-C Screening	75.36%	76.07%	78.59%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.03%	77.01%	78.59%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	37.10%	36.49%	31.87%	↔
Controlling High Blood Pressure	—	—	56.20%	Not Comparable
Immunizations for Adolescents—Combination 1	—	54.18%	65.77%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	77.04%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	52.55%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	62.26%	60.10%	58.73%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.16%	91.52%	91.90%	↔
Use of Imaging Studies for Low Back Pain	77.57%	83.83%	83.22%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	55.23%	58.68%	70.56%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	63.26%	65.75%	65.69%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	41.12%	40.18%	58.15%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.60%	71.11%	70.47%	↔

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

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

Table B.30—HEDIS 2013 Trend Table for Health Net Community Solutions, Inc.—Tulare County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	11.86%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	39.30	41.73	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	386.74	467.09	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	83.59%	83.50%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	79.73%	84.60%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	17.54%	22.85%	26.14%	↔
Cervical Cancer Screening	77.75%	78.83%	63.54%	↓
Childhood Immunization Status—Combination 3	76.32%	78.93%	78.47%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	97.32%	97.76%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	92.25%	92.37%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	92.76%	91.72%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	91.48%	93.05%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	71.33%	67.45%	54.26%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	56.40%	56.84%	41.85%	↓
Comprehensive Diabetes Care—HbA1c Testing	86.49%	83.02%	86.62%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.58%	47.88%	49.64%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.23%	36.56%	36.50%	↔
Comprehensive Diabetes Care—LDL-C Screening	77.49%	76.18%	77.86%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.94%	82.78%	82.00%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	41.71%	43.40%	43.55%	↔
Controlling High Blood Pressure	—	—	54.01%	Not Comparable
Immunizations for Adolescents—Combination 1	—	61.80%	78.32%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	72.85%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	47.68%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	68.38%	67.93%	65.57%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.21%	93.75%	90.16%	↔
Use of Imaging Studies for Low Back Pain	73.08%	82.72%	80.00%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	73.40%	77.57%	76.64%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	66.75%	66.36%	66.42%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	49.17%	45.33%	49.15%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.25%	77.32%	73.31%	↔

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

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

Table B.31—HEDIS 2013 Trend Table for Health Plan of San Joaquin—San Joaquin County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	7.07%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	38.16	46.68	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	283.73	274.87	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	92.11%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	85.56%	83.69%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	85.05%	84.58%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	27.13%	25.42%	29.24%	↔
Cervical Cancer Screening	68.61%	68.61%	64.23%	↔
Childhood Immunization Status—Combination 3	74.45%	77.13%	76.40%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.66%	97.49%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	86.82%	87.59%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	84.17%	85.71%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	83.53%	84.94%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	75.18%	77.62%	78.28%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.31%	53.28%	45.62%	↓
Comprehensive Diabetes Care—HbA1c Testing	80.54%	81.51%	80.66%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	51.82%	55.96%	52.37%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	31.39%	39.17%	35.22%	↔
Comprehensive Diabetes Care—LDL-C Screening	75.91%	78.59%	75.55%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.16%	80.29%	82.12%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	41.36%	36.74%	39.60%	↔
Controlling High Blood Pressure	—	—	66.42%	Not Comparable
Immunizations for Adolescents—Combination 1	—	63.99%	67.15%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	40.72%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	21.82%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	65.21%	68.61%	64.48%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.83%	88.08%	85.64%	↔
Use of Imaging Studies for Low Back Pain	82.45%	80.67%	81.80%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	67.15%	73.48%	69.10%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	69.59%	72.51%	72.75%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	58.15%	65.69%	61.80%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.27%	80.54%	76.16%	↔

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

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

Table B.32—HEDIS 2013 Trend Table for Health Plan of San Mateo—San Mateo County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.52%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	51.62	52.11	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	483.04	546.12	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	92.71%	94.95%	↔
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	89.28%	89.51%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	89.85%	90.57%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.49%	34.06%	34.46%	↔
Cervical Cancer Screening	61.20%	61.99%	66.33%	↔
Childhood Immunization Status—Combination 3	83.67%	80.29%	75.56%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.89%	96.70%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	88.34%	88.32%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	87.75%	89.36%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	84.89%	85.61%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.26%	66.18%	56.93%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	59.85%	61.07%	57.42%	↔
Comprehensive Diabetes Care—HbA1c Testing	86.62%	79.81%	83.70%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	57.42%	55.72%	56.45%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.96%	46.47%	46.96%	↔
Comprehensive Diabetes Care—LDL-C Screening	84.18%	82.00%	80.78%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.62%	87.83%	82.97%	↓
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	34.06%	37.96%	35.28%	↔
Controlling High Blood Pressure	—	—	51.34%	Not Comparable
Immunizations for Adolescents—Combination 1	—	68.49%	70.28%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	48.51%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	26.38%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	61.84%	61.22%	59.18%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.16%	81.89%	84.18%	↔
Use of Imaging Studies for Low Back Pain	84.62%	81.51%	80.07%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	47.89%	66.67%	55.47%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	75.43%	77.62%	70.05%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	59.06%	63.99%	53.91%	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.44%	73.80%	77.13%	↔

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

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

Table B.33—HEDIS 2013 Trend Table for Inland Empire Health Plan—San Bernardino/Riverside Counties

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.24%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	49.54	51.67	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	326.35	347.94	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	89.45%	91.99%	↔
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	84.22%	86.98%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	83.53%	86.07%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.88%	22.10%	22.53%	↔
Cervical Cancer Screening	71.66%	72.03%	68.53%	↔
Childhood Immunization Status—Combination 3	69.44%	77.78%	78.24%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.33%	96.75%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	86.92%	86.91%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	83.53%	83.18%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	86.30%	86.72%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	70.94%	75.76%	71.00%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	42.31%	52.68%	59.40%	↑
Comprehensive Diabetes Care—HbA1c Testing	79.49%	82.98%	85.61%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.94%	48.72%	50.81%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.39%	38.69%	42.00%	↔
Comprehensive Diabetes Care—LDL-C Screening	79.70%	81.12%	83.53%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.34%	83.68%	84.45%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	43.80%	40.79%	36.19%	↔
Controlling High Blood Pressure	—	—	62.91%	Not Comparable
Immunizations for Adolescents—Combination 1	—	63.66%	71.99%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	44.25%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	21.96%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	62.94%	63.23%	59.63%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.08%	86.42%	88.40%	↔
Use of Imaging Studies for Low Back Pain	78.42%	75.58%	77.47%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	57.64%	77.55%	78.94%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	65.97%	79.63%	74.54%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	38.19%	52.78%	47.69%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.31%	72.19%	75.69%	↔

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

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

Table B.34—HEDIS 2013 Trend Table for Kaiser—Sacramento County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	15.71%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	53.84	57.00	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	413.25	410.03	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	93.04%	94.54%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	92.53%	93.99%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	54.76%	47.17%	54.55%	↔
Cervical Cancer Screening	84.12%	83.91%	83.10%	↔
Childhood Immunization Status—Combination 3	80.24%	82.39%	83.88%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	99.29%	98.38%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	91.81%	90.32%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	91.19%	91.82%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	92.95%	92.53%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	77.76%	81.69%	79.87%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	67.52%	71.89%	66.16%	↓
Comprehensive Diabetes Care—HbA1c Testing	94.00%	95.57%	94.09%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	63.11%	61.41%	59.37%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	62.67%	65.59%	66.79%	↔
Comprehensive Diabetes Care—LDL-C Screening	92.06%	94.29%	92.70%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.14%	89.44%	89.18%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	21.54%	26.06%	27.30%	↔
Controlling High Blood Pressure	—	—	76.40%	Not Comparable
Immunizations for Adolescents—Combination 1	—	80.91%	88.91%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	56.75%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	27.16%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	71.71%	75.00%	75.55%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.64%	93.33%	91.61%	↔
Use of Imaging Studies for Low Back Pain	87.46%	92.05%	89.48%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	52.82%	73.52%	89.84%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	60.33%	75.92%	89.41%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	59.84%	75.56%	89.36%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.03%	72.22%	77.88%	↑

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

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

Table B.35—HEDIS 2013 Trend Table for Kaiser—San Diego County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	17.51%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	37.16	38.94	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	478.54	479.83	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	92.20%	93.22%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	91.69%	92.74%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	20.48%	38.30%	NA	Not Comparable
Cervical Cancer Screening	84.31%	85.04%	84.98%	↔
Childhood Immunization Status—Combination 3	84.13%	87.02%	87.91%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	99.48%	99.52%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	94.39%	94.40%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	94.52%	95.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	96.49%	96.97%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	85.78%	87.95%	85.10%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	77.12%	75.15%	76.07%	↔
Comprehensive Diabetes Care—HbA1c Testing	93.95%	96.23%	94.84%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	65.52%	69.73%	69.91%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	66.50%	69.43%	69.91%	↔
Comprehensive Diabetes Care—LDL-C Screening	93.63%	95.18%	92.84%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	94.61%	95.18%	93.41%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	21.24%	18.98%	18.34%	↔
Controlling High Blood Pressure	—	—	84.18%	Not Comparable
Immunizations for Adolescents—Combination 1	—	88.30%	89.00%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	61.18%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	29.80%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	68.47%	73.21%	70.20%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.19%	94.74%	91.41%	↔
Use of Imaging Studies for Low Back Pain	84.18%	76.00%	83.03%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	98.06%	97.80%	99.49%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	51.17%	65.11%	91.46%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	59.75%	76.31%	94.11%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.58%	68.55%	70.72%	↔

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

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

Table B.36—HEDIS 2013 Trend Table for Kern Family Health Care—Kern County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	8.77%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	46.64	51.02	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	282.07	255.50	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	90.74%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	83.81%	87.71%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	84.24%	87.62%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	18.27%	15.69%	23.02%	↑
Cervical Cancer Screening	63.17%	65.69%	64.72%	↔
Childhood Immunization Status—Combination 3	74.21%	68.61%	65.45%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.23%	92.37%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	84.12%	82.18%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	79.80%	79.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	81.78%	82.20%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	64.96%	72.81%	75.36%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	32.36%	52.55%	45.80%	↓
Comprehensive Diabetes Care—HbA1c Testing	79.81%	82.12%	80.29%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	36.50%	45.26%	47.45%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.20%	34.31%	33.58%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.40%	79.38%	76.28%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.45%	80.11%	77.55%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	54.26%	45.99%	44.53%	↔
Controlling High Blood Pressure	—	—	64.96%	Not Comparable
Immunizations for Adolescents—Combination 1	—	62.53%	75.67%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	45.85%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	21.75%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	61.07%	60.34%	62.04%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	78.35%	81.27%	83.70%	↔
Use of Imaging Studies for Low Back Pain	71.89%	76.45%	74.07%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	62.29%	61.80%	64.23%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	46.96%	51.58%	66.42%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	29.44%	38.44%	48.91%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.32%	69.10%	67.64%	↔

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

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

Table B.37—HEDIS 2013 Trend Table for L.A. Care Health Plan—Los Angeles County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	17.05%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	31.02	32.23	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	191.44	185.93	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	78.85%	78.09%	↔
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	73.44%	73.03%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	72.28%	72.87%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	40.68%	32.31%	35.44%	↑
Cervical Cancer Screening	67.88%	72.46%	66.34%	↔
Childhood Immunization Status—Combination 3	79.95%	81.45%	80.15%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.16%	91.06%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	86.98%	82.93%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	88.20%	87.15%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	86.43%	85.89%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58.45%	64.25%	65.94%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.72%	50.72%	49.76%	↔
Comprehensive Diabetes Care—HbA1c Testing	85.02%	83.82%	84.30%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.65%	42.27%	48.07%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.44%	36.96%	37.68%	↔
Comprehensive Diabetes Care—LDL-C Screening	78.99%	79.23%	79.95%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.26%	79.47%	81.64%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	41.55%	42.03%	39.37%	↔
Controlling High Blood Pressure	—	—	61.59%	Not Comparable
Immunizations for Adolescents—Combination 1	—	60.53%	72.15%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	79.80%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	57.70%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	55.31%	61.26%	55.80%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.13%	80.63%	85.75%	↑
Use of Imaging Studies for Low Back Pain	80.18%	81.64%	80.14%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	65.62%	64.65%	71.91%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	68.28%	70.22%	74.58%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	58.35%	57.63%	67.31%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	80.63%	77.54%	72.46%	↔

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

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

Table B.38—HEDIS 2013 Trend Table for Molina Healthcare of California Partner Plan, Inc.—San Bernardino/Riverside Counties

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.65%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	43.22	43.60	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	285.69	260.50	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	92.11%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	81.55%	86.05%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	81.41%	84.41%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	21.50%	20.13%	30.23%	↑
Cervical Cancer Screening	62.17%	62.00%	52.75%	↓
Childhood Immunization Status—Combination 3	53.04%	59.63%	63.86%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.88%	93.65%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	83.76%	83.03%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	82.68%	81.96%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	84.19%	84.51%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58.09%	59.33%	56.52%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	37.36%	54.83%	46.68%	↓
Comprehensive Diabetes Care—HbA1c Testing	78.13%	78.65%	81.92%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	34.40%	40.00%	43.48%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.70%	34.83%	35.93%	↔
Comprehensive Diabetes Care—LDL-C Screening	75.63%	77.30%	82.61%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.73%	81.80%	83.30%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	55.58%	48.76%	43.71%	↔
Controlling High Blood Pressure	—	—	53.83%	Not Comparable
Immunizations for Adolescents—Combination 1	—	60.88%	69.10%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	31.87%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	14.51%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	50.88%	43.84%	28.99%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	68.58%	77.17%	64.27%	↓
Use of Imaging Studies for Low Back Pain	76.13%	76.40%	78.21%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	42.46%	44.32%	42.00%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	55.22%	64.97%	59.40%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	44.08%	57.08%	49.42%	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.50%	74.77%	68.39%	↔

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

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

Table B.39—HEDIS 2013 Trend Table for Molina Healthcare of California Partner Plan, Inc.—Sacramento County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.20%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	44.96	47.83	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	238.15	261.22	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	78.84%	73.99%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	74.23%	73.63%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	27.19%	28.29%	23.08%	↔
Cervical Cancer Screening	60.14%	63.11%	50.51%	↓
Childhood Immunization Status—Combination 3	54.31%	50.12%	54.06%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.79%	94.81%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	84.21%	84.09%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	83.45%	83.80%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	83.38%	84.20%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.62%	58.22%	54.65%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.83%	56.22%	47.91%	↓
Comprehensive Diabetes Care—HbA1c Testing	79.34%	81.78%	78.60%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.77%	46.89%	46.05%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.15%	33.78%	31.63%	↔
Comprehensive Diabetes Care—LDL-C Screening	69.48%	69.33%	70.00%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.00%	83.11%	80.47%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	41.78%	40.89%	43.26%	↔
Controlling High Blood Pressure	—	—	51.29%	Not Comparable
Immunizations for Adolescents—Combination 1	—	55.32%	66.04%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	31.72%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	17.24%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	49.44%	51.36%	37.47%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	73.27%	81.45%	69.62%	↓
Use of Imaging Studies for Low Back Pain	78.95%	84.03%	83.24%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	61.95%	62.33%	54.61%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	62.65%	64.65%	59.34%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	55.68%	58.37%	49.65%	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.49%	76.10%	73.21%	↔

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

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

Table B.40—HEDIS 2013 Trend Table for Molina Healthcare of California Partner Plan, Inc.—San Diego County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.45%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	43.30	45.58	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	331.91	305.90	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	94.74%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	86.72%	85.15%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	85.85%	86.01%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	17.28%	18.21%	17.33%	↔
Cervical Cancer Screening	70.79%	68.91%	59.51%	↓
Childhood Immunization Status—Combination 3	72.33%	73.19%	75.00%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.76%	95.93%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	88.46%	88.02%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	87.55%	88.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	83.75%	85.26%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	70.40%	62.00%	62.30%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	49.33%	56.44%	58.55%	↔
Comprehensive Diabetes Care—HbA1c Testing	82.06%	84.44%	88.76%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	42.60%	46.22%	57.85%	↑
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	35.65%	42.22%	47.54%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.91%	78.22%	86.42%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.35%	80.22%	84.31%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	48.21%	46.67%	32.55%	▲
Controlling High Blood Pressure	—	—	52.76%	Not Comparable
Immunizations for Adolescents—Combination 1	—	71.30%	80.83%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	35.33%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	18.63%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	63.19%	61.40%	51.52%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.59%	88.94%	79.72%	↓
Use of Imaging Studies for Low Back Pain	77.66%	71.98%	72.00%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	53.01%	57.67%	64.79%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	58.56%	61.86%	65.96%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	54.63%	52.33%	55.16%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.71%	78.89%	74.74%	↔

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

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

Table B.41—HEDIS 2013 Trend Table for Partnership HealthPlan of California—Marin County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	16.04%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	—	48.34	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	—	304.46	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	76.74%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	76.71%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	NA	Not Comparable
Cervical Cancer Screening	—	—	64.73%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	78.35%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	98.76%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	87.69%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	60.71%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	42.46%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	—	87.70%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	50.40%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	34.13%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	—	71.03%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	79.37%	Not Comparable
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	—	—	40.08%	Not Comparable
Controlling High Blood Pressure	—	—	50.65%	Not Comparable
Immunizations for Adolescents—Combination 1	—	—	67.47%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	57.75%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	78.17%	Not Comparable
Use of Imaging Studies for Low Back Pain	—	—	85.71%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	83.33%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	63.89%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	44.44%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	67.59%	Not Comparable

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

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

Table B.42—HEDIS 2013 Trend Table for Partnership HealthPlan of California—Mendocino County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	9.81%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	—	57.94	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	—	331.59	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	84.48%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	85.61%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	28.57%	Not Comparable
Cervical Cancer Screening	—	—	58.82%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	61.86%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	95.45%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	89.15%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	57.18%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	38.86%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	—	92.82%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	49.75%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	37.38%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	—	76.73%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	78.71%	Not Comparable
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	—	—	37.38%	Not Comparable
Controlling High Blood Pressure	—	—	57.43%	Not Comparable
Immunizations for Adolescents—Combination 1	—	—	51.46%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	69.68%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	88.01%	Not Comparable
Use of Imaging Studies for Low Back Pain	—	—	88.05%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	69.91%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	55.79%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	31.71%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	62.04%	Not Comparable

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

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

Table B.43—HEDIS 2013 Trend Table for Partnership HealthPlan of California—Napa/Solano/Yolo Counties

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.25%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	47.82	52.33	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	256.88	312.13	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	80.88%	90.48%	↔
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	82.13%	84.46%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	82.38%	82.35%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.08%	42.76%	33.18%	↓
Cervical Cancer Screening	67.95%	65.71%	65.41%	↔
Childhood Immunization Status—Combination 3	70.14%	71.93%	68.87%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.91%	96.49%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	82.91%	86.42%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	80.35%	83.67%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	77.25%	84.94%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	60.31%	69.27%	66.67%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	54.77%	56.79%	53.42%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.04%	86.64%	85.65%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	54.77%	60.58%	53.64%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	49.89%	49.22%	42.16%	↓
Comprehensive Diabetes Care—LDL-C Screening	79.38%	78.17%	77.70%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.49%	83.74%	84.33%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	34.59%	28.73%	35.76%	▼
Controlling High Blood Pressure	—	—	53.86%	Not Comparable
Immunizations for Adolescents—Combination 1	—	56.81%	65.33%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	59.90%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	39.41%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	69.51%	70.29%	75.92%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.02%	87.27%	81.41%	↓
Use of Imaging Studies for Low Back Pain	88.42%	88.52%	88.95%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	57.41%	74.77%	77.44%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	49.77%	65.05%	67.91%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	42.13%	53.70%	52.79%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.54%	74.34%	74.26%	↔

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

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

Table B.44—HEDIS 2013 Trend Table for Partnership HealthPlan of California—Sonoma County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.05%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	43.17	44.10	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	283.01	345.59	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	88.57%	85.29%	↔
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	71.41%	69.27%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	73.94%	72.08%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	20.97%	47.47%	27.33%	↓
Cervical Cancer Screening	60.31%	71.60%	70.65%	↔
Childhood Immunization Status—Combination 3	71.00%	76.62%	74.01%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.24%	96.25%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	86.47%	88.58%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	83.26%	85.70%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	84.36%	88.23%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.22%	76.12%	69.98%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	49.56%	54.24%	57.62%	↔
Comprehensive Diabetes Care—HbA1c Testing	87.33%	90.18%	92.27%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	51.78%	59.38%	51.66%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.44%	43.75%	39.74%	↔
Comprehensive Diabetes Care—LDL-C Screening	68.89%	74.33%	76.60%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.33%	80.13%	80.13%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	37.11%	27.01%	34.88%	▼
Controlling High Blood Pressure	—	—	54.53%	Not Comparable
Immunizations for Adolescents—Combination 1	—	53.01%	65.66%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	63.71%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	41.62%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	67.06%	75.69%	73.73%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.15%	82.96%	85.97%	↔
Use of Imaging Studies for Low Back Pain	90.15%	90.42%	90.32%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	77.31%	86.31%	87.15%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	54.40%	69.37%	68.46%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	47.69%	54.99%	51.64%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.69%	72.16%	74.43%	↔

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

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

Table B.45—HEDIS 2013 Trend Table for San Francisco Health Plan—San Francisco County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	15.81%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	26.68	35.34	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	354.39	348.95	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	81.82%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	73.20%	76.81%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	71.43%	78.74%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	44.53%	45.45%	53.75%	↔
Cervical Cancer Screening	79.35%	80.19%	76.76%	↔
Childhood Immunization Status—Combination 3	87.27%	87.04%	85.81%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	92.98%	95.95%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	87.90%	89.57%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	90.08%	93.16%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	86.78%	91.13%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	73.71%	78.64%	74.77%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.10%	69.72%	67.59%	↔
Comprehensive Diabetes Care—HbA1c Testing	90.38%	91.08%	90.97%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	64.09%	63.38%	62.27%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	47.94%	48.83%	47.69%	↔
Comprehensive Diabetes Care—LDL-C Screening	83.16%	83.33%	80.56%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.05%	83.57%	87.73%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	26.29%	26.53%	26.39%	↔
Controlling High Blood Pressure	—	—	66.46%	Not Comparable
Immunizations for Adolescents—Combination 1	—	64.35%	81.02%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	42.82%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	21.55%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	63.57%	75.64%	71.76%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.26%	93.44%	87.96%	↓
Use of Imaging Studies for Low Back Pain	82.23%	82.98%	86.53%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	60.65%	76.16%	85.19%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	78.47%	80.56%	85.19%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	70.37%	72.69%	83.80%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	85.19%	84.95%	84.26%	↔

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

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

Table B.46—HEDIS 2013 Trend Table for Santa Clara Family Health Plan—Santa Clara County

Measure	2011	2012	2013	2012–13 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.77%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	—	35.89	34.79	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	—	292.77	267.45	Not Tested
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	87.18%	88.10%	↔
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	86.05%	87.60%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	84.85%	88.08%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	31.41%	25.81%	26.43%	↔
Cervical Cancer Screening	74.36%	71.29%	68.13%	↔
Childhood Immunization Status—Combination 3	79.40%	80.05%	73.72%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.22%	96.87%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	88.63%	88.90%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	89.69%	88.92%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	86.78%	87.81%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.70%	45.01%	53.53%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	51.52%	47.69%	41.85%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.38%	86.62%	86.62%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.41%	51.09%	55.47%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	51.28%	37.96%	42.82%	↔
Comprehensive Diabetes Care—LDL-C Screening	78.32%	81.02%	79.08%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.22%	80.05%	79.81%	↔
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)***	34.73%	40.88%	34.79%	↔
Controlling High Blood Pressure	—	—	52.80%	Not Comparable
Immunizations for Adolescents—Combination 1	—	69.34%	75.67%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	58.61%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	35.95%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	62.73%	58.39%	67.40%	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.56%	82.73%	82.97%	↔
Use of Imaging Studies for Low Back Pain	82.30%	80.37%	82.42%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	60.88%	64.23%	66.91%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	61.81%	63.99%	67.88%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	40.05%	45.74%	41.85%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.61%	75.67%	72.75%	↔

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

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

Appendix C. MEDI-CAL MANAGED CARE HEDIS 2013 AT-A-GLANCE PERFORMANCE SUMMARY

Table C.1 provides abbreviations used throughout Appendix C, which provides a summary of each full-scope MCP's performance.

Table C.1—HEDIS Performance Measures Name Key

Abbreviation	Full Name
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
CAP-1224	*Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months*
CAP-256	*Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years*
CAP-711	*Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years*
CAP-1219	*Children 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—HbA1c Poor 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, MPM-ACE, CBP, and MMA are not presented in the tables of this appendix because MPLs and HPLs were not applied to these measures in 2013.	

Tables C.2 and C.3 provide a summary of each full-scope MCP's rates for each measure relative to the DHCS-established MPLs and HPLs.

Table C.2—MCP Comparisons to DHCS's Minimum Performance Levels (MPLs) and High Performance Levels (HPLs)

Managed Care Plan Name	County	Total Measures Below MPLs	Total Measures at or Above HPLs
Alameda Alliance for Health	Alameda	6	2
Anthem Blue Cross Partnership Plan	Alameda	18	2
Anthem Blue Cross Partnership Plan	Contra Costa	16	1
Anthem Blue Cross Partnership Plan	Fresno	12	1
Anthem Blue Cross Partnership Plan	Kings	12	0
Anthem Blue Cross Partnership Plan	Madera	7	1
Anthem Blue Cross Partnership Plan	Sacramento	16	1
Anthem Blue Cross Partnership Plan	San Francisco	2	3
Anthem Blue Cross Partnership Plan	San Joaquin	16	1
Anthem Blue Cross Partnership Plan	Santa Clara	3	1
Anthem Blue Cross Partnership Plan	Stanislaus	9	0
Anthem Blue Cross Partnership Plan	Tulare	12	1
CalOptima	Orange	1	5
CalViva Health	Fresno	4	2
CalViva Health	Kings	9	0
CalViva Health	Madera	4	3
Care1st Partner Plan	San Diego	9	0
CenCal Health	Santa Barbara	1	3
CenCal Health	San Luis Obispo	4	1
Central California Alliance for Health	Merced	1	1
Central California Alliance for Health	Monterey/Santa Cruz	0	6
Community Health Group Partnership Plan	San Diego	1	2
Contra Costa Health Plan	Contra Costa	5	3
Gold Coast Health Plan	Ventura	10	0
Health Net Community Solutions, Inc.	Kern	15	1
Health Net Community Solutions, Inc.	Los Angeles	12	3
Health Net Community Solutions, Inc.	Sacramento	13	3
Health Net Community Solutions, Inc.	San Diego	9	3
Health Net Community Solutions, Inc.	Stanislaus	4	1
Health Net Community Solutions, Inc.	Tulare	3	1
Health Plan of San Joaquin	San Joaquin	3	1

Table C.2—MCP Comparisons to DHCS's Minimum Performance Levels (MPLs) and High Performance Levels (HPLs)

Managed Care Plan Name	County	Total Measures Below MPLs	Total Measures at or Above HPLs
Health Plan of San Mateo	San Mateo	1	2
Inland Empire Health Plan	San Bernardino/Riverside	1	2
Kaiser—Sacramento County	Sacramento	0	18
Kaiser—San Diego County	San Diego	0	21
Kern Family Health Care	Kern	4	0
L.A. Care Health Plan	Los Angeles	8	2
Molina Healthcare of California Partner Plan, Inc.	Sacramento	11	1
Molina Healthcare of California Partner Plan, Inc.	San Bernardino/Riverside	8	0
Molina Healthcare of California Partner Plan, Inc.	San Diego	6	2
Partnership HealthPlan of California	Marin	5	3
Partnership HealthPlan of California	Mendocino	5	2
Partnership HealthPlan of California	Napa/Solano/Yolo	4	3
Partnership HealthPlan of California	Sonoma	4	3
San Francisco Health Plan	San Francisco	3	12
Santa Clara Family Health Plan	Santa Clara	2	1

The following symbols are used in Table C.3 below:

- ● Measures below MPL
- ○ Measures at or above HPL

Table C.3—Medi-Cal Managed Care HEDIS 2013 Performance Summary

Managed Care Plan Name	County	AAB	CAP-1224	CAP-256	CAP-711	CAP-1219	CCS
Alameda Alliance for Health	Alameda	○	●	●	●	●	
Anthem Blue Cross Partnership Plan	Alameda	○	●	●	●	●	●
Anthem Blue Cross Partnership Plan	Contra Costa	○		●	●	●	●
Anthem Blue Cross Partnership Plan	Fresno		●	●	●	●	●
Anthem Blue Cross Partnership Plan	Kings		●	●			●
Anthem Blue Cross Partnership Plan	Madera	●					●
Anthem Blue Cross Partnership Plan	Sacramento		●	●	●	●	●
Anthem Blue Cross Partnership Plan	San Francisco	○					
Anthem Blue Cross Partnership Plan	San Joaquin	●	●	●	●	●	●
Anthem Blue Cross Partnership Plan	Santa Clara						●
Anthem Blue Cross Partnership Plan	Stanislaus			●	●	●	●
Anthem Blue Cross Partnership Plan	Tulare		●	●	●	●	
CalOptima	Orange						
CalViva Health	Fresno	○					
CalViva Health	Kings						●
CalViva Health	Madera		○				●
Care1st Partner Plan	San Diego		●	●	●	●	●
CenCal Health	Santa Barbara						
CenCal Health	San Luis Obispo	●	●	●			
Central California Alliance for Health	Merced	●					
Central California Alliance for Health	Monterey/Santa Cruz		○				
Community Health Group	San Diego						
Contra Costa Health Plan	Contra Costa	○	●	●	●	●	

Table C.3—Medi-Cal Managed Care HEDIS 2013 Performance Summary (continued)

Managed Care Plan Name	County	AAB	CAP-1224	CAP-256	CAP-711	CAP-1219	CCS
Gold Coast Health Plan	Ventura	●	●	●			●
Health Net Community Solutions, Inc.	Kern		●	●	●	●	●
Health Net Community Solutions, Inc.	Los Angeles	○	●	●	●	●	
Health Net Community Solutions, Inc.	Sacramento	○	●	●	●	●	●
Health Net Community Solutions, Inc.	San Diego	○	●	●	●	●	●
Health Net Community Solutions, Inc.	Stanislaus				●	●	●
Health Net Community Solutions, Inc.	Tulare					○	
Health Plan of San Joaquin	San Joaquin				●	●	
Health Plan of San Mateo	San Mateo	○				●	
Inland Empire Health Plan	San Bernardino/Riverside				●		
Kaiser—Sacramento County	Sacramento	○					○
Kaiser—San Diego County	San Diego		○	○	○	○	○
Kern Family Health Care	Kern		●	●	●	●	
L.A. Care Health Plan	Los Angeles	○	●	●	●	●	
Molina Healthcare of California Partner Plan, Inc.	Sacramento		●	●	●	●	●
Molina Healthcare of California Partner Plan, Inc.	San Bernardino/Riverside		●	●	●	●	●
Molina Healthcare of California Partner Plan, Inc.	San Diego	●				●	●
Partnership HealthPlan of California	Marin		○				
Partnership HealthPlan of California	Mendocino		●				●
Partnership HealthPlan of California	Napa/Solano/Yolo			●	●	●	
Partnership HealthPlan of California	Sonoma				●		
San Francisco Health Plan	San Francisco	○					
Santa Clara Family Health Plan	Santa Clara						

Table C.3—Medi-Cal Managed Care HEDIS 2013 Performance Summary (continued)

Managed Care Plan Name	County	CDC-H8	CDC-BP	CDC-LC	CDC-E	CDC-LS	CDC-N	CDC-H9	CDC-HT
Alameda Alliance for Health	Alameda								
Anthem Blue Cross Partnership Plan	Alameda	●	●	●	●	●	●	●	●
Anthem Blue Cross Partnership Plan	Contra Costa	●	●		●	●	●	●	●
Anthem Blue Cross Partnership Plan	Fresno	●			●				●
Anthem Blue Cross Partnership Plan	Kings	●		●	●		●	●	●
Anthem Blue Cross Partnership Plan	Madera								
Anthem Blue Cross Partnership Plan	Sacramento			●	●	●	●		●
Anthem Blue Cross Partnership Plan	San Francisco								
Anthem Blue Cross Partnership Plan	San Joaquin	●	●		●	●		●	●
Anthem Blue Cross Partnership Plan	Santa Clara								
Anthem Blue Cross Partnership Plan	Stanislaus				●	●			●
Anthem Blue Cross Partnership Plan	Tulare				●	●			●
CalOptima	Orange								
CalViva Health	Fresno		●						
CalViva Health	Kings	●	●	●	●			●	
CalViva Health	Madera					●			

Table C.3—Medi-Cal Managed Care HEDIS 2013 Performance Summary (continued)

Managed Care Plan Name	County	CDC-H8	CDC-BP	CDC-LC	CDC-E	CDC-LS	CDC-N	CDC-H9	CDC-HT
Care1st Partner Plan	San Diego				●				
CenCal Health	Santa Barbara	○			○				
CenCal Health	San Luis Obispo	○							
Central California Alliance for Health	Merced								
Central California Alliance for Health	Monterey/Santa Cruz								
Community Health Group	San Diego					○			
Contra Costa Health Plan	Contra Costa								
Gold Coast Health Plan	Ventura	●			●			●	
Health Net Community Solutions, Inc.	Kern	●	●		●			●	●
Health Net Community Solutions, Inc.	Los Angeles	●	●						●
Health Net Community Solutions, Inc.	Sacramento		●		●	●			●
Health Net Community Solutions, Inc.	San Diego		●						
Health Net Community Solutions, Inc.	Stanislaus				●				
Health Net Community Solutions, Inc.	Tulare		●		●				
Health Plan of San Joaquin	San Joaquin		○						
Health Plan of San Mateo	San Mateo			○					
Inland Empire Health Plan	San Bernardino/Riverside					○			
Kaiser—Sacramento County	Sacramento	○	○	○		○	○	○	○
Kaiser—San Diego County	San Diego	○	○	○	○	○	○	○	○
Kern Family Health Care	Kern								

Table C.3—Medi-Cal Managed Care HEDIS 2013 Performance Summary (continued)

Managed Care Plan Name	County	CDC-H8	CDC-BP	CDC-LC	CDC-E	CDC-LS	CDC-N	CDC-H9	CDC-HT
L.A. Care Health Plan	Los Angeles								
Molina Healthcare of California Partner Plan, Inc.	Sacramento					●			
Molina Healthcare of California Partner Plan, Inc.	San Bernardino/Riverside								
Molina Healthcare of California Partner Plan, Inc.	San Diego			○		○			
Partnership HealthPlan of California	Marin				●				
Partnership HealthPlan of California	Mendocino				●				○
Partnership HealthPlan of California	Napa/Solano/Yolo								
Partnership HealthPlan of California	Sonoma								○
San Francisco Health Plan	San Francisco	○		○			○	○	
Santa Clara Family Health Plan	Santa Clara		●		●				

Table C.3—Medi-Cal Managed Care HEDIS 2013 Performance Summary (continued)

Managed Care Plan Name	County	CIS-3	IMA-CO1	LBP	MPM-ACE	MPM-DIG	MPM-DIU
Alameda Alliance for Health	Alameda			○			●
Anthem Blue Cross Partnership Plan	Alameda			○	●		●
Anthem Blue Cross Partnership Plan	Contra Costa				●		●
Anthem Blue Cross Partnership Plan	Fresno			○	●		●
Anthem Blue Cross Partnership Plan	Kings						
Anthem Blue Cross Partnership Plan	Madera			●	●		●
Anthem Blue Cross Partnership Plan	Sacramento	●		○	●	●	●
Anthem Blue Cross Partnership Plan	San Francisco			○	●		●
Anthem Blue Cross Partnership Plan	San Joaquin				●		●
Anthem Blue Cross Partnership Plan	Santa Clara			○			
Anthem Blue Cross Partnership Plan	Stanislaus						
Anthem Blue Cross Partnership Plan	Tulare				●		●
CalOptima	Orange	○					
CalViva Health	Fresno			○	●	●	●
CalViva Health	Kings				●		●
CalViva Health	Madera				●		●
Care1st Partner Plan	San Diego			●	●		●

Table C.3—Medi-Cal Managed Care HEDIS 2013 Performance Summary (continued)

Managed Care Plan Name	County	CIS-3	IMA-CO1	LBP	MPM-ACE	MPM-DIG	MPM-DIU
CenCal Health	Santa Barbara	○				●	
CenCal Health	San Luis Obispo				●		
Central California Alliance for Health	Merced						
Central California Alliance for Health	Monterey/Santa Cruz	○		○			
Community Health Group	San Diego						
Contra Costa Health Plan	Contra Costa	○		○		●	
Gold Coast Health Plan	Ventura						
Health Net Community Solutions, Inc.	Kern				●	●	●
Health Net Community Solutions, Inc.	Los Angeles				●	●	●
Health Net Community Solutions, Inc.	Sacramento			○	●	●	●
Health Net Community Solutions, Inc.	San Diego				●	○	
Health Net Community Solutions, Inc.	Stanislaus			○			
Health Net Community Solutions, Inc.	Tulare				●		
Health Plan of San Joaquin	San Joaquin				●		
Health Plan of San Mateo	San Mateo						
Inland Empire Health Plan	San Bernardino/Riverside						
Kaiser—Sacramento County	Sacramento	○	○	○	○		○
Kaiser—San Diego County	San Diego	○	○	○	○		○
Kern Family Health Care	Kern						
L.A. Care Health Plan	Los Angeles				●	●	●

Table C.3—Medi-Cal Managed Care HEDIS 2013 Performance Summary (continued)

Managed Care Plan Name	County	CIS-3	IMA-CO1	LBP	MPM-ACE	MPM-DIG	MPM-DIU
Molina Healthcare of California Partner Plan, Inc.	Sacramento	●		○	●		●
Molina Healthcare of California Partner Plan, Inc.	San Bernardino/Riverside	●					
Molina Healthcare of California Partner Plan, Inc.	San Diego			●			
Partnership HealthPlan of California	Marin			○	●		●
Partnership HealthPlan of California	Mendocino	●		○			
Partnership HealthPlan of California	Napa/Solano/Yolo			○			●
Partnership HealthPlan of California	Sonoma			○	●	●	●
San Francisco Health Plan	San Francisco	○	○	○	●	●	●
Santa Clara Family Health Plan	Santa Clara			○			

Table C.3—Medi-Cal Managed Care HEDIS 2013 Performance Summary (continued)

Managed Care Plan Name	County	PPC-Pst	PPC-Pre	W34	WCC-BMI	WCC-N	WCC-PA
Alameda Alliance for Health	Alameda	●					
Anthem Blue Cross Partnership Plan	Alameda	●	●	●			
Anthem Blue Cross Partnership Plan	Contra Costa	●	●	●			
Anthem Blue Cross Partnership Plan	Fresno	●	●				
Anthem Blue Cross Partnership Plan	Kings	●		●			●
Anthem Blue Cross Partnership Plan	Madera	●	●		○		
Anthem Blue Cross Partnership Plan	Sacramento	●	●				
Anthem Blue Cross Partnership Plan	San Francisco						○
Anthem Blue Cross Partnership Plan	San Joaquin	●	●			○	
Anthem Blue Cross Partnership Plan	Santa Clara	●	●				
Anthem Blue Cross Partnership Plan	Stanislaus	●		●			
Anthem Blue Cross Partnership Plan	Tulare	●	●	●	○		
CalOptima	Orange		●	○	○	○	○
CalViva Health	Fresno						
CalViva Health	Kings	●					
CalViva Health	Madera		○	○			
Care1st Partner Plan	San Diego						

Table C.3—Medi-Cal Managed Care HEDIS 2013 Performance Summary (continued)

Managed Care Plan Name	County	PPC-Pst	PPC-Pre	W34	WCC-BMI	WCC-N	WCC-PA
CenCal Health	Santa Barbara						
CenCal Health	San Luis Obispo						
Central California Alliance for Health	Merced				○		
Central California Alliance for Health	Monterey				○	○	○
Community Health Group	San Diego	●			○		
Contra Costa Health Plan	Contra Costa						
Gold Coast Health Plan	Ventura			●		●	●
Health Net Community Solutions, Inc.	Kern	●	●			○	
Health Net Community Solutions, Inc.	Los Angeles	●	●			○	○
Health Net Community Solutions, Inc.	Sacramento	●			○		
Health Net Community Solutions, Inc.	San Diego	●	●				○
Health Net Community Solutions, Inc.	Stanislaus						
Health Net Community Solutions, Inc.	Tulare						
Health Plan of San Joaquin	San Joaquin						
Health Plan of San Mateo	San Mateo						
Inland Empire Health Plan	San Bernardino/Riverside				○		
Kaiser—Sacramento County	Sacramento	○			○	○	○
Kaiser—San Diego County	San Diego				○	○	○
Kern Family Health Care	Kern						
L.A. Care Health Plan	Los Angeles	●					○

Table C.3—Medi-Cal Managed Care HEDIS 2013 Performance Summary (continued)

Managed Care Plan Name	County	PPC-Pst	PPC-Pre	W34	WCC-BMI	WCC-N	WCC-PA
Molina Healthcare of California Partner Plan, Inc.	Sacramento	●	●				
Molina Healthcare of California Partner Plan, Inc.	San Bernardino/Riverside	●	●				
Molina Healthcare of California Partner Plan, Inc.	San Diego	●	●				
Partnership HealthPlan of California	Marin	●	●		○		
Partnership HealthPlan of California	Mendocino			●			
Partnership HealthPlan of California	Napa/Solano/Yolo	○			○		
Partnership HealthPlan of California	Sonoma				○		
San Francisco Health Plan	San Francisco			○	○	○	○
Santa Clara Family Health Plan	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.

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 the National Committee for Quality Assurance (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 & 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 American Medical Association (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.

DHCS

The Department of Health Care Services. 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. 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 Audit Finding

The auditor's final determination, based on audit findings, of the appropriateness of the health plan publicly reporting its Healthcare Effectiveness Data and Information Set (HEDIS) measure rates. Each measure included in the HEDIS audit receives a *Reportable*, *Small Denominator*, *Not Reportable*, or *Benefit Not Offered* audit finding.

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: 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, 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.

IPV

Inactivated poliovirus vaccine.

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.

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).

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.

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.

Member Months

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

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

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.